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Coping and Religiosity of Polish Breast Cancer Patients

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Abstract: Religiosity can support a patient in coping with a stressful situation such as breast cancer. In this study, the authors aimed to explain the relationships between the religiosity of the respondents and the religious crises they experienced and coping strategies, as well as between coping strategies and the disease duration. The research method used is the method of diagnostic survey, and the tools: a questionnaire of our own, making it possible to determine sociodemographic variables and standardized scales: the Inventory for Measuring Coping with Stress—Mini-COPE (the brief COPE), the Polish Centrality of Religiosity Scale (CRS) and the Religious Crisis Scale by W. Prężyna (RCS). With approval from the Bioethics Committee at the Medical University of Lublin (KE-0254/133/2015), 69 female subjects with breast cancer were studied. The results showed statistically significant positive correlations between the centrality of religiosity and selected components of religiosity and action-oriented coping strategies. RCS scores correlate negatively with more adaptive coping strategies and positively with ineffective ones. Additionally, patients suffering from breast cancer for more than five years, are statistically significantly different from those with shorter disease duration only in their scores for the CRS "public practice" subscale. Mature religiosity promotes the adoption of constructive coping strategies, while religious crisis hinders the process of coping with stressful situations. It appears necessary to integrate spiritual care into the treatment process of cancer patients.

Keywords: Mini-COPE; spiritual care; CRS; religious crisis; coping; stress; centrality of religiosity; breast cancer

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1. Introduction

In Poland, 19,620 women were diagnosed with breast cancer in 2019, according to data collected from the National Cancer Registry (Krajowy Rejestr Nowotworów 2019). In the following year, breast cancer was also the most commonly diagnosed type of cancer among women (23.8% of all cancers registered in women in Poland) (Wojciechowska et al. 2022). Although the prognosis of cancer diagnosis has improved significantly over the past few decades and it currently has the status of a chronic disease, it is still associated with severe stress for the patient. Among patients in Poland, the oncological disease is still associated with a high mortality rate, onerous, painful, and prolonged treatment, and a significant deterioration in socioeconomic status as a result of having to give up previously fulfilled social and professional roles (Gołota et al. 2017; Drożdż 2016). Studies prove that patients diagnosed with cancer experience not only strong negative emotions, but as many as 15–80% of them experience the signs of post-traumatic stress (Ogińska-Bulik 2015; Rybarski 2018). Polish researchers indicate that individuals with cancer experience anxiety much more often than patients with other chronic diseases, not only at the time of diagnosis. Furthermore, anxiety in cancer patients is higher and can more often take a pathological form, as it is intense and lasts for a long time (Gołota et al. 2017; Dryhinicz and Rzepa 2018; Komendarek-Kowalska 2018; Rogala and Dombrowska-Pali 2018; Żołnierz 2019). Reactions are particularly pronounced in patients suffering from cancers of the reproductive organs, breast, or genitourinary system. Then, in addition, anxiety reactions resulting from a life-threatening disease are strongly associated with feelings of shame

and loss of one's own performance abilities or self-attractiveness. In this light, the effects of chemotherapy or surgical treatment for breast cancer remain extremely traumatic for women, often permanently altering their body image, forcing them to confront difficult questions, even about their sense of their own gender identity (Cieślak and Golusiński 2018). This, in turn, secondarily affects patients functionally in other dimensions of their lives, which creates further problems and heightens feelings of hopelessness, loneliness, and depression (Bober et al. 2016; Jabłoński et al. 2018; Jarząbek-Bielecka 2018; Kulpa et al. 2017; Ośmiałowska et al. 2018). It can also trigger a "spiral of loss" and loss of resources, according to Hobfoll's concept, intensifying anxiety and insecurity resulting from the disease (Drożdż 2016; Żołnierz 2019).

