Research Article

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"If you and I and our Lord . . .": A qualitative study of religious coping in Hodgkin's disease

Archive for the Psychology of Religion
2021, Vol. 43(1) 3–20

DOI: 10.1177/0084672420983482
journals.sagepub.com/home/prj
SAGE

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Abstract

Religious coping and spiritual struggles were qualitatively analyzed in 15 semi-structured interviews with Norwegian Hodgkin's disease survivors. We asked, *How is religious coping expressed in 15 Norwegian Hodgkin's disease survivors?* The analyses were theory-driven, using religious coping and spiritual struggles theories as explorative tools. Especially we focused on coping processes, coping dynamics, coping styles, and coping activities. The analyses show that religiousness functioned as a positive factor in coping with cancer in 14 of the 15 participants, equally distributed as conservational and transformational coping. The combination of the belief in a good, present God, eventually positive divine power, accessible through prayer, and religious support from people around the participants, were the most prominent activities in the religious coping processes. The religious coping had a character of being collaborative for almost all of the participants. Many participants had severe spiritual struggles. For many of the participants, it was difficult not only to be sick, but also to be a survivor. Theories on religious coping and spiritual struggles were useful and adaptable to a Norwegian sample regarding the main dynamics in the religious coping and spiritual struggles processes. The analyses detected a few different religious coping activities in this Norwegian sample compared to those identified in American samples, with the importance of meeting God in nature as the most significant difference.

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Keywords
Cancer, Hodgkin's disease, qualitative methods, religious coping

Introduction

Religious coping

Religious coping is a phenomenon as old as religion itself (Koenig et al., 2012, p. 15). As an object of research in psychology of religion, it has developed enormously over the last two decades (Koenig et al., 2012; Pargament, 2003; Pargament & Abu-Raiya, 2007; Pargament et al., 2013). Here coping is understood as a multi-factorial and processual phenomenon. Religious coping has been defined as a "search for significance . . . in stressful times . . . in ways related to the sacred" (Pargament, 1997, p. 32; Pargament et al., 1998, p. 711).

The religious coping process consists of several key elements: stressors, appraisals of stressors and resources, orienting systems, coping activities, and results and final appraisals. Several religious coping activities have been identified, such as prayer, religious support, and religious reframing. In addition, four different religious styles for achieving control in coping have been identified: self-directing, deferring, collaborative, and petitionary (Pargament, 1997, p. 183).

Coping dynamics can follow two interdependent courses, conservation and transformation. Different religious coping activities have been placed in these two interdependent processes depending on whether they conserve the means and ends in the search for significance (preservation), transform the means and preserve the ends (reconstruction), preserve means and transform ends (revaluation), or transform both means and ends (recreation). In some studies, the different coping dynamics are simplified to conservation and transformation (Pargament, 2007, Chapters 5–6). This approach was also taken in this study.

Together with Exline, Pargament has extended the theory of religious coping by elaborating on a theory of spiritual struggles, a term which has largely replaced the term, negative religious coping (Abu-Raiya, Exline et al., 2015; Exline et al., 2014). Spiritual struggles can be understood in terms of three domains—divine, intrapsychic, or interpersonal struggles (Pargament, 2007, p. 213). The Religious and Spiritual Struggles Scale (RSSS) assesses struggles more finely in terms of six struggle subscales: Divine, Demonic, Interpersonal, Moral, Doubt, and Ultimate Meaning (Exline et al., 2014; Sedlar et al., 2018) and is tested in different cultural contexts (Abu-Raiya, Exline, et al., 2015; Abu-Raiya, Pargament, et al., 2015; Abu-Raiya et al., 2016).

Religious coping research

Religious coping has been studied through both quantitative and qualitative designs. Most research on religious coping consists of quantitative North American studies and has focused in particular on the implications of positive and negative religious coping (i.e. spiritual struggles) for health and well-being. The terms positive and negative coping are descriptive of the content of the coping. They do not "speak" to the longer term positive or negative impact of the coping methods, though studies do suggest that the two forms of religious coping are generally tied to positive and negative outcomes, respectively. Positive religious coping, for instance, has emerged as a robust predictor of stress-related growth (Prati & Pietrantoni, 2009), well-being over time among African Americans (Park et al., 2017), and mental health among members of diverse religious groups (Abu-Raiya & Pargament, 2015).

Quantitative studies of religious coping in other cultural contexts are less commonplace. Even so, they have begun to increase and have generally shown similar advantages and disadvantages to positive and negative religious coping, respectively. These include studies of Brazilian dialysis

patients (Vitorino et al., 2018), Danish lung disease patients (Pedersen et al., 2013), and Polish Roman Catholics (Zarzycka et al., 2017).

These quantitative studies have been supplemented by qualitative research, particularly within the European context (Ahmadi, 2006; Ekedahl, 2001; Ganzevoort, 1994; Lundmark, 2002, 2010, 2015, 2016a, 2016b). For further presentation of European and Scandinavian research, see Lundmark (2017, 2019). Together, these studies have enriched religious coping theory and research by underscoring the role of cultural context in shaping the forms and expressions of religious coping. To take just a few examples, Ahmadi (2013) conducted a qualitative research study of cancer patients in Sweden, most of whom approach their spirituality non-theistically, and found that for many, music was a key to their sacred connection and was intimately involved in their coping process. Pieper and Van Uden (2005) noted that Pargament's religious problem-solving scales assume an active God's involvement in the coping process. Noting the prevalence of more impersonal God views in Europe, they developed and tested another religious problem-solving style, a receptivity scale that takes a less active and more trusting approach to difficult situations.

Cancer-specific religious coping

A review of religious coping in individuals with medical conditions (Cummings & Pargament, 2010) included 18 cancer-specific studies, showing that cancer-specific religious coping is of importance to cancer patients and survivors in both European and American samples, and yields health outcomes similar to those associated with religious coping with other major life stressors. Specifically, the stresses associated with cancer can trigger an increased use of religious coping. Negative religious coping (i.e. spiritual struggle) is not frequent, but consistently tied to negative health outcomes. Positive religious coping is associated with higher quality of life, active coping, and the regulation of emotions (Cummings & Pargament, 2010; Homolka et al., 2018; King et al., 2018).

Religious methods of reframing illness through a positive spiritual lens appear to be a particularly important source of meaning to cancer patients (Sherman & Simonton, 2001). Religious coping with cancer is also associated with high levels of spiritual support. However, cancer patients and survivors have not received levels of pastoral or spiritual care commensurate with the importance they attach to it (Torbjørnsen et al., 2000).

