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Religious coping among caregivers of differently-abled children

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Abstract

Caregivers of differently-abled children go through significant challenges in their lives. A number of studies have shown the impact of child disability on the caregivers, although only a handful of studies have shown the different coping strategies used by caregivers in order to buffer against their stressful life events. Hence, the aim of the present research was to study religious coping among the caregivers of differently-abled children with respect to their age and type of child disability. Two hundred caregivers from different rehabilitation schools and centers of the Kashmir valley were selected through a purposive sampling technique. The mean age and standard deviation of the caregivers were 40.04 and 5.31, respectively. Welch's test, followed by the Games-Howell Post-hoc test, were carried out to analyze the data. The results revealed that children with older caregivers (40-52 years old) scored high on religious coping as compared to children with younger caregivers (27-39 years old). Furthermore, results also revealed that all the caregivers use religious coping as a means to cope with their day-to-day stressful life events, except for caregivers with visually-impaired children, who practice the strategy less as compared to their counterparts.

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1. Introduction

Caregivers of children with disabilities go through significant challenges in their daily lives. They experience a wide range of emotions like anger, depression, denial, guilt, shame, hopelessness, shock, financial burden, marital conflict, and even withdrawal. These emotions keep them at stake and significantly impact their physical and mental health. Previous studies have examined the role of emotional and problem-focused coping strategies (Folkman & Lazarus, 1984) among caregivers of differently-abled children. Emotional coping strategies are applied by caregivers to reduce negative emotions like fear, anxiety, depression, embarrassment, and frustration, whereas problem-focused coping strategies are adopted to tackle the problem and to reduce the situation causing stress to the caregivers. Religious coping is the third strategy, besides emotional and problem-focused coping strategies, which could play a buffering role against these stressful life events. Several studies have shown a significant positive impact of religious coping on caregivers assisting patients with diseases like Alzheimer's disease, terminally ill cancer patients, patients with stroke, Thalassemia, mental illness, dementia, and many other diseases (Stolley, Buckwalter, & Koenig, 1999; Pearce, Singer, & Prigerson, 2006; Rathier, Davis, Papandonatos, Grover, & Tremont, 2015; Pearce, Medoff, Lawrence, & Dixon, 2016; Chong, Chong, Tang, Ramoo, Chui, & Hmwe, 2019; Kes & Aydin Yildirim, 2020).

Religious coping refers to the use of cognitive-behavioral techniques to manage stressful situations in the light of one's spirituality or religious beliefs (Pargament, 1997). Epidemiological studies (and the resulting meta-analyses) have shown that people frequently rely on religion to cope with life stresses, demonstrating the positive impact that religious coping may have on the general well-being of individuals (Harrison, Koenig, Hays, Eme-Akwari, & Pargament, 2001; Ano & Vasconcelles, 2005). Moreover, a smaller number of studies have found religious coping to moderate the relationship between stress and well-being, providing support for the buffering hypothesis (Tix & Frazier, 1998; Aydin, Fischer, & Frey, 2010; Carpenter, Laney, & Mezulis, 2012; Fernandez & Loukas, 2014). These findings elucidate the two mechanisms by which religious coping can affect the outcomes of adaptation (Ensel & Lin, 1991).

Researchers have identified a variety of ways in which people use religion to cope with stressful life situations, including engaging in religious practices, seeking social support through religious leaders and

congregations, and reframing stressful events in reference to their relationship with God (Boudreaux, Catz, Ryan, Amaral-Melendez, & Brantley, 1995; Pargament, Smith, Koenig, & Perez, 1998; Krägeloh, Chai, Shepherd, & Billington, 2012). Some researchers have focused more exclusively on the cognitive aspects of religious coping (Pargament *et al.*, 1998). Boudreaux and colleagues (1995) have explored the importance of outward religious practices and social support accessed via religious networks. Their results suggest that different facets of religious coping may differentially impact the outcomes of the well-being of individuals. These findings highlight the potential independence of the cognitive, behavioral, and social dimensions of religious coping.

Religious coping is a process of coping with difficult circumstances through religion that can help in a variety of ways.

Pargament (1997) posited three approaches to the issue of control in religious coping.

1. Deferring mode of relationship: Praying in order to put the problem completely in the hands of God.
2. Collaborative mode of relationship: Praying in which the supplicant and God work together on the problem.
3. Self-directive approach: Praying in which God is acknowledged but the problem requires personal rather than divine solutions.