The presented patient's reactions to the situation of their cancer problem remain in the area of intensive scientific research of the relatively young psychological field—psycho-oncology, but they are explainable and can be described with the help of well-known and already well-established psychological concepts of stress and coping. The dominant concept is Lazarus and Folkman's transactional theory of stress (Lazarus and Folkman 1984), and tools for studying coping strategies are questionnaires, including Lazarus and Folkman's WCQ, Endler and Parker's CISS, Moos' HDL-CS, and the COPE (an abbreviated version of which was used in the study, described in this article) by Carver et al. (Juczyński 1999). Coping involves adapting to the disease and functioning optimally in all areas of life, in spite of the whole cancer experience. Researchers have divided strategies into constructive ones, i.e., those that promote adaptation to the stressful situation of the disease (positive reevaluation and fighting spirit) and destructive ones (helplessness and anxiety preoccupation) (Drożdż 2016; Watson et al. 1988, 1999). In this context, it is also important to recall the concept of religious coping and mention the functions that religion plays in human life. Researchers distinguish, among other things, the meaning-producing role of religion, which allows one to ascribe value to life, especially in the face of problems or traumatic events. Being a source of hope, religion allows one to look at difficulties from a different perspective, which is an opportunity to positively reevaluate difficulties and to better cope with them (Piskozub 2010; Juczyński 2016). From this function of religion, there stems the concept of religious coping (Pargament et al. 2000, 2011; Cummings and Pargament 2010; Arbinaga et al. 2021). Moreover, religion provides a sense of security, and thus forms a basis for the proper construction of the personality and a sense of self-dignity, if, of course, the relationship with God is based on trust and the individual presents a positive image of Him (Piskozub 2010; Chlewiński 1982; Kirkpatrick 1992; Kulesz 2013; Matys and Bartczuk 2011; Renz et al. 2018; Żołnierz and Sak 2017). This is because thanks to religion, man has the opportunity to find his place in the world, in relation to God, the other person, and himself. In this way, religion also performs an auto-identification function, which is particularly important in the formation of healthy interpersonal relationships, and a sense of identification with the group and affects adaptation to life in society, which secondarily allows the individual to avoid rejection and negative emotions as a result of transgressing group norms (Chlewiński 1982; Sadłoń 2017). Religion triggers self-therapeutic functions, helping a person understand the limits of self-responsibility and cope with guilt and tensions arising from crises, especially the crisis connected with the meaning of life (Żołnierz 2019; Chlewiński 1982; Kulesz 2013; Bejda et al. 2019; Pawlikowski 2013). The presented functions of religion are intensively studied by researchers in various fields, as they form the basis of numerous concepts useful in explaining the positive relationship between religiosity and quality of life, well-being, or the health status of patients (Koenig 2008, 2009). However, researchers interested in the issue of religiosity also pay attention to the negative impact of religiosity on patients' functioning that occurs, such as in the case of religious or personality immaturity, a negative image of God, which is currently most often addressed in research on the concept of religious struggle/religious crisis (Ogińska-Bulik 2015; Żołnierz 2019; Pargament et al. 2000; Wilt et al. 2016; Zarzycka 2018; Zarzycka and Puchalska-Wasyl 2020; Zarzycka and Zietek 2019).

The purpose of the research conducted and described in this article was to identify the relationship between the level of patients' religiosity, the religious crises they experienced, and the coping strategies they presented, as well as to obtain information on the relationship between the duration of the disease and the patients' coping strategies. The authors hypothesized that higher patients' religiosity would be positively correlated with more constructive coping strategies (Hypothesis 1), that the greater the severity of the religious crisis, the more frequently used and more preferred destructive coping styles (Hypothesis 2), and that patients with shorter diseases would manifest less adaptive coping strategies (Hypothesis 3).

2. Results

The study included 69 women with breast cancer treated at the St. John of Dukla Oncology Center of Lublin Voivodeship in Lublin. Most of the studied patients lived in rural areas constituting 37.68%. The remaining 42 subjects lived in small cities (up to 100,000 residents) (N = 21) and large cities (over 100,000 residents) (N = 21). The largest group among the subjects was married women (81.16%), while the smallest group was unmarried women (N = 3). Most of the female patients surveyed had secondary or vocational education (N = 35). On the other hand, 44.93% of all subjects had a college or incomplete college education. Thirty of the surveyed women were economically active, while nearly half of the surveyed (47.83%) remained on pension or retirement. When asked about surgical treatment, 47 patients answered affirmatively, while 2 did not answer this question. 28.99% of the respondents were not operated on. During treatment, 37 patients received radiation therapy and 61 received chemotherapy (Table 1).

Table 1. Characteristics of respondents by sociodemographic data.

Analysed Variable		N	%
Dwelling place	rural area	26	37.68
	city up to 100 K	21	30.43
	city over 100 K	21	30.43
	absence of data	1	1.45
Marital status	single	3	4.35
	married	56	81.16
	divorced	4	5.80
	widow	6	8.70
Education	elementary	3	4.35
	secondary or vocational	35	50.72
	licenciate or higher	31	44.93
Professional activity	active	30	43.48
	unemployed	4	5.80
	retired/pension	33	47.83
	absence of data	2	2.90
Surgery	no	20	28.99
	yes	47	68.12
	absence	2	2.90
Radiotherapy	no	27	39.13
	yes	37	53.62
	absence of data	5	7.25
Chemotherapy	no	4	5.80
	yes	61	88.41
	absence of data	4	5.80

The study included a group of female patients between the ages of 30 and 78. The average age of the women studied was 53.3 years (SD = 10.6). The shortest time since

surgery was 2 weeks, and the longest was 22 years. The average time since surgery, on the other hand, is 189.1 weeks (SD = 279.45). The shortest duration of the disease is 1 month, and the longest is 34 years. The mean duration of the disease, on the other hand, is 51.1 months (SD = 74.8) (Table 2).

Table 2. Characteristics of the subjects by age, disease duration, and time since surgery.