Religiosity and religious coping in Hodgkin's disease survivors

Although there are several studies on Hodgkin's lymphoma and Hodgkin's disease survivors (see, for instance, Micozzi, 2006, and Heinz, 2005, for international reviews, and Abrahamsen, 1999, and Loge, 1999, for Norwegian studies), little attention is paid to Hodgkin's survivors' religiosity and religious coping, with a few exceptions. One study of a Norwegian sample (Torbjørnsen et al., 2000, reviewed in Micozzi, 2006, p. 103, and referred in Heinz, 2005, p. 231), showed little difference between Hodgkin's disease survivors' religiosity and that of the Norwegian population in general. A central finding was that cancer disease activates religiosity, and that religiosity may help patients cope with their disease (Torbjørnsen et al., 2000, p. 346). The present qualitative study is a follow-up on the assessment of *religious coping and spiritual struggles*.

Research question

How is religious coping expressed in 15 Norwegian Hodgkin's disease survivors? To answer this question, we focus specifically on coping processes, coping dynamics, coping styles, coping activities, and spiritual struggles. The focus on coping processes and dynamics sets this study apart from

the larger body of research in this area that has been primarily concerned with the distinction between positive and negative forms of religious coping and their implications for health and well-being.

Definitions

Coping process is the psychological coping process as described by Lazarus, Pargament, and others (Lazarus & Folkman, 1984; Pargament, 1997, pp. 90–127), with stressor(s); primary, secondary, and tertiary appraisals; orienting system; coping activities; outcome; and final evaluations of the process. *Coping dynamics* involve conservation and/or transformation of means and ends in the coping processes (Pargament, 1997, pp. 106–114). *Coping style* refers to the degree to which the coping processes are self-directing, deferring, collaborative, or petitionary (Pargament, 1997, pp. 180–183). *Coping activities* are religious activities of different kinds, used in the coping processes, such as prayer, religious support, church attendance, use of rituals, and religious reframing (Pargament, 1997, pp. 198–271). *Spiritual struggles* involve tensions, strains, and conflicts with respect to the divine, the interpersonal and/or the intrapersonal arenas (Exline et al., 2014, pp. 208–209). More specifically, these struggles can be operationalized in terms of divine, demonic, interpersonal, moral, doubt, and ultimate meaning struggles (Exline et al., 2014, p. 208).

Method

As the investigation of religious coping in Hodgkin's disease survivors is sparse, an exploratory qualitative approach with in-depth interviews is suitable (Kvale, 1996). The transcribed audio-recorded interviews were analyzed applying categories from Pargament's theory on religious coping and spiritual struggle as analytical tools to identify coping strategies, as defined under "Definitions" in the previous paragraph (process, stressors, dynamics, style, and activities). Fifteen participants were recruited randomly from a previous sample, which consisted of 107 Hodgkin's survivors in follow-up treatment at The Norwegian Radium Hospital (NRH) in Oslo (Torbjørnsen, 2011; Torbjørnsen et al., 2000). These respondents had on regular basis treatment and follow-up care at that hospital. Some days before the consultation, they were invited to be interviewed after this consultation. The first 10 who gave their consent, were included. When these 10 interviews were completed, we recruited additional participants from the survey, this time strategically in order to get more information about religious coping particularly among religiously active persons. Information about religious belief and activities could be deduced from the participants' responses in the first survey. When five such interviews were conducted, and the total reached 15, we found that the material had what Malterud et al. (2016) later have called satisfactory information power.

A semi-structured interview guide was used (Popp-Baier, 2003, p. 187) with the following themes: personal information, life story before the disease, religious history, their sickness history, and how they managed to cope with it. A successful first interview showed that the interview guide functioned as intended. The interview guide was followed largely in the first interviews, and more as a check-list in the following interviews to make sure that all themes were included. The interviews were conducted between November 1995 and May 1998 by the first author (except for one which was done by a colleague), audio-recorded, and transcribed by the first author.

All text in the transcripts was analyzed theory-driven using the following coping categories: *coping process, coping dynamics, coping style, coping activities*, and *spiritual struggles*. We have presented these categories above under "Definitions."

The study was approved by the Norwegian ethical authorities for medical research. We will show under "Discussion" that the findings are still relevant in 2020. The main researcher (first

author) is a hospital chaplain, not at the same hospital, but that might have affected the process. It is not an unusual situation that health personnel do research on patients, and transparency and reflexivity are needed to avoid undiscovered effects of the researcher and his or her profession and other characteristics (Palaganas et al., 2017). However, the material was analyzed and discussed together with others in the research group to diminish a possible researcher-effect.

Material

The 15 Hodgkin's disease survivors had received oncological treatment at NRH. At the time of the interviews, they were all medically followed up for relapse, side effects of the cancer or the treatment such as fatigue and insomnia, partly at NRH and partly at their local hospitals. Two of the survivors had a relapse.

Eight of the 15 survivors were women. Nine of the survivors were married, and nine had children. The age of the survivors ranged from early 20s to late 50s, with most in their 30s. All survivors came from Southern or Eastern Norway. With one exception, they were all living in cities or towns. Most had service occupations, and two were students. None reported an ethnic minority background. Only one participant, Yngve, reported that he could not remember details from his sickness period, because it was so long ago. The others remembered well what had happened. Nevertheless, it is important to stress that the material in this study does not reflect what had actually taken place during the sickness period, but the participants' recollections about their experiences.

Presentation of the participants' narratives

In the following, 13 of the participants' stories will be presented briefly. They differ in size and the ways they are present in accordance with how we understand the individuals' characteristics. The two last narratives will be presented in more detail to give thicker descriptions of two of the cases, which exemplify different ways of religious coping. We find it fruitful to study coping within a narrative context of the individuals' life history (Ganzevoort, 1998). Ideally, we could have given more room for all the participants' life stories; however, by lifting up and giving more space to two rich and interesting, yet very different life stories, this perspective is taken into account. All participants are given fictitious names, and the information is anonymized.

Thirteen brief narratives

Anna (female), in the middle of her 20s, was a teacher and mother to a preschool child when she received her diagnosis. She struggled with thoughts about her cancer and death anxiety, but believed that the God she knew from her upbringing was good, near, and strong and helped her to cope. When she at first thought that she would die, she found comfort in her belief that she would come to God in heaven after death. When the oncological treatment started to work, she thought about the oncological staff and treatment as worldly servants to God. Anna received strength from praying and being prayed for, and she experienced support from her family, pastor, and congregational friends through the treatment period. As a cancer survivor, she held on to the same God image as she had from her upbringing.

Bente (female), in her late 20s, was a psychiatric outpatient and mother to a young child. At first, she neglected her cancer and skipped oncological treatment. But the social services in her local community helped her to start on it. Her struggle with a harsh God, who would have sent her to hell if she died of cancer, motivated her to follow-up on her treatment. She also perceived the cancer as

a warning from God to start forgiving her father who had misused her sexually as a child. Both accepting treatment and forgiving her father changed her perception of herself, God, and others. Her religious coping and spiritual struggles gave Bente a new perspective on life; she had survived to take care of her daughter and father.

