Do Religion and Spirituality Influence Coping in End-Stage Emphysema Patients?

COPD is a chronic and progressive disease associated with poor quality of life and an increased risk of psychological distress.[1] While the physical and psychosocial impact of end-stage lung disease has been evaluated, few studies have explored the influence of religious and spiritual coping on these domains, or how they affect outcomes. Most of the research on end-stage lung disease and religious and spiritual coping has been conducted with patients awaiting lung transplantation, and included patients with cystic fibrosis as well as COPD. The cystic fibrosis population was found to be distinct from the COPD population on a variety of measures, including coping styles.[2] However, patients with COPD in those studies may have had a similar illness severity to the subjects included in the research by Green et al in this issue of RESPIRATORY CARE,[3] as the mean percent-of-predicted FEV_1 in the study by Green et al was $< 25\%$.

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The paper by Green et al[3] is a welcome addition to the religious and spiritual coping literature, with a focus on COPD patients sampled from the National Emphysema Treatment Trial. Green et al reviewed the use of religious and spiritual coping and general coping strategies in 40 patients at baseline, and at 2-year follow-up, to determine whether there was an association between religious and spiritual coping and measures of pulmonary function, psychological well-being, and quality of life. A comparison sample of healthy subjects was also included. The results are interesting because of their deviation from previous studies on religious and spiritual coping in illness and end-stage lung disease.

Contrary to previous literature, in the study by Green et al[3] religious and spiritual coping was not associated with psychological functioning (positive or negative), at baseline or follow-up. Poorer disease-specific quality of life was associated with religious and spiritual coping at baseline, but quality of life did not predict religious and spiritual coping at 2-year follow-up. Unfortunately, Green et al used different measures of religious and spiritual coping at baseline and follow-up, which makes comparisons of time-by-group interaction difficult. Only the Brief COPE questionnaire, with 2 items on religion, was used in the baseline assessment, whereas a more comprehensive assessment was conducted at follow-up, with the Brief Religious Coping Questionnaire and the Brief Multidimensional Measure of Religion and Spirituality. This issue also makes it difficult to compare other studies, because the definitions and measures of spirituality and religion have often differed between studies.

However, taking these limitations into account, certain generalizations warrant remark. For example, previous studies of religious and spiritual coping during illness found better psychosocial functioning,[4] including fewer depression symptoms.[5] However, in a cohort of patients with end-stage disease awaiting lung transplantation, both positive and negative religious and spiritual coping, as measured with the Brief Religious Coping Questionnaire, were associated with psychosocial disability.[2] Similar outcomes were also found in another group of lung-transplant candidates,[6] in whom "increased religiosity was related to fewer problems with social functioning, but more symptoms of anxiety and hostility." Green et al[3] found relatively infrequent use of negative religious and spiritual coping among emphysema patients. This finding also differs from previous studies of patients with end-stage lung disease, which found a significant interaction between this variable and outcomes.[7]

What is unknown from the study by Green et al[3] is whether overall coping strategies were associated with psychological well-being or quality of life, as this may have explained the lack of religious and spiritual coping influence over these variables. The results showed higher rates of active coping, emotional support, and instrumental support, which differ from another study that found COPD subjects taking more passive approaches to their illness.[2] Also, measures of psychological well-being at baseline were not reported, and this information was not gathered at follow-up, making it difficult to fully understand the results. The level of psychological distress (mild verses severe) can enhance understanding of the study's outcomes. For example, psychological distress has been classified as a coping mobilizer,[2] and greater psychological distress may precipitate the use of coping mechanisms.

Additional research, with a larger sample size and a general population of patients with end-stage COPD, would help to further clarify the role of religious and

spiritual coping. Also, including more minority patients might provide different results; the population in the Green et al study was 95% white. Previous studies that compared coping styles among African-American, Latino, and European American cultures found that African Americans use religious coping in greater numbers.[8] In the meantime, the study by Green et al is the first to review the effects of religious and spiritual coping in only patients with COPD, and provides a starting point for future research hypotheses and clinical interventions.

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