Analysed Variable	N	M	Me	Min	Max	Q1	Q3	SD
Age	69	53.3	54	30	78	45	62	10.6
Disease duration [in months]	66	51.1	14.5	1	408	6	84	74.8
Time from surgery [in weeks]	42	189.1	46	2	1056	20	240	279.5

In the studied sample, religiosity played a marginal role for 1 person. 31 respondents were characterized by subordinated religiosity, while more than half: 53.62% presented high religiosity (N = 37) (Table 3).

Table 3. Level of religiosity of the respondents according to the results obtained on the CRS scale.

Religiosity	N	%
marginal	1	1.45
subordinated	31	44.93
central	37	53.62

Analysis of the results obtained by the patients on the Religious Crisis Scale, presented in quartiles, allows us to conclude the presence of a religious crisis in 20 of the subjects, while 13 did not experience a crisis (N = 13). In the majority, the crisis occurs temporarily (52.17%) (Table 4).

Table 4. Intensity of religious crisis—RCS scores in quartiles.

Intensity of Religious Crisis	N	%
absence of religious crisis	13	18.84
transient crisis	36	52.17
religious crisis	20	29.00

Descriptive statistics of the variables: centrality of religiosity, religious crisis, and stress coping strategies are shown in Table 5.

In the following analyses, Spearman's rank correlation coefficient was used to verify Hypothesis 1 and Hypothesis 2. Statistically significant results at $p < 0.050$ are marked in red in the table (Table 6). Based on the analyses, there was a statistically significant positive correlation between the overall score on the CRS scale and the three problem-focused coping strategies "active coping", "positive reframing", and "seeking instrumental support", as well as the emotion-focused strategy "turning to religion". It was also found that the higher the centrality of religiosity in each of the CRS subscales, the more frequently the stress coping strategy used: "turning to religion", but also "seeking instrumental support". It was further observed that the higher the scores on the CRS subscales "intellectual", "private practice", "religious experience", and "public practice", the more frequently the strategy of "active coping" used. Higher scores on the "private practice" subscale also correlate positively with other constructive stress coping strategies: "positive reframing" and "planning". In addition, the "planning" strategy is more frequently used by patients scoring higher on the CRS "public practice" subscale. "Sense of humor", in turn, positively correlates with "religious experience" and "intellectual" dimension. In contrast, analysis of the results obtained for the Religious Crisis Scale revealed that the higher the intensity of the crisis, the less frequently the "turning to religion" and constructive stress coping

strategies used: "active coping", "positive reframing" and "planning". In addition, those scoring higher on the RCS are more likely to blame themselves for the situation and are also more likely to use the "behavioral disengagement" strategy (Table 6).

Table 5. Descriptive statistics of CRS, RCS, and Mini-COPE scores in the total group.

Analysed Variable	M	Me	Min	Max	Q1	Q3	SD
CRS Intellectual	9.9	11	3	15	8	12	2.8
CRS Ideological	12.9	14	4	15	12	15	2.4
CRS Private practice	12.7	14	3	15	11	15	2.8
CRS Religious experience	10.5	10	3	15	9	12	2.8
CRS Public practice	11.7	13	3	15	10	14	3.2
CRS Centrality in general	57.8	60	16	75	53	66	11.9
RCS in general	17.1	16	7	35	13	21	5.2
M-COPE.1. Active coping	3.2	3	1	4	3	3.5	0.7
M-COPE.2.Planning	3.1	3	1	4	2	3.5	0.7
M-COPE.3. Positive reframing	2.8	3	1	4	2.5	3	0.8
M-COPE.4. Acceptance	3.2	3.5	1	4	3	3.5	0.6
M-COPE.5. Sense of humor	1.9	2	1	4	1.5	2.5	0.6
M-COPE.6. Turning to religion	3.1	3	1	4	2.5	4	0.9
M-COPE.7. Seeking emotional support	3.1	3	1	4	2.5	4	0.8
M-COPE.8. Seeking instrumental support	2.9	3	1	4	2.5	3.5	0.7
M-COPE.9. Self-distraction	3.1	3	1	4	3	3.5	0.7
M-COPE.10. Denial	2.2	2	1	4	1.5	2.5	0.7
M-COPE.11. Venting	2.4	2.5	1	4	2	3	0.7
M-COPE.12. Substance use	1.1	1	1	2.5	1	1	0.3
M-COPE.13. Behavioral disengagement	1.8	1.5	1	4	1	2.5	0.7
M-COPE.14. Self-blame	1.9	2	1	4	1.5	2.5	0.7

Table 6. Relationship of religious centrality and religious crisis scores with stress coping strategy scores.

