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The Importance of Religion for Parents Coping With a Chronically Ill Child

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This study examines differences in the stability and consequences of religious coping among parents (N = 102) of chronically ill children. Analyses revealed that changes in religious patterns due to a child's illness were reflected in changes in other, non-religious coping resources. Specifically, parents whose pre-illness religious patterns were satisfactory did not alter their use of other coping resources, whereas parents who reported changes in their religious patterns also made changes in their use of familial, financial, and social support systems.

A child who is ill is perhaps the greatest worry of most parents. When an illness is prolonged and becomes chronic, this worry is easily magnified, becoming a significant stressor on all members of a family (Fife, 1985; Green, 1982). The indirect effects of this form of long-term stress on family members are many and varied, but may include abrupt changes in family roles and patterns of intimacy, social isolation, and marital stress and dysfunctioning (Flynn, 1980; Kaplan, Smith, Grobstein, & Fischman, 1977; Mattson, 1977; McCubbin, McCubbin, Patterson, Cauble, Wilson, & Warwick, 1983). The child may have additional problems, including absence of peer relationships, overprotection, and difficulty re-integrating into the family system. Complicating an already difficult situation for parents is their primary responsibility for managing the stress of not only the child but the entire family. How parents cope with a chronic illness of the child can influence not only their own levels of distress (Fife, 1985; Green, 1982; Gibbons & Boren, 1984; Kaplan et al., 1977; McCubbin et al., 1983; Stein & Riessman, 1980; Tomlinson, 1986), but also the adjustment of their child and his or her siblings.

Pargament (1990) defined coping as "a highly interactive process through which individuals try to understand and deal with significant personal or situational demands in their lives." Coping resources and constraints may direct people toward particular appraisals of their situation and channel coping activities (Pargament, 1990). Religion can be utilized as a coping resource in dealing with a child's

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chronic illness. Pargament (1990) has developed a theoretical framework which describes how religion may function as a part of, a contributor to, and/or a product of the coping process.

In utilizing religion as a part of the coping process (Kaplan & Blazer, in press; Sherrill, Kaplan, & Larson, 1989), one may become involved in church or synagogue activities, as well as develop a personal relationship with God, or allow God to assist in solving the problem at hand. As a contributor to the coping process, religious resources can affect or mediate how one perceives a stressful situation and how one chooses to handle it. Finally, as a product of the coping process, one might turn to religion or increase the role that religion plays in one's life as an adaptation or reaction to a stressful situation. The coping process may also be shaped by other personal or social resources such as financial status, social support, the health-care system, or one's family (Barrera, 1986; Flynn, 1980; Kaplan, Cassell, & Gore, 1977; McCubbin & Boss, 1980; Sherrill & Larson, 1988; Tomlinson, 1986).

Religious coping manifests its adaptive role both intrapsychically (through values, beliefs, and attitudes) and institutionally (through religious attendance and fellowship) (Koenig, Siegler, & George, 1989). Study of the effects of these types of religious coping has practical implications, such as helping to identify both individuals who have problems coping with illness, barriers to the utilization of medical treatment, and to its successful therapeutic outcomes. Considerable research has now demonstrated the salutary effects of religious involvement, both clinically (Braverman, 1987) and epidemiologically (Levin & Vanderpool, 1992), and has described the centrality of religious institutions as sources of informal support, especially in elderly, distressed and underserved populations (Taylor & Chatters, 1986a, 1986b, 1988).

Despite these efforts, few studies have examined the role of intrapsychic and institutional forms of religious coping in buffering the stress inherent in coping with *someone else's* illness, such as one's child. While several parent-focused coping instruments have been developed, most of these tools address financial, social, familial, personal and health-care dimensions of coping without measuring the religious component or dimension of the coping process (Hymovich, 1984; Judson & Burden, 1980; Lloyd & Abidin, 1985; McCubbin et al., 1983; Mishel, 1983; Stein & Riessman, 1980). One scale of family social-environmental characteristics (Moos & Moos, 1986) does include a religious dimension, but does not treat religion as a coping resource (Varni, Rubenfeld, Talbot, & Setoguchi, 1989). Another excellent scale (Pargament, Kennell, Hathaway, Grevengoed, Newman, & Jones, 1988) focuses on religion as a coping resource, but seems to operationalize coping as a static state rather than dynamically, which may be necessary when specifically studying responses to a child's chronic illness.

Using existing religiosity scales to assess religious coping is also ill-advised. Scales which measure the salience or dimensions of religious belief (Glock & Stark, 1965), assess types of personality orientations such as the intrinsic-extrinsic indices based on the work of Allport (1963), or multidimensionally model religious activity or involvement (Ainlay & Smith, 1984; Chatters, Levin, & Taylor, 1992; Mindel & Vaughan, 1978) all assess static states. That is, none of these scales was developed specifically to directly assess changes in religious patterns, something required if the process of coping with the stress of an ill child is to be properly specified in theoretical terms and thus assessed as a multifactorial process.