Eva (female) was a mid-30-year-old secretary. She had experienced several traumas, had gained new faith and hope from spiritually integrated psychotherapy, and believed that God loved her. When she developed cancer, members of her congregation had told her that the cancer was a punishment from God for her former sins. She could not believe that. Even so, the effort to hold on to her new faith in a loving God had been and was still a spiritual struggle. Eva also had a hard time fighting her death anxiety when new friends from the cancer youth group died. Nevertheless, she believed that God had given her support as a cancer survivor. She gained support from praying, taking part in services, and being together with friends and relatives.

Øyvind (male) was a mid-20s student in history of religion. He was not adequately diagnosed at first, so the treatment of his cancer was postponed by at least 1 year. Øyvind had neither faith in doctors nor in God, but instead used a secular coping strategy that had helped him going through treatment. God's existence was not rejected by Øyvind, but he did not need help from God or people because having cancer and taking treatment for it were not unmanageable experiences for him.

Grete (female) was a middle-aged community servant. She had experienced many life crises before she developed cancer. The cancer diagnosis was kind of a relief for Grete, because she believed she could survive it with the aid of the oncological staff and her deceased father who was her helper "on the other side." Cancer, she felt, helped her to gain more self-confidence and autonomy. She had changed her relationships to her spouse, family, and friends and gained strength through contact in prayer with her helper. Thus, Grete had found inner peace of mind amid the cancer treatment. Her perception of the Divine had changed from an impersonal power to a personal God whom she experienced as not only guiding and supportive, but also demanding. Her God had become much more like her father.

Yngve (male), in his mid-20s, was a warehouse worker who was well established as a survivor and bachelor. He could hardly remember details from the cancer incident because it was so long ago. He was in the middle of college, but had to quit because of the demanding treatment. He recovered after one and a half years, but did not see himself as a survivor. He had hardly appraised the cancer as deadly. On the contrary, the cancer incident was positive; it ended his turbulent youth and made him take his schoolwork seriously. The social worker at the hospital had helped him to get a job he liked. Yngve was not a convinced Christian, but he had relatives who were religious. Although he assumed that religious coping might have been a good strategy, he did not regard himself as a believer and did not report anything that we identified as religious coping. His cancer incident did not change his religious attitude.

Hilde (female), in her late 20s, had a relapse of cancer in the midst of her pregnancy and wanted to give birth to her child before the onset of chemotherapy again, so her child could survive. For that reason, she was hospitalized. When the child was born and well, Hilde took up chemotherapy again and recovered. She thanked God for the child and for her own survival. She needed psychotherapeutic help after what she had been through and had to fight with the hospital staff to get it. She did not conceptualize God in personal categories, but nevertheless, she thanked him for the medical treatment and his help. She started to pray on a daily basis, but she was convinced that she would not be a regular churchgoer.

Jorunn (female), a student in her late 20s, developed Hodgkin's disease as a teenager. She was the second in her family with that diagnosis. Her older brother was the first and he became jealous of Jorunn for "stealing" his illness. Jorunn had a difficult childhood with a mentally ill mother and an absent father. Her mother had been a member of two different Christian faith communities.

Jorunn remembered those periods as funny, mostly because there were a lot of children present at the gatherings. She had difficulties as a young adult to manage to resign from the latest community her family was member of, which had contributed to her opposition against it. She also was a member of The Church of Norway, a Lutheran majority Church, and she claimed that her religiosity had not been influenced by the mentioned communities. She did not trust people, but instead relied on God whom she thought of as impersonal, but still a good power who resided in and between people. Therefore, Jorunn experienced the staff and the treatment at the cancer hospital as divine. She was met with respect from people who had helped her regain her health, and the treatment and hospitalization had been a break from all of her other troubles and difficulties with her family. In this sense, the cancer incident had been a positive experience that held divine character.

Kari (female), in her late 40s, was a housewife who denied or suppressed the seriousness of her illness and did her best to avoid being affected by the situation. Kari had a sincere, conservative upbringing in an evangelical congregation. At the time she had cancer, she did not consider herself a devoted Christian. Not until she started to worry for her teenage daughter did she begin to pray and develop a personal relationship with God. Her religious coping capacity was then triggered; she prayed to God for help to stop smoking, and did so 3 weeks later.

Martin (male), in his early 30s, was a single carpenter who had a positive God image from his upbringing, which he kept through the cancer incident. He prayed more than usual when he became sick, and found it to be mentally supportive and helpful for coping with his cancer. It was unnecessary for him to go to church to have a praying relation to God. The cancer society's youth group served a kind of congregational function for him. After he had survived Hodgkin's disease, he helped other members of the group.

Nils (male), in his early 30s, was an engineer who became utterly afraid of dying when he developed Hodgkin's disease. He was afraid to die and leave his foreign wife alone in Norway. Praying for survival and then thanking God for it, made him move from a deistic/non-personal to a theistic/personal relationship with God.

Ole (male), in his mid-30s, was a trained nurse and a father of young children. He was treated for Hodgkin's disease 8 years before the interview and had always been very outspoken about the disease. His sister died in a car accident while he underwent chemotherapy and both the relapse and the loss of his sister resulted in death anxiety. He then changed his taken-for-granted belief from his upbringing that he would have gone to hell if he died without being a devoted Christian. His faith was changed, and he began to believe in a more supportive God he could cooperate with.

Arne (male), in his late 50s, was a factory worker and a devout Christian. He had a Christian upbringing amid severe family troubles, which he had passed on to his grown-up sons. He had experienced many difficulties of different kinds throughout his life. When he was diagnosed with cancer at the age of 50 and believed he could die, he was relieved. He thought he could escape his struggles and find a better life in heaven. Cancer was not the main issue in Arne's life. He had not "learned anything" from being sick, but he was very satisfied with the support he had received from his pastor and congregation while he was hospitalized.

Two thicker narratives

The stories of the two remaining persons, Ragnar (male) and Inger (female), will be presented in more detail to illustrate the coping dynamics in cancer survival.

Ragnar. *Ragnar* was in his mid-30s, and came from a rural district in the central eastern area of Norway. He was a forestry graduate and worked in forestry. He and his wife had two young children. He was interviewed immediately after he had been on half-yearly control at The NRH, 5 years after he received his second round of treatment for *lymphoma*.

Disease history. Ragnar soberly told a dramatic story about the lymphoma that he had received treatment for twice. His first treatment was very critical because he was seriously ill while newly married, not established in a new place, and with a sick, pregnant wife. But they got through it. At the end of chemotherapy treatment, Ragnar had a relapse. He needed treatment again, this time radiotherapy; fortunately, he survived the relapse too. At the time of the interview, he was back at work in forestry, living a normal family life and coming to control at The Radium Hospital every 6 months.