Strategies of Dealing with Stress	CRS Intellectual	CRS Ideological	CRS Private Practice	CRS Religious Experience	CRS Public Practice	CRS Centrality in General	RCS in General
1. Active coping	0.289	0.203	0.351	0.261	0.323	0.358	−0.290
2. Planning	−0.019	0.123	0.249	0.142	0.270	0.177	−0.266
3. Positive reframing	0.270	0.241	0.243	0.224	0.224	0.259	−0.276
4. Acceptance	0.114	−0.015	0.109	0.056	0.0319	0.057	−0.106
5. Sense of humor	0.270	0.151	0.139	0.254	0.173	0.214	−0.094
6. Turning to religion	0.579	0.554	0.556	0.603	0.549	0.672	−0.295
7. Seeking emotional support	0.155	0.137	0.202	0.229	0.104	0.166	−0.187
8. Seeking instrumental support	0.259	0.283	0.292	0.295	0.298	0.317	−0.221
9. Self-distraction	0.041	−0.089	−0.043	0.025	−0.027	−0.0211	−0.027
10. Denial	0.128	−0.053	0.067	0.195	0.047	0.098	0.074
11. Venting	−0.015	0.001	−0.048	0.152	0.027	0.011	−0.012
12. Substances use	−0.208	−0.127	−0.069	−0.211	−0.210	−0.178	0.018
13. Behavioral disengagement	0.029	−0.054	−0.198	−0.037	−0.041	−0.063	0.244
14. Self-blame	−0.066	−0.197	−0.182	−0.045	−0.055	−0.083	0.296

To verify Hypothesis 3, analyses were carried out for the variables: coping strategies and duration of disease (Table 7). In addition, analyses were carried out for the variables: the centrality of religiosity and religious crisis (Tables 8 and 9). The authors also checked for correlations between the age of female patients and the variables: stress coping strategies, the centrality of religiosity, and religious crisis (Tables 7–9). In the analysis of the variables: coping strategies, the centrality of religiosity and religious crisis, the division into two subgroups of the subjects was taken into account: those ill up to five years of duration and those with more than five years of duration (Tables 10 and 11).

Table 7. Correlation of stress coping strategies scores with patients' age and duration of disease.

Strategies for Coping with Stress	Correlations with Age		Correlations with Duration of an Disease	
	R	*p*	R	*p*
1. Active coping	−0.087	0.477	−0.050	0.693
2. Planning	−0.096	0.432	−0.008	0.948
3. Positive reframing	−0.020	0.871	−0.158	0.204
4. Acceptance	0.143	0.241	0.005	0.968
5. Sense of humour	−0.179	0.141	0.070	0.575
6. Turning to religion	0.333	0.005	0.142	0.255
7. Seeking emotional support	0.081	0.509	−0.078	0.536
8. Seeking instrumental support	0.169	0.165	0.152	0.223
9. Self-distraction	−0.041	0.738	−0.149	0.232
10. Denial	0.257	0.033	−0.003	0.979
11. Venting	−0.096	0.433	0.052	0.680
12. Substance use	−0.295	0.014	−0.110	0.378
13. Behavioral disengagement	0.005	0.966	−0.018	0.888
14. Self-blame	0.089	0.469	0.152	0.222

Table 8. Relationship of religiosity centrality scores with patient age and disease duration.

The Centrality of Religiosity	Correlations with Age		Correlations with Duration of an Disease	
	R	*p*	R	*p*
1. Intellectual	0.270	0.025	0.069	0.583
2. Ideological	0.167	0.170	0.061	0.626
3. Private practice	0.327	0.006	0.161	0.196
4. Religious experience	0.317	0.007	0.199	0.108
5. Public practice	0.239	0.048	0.340	0.005
6. Centrality in general	0.304	0.011	0.233	0.060

Table 9. Relationship of religious crisis scores with age of patients and duration of disease.

Religious Crisis	Correlations with Age		Correlations with Duration of an Disease	
	R	*p*	R	*p*
Religious crisis in general	0.048	0.695	−0.180	0.149

Table 10. Subgroupdivision as for the duration of disease.

Groups	N	%
Up to 5 years of disease duration	48	69.57
Over 5 years of disease duration	18	26.09
Absence	3	4.35

There was a statistically significant correlation between disease duration and the CRS "public practice" score (R = 0.340, $p = 0.005$). Higher disease duration scores correspond to higher scores on the CRS "public practice" measure—thus, the longer the disease lasts, the more often the patients attend religious services and are more likely to pursue this form of practicing their religiosity (Table 8). Other than this one, there were no statistically significant correlations of disease duration with other CRS scores, nor RCS and mini-COPE (Tables 7–9). However, a correlation was found, at the level of statistical tendency ($p = 0.06$) between overall religiosity centrality and disease duration.

Table 11. Comparison of results of subjects with shorter and longer disease duration.