The purpose of the present article is to examine the role of religion as a coping resource for parents with a chronically ill child. Specifically, two research questions are addressed:

1. Are there differences between parents undergoing high or low levels of religious change in their reliance on other coping resources, namely familial, personal, financial, social and health-care coping?

2. Can these differences, if present, be explained away by other factors, such as parent's age, marital status or education, or child's age or length of illness?

Method

Data for these analyses came from a study conducted in Virginia from 1986 to 1988. Questionnaire items were developed in several phases, utilizing (1) parental interviews, (2) assessment of existing measurement instruments, (3) the researcher's clinical experience, (4) evaluation by an expert panel of two pediatric nurse practitioners, a chaplain working with families of chronically ill children, and a pediatrician, and (5) pre-testing. Study subjects included 135 parents of chronically ill children who were receiving care from selected clinics or participating in selected support groups. Questionnaires were administered while parents waited for their child's clinic visit or when they attended a support group meeting, and were either mailed or hand-delivered to the researcher in a sealed envelope. All of the parents approached during their child's clinic visit completed the survey (n = 95). Of the 75 parents approached during support group meetings, 40 returned their survey. Parents were informed that completion of the questionnaire implied consent and that they could withdraw from the study at any time. Anonymity was maintained since no names or other forms of identification were recorded on the questionnaires or envelopes.

The sample of parents was mostly female (68.7%) and white (89.9%), with 54.7% high school graduates, a mean age of 28.5 (sd = 14.5), and religious affiliation split among Protestants (58.2%), Catholics (23.5%), and Jews (16.3%). The modal number of children was two (range = 1-7); occupation was split among blue collar (31.9%), white collar (37.2%), and homemaker (29.8%); 58.9% of households had an annual income of no more than $30,000; and most parents (90.8%) were married to the child's other biological parent at the time of the study. The chronically ill children of these parents were predominantly male (64%), all were 18 years old or younger (mean = 6.5 years old, sd = 5.1), and averaged 5.0 years (sd = 4.0) since diagnosis with one of five chronic illnesses (juvenile diabetes, juvenile rheumatoid arthritis, cystic fibrosis, epilepsy, or spina bifida). These illnesses are similar in that they are all long-term conditions which in this study were not imposing an immediate threat to life. The children were all still at home, being cared for by their parent(s). Thus, study findings are unlikely to be confounded by severity of illness, which is fairly constant. Parents of children with a sixth illness, schizophrenia, were excluded from these particular analyses in order to preserve this homogeneity; these schizophrenic children and their parents were also considerably older than the rest of the sample.

Four items measuring religious coping, (each coded such that 1 = rarely true, 2 = slightly true, 3 = moderately true, and 4 = usually true) included, "My feelings toward the church/synagogue have changed" (mean = 1.83, sd = 1.13), "My feelings toward God have remained the same" (mean = 3.37, sd = 1.06), "I turn to the

church for comfort the same as I did before I had a child with a health problem" (mean = 2.96, sd = 1.24), and, "I do not attend church as often as I did before I had a child with a health problem" (mean = 1.89, sd = 1.21). Preliminary analyses found that all four religious coping items were significantly intercorrelated. In instances where religious change is indicated, it is deduced that religion has not functioned effectively as a coping resource and that the parent is making changes in order to utilize religious resources more effectively or to minimize the constraints they impose. Additional items measured health-care (5 items), social (5 items), personal (14 items), familial (11 items), and financial (4 items) coping resources. The effects of several personal characteristics were controlled for in these analyses, including parent's age, marital status (0 = unmarried, 1 = married), education level, and child's age and length of illness.

All coping scales were systematically validated. Face validity was confirmed by a pre-test panel of 30 parents, test-retest reliability (r = .85) was confirmed in 22 parents who answered the items a month apart, and internal consistency was found for the religious items (Cronbach's alpha = .71) as well as the other five coping dimensions (alphas from .74 to .82). In addition, confirmatory factor analysis determined that the four religious coping items available in the survey constituted an excellent fitting unidimensional scale according to accepted technical criteria for this procedure (factor loadings ranged from .554 to .730; $\chi^2/df = .49$, $p = .485$, GFI = .998, AGFI = .980, BBI = .995, TLI = 1.033).

Analyses sought to identify differences in dimensions of coping resources between parents in whom religion as practiced was a satisfactory coping resource and parents who felt a need to change their religious practices in order to cope better. Religious coping was measured by summing the four religious items, which were recoded where necessary so that high scores denoted stability and low scores denoted change (range: 4-16). This summary scale was then dichotomized at the median (stability ≥ 13; change < 13). The use of coping resources pertaining to the other five dimensions (family, personal, financial, social, and health care) were compared across the two categories of religious coping using analysis of variance (ANOVA), and were rerun controlling for the effects of the background variables using analysis of covariance (ANCOVA).