He told his disease history without mentioning God or faith a single time, even though he was sitting in the chaplain's office where the interview took place. He also knew that the researcher was a chaplain, doing research on cancer and faith, and that the interview would be about that topic.

Religious history. When asked about his upbringing, Ragnar noted that he was raised in a Christian family with parents who were active at the chapel in the nearby village. Christian faith was a natural part of his upbringing, but Ragnar did not like to go to services. He would rather hike in the woods with his dog. When he had to do military service, he realized he had to live a more active Christian life, and decided to read the Bible. It created a stir, but was nevertheless accepted by the others in his military barracks. Ragnar had a specific religious experience, a turning point. One night while serving as guard at an army exercise, he prayed to God to help him through the night. Ragnar sat alone outside in the snow where it was cold, dark, and nasty. Ragnar felt he received an answer from God, felt that God was with him, and so it continued throughout the military service. He managed well, felt an inner peace, and was content with life.

After this experience, Ragnar knew that he could "draw strength" from God. It came in handy when he developed cancer because he was afraid he would die away from his wife and children.

Ragnar and his wife prayed together while he was sick, and parents, in-laws, and relatives supported and prayed for him. Ragnar said that it had made a big impression on him.

As Ragnar worked with forestry and was often outdoors, he was asked if he thought he met God as much hiking in the woods as at meetings in the chapel. He said that maybe it was even more.

Ragnar imagined God as a caregiver with an infinite love. His relationship with God was like the barrel of Sarepta (1 Kings 17:7–16; Luke 4:26), it never went empty.

There were another two things Ragnar talked about concerning his faith; one was that he used to say he was a Christian when he came to new contexts. The other was that he had told the oncologist at the beginning of treatment that

> if you and I and our Lord cooperate, we'll manage.

And they had managed, Ragnar was still in good health 5 years after treatment, and was back to normal with work, family, and church life.

Ragnar's religious coping. Ragnar talked about effective coping with Hodgkin's disease. Ragnar had qualifications for "good" coping. He was in good physical shape. He emphasized this as an important condition to endure the treatment. But he was not only in good physical shape, his faith was transformed through religious coping activities.

Ragnar described three different religious coping activities. The first involved marking his religious boundaries (Pargament, 1997, p. 201) in relation to health personnel. Ragnar told the oncologist that he "was a Christian." Raised as he was in a religious family and active in a chapel environment, it had not been necessary for him in his childhood to make his mark as a Christian, but when he served in the armed forces, it became important.

On the question if he talked about his faith to the doctor or others, he answered,

Ragnar: Yes, it was after that year in the Forces, when I made up my mind and told the others, and made it clear that I was a Christian and wanted to go all in,—since then I have usually made it clear when I have started a new job or entered new environments, that this is who I am. That's ok for other people, so they will not come in an awkward position, and I know my position. So yes, I think it is ok to declare where I stand.

Ragnar brought with him this religious coping activity when he developed cancer.

A second religious coping activity was addressed directly to the disease. It also first occurred when Ragnar served in the armed forces and had a night watch: the feeling that God was present and with him (Pargament, 1997, pp. 208–209). It was prayer that mediated the divine presence and divine support.

Ragnar: Prayer is the best way of contact for me . . . I do not practice very much actual praying, outside of worship time, but I talk with God while I am walking around. I say that to my wife, too, I have always done that. That's maybe because I have had a lot of work where I have been on my own. Lumberjack with a chainsaw, not easy to combine with social contact (laughs). I was also a salesman and drove around a lot. As a forest planner, I spend a lot of time in the forest on my own, from Easter until November, every day. Then, you have to enjoy your own company, and in that type of work situation it is extremely important to me to be in contact with God, and that is part of my prayer life. Maybe a little bit weird, but that's how I do it (laughs).

I: Then we should ask you to say a little about God and nature, they seem to be closely linked for you? Maybe you have as good contact with God in the outdoors, as you have indoors in the church?

Ragnar: That is right, sometimes even better. There, I can be just myself, it is just me and God, and all the nice things He has created that surrounds us.

These two life situations, enduring in the armed forces and being diagnosed with cancer, with the threat of dying and leaving his wife and children, are very different life experiences. The first incident triggered religious coping skills that were tested and present when he developed cancer. For Ragnar, there was a very close relationship between the experience of God's direct presence and the support he had from spouse, family, and fellow believers (Pargament, 1997, pp. 210–212). These two religious coping activities had the same effect, they strengthened him.

This shows that Ragnar in his religious coping with cancer could draw both on the religious activities he has already established and maintain the religious significance he had before he became ill. His coping with cancer can be characterized as preservative. His image of God had not been changed, but rather consolidated.

The third of Ragnar's religious coping activities is his collaborative attitude both with God and the oncologist:

Ragnar: So, I told the doctor, I think it was quite early in the process, when I was introduced to the treatment plans and so on, that "if you and I and our Lord cooperate, we'll manage." I don't know what the doctor thought about that (laughs), but that is not important, it just lay there the whole time.

This is important for a functional religiosity facing secular society, in Ragnar's case oncological treatment. It could have been possible for Ragnar to mark his religious boundary and engage in religious coping alone, and thus say no to oncological treatment. He did not do so, probably because he shared the general confidence in the health care system that prevails in most religious communities in Norway. His religious coping worked in cooperation with other forms of coping in facing the disease, and so secured him greater latitude in dealing with the disease. This is also evident in

Ragnar's ability to express himself in both a secular medical language and in a religious one, his ability to phase-shift as the Swedish psychologist of religion, Hjalmar Sundén has called it (Holm & Belzen, 1995; Sundén, 1959). That this collaborative religious coping style also has other advantages is shown by Pargament (1997, pp. 180–183), namely, that this coping style is correlated with high frequency of prayer and intrinsic religious orientation. This description is also appropriate to Ragnar's religiosity. That this collaborative religious coping style occurs together with marking religious boundaries shows how complex and adaptable Ragnar's total religious coping was. He was able both to preserve his religion and interact with other understandings of reality through it.

Inger. *Inger*, a middle-aged woman, developed Hodgkin's disease in her late 20s. She had been striving to get education as an actress and had not been occupied with planning a family life as her friends had done. She experienced her diagnosis as the final confirmation of not being able to handle life. She received chemotherapy, but felt at first that it "did not work." So, Inger started to meditate and had an out of body experience.