Analysed Variable	Duration of an Disease	M	Me	Min	Max	Q1	Q3	SD	U *p*
CRS Intellectual	up to 5 years	9.8	10	3	15	8	12	3	U = 401.0
	over 5 years	10.7	11	6	14	9	12	2.15	$p = 0.663$
CRS Ideological	up to 5 years	12.8	13.5	4	15	12	15	2.6	U = 391.0
	over 5 years	13.3	14	9	15	13	15	1.9	$p = 0.563$
CRS Private practice	up to 5 years	12.4	14	3	15	10.5	15	3.1	U = 396.0
	over 5 years	13.4	14	7	15	13	15	1.9	$p = 0.612$
CRS Religious experience	up to 5 years	10.1	10	3	15	8.5	12	2.9	U = 323.5
	over 5 years	11.3	11.5	7	15	9	13	2.5	$p = 0.120$
CRS Public practice	up to 5 years	11	12	3	15	8	14	3.4	U = 262.0
	over 5 years	13.2	14	6	15	13	15	2.6	$p = 0.014$
CRS Centrality in general	up to 5 years	56.1	58.5	16	75	50.5	65	12.9	U = 310.5
	over 5 years	61.4	64.5	37	72	56	67	9.2	$p = 0.080$
RCS in general	up to 5 years	17.6	17	7	35	14	21.5	5.4	U = 345.0
	over 5 years	15.8	14.5	11	23	11	20	4.8	$p = 0.215$
M-COPE 1. Active coping	up to 5 years	3.1	3	1	4	3	3.5	0.7	U = 402.0
	over 5 years	3.3	3	2	4	3	4	0.6	$p = 0.674$
M-COPE 2. Planning	up to 5 years	3.1	3	1	4	2.8	3.5	0.7	U = 424.5
	over 5 years	3	3	1	4	2.5	4	0.9	$p = 0.915$
M-COPE 3. Positive reframing	up to 5 years	2.9	3	1	4	2.5	3.3	0.8	U = 341.0
	over 5 years	2.6	2.5	1	4	2.5	3	0.7	$p = 0.194$
M-COPE 4. Acceptance	up to 5 years	3.2	3.3	1	4	3	3.5	0.6	U = 405.5
	over 5 years	3.1	3	1.5	4	2.5	4	0.7	$p = 0.705$
M-COPE 5. Sense of humor	up to 5 years	1.9	2	1	4	1.5	2.5	0.7	U = 429.0
	over 5 years	1.9	2	1	3	1.5	2	0.6	$p = 0.972$
M-COPE 6. Turning to religion	up to 5 years	3	3	1	4	2.5	3.5	0.8	U = 380.5
	over 5 years	3.1	3	1	4	3	4	0.9	$p = 0.462$
M-COPE 7. Seeking emotional support	up to 5 years	3.2	3	1	4	2.8	4	0.7	U = 333.5
	over 5 years	2.9	3	1.5	4	2.5	3.5	0.8	$p = 0.157$
M-COPE 8. Seeking instrumental support	up to 5 years	2.8	3	1	4	2.5	3.5	0.7	U = 411.5
	over 5 years	2.9	3	1.5	4	2.5	3	0.7	$p = 0.770$
M-COPE 9. Self-distraction	up to 5 years	3.1	3	1.5	4	3	3.5	0.7	U = 346.0
	over 5 years	2.8	3	1	4	2.5	3.5	0.9	$p = 0.221$
M-COPE 10. Denial	up to 5 years	2.2	2	1	4	1.5	2.8	0.8	U = 414.0
	over 5 years	2.1	2	1	3	2	2.5	0.6	$p = 0.803$
M-COPE 11. Venting	up to 5 years	2.3	2.5	1	4	2	3	0.7	U = 409.0
	over 5 years	2.4	2.5	1	4	2	2.5	0.6	$p = 0.748$
M-COPE 12. Substances use	up to 5 years	1.1	1	1	2	1	1	0.3	U = 413.5
	over 5 years	1.1	1	1	2.5	1	1	0.6	$p = 0.792$
M-COPE 13. Behavioral disengagement	up to 5 years	1.8	1.5	1	4	1	2.5	0.8	U = 389.0
	over 5 years	1.8	1.8	1	3	1.5	2.5	0.7	$p = 0.544$
M-COPE 14. Self-blame	up to 5 years	1.8	1.8	1	4	1.5	2	0.7	U = 316.0
	over 5 years	2.2	2	1	3	1.5	2.5	0.8	$p = 0.097$

As for statistically significant correlations of patients' age to stress coping strategies, such were detected for three strategies: "turning to religion", "denial", and "substance use". As patients get older, they are more willing and more likely to use their religiosity as a method of coping with stress, and they are also more likely, although this is a weak relationship, to deny the stressful situation. The older they are, the less often they use

psychoactive substances to cope with stress (Table 7). Almost all subscales of the CRS and the overall score of this scale also correlate positively with the age of the patients. The strongest of the detected correlations are with the subscales "private practice", "religious experience", and the total score. The age of the subjects does not correlate in a statistically significant way only with the CRS scores for the subscale "ideological". There were also no statistically significant correlations between the patients' age with the results of the Religious Crisis Scale (Tables 8 and 9).

The analysis of the literature prompted the authors to carry out a comparison of the results obtained by female patients with diseases up to five years with the results of female patients with diseases above that time. This is because it has been pointed out that the limit of five years from diagnosis is a turning point in the perception of the chances of survival, and may therefore differentiate patients in terms of the coping strategies used (Cieślak and Golusiński 2018). In our study, respondents were therefore divided into two subgroups. The first included women with a disease duration of up to five years, while the second subgroup included women who had been ill for more than five years. The first group represents the majority, 69.57% of all respondents. Three people did not answer the question about the duration of the disease (Table 10).