Results

Table 1 presents ANOVA results comparing the five dimensions of coping resources between those who experienced high and low levels of religious change. Findings revealed significantly more stability in use of coping resources for three of the five coping dimensions among those parents who exhibited stability in religious coping. In other words, parents whose current religious practice met their needs in coping with their child's illness were more likely to require little or no change in familial, financial, and social coping resources than parents who reported needing changes to occur in their religious life. Similar trends were also present for personal and health-care resources, but they did not attain statistical significance in this sample. These differences remained statistically significant even after rerunning the analyses using ANCOVA to control for the effects of parents' age, marital status, education level, and child's age and length of illness.

Table 1

Differences in Coping Resources by Stability of Religious Coping

	Religious Coping*			
	Stable (N = 58)		Changed (N = 44)	
Coping Resource	mean	sd	mean	sd
Family Coping[b]	19.5	3.6	15.8	3.6
Personal Coping	17.8	1.9	17.2	2.0
Financial Coping[a]	12.4	3.7	10.0	3.7
Social Coping[b]	14.2	2.4	12.1	3.4
Health-Care Coping	20.9	3.5	20.5	3.7

* High scores denote stability (i.e., low levels of change) in coping dimensions; low scores denote change. Reported Ns are maximums; for particular variables, these may differ slightly due to missing values.

[a] $p < .01$

[b] $p < .001$

Discussion

To summarize, two conclusions are apparent from these findings. First, parents who participated in this study reported minimal change in their use of religious resources as a result of their child's chronic illness. This is either because religion as experienced was not producing a constraint on the parent's ability to cope with their child's illness or because parents perceived that no additional religious involvement was needed as a resource to facilitate the coping process. Second, and more importantly, parents who did report religious changes also had to make changes in their use of familial, financial and social coping resources regardless of their age, marital status, education level or their child's age or length of illness. That is, parents whose religious patterns were unsatisfactory for their needs also simultaneously adjusted their family, financial, and social support systems. While these data are cross-sectional and we thus cannot assert causation, these findings possibly suggest that if religion is not serving parents' coping needs, then other areas may suffer. Therefore, it is imperative that clinical needs assessments identify those parents in whom religion may be constraining the coping process as well as those parents for whom religion serves as a successful coping resource, so that broad-based interventions can be planned and implemented to assist in effective coping.

If it is noted that parents are indeed undergoing religious changes, the provider may wish to explore such changes further to determine if religion is (1) functioning as a part of the coping process and thus enabling the parent to cope more effectively, (2) contributing to the coping process and thus enabling the parent to choose how to handle the situation, or (3) a product of the coping process and thus becoming an integral part of the parent's life on the one hand or turning them away from God and their church or synagogue on the other (Judson & Burden, 1980). Regardless of the way in which religion functions as a coping resource for a partic-

ular parent, changes in religious patterns ought to be identified, as they may represent a salient influence on both the coping process and overall well-being.

These findings may require qualification due to several possible limitations. First, the concept of religious coping may be multidimensional, and thus more than four items would likely be required to obtain full content validity. However, the four items available did constitute an acceptable unidimensional index. Second, since parents were asked to complete the questionnaire at their convenience and then return it to the investigator, some selection bias may have been operating such that a difference may exist between parents who chose to participate and those who did not. For example, 98 percent of parents specified a religious affiliation. Results might have been different if more non-religious parents had been included. Third, the findings reported here are cross-sectional, while to best assess coping with the stress of a chronically ill child it would have been ideal (although cumbersome) to assess religious change prospectively through pre- and post-diagnostic surveys. Further, the cross-sectional design may mask the operation of a single, higher-order coping factor. It could be that change in religious coping goes hand in hand with changes in other coping domains without representing a causal influence of religious coping.

Subsequent research will be needed to more completely specify the relationships among religious and other forms of coping and those psychosocial and health-related constructs which may affect or modify these relationships. Such analyses will require the positing and testing of multifactorial models using validated measurement instruments. This will require a much larger sample and more sophisticated operational features than was possible here.

In summary, these findings suggest that the ways in which coping resources are utilized by parents of a chronically ill child are related to the effectiveness of a parent's current religious patterns. That is, when religion as practiced is deemed satisfactory, then the levels of engagement of other coping dimensions are likewise stable. An unsatisfactory religious life, on the other hand, is associated with adaptation through the increasing use of secular resources. The results presented here suggest that religion and coping are meaningfully interconnected and that further exploration may be both highly provocative and of substantial clinical importance.

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