> Inger: I felt that I needed to do my share of the job. I couldn't just lay my body down in front of a doctor and say "cure me!" That's not what it was like. So, I felt that I had to do my share to get well, and then the doctors would have to do theirs. I felt it was a combination. So, I worked a lot on my inner life, thoughts and memories and everything. Did quite a lot of meditation. Then I experienced, during some sort of meditation, that I came out of my body, I could see my own body from above. I looked down at it, and I could see other dimensions, that helped me. And what they did, was to transmit a kind of energy. There was something sitting on my sternum, that they were taking images of when I came to examination. Then they cooperated a lot, they were spirits, or some ancestors, there were several of them. So, they helped, and I felt a physical pain in that area. I was outside the body and in it, at the same time. And when I came to my senses after some time, I could recall the pain in my chest by imagining the experience. Meditate, think, put myself in a kind of silent mood and see. For a long time afterwards, I did that daily. Something inside me understood that this is important, I have to use this. So, every day, when I did this, I felt the same pointed pain in my chest. I did that several times every day, because I was sure that now, something happens.—Then I came in for my next examination, and first, images were taken. That was when he (the doctor) was about to implement the treatment. At last, he said: "There he is! Now we can see improvement, at last." And from then on everything worked, chemotherapy and everything.

At that point, she felt that the treatment started to work. After a while, she perceived the onset of cancer as a divine intervention to change her life plan. After ending treatment, she constructed a whole new lifestyle. She abandoned her unsuccessful career as an actress and began to give lectures and seminars to other cancer patients on how they could use their creativity in the coping process. With a secularized upbringing, she did not perceive herself as a Christian, but found inspiration in Eastern religiosity and meditation. However, aware of her Christian heritage, she used the Paternoster as a mantra. It is considered typically Norwegian to "find God in nature" and not have to go to church for that purpose, but not so with Inger. She loved churches, because she "found" God there. Even so, she preferred the churches empty, without services and clergy.

Inger's religious coping. Inger understood the divine as a non-personal category that could be reached through meditation, prayer, and contemplative church visits.

> Inger: I used to sing in a choir when I was a child, it was not a Christian choir, but we did had concerts for Christmas, a lot of concerts in churches. So, I am used to churches, the sanctuary spaces, church music. I love church music. Today I still love churches, but I prefer that they are empty.

I would rather not hear priests and words, I want to hear music. Experiencing the silent churches is the best I know. That, and being outdoors, in nature. If I travel down in Europe, for example, I find it very convenient, since the churches are always open. Then I normally go inside, and sit for a while

I: So, can you address God directly, so to speak?

Inger: Yes, a silent moment with meditation, with prayer, whatever, or just sit in silence. Then I feel . . . because I can feel the difference. Sometimes I feel the direct contact easily, other times, it is mute, and interrupted.

I: It sounds like architecture sometimes may play a role?

Inger: Yes, it can be several things. But I feel that the easiest way to get into contact with what I believe in, God, or something—yes, that is not outdoors in nature. It is in churches, mainly.

While sick, she changed her life totally. She changed career plans when she developed the disease, and she had good emotional and cognitive coping. Inger felt that her general coping worked well. For her, meditation and prayer were necessary prerequisites to be physically healthy. General and religious coping could not be separated from each other in Inger's case, because the mundane coping was conveyed by religious meditation as a channel for spiritual support from the divine.

Inger's re-creational religious coping could be described as a conversion, a change of both religious means (meditation and prayer) and ends (contact with the divine) and was essential both for cancer coping and for her whole life development.

Inger: When I was ill, I did a lot of meditation, I learned how to relax and to meditate. And then it has expanded. Like when you combine meditation and prayer, they somewhat integrate. Meditation is not just relaxation to me, meditation is something spiritual to me, a contact with God and with something inside me, that is greater than myself, or how I should put it. And it is important. It adjusts me the whole time, the schedule of my life. My direction has changed a lot after I became ill.

Findings—religious coping strategies

Religious coping

When analyzing the narratives by means of Pargament's religious coping dynamics, we found that religiosity functioned as a way of coping with cancer in 14 of the 15 participants. Except for Øyvind, who reported no form of religious coping, the psychological coping processes as described in the psychology of religion and coping literature were visible in all of the interviews. This is evident in spite of different God images, life orientations, and denominational affiliations among the participants. Participants also differed in terms of whether the cancer was their only stressor. Four participants (Anna, Martin, Nils, and Øyvind) reported Hodgkin's disease as their only stressor, the other 11 had multiple stressors including relational problems, divorce, poor mental health, other diseases, death of family members, road accident, smoking, worries about children, pregnancy amid the Hodgkin's disease, turbulent youth, and alcoholism of the spouse. The significance of Hodgkin's disease was appraised in the context of their other stressors. The religious coping activities used by the participants were marking boundaries; spiritual support, both directly from the divine (both prayer, meditation and divine presence both in churches and in nature) and mediated through other people, both pastors, family (both living and dead), friends, hospital chaplains, and medical staff members; and spiritual support from religious literature, religious reframing, religious forgiving, giving religious support, and religious switching (changing groups).

Six of the participants, Ole, Eva, Anna, Bente, Inger, and Nils, had spiritual struggles understood in the threefold sense, and seven, the before mentioned plus Grete, reported spiritual struggles as operationalized in the RSSS (Exline et al., 2014).

Conservation

Religious coping was a dynamic process of conservational character for six of the participants (Anna, Grete, Ragnar, Eva, Yngve, and Arne). They made use of the same kinds of coping methods both of religious and non-religious character that they had used before they developed cancer. The combination of their belief in a good, present God, eventually positive divine power, accessible through prayer, and religious support from people around them were the most important elements in the religious coping processes. Along with behavioral and emotional help to the participants, these elements enabled them to come through both the disease and the time after. To be ill did not change what they held to be of significance or the way they hold on to it.

Transformation

For eight of the participants (Ole, Jorunn, Martin, Bente, Inger, Hilde, Kari, and Nils), being sick challenged their beliefs and values, and led to changes in what was significant for them and/or the ways they could reach it. Their religious coping was a dynamic, transforming process. Some experienced a dramatic change in their beliefs and view of life/orienting system.

Collaboration

All of the 14 participants who reported religious coping had a collaborative style; that is, they saw religious coping as a cooperative process or partnership between themselves, the oncological treatment (and the oncological staff), and God/the divine force that they believed in. Oncology, alternative treatment, and traditional religious coping methods such as prayer were not seen as competing, but rather complementary coping approaches to cancer.

As Ragnar had told the oncologist, “If you and I and our Lord cooperate, we’ll manage.”

We must add, though, that Arne’s story is atypical. He said that receiving the cancer diagnosis was appraised as a relief, because dying and going to heaven was a better perspective than continuing with his burdened life. His lifelong faith in God and an afterlife gave trust and hope, not for surviving, but for escaping from his sorrows.

Surviving

For some of the participants, it was difficult not only to be sick but also to be a survivor. Therefore, both the illness and being survivor represented challenges for religious coping.