Analyses comparing the results of the subgroup of patients ill up to five years with those of patients ill longer than that, found a statistically significant relationship only for the CRS "public practice" score, as well as a difference at the level of statistical trend ($p = 0.08$) with regard to the overall centrality of religiosity. It turns out that women who have been ill for more than five years are more likely to practice their faith in public and participation in worship services is an important dimension of their functioning. In terms of other outcomes, the two subgroups are not statistically significantly different (Table 11).

The revealed correlations between RCS and mini-COPE scores encouraged the authors to also test whether it would be possible to predict the risk of a religious crisis based on mini-COPE scores. To this end, they divided all respondents based on their overall RCS score. Based on the analysis of the RCS total score, two subgroups were distinguished: those not experiencing a crisis or experiencing it temporarily, sporadically (RCS scores lower than 21), and those experiencing a religious crisis (scores equal to or higher than 21). The first subgroup included 49 people (71.01%), while the second group accounted for 20 people, or 28.99% of all respondents.

For the resulting distribution, a univariate logistic regression analysis was performed. Logistic regression analysis was performed only for those stress-coping strategies for which there were statistically significant correlations with the RCS score (Table 7). Only three of the strategies analyzed were found to be statistically significant in univariate regression analysis, these were "active coping" (OR = 0.254, 95% CI 0.102–0.629, $p = 0.003$), "planning" (OR = 0.433, 95% CI 0.203–0.924, $p = 0.030$) and "positive reframing" (OR = 0.453, 95% CI 0.217–0.950, $p = 0.036$). In all cases, higher scores on these coping strategies reduced the risk of religious crisis (Table 12).

Table 12. Analysis of logistic regression results for stress coping strategies.

Strategies for Coping with Stress	Statistical Significance of the Reliability Quotient Test	OR	95% CI	*p*
1. Active coping	0.001	0.254	0.102–0.629	0.003
2. Planning	0.024	0.433	0.203–0.924	0.030
3. Positive reframing	0.029	0.453	0.217–0.950	0.036
6. Turning to religion	0.278	0.717	0.393–1.308	0.278
13. Behavioral disengagement	0.393	1.362	0.671–2.764	0.393
14. Self-blame	0.075	1.903	0.927–3.906	0.079

3. Discussion

The results of the statistical analyses presented above confirmed Hypothesis 1. The authors hypothesized that higher religiosity of female patients would be positively cor-

related with more constructive coping strategies. The results confirmed that the more autonomous, i.e., high, mature religiosity of female patients is, the more frequently most of the adaptive coping strategies, i.e., proble4.m-focused strategies, which include "positive reframing", "active coping", or "seeking instrumental support" are utilized (Carver et al. 2012b). This finding is completely consistent with the results of other studies on religiosity and coping strategies, which indicate that internal religious orientation is strongly related to problem-focused strategies, while external orientation is based on the cognitive functions of avoidance strategies (Arbinaga et al. 2021; Pargament et al. 1992). It is noteworthy, however, that the strategy of seeking instrumental support, in particular, remains important for strengthening cognitive processes (Juczyński 2016; Janowski et al. 2016), and it is this strategy that, in the study group of female patients scoring high on the CRS, is one strategy that correlates positively with all measured aspects of religiosity, as well as with the overall religiosity centrality score.

The second strategy that correlates strongly positively with all components of CRS and also with the overall score of the centrality of religiosity in the studied group of female patients is "turning to religion". This result, too, does not differ from previous observations made by other researchers. Moreover, it fits perfectly into the discussion of whether religious coping is an independent strategy or rather mediates other "secular" strategies for coping with stress (Pargament et al. 2000, 2011; Arbinaga et al. 2021; Holtmaat et al. 2019; Fradelos et al. 2018). In this context, the research conducted only allows us to conclude that the use of the strategy "turning to religion" is in a strong relationship with the high religiosity of the respondents. It is also worth noting that the higher the centrality of religiosity in the two components: "religious experience" and "intellectual", the more frequently the strategy "sense of humor" is used. Additionally, although this strategy is categorized as an evasive strategy that, when used over a long period of time, can prove destructive, Juczynski points out that in certain circumstances this strategy can prove extremely useful. This happens when the problem encountered seems impossible to overcome with any active action. In the face of one's own helplessness and immense stress, an evasive strategy in the form of humor can prove effective (Żołnierz 2019; Juczyński 2016; Carver et al. 2012a, 2012b; Juczyński and Chrystowska-Jabłońska 1999; Kalembrik and Juczyński 2001; Sosnowski et al. 2017). Previous scientific studies have provided information on the existence of positive relationships between individual and collective religious practices and the patient's functioning in various dimensions of his life (Koenig 2008, 2009, 2012; Jim et al. 2015; Koenig et al. 2001).

Our own research partially confirms these scientific reports. Indeed, participation in religious services as a component of the CRS tool correlates positively with the strategies "planning", "active coping" and "seeking instrumental support", and prayer additionally further with "positive reframing". As evidenced by scientific research, these strategies in particular help the patient to accept the disease, regain control and hope, strengthen self-esteem, and thus are not without impact on his quality of life (Żołnierz 2019; Cieślak and Golusiński 2018; Piskozub 2010; Juczyński 2016; Janowski et al. 2016; Koenig 2012; Wnuk et al. 2010; Büssing et al. 2016). This is particularly important in the context of the statistically significant correlations detected in our study between the duration of disease and the CRS "public practice" subscale. The longer the duration of the disease, the more important and more frequent the participation in worship. In addition, "public practice" is the only one of the variables that statistically significantly differentiates the subgroup of patients with diseases up to five years from those with longer diseases (falsifying Hypothesis 3, as no statistically significant differences in stress coping strategies were detected between the groups). This seems to be consistent with the results of the studies cited above.

Analysis of the results of the study revealed that more than half of the surveyed people are characterized by a high religiosity. Additionally, a large proportion, as many as 31 people, are characterized by a moderate level of religiosity. Such a high rate of religiosity among the respondents can be explained by their specific life situations. An attempt to

explain this phenomenon, also observed in their research among Polish oncology patients, was made by Walczak et al. They indicated that the observed greater intensity of religious attitudes may be related to a sense of danger and an attempt to find support in a Higher Being (Walczak et al. 2018). The assumption of greater religiosity/spirituality of people with cancer, compared to healthy people, was also made by Arbinaga's team, conducting a study among Spanish patients (Arbinaga et al. 2021).

The authors also assumed that the greater the severity of the religious crisis, the more frequently used and more preferred destructive coping styles (Hypothesis 2). The analyses conducted also helped confirm this hypothesis. Religious crisis is positively correlated with blaming oneself and stopping action, and these are categorized as evasive strategies, and although they can be useful in some situations, especially disease exacerbation, researchers question their effectiveness, especially when used for a long time (Carver et al. 2012a, 2012b).

Analysis of the research results further revealed that as the intensity of the religious crisis increases, action-focused coping strategies are less frequently undertaken. The research confirmed the existence of this relationship between RCS scores and the strategies "active coping", "positive reframing" and "planning". These are disturbing observations, especially since, of the female patients included in the study, nearly one-third were experiencing a religious crisis. This leads to the conclusion that medical care for cancer patients should also include spiritual care, especially in terms of the religious crises they experience. The literature lists numerous negative effects of the experienced religious crisis, ranging from unpleasant emotions, psychological tensions, depressive states, ending with personality disintegration and suicide attempts, symptoms of post-traumatic stress disorder and somatic symptoms, i.e., pain symptoms, impaired immune system function and increased mortality (Zarzycka and Zietek 2019; Nowosielski and Bartczuk 2011; Pargament and Exline 2023; Tomczyk 2007; Sherman et al. 2015). Properly helping a patient cope with a religious crisis can provide an opportunity for the revision of life goals and the patient's personal and post-traumatic growth (Ogińska-Bulik 2015; Żołnierz 2019; Nowosielski and Bartczuk 2011; Tomczyk 2007).

4. Materials and Methods

In the study, stress coping strategies, religious centrality, and religious crisis were taken as interchangeable dependent variables. The age of the patients and the duration of the disease are independent variables. The research method used is the diagnostic survey method, and the research technique is the survey technique. The tools used are: a questionnaire of our own making it possible to determine sociodemographic variables (gender, age, marital status, place of residence, living with someone or alone, religion, education, duration and type of disease, type of treatment used—surgery, chemotherapy, radiation therapy) and standardized scales for the study of dependent variables: the Inventory for Measuring Coping with Stress (Mini-COPE) (Carver et al. 2012b), the Polish adaptation of S. Huber's Centrality of Religiosity Scale (CRS) (Zarzycka 2011), and the Religious Crisis Scale by W. Prężyna (RCS) (Nowosielski and Bartczuk 2011).

The choice of specific research tools was preceded by deep reflection and literature research. The indicated scales for the study of religiosity—the Polish Centrality of Religiosity Scale (CRS) and the Religious Crisis Scale by W. Prężyna (RCS) are popular tools in Poland, allowing a comprehensive and multifaceted study of religiosity and remain culturally sensitive, meeting the needs of Polish respondents. The Inventory for Measuring Coping with Stress—Mini-COPE (the brief COPE) is also a popular research tool, making it easier to compare survey results and present more accurate interpretations. The questionnaires of the indicated tools are also short, which is of considerable importance for the comfort of inpatients or outpatients, too. The study using the indicated scales took place with the permission of the authors of the tools and with respect to their copyright.