This was the case both with Inger and Grete who felt compelled to create a new lifestyle after they recovered.

Discussion

The study exemplifies that as important and stressful as Hodgkin’s disease is, it can be accompanied by several other stressors and together these stressors are appraised according to their potential impact on what people hold significant.

It may be tempting to believe that people who have had Hodgkin’s disease would experience their cancer as their dominant stressor, both while they were ill and after they had survived. Although four participants described Hodgkin’s disease as their sole stressor, the other participants voiced other concerns, which sometimes in their opinion represented more severe stressors than Hodgkin’s disease.

Hodgkin's disease as a stressor was therefore for most of the participants appraised in a context of stressors that required multiple ways of coping. How important Hodgkin's disease was in the overall picture often fluctuated.

Religious coping functions as both a source of conservation and transformation

These two dynamics are not often examined in religious coping studies, but both dynamics were apparent in this study. That these two dynamics operate interdependently is also very clear in the reports of several of the participants. When means and/or ends are transformed, the new significance is conserved.

The religious coping activities used by the participants were mainstream, general religious phenomena transformed to religious coping devices. Mostly, there was cultural resemblance between the Norwegian religious coping activities and those reported in American samples (Pargament, 1997), but with a greater emphasis on meeting God in nature than normally recounted in American samples. The analyses show that Pargament's theory is adaptable also to a Norwegian sample regarding the main dynamics in the religious coping processes. The analyses detect fewer different religious coping methods than those identified in Pargament's dominantly American samples. One of these involves support from God mediated by nature as for instance Ragnar told. This is also reported among people with cancer from Sweden (Ahmadi, 2006, p. 133f). Some coping methods, especially the use of rituals, have a different coping dynamic (viz. conservational) than found in American studies. Furthermore, these analyses show that "negative religious coping" has to be differentiated (as Pargament has done in later studies) to be used meaningfully in this study. The concept of spiritual struggles (Cummings & Pargament, 2010, p. 42; Exline & Rose, 2005) can do so. The concept of spiritual struggles (Pargament, 2009) is important in this study. Many of the participants described an interpersonal religious struggle, intrapsychic religious struggle and/or struggles with their image of God. Depending on the outcome of the religious spiritual struggle (Pargament, 2009, pp. 220–221), it can lead to positive religious coping or further negative religious coping. This modifies the dichotomy between positive and negative religious coping as constructs (Pargament et al., 1998).

The resemblance between religious coping in this Norwegian material and corresponding North American materials might not be explained merely sociologically, taken into account that many mainstream religious traditions in North America are inherited not only from Europe but also through the psychology of religion. The idea that the religious person and God can be partners in an I–you relationship suggests that there is an inner resemblance between Norwegian and American mainstream religious copers. In both groups, a partnership with God may grow out of a desire for greater mastery, intimacy, and emotional security in their lives (Pargament et al., 1988). This collaborative relationship may also give rise to experiences of the presence of God or religious activities like prayer.

Knowledge of religious coping is of importance both for health professionals and members of the pastoral disciplines. Religious coping was clearly linked to health not only in this study but also in many other studies (Koenig et al., 2012). Thus, it is important for health professionals to be aware of the deep meaning of both religious coping and spiritual struggles. Chaplains and others from the pastoral disciplines should draw on evidence-based knowledge to communicate better with the medical staff about the importance of religious coping related to cancer. Together these helpers can contribute to the empowerment of cancer patients and survivors.

As we have described, there is a body of research on religious coping in the Nordic countries. M. Lundmark has produced several interesting research reports with a basis in rural Sweden, with

respondents that are based in a more conservative Christian environment. This makes them in some respects similar to North American respondents with their church-based coping, and it sets them somewhat apart from the respondents in our study with Norwegian respondents, whose religiosity is of a more mainline, Lutheran character (Lundmark, 2017, 2019). But despite a growing body of psychology of religion research in Norway, and increasing interest in religion as a theme in other research settings, there has not been much research on religious coping in Norway. Therefore, more research is needed, both quantitatively and qualitatively. Spiritual struggles and the importance of God images for cancer survivors are just two of many possible topics for further research. Religious coping should be studied further in the Norwegian context.

Although the data are now over 20 years old, we find it still highly relevant and interesting for international publication. Core religious processes such as those of interest to William James (e.g. mysticism, conversion) and religious coping have been evidenced in religious literature for hundreds of years. They can certainly be found within the scriptures of major religious traditions. Thus, these phenomena are not likely to be ephemeral or of passing interest. Certainly, the nature of the life stressors people are facing may vary over time, as illustrated by the prominence of religious coping with modern trauma such as terrorism, climate change, or pandemics. However, we believe that the challenges elicited by major medical illnesses like cancer as well as the religious ways of understanding and dealing with these challenges are likely to be relatively stable over time, a notion supported by more recent Scandinavian studies (Pedersen et al., 2013).

In this regard, the present study contributes to the ongoing research on religious and spiritual coping in times of illness and other adversity, and thus, it adds to the growing field of coping-related research also performed in Scandinavia (Ahmadi, 2006, 2013; Lundmark, 2017). As mentioned initially, this study also stands out by the focus on coping processes and dynamics and not only on the distinction between positive and negative religious coping and possible health implications. The present study has been referred to in different other studies (e.g. Lundmark, 2017), but has so far only been available for scholars who read a Scandinavian language. Thus, we find international publishing valuable for further research on religious coping.

Strengths and limitations of the study

Strengths. One strength of the present study is that it shows that religiosity can appear as a coping factor among Hodgkin's disease survivors. Another strength is that it offers new information about religious coping outside of the American context and points at possible differences and similarities between Norwegian and American religious coping. A third strength is that the study is conducted with participants with a specific cancer diagnosis in a specific stage.

Limitations. One limitation of this study is that it does not provide gender-specific analysis. Even though Hodgkin's disease is not gender specific, it is possible that there are important differences in religious coping as a function of gender. Gender-specific analyses in cancer studies were conducted in a Danish qualitative study (Jacobsen et al., 1998) and a Swedish one (Ahmadi, 2006, p. 173) showing different reactional patterns between men and women. Furthermore, it can be argued that the problem of the retrospective methodology, including problems in recall, interference, and potential bias or distortion in memories can limit the study's reliability. It must be underlined that the stories in the material present the participants' interpreted narratives of how they understood their sickness history and coping dynamics at the time when they were interviewed. The qualitative design does of course not allow for generalizations. However, the

purpose of this study has not been to quantify and show significant associations, but to qualitatively explore religious coping dynamics in a group of individuals who have survived a potentially life-threatening diagnosis. Thus, insights from this project may be transferable (external validity) and recognizable (Konradsen et al., 2013) and useful in other contexts. It would be of great interest to examine these dynamics among people closer to the time of initial diagnosis and over the course of their illness, treatment, and recovery.

Conclusion

We have showed by means of qualitative methods how 15 Hodgkin's disease survivors reported religious coping. Important diversity among the Norwegian participants was detected regarding life history, how Hodgkin's disease functioned as a stressor, and how other stressors interacted and made the strategies of coping complex. We find the complexity and the different dynamics in religious coping in this study comparable with other descriptions of religious coping obtained from other cultures, and through the application of different methodological approaches.

This can indicate that the concept of religious coping is transferable from its primary North American cradle, as also shown in other Scandinavian studies (Ekedahl, 2001; Lundmark, 2017). At least, the religious coping theory has been useful for us to understand the importance of religiosity for many of the 15 cancer survivors in this study, and how they dealt with their life-threatening situations. Particularly, their life stories and total life situations, as well as their relationships with family, friends, and for some also health personnel, formed a significant context for their religious coping, both the coping process and its outcome.

Religious coping can be identified as a dynamic process in this group. Does that mean that there are basic similarities among humans as we encounter pain and suffering? Are our mental resources, including spiritual resources, used in similar ways by many of us? It is easy to identify cultural and religious variations between this Norwegian sample and American studies (Pargament, 2007). For example, North Americans (which also is a very diverse population) seem to do religious coping in more church-based and urban ways, whereas Norwegians, at least those we interviewed, tend to link their religious coping more to experiences with and in nature. Both historical and geographical conditions may be thought of as possible reasons for such differences. The design of this study does not allow for general conclusions. However, it is possible to suggest that the religious coping theory is a valuable tool for exploring the role of religiosity in stressful times, not only in spite of different cultural contexts but within and in interactions with these contexts.

Acknowledgements

Parts of this manuscript have been previously published in Tor Torbjørnsen's PhD thesis in Norwegian: Torbjørnsen, T. (2011). *"Gud hjelpe meg!": religiøs mestring hos pasienter med Hodgkins sykdom: en empirisk, religionspsykologisk studie*, Oslo: MF Norwegian School of Theology, Religion and Society.

Declaration of conflicting interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: Thanks to Innlandet Hospital Trust, Norway, and The Norwegian Cancer Society for funding.

References

Abrahamsen, A. F. (1999). *Clinical studies in Hodgkin's disease. With special reference to treatment results and medical and psychosocial sequels* [Thesis, University of Oslo].

Abu-Raiya, H., Exline, J. J., Pargament, K. I., & Agbaria, Q. (2015). Prevalence, predictors, and implications of religious/spiritual struggles among Muslims. *Journal for the Scientific Study of Religion*, *54*(4), 631–648.

Abu-Raiya, H., & Pargament, K. I. (2015). Religious coping among diverse religions: Commonalities and divergences. *Psychology of Religion and Spirituality*, *7*, 24–33.

Abu-Raiya, H., Pargament, K. I., Krause, N., & Ironson, G. (2015). Robust links between religious/spiritual struggles, psychological distress, and well-being in a national sample of American adults. *American Journal of Orthopsychiatry*, *85*(6), 565–575.

Abu-Raiya, H., Pargament, K. I., Weissberger, A., & Exline, J. (2016). An empirical examination of religious/spiritual struggle among Israeli Jews. *The International Journal for the Psychology of Religion*, *26*(1), 61–79.

Ahmadi, F. (2006). *Culture, religion and spirituality in coping. The example of cancer patients in Sweden*. Uppsala Universitet.

Ahmadi, F. (2013). Music as a method of coping with cancer: A qualitative study among cancer patients in Sweden. *Arts and Health*, *5*, 152–165.

Cummings, J., & Pargament, K. I. (2010). Medicine for the spirit: Religious coping in individuals with medical conditions. *Religions*, *1*, 28–53.

Ekedahl, M. (2001). *Hur orkar man i det svåraste? Copingprocesser hos sjukhussjälavårdare i möte med existentiell problematik. En religionspsykologisk studie* [Coping processes among hospital chaplains confronting existential issues. A psychology of religion study]. Uppsala Universitet.

Exline, J. J., Grubbs, J. B., Pargament, K. I., & Yali, A. M. (2014). The Religious and Spiritual Struggles Scale: Development and initial validation. *Psychology of Religion and Spirituality*, *6*(3), 208–222.

Exline, J. J., & Rose, E. (2005). Religious and spiritual struggles. In: R. F. Paloutzian & C. L. Parks (Eds.), *Handbook of the psychology of religion and spirituality* (2nd ed., pp. 380–398). Guilford.

Ganzevoort, R. R. (1994). *Een Cruciaal Moment. Functie en verandering van geloof in een crisis* [A crucial moment. Function and change of belief in a crisis]. Proefschrift aan de Universiteit Utrecht, Boekencentrum.

Ganzevoort, R. R. (1998). Religious coping reconsidered, part two: A narrative reformulation. *Journal of Psychology and Theology*, 26(3), 276–286.

Heinz, B. C. (Ed.). (2005). *Trends in Hodgkin's disease research*. Nova.

Holm, N. G., & Belzen, J. A. (Eds.). (1995). *Sundén's role theory—An impetus to contemporary psychology of religion* (Religionsvetenskapliga skrifter nr 27). Åbo Akademi.

Homolka, S. J., Exline, J. J., Wilt, J. A., & Pargament, K. I. (2018). Religious and spiritual struggles among adolescents. In B. D. Espinoza, J. R. Estep, Jr., & S. Morgenthaler (Eds.), *Story, formation and culture. From theory to practice in ministry with children*. Pickwick. 253–270

Jacobsen, B., Jørgensen, S. D., & Jørgensen, S. E. (1998). *Kræft og eksistens—om at leve med kræft* [*Cancer and existence—On living with cancer*]. Dansk Psykologisk Forlag.

King, S. D., Fitchett, G., Murphy, P. E., Rajaee, G., Pargament, K. I., Loggers, E. T., & Johnson, R. H. (2018). Religious/spiritual struggle in young adult hematopoietic cell transplant survivors. *Journal of Adolescent and Young Adult Oncology*, *7*(2), 210–216.

Koenig, H. G., King, D. E., & Carson, V. B. (2012). *Handbook of religion and health* (2nd ed.). Oxford University Press.

Konradsen, H., Kirkevold, M., & Olson, K. (2013). Recognizability: A strategy for assessing external validity and for facilitating knowledge transfer in qualitative research. *Advances in Nursing Science*, *36*(2), E66–E76.

Kvale, S. (1996). *Interviews: An introduction to qualitative research inquiry*. SAGE.

Lazarus, R. S., & Folkman, S. (1984). Coping and adaptation. In W. D. Gentry (Ed.), *The handbook of behavioral medicine* (pp. 282–325). Guilford.