The Inventory for Measuring Coping with Stress—Mini-COPE (the brief COPE) is used to examine typical reactions to a stressful situation and is an abbreviated version of a 60-item popular tool by (Carver et al. 1989, 2012a; Carver and Scheier 1994). Adaptation

to Polish conditions of the abbreviated version of the scale was made by Juczynski and Oginska-Bulik (Carver et al. 2012b). The Mini-COPE allows the examination of 14 stress-coping strategies. The study is carried out by assigning a certain number of points from 0 to 3 on the scale next to each of the 28 statements. The number of points obtained in the two statements assigned to a particular strategy is then summed. Juczynski and Oginska-Bulik, in their commentary on the tool's description, point out that all 14 strategies can be divided into three main categories—problem-focused strategies, emotion-focused strategies, and avoidance strategies. In the first category, they included "seeking instrumental support" and "planning", in the second such strategy as "denial" or "turning to religion", for example, while in the third—evasive: "substance use" or "sense of humor" (Żołnierz 2019; Arbinaga et al. 2021; Carver et al. 2012b).

The Polish Centrality of Religiosity Scale (CRS), made by Zarzycka, consists of 15 statements (Zarzycka 2011; Huber and Huber 2012). This short tool makes it possible to determine the centrality of religiosity in the personality, as a whole (the sum of all the points obtained for each of the 15 statements) or the centrality of religiosity in five specific content aspects, i.e., religious beliefs ("ideological"), prayer ("private practice"), interest in religious issues ("intellectual"), worship ("public practice"), and religious experience. The higher the score, the greater the centrality of religiosity in the personality, and therefore the greater its impact on the individual's life. The global number of points obtained in all of the 15 statements makes it possible to determine whether the respondent's religiosity is autonomous (high religiosity/central religiosity) or subordinated (moderate religiosity), or at a marginal level (Żołnierz 2019; Zarzycka 2011; Żołnierz et al. 2017).

The Religious Crisis Scale by W. Prężyna (RCS) is a very short tool, as it consists of five statements that can be answered using a 7-point Likert scale (Nowosielski and Bartczuk 2011). The sum of the scores given for each of the five questions informs about the intensity of the religious crisis—low scores inform about the absence of a crisis, high scores inform about the presence of a crisis, while moderate scores are interpreted as psychological tensions of temporary, temporary difficulties in the relationship with God, but without the signs of a crisis. The author of the tool is Prężyna, but before his death, he did not manage to complete the work on the scale, hence its continuation was handled by Nowosielski and Bartczuk (Żołnierz 2019; Nowosielski and Bartczuk 2011; Żołnierz et al. 2017).

The study was initiated after obtaining approval from the Bioethics Committee at the Medical University of Lublin (KE-0254/133/2015). The study was conducted from November 2017 to March 2019 among inpatients and outpatients at the St. John of Dukla Cancer Center of Lublin Voivodeship and the Chemotherapy Outpatient Clinic of the Specialized Outpatient Clinic Complex of the St. John of Dukla Cancer Center of Lublin Voivodeship. The survey was completed anonymously after providing information about the study and obtaining the patient's consent of participation. The inclusion criterion for the study was: patient's age above 18 years of age, gender—female, diagnosis—breast cancer, ability to participate in the study—completion of the questionnaire. The exclusion criteria were: minors, lack of consent to complete the questionnaire, and time since surgery of less than 2 days. Sixty-nine completely completed survey questionnaires were qualified for statistical analysis.

The results obtained were subjected to statistical analysis. The values of the quantitative variables analyzed were presented using mean, median, lower and upper quartiles, minimum and maximum values, and standard deviation, and the qualitative variables were presented using count and percentage. Spearman's rank correlations were used to assess the correlation of the analyzed variables, and the Mann–Whitney U test was used to assess the differences between groups. Logistic regression analysis was used to estimate the risk of religious crisis due to the results of stress coping strategies. A significance level of $p < 0.05$ was adopted, indicating the existence of statistically significant relationships. Statistical analysis was performed using Statistica 9.1 and PQStat 1.8.2 software.

5. Limitations

Limitations of our study include the heterogeneity of the study group in terms of treatment methods and stage of cancer, as well as the method of selecting the study group. The inclusion of these variables in the selection of study participants in future research work would allow for more accurate analyses and facilitate the interpretation of the data obtained on patients' stress-coping strategies and religiosity.

6. Conclusions

1. More than half of the breast cancer patients included in the study present a high level of religiosity. The study confirmed that the higher the centrality of religiosity, the more frequently the stress-coping strategy: "turning to religion" was used. Thus, for some patients, religiosity is an important resource used in coping with the disease situation.
2. Our own research confirmed other scientific reports—mature religiosity is conducive to undertaking constructive coping strategies, while religious crisis hinders the process of coping with a stressful situation.
3. Nearly 1/3 of the patients included in the study experience a religious crisis. Thus, in order to provide comprehensive medical care to the cancer patient, it is necessary to pay attention to and take care of their religiosity/spirituality.
4. Female oncology patients using problem-oriented stress-coping strategies were found to be less likely to experience a religious crisis. Thus, in caring for patients, it is important to pay attention to how they cope with disease in order to prevent religious crisis, which destructively affects patient functioning.

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