Loge, J. H. (1999). *Health-related quality of life in Hodgkin's disease survivors—Methodological and clinical issues* [Thesis, University of Oslo/Norwegian Cancer Society].

Lundmark, M. (2002). *Bön och cancer. En religionspsykologisk studie av bönens uttryck och funktion hos cancersjuka troende kristna* [Prayer and cancer. A psychology of religion study, expression and function of prayer in Christian cancer patients]. Examensarbete, Religionsvetenskap. Institutionen för Religionsvetenskap, Umeå universitet. http://www8.umu.se/religion/personal/mikael.lundmark/

Lundmark, M. (2010). When Mrs. B met Jesus during radiotherapy—A single case study of a Christic vision—Psychological prerequisites and functions and considerations on narrative methodology. *Archive for the Psychology of Religion*, *32*(1), 27–68.

Lundmark, M. (2015). Religious objects and the coping process. *Archive for the Psychology of Religion*, *37*(1), 54–83.

Lundmark, M. (2016a). Sanctification of health care interventions as a coping method. In D. O. Moberg & M. Lynn (Eds.), *Research in the social scientific study of religion* (Vol. 27, pp. 1–23). Brill.

Lundmark, M. (2016b). Suffering for others as religious meaning-making: Varieties, prerequisites, and functions in the coping process of a sample of practicing Christians living with cancer. *Mental Health, Religion & Culture*, *19*(6), 522–537.

Lundmark, M. (2017). *Religiositet och coping. Religionspsykologiska studier av kristna med cancer* [Religiosity and coping: Studies in psychology of religion of Christians living with cancer] [Doctoral thesis, Umeå University].

Lundmark, M. (2019). The Bible as coping tool: Its use and psychological functions in a sample of practicing Christians living with cancer. *Archive for the Psychology of Religion*, *41*(2), 141–158.

Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample size in qualitative interview studies: Guided by information power. *Qualitative Health Research*, *26*(13), 1753–1760.

Micozzi, M. S. (Ed.) (2006). *Complementary and integrative medicine in cancer care and prevention: Foundations and evidence-based interventions*. Springer Publishing Company.

Palaganas, E. C., Sanchez, M. C., Molintas, V. P., & Caricativo, R. D. (2017). Reflexivity in qualitative research: A journey of learning. *Qualitative Report*, *22*(2), 426–438.

Pargament, K. I. (1997). *The psychology of religion and coping—Theory, research, practice*. Guilford.

Pargament, K. I. (2003). God help me: Advances in the psychology of religion and coping. *Archiv fur Religionpsychologie*, *24*, 48–63.

Pargament, K. I. (2007). *Spiritually integrated psychotherapy*. Guilford.

Pargament, K. I. (2009). The spiritual dimension of coping: Theoretical and practical considerations. In M. de Souza, L. J. Francis, J. O'Higgins-Norman, & D. G. Scott (Eds.), *International handbook of education for spirituality, care and wellbeing* (pp. 209–230). Springer Science + Business Media.

Pargament, K. I., & Abu-Raiya, H. (2007). A decade of research on the psychology of religion and coping: Things we assumed and lessons we learned. *Psyke & Logos*, *28*(2), 742–766.

Pargament, K. I., Falb, M., Ano, G., & Wachholtz, A. (2013). Religion and coping. In R. Paloutzian & C. Park (Eds.), *Handbook of psychology of religion and spirituality* (pp. 560–579). Guilford.

Pargament, K. I., Kennell, J., Hathaway, W., Grevengoed, N., Newman, J., & Jones, W. (1988). Religion and the problem-solving process: Three styles of coping. *Journal for the Scientific Study of Religion*, *27*, 90–104.

Pargament, K. I., Smith, B. W., Koenig, H. G., & Perez, L. (1998). Patterns of positive and negative religious coping with major life stressors. *Journal for the Scientific Study of Religion*, *37*(4), 710–724.

Pedersen, H. F., Pargament, K. I., Pedersen, C. G., & Zachariae, R. (2013). Religious coping and quality of life among severely ill lung patients in a secular society. *International Journal for the Psychology of Religion*, *23*(3), 188–203.

Pieper, J., & van Uden, M. (2005). *Religion and coping in mental health care*. Rodopi.

Popp-Baier, U. (2003). Qualitative Methoden in der Religionspsychologie [Qualitative Methods in the Psychology of Religion]. In C. Henning, S. Murken, & E. Nestler (Eds.), *Einführung in die Religionspsychologie* [*Introduction to the Psychology of Religion*] (pp. 184–229). Ferdinand Schöningh.

Prati, G., & Pietrantoni, L. (2009). Optimism, social support, and coping strategies as factors contributing to posttraumatic growth: A meta-analysis. *Journal of Loss and Trauma*, *14*:, 364–388.

Sedlar, A., Stauner, N., Pargament, K., Exline, J., Grubbs, J., & Bradley, D. (2018). Spiritual struggles among atheists: Links to psychological distress and well-being. *Religions*, *9*(8), 242.

Sherman, A., & Simonton, S. (2001). Religious involvement among cancer patients. Associations with adjustment and quality of life. In T. G. Plante & A. G. Sherman (Eds.), *Faith and health. Psychological perspectives* (pp. 167–194). Guilford.

Sundén, H. (1959). *Religionen och rollerna* [Religion and the Roles]. Verbum. (German translation (1966) Die Religion und die Rollen. Alfred Töpelmann).

Torbjørnsen, T. (2011). *Gud hjelpe meg!": religiøs mestring hos pasienter med Hodgkins sykdom: en empirisk, religionspsykologisk studie* [God help me!" : Religious coping in patients with Hodgkin's disease. An empirical psychology of religion study]. [Doctoral thesis, MF].

Torbjørnsen, T., Stifoss-Hanssen, H., Abrahamsen, A. F., & Hannisdal, E. (2000). Kreft og religiøsitet—en etterundersøkelse av pasienter med Hodgkins sykdom [Cancer and religiosity. An investigation among Hodgkin's disease survivors]. *Tidsskr Nor Lægeforen*, *120*, 346–348.

Vitorino, L. M., Soares, R. D. C. E. S., Santos, A. E. O., Lucchetti, A. L. G., Cruz, J. P., Cortez, P. J. O., & Lucchetti, G. (2018). Two sides of the same coin: The positive and negative impact of spiritual religious coping on quality of life and depression in dialysis patients. *Journal of Holistic Nursing*, 36(4), 332–340.

Zarzycka, B., Rybarski, R., & Sliwak, J. (2017). The relationship of religious comfort and struggle with anxiety and satisfaction with life in Roman Catholic Polish men: The moderating effect of sexual orientation. *Journal of Religion and Health*, *56*, 2162–2179.