Other authors (Maynard, Gorsuch, & Bjorck, 2001; Wong-McDonald & Gorsuch, 2004) proposed a fourth style of religious coping, called surrender, which is similar to the deferring prayer.

In spite of the wealth of knowledge on religious coping present in the literature, to the best of our knowledge, no research has been conducted on the use of religious coping by caregivers of differently-abled children.

2. Objectives

The objectives of the study here conducted were the following:

1. To understand if there were significant differences on religious coping among caregivers of differently-abled children that could be explained by the age of the caregivers and type of child disability.

2. To understand if there were significant differences on the dimensions of religious coping among caregivers of differently-abled children that could be affected by the age of the caregivers and type of child disability.

3. Hypotheses

The following constructs were hypothesized:

1. There were no differences on religious coping among caregivers of differently-abled children with respect to their age and type of child disability.
2. There were no differences on the dimensions of religious coping among caregivers of differently-abled children with respect to their age and type of child disability.

4. Methods

4.1. Participants

Two hundred caregivers (108 fathers and 92 mothers) of differently-abled children were selected through a purposive sampling technique. Participants age ranged between 27 to 52 years old with a mean age of 40.03 years (*SD* = 5.31; see Tab. 1 for details).

Table 1 – *Characteristics of the study population*

Variables	Group/Category	Frequency	Percentage
Caregiver Age	27-39	44	22.0%
	40-52	156	78.0%
Type of Disability	Autism	11	5.5%
	Visual Impairment	4	2.0%
	Cerebral Palsy	6	3.0%
	Down Syndrome	16	8.0%
	Intellectual Disability	71	35.5%
	Locomotor Disability	19	9.5%
	Microcephaly	5	2.5%
	Multiple Disability	42	21.0%
	Seizure Disorder	10	5.0%
	Speech Problems	16	8.0%

Caregivers (either the mother, father or both) whose child was less than 14 years old (*M* = 3.53; *SD* = .86) were included in the study. The data was collected from the Chotay Taray Foundation School (Rawat Pora Bhagat, Srinagar, India), the Composite Regional Centre (Bemina, Srinagar, India),

the Kamraz School for differently-abled children (Baramulla, Jammu and Kashmir, India) and the Zaiba Aapa Institute of Inclusive Education (Bijbehara, Anantnag, India). All the children with disability were identified by professionals (i.e. rehabilitation psychologics, clinical psychologists, etc.) working in the field of disability and rehabilitation.

4.2. Measure used

4.2.1. Religious Coping Scale

The Religious Coping Scale, developed by Gull and Husain (2020), was used to measure the religious coping among the caregivers of differently-abled children. The scale was developed for caregivers of differently-abled children irrespective of their cast, creed, culture, gender, and religion. This scale is an 18-item instrument, based on a 4-point ranked scale, ranging from "never" to "always". In addition, the religious coping scale has five dimensions (see Tab. 2 and details in text). All the items were scored in a positive direction, i.e. from 1 to 4. Total scores ranged from 18 to 72. The higher the score, the more the subject tended to engage in religious practices and this applied to all the dimensions described. The internal consistency of the Religious Coping Scale for this study was α = .84.

Table 2 – *Religious Coping Scale's structure and internal consistency*

Dimensions	Items	Number of items	Cronbach *α*
Divinely Seeking	16, 15, 18, 17, 05	05	.80
Coping Attitude	04, 07, 06	03	.75
Religious Faith	01, 02, 03	03	.82
Sense of Possibility	14, 12, 13	03	.70
Spiritual and Social Support	09, 10, 08, 11	04	.77
Total		18	.84

The five dimensions were, as follows:

- *Divinely Seeking*: Islamic culture is based on God's support. Parents of disabled children perceive that Divinely seeking will be more beneficial in the recovery of the disability process of their children. It has been demonstrated that humans are likely to call out to God, when in distress or suffering from tribulations (Utz, 2011).

- *Coping Attitude:* For most Muslims Coping attitude is an important aspect of the coping process. Gathering in prayer and performing religious practices for the recovery of children's disability is a way of life for parents.
- *Religious Faith:* Religious faith leads to positive coping, where parents establish a connection with God, ask God for forgiveness of their sins and feel comfort in religion. The contents of the dimension suggest that these are the sources of every Muslim's faith and practice. Religious faith or belief impacts upon coping in a miraculous way.
- *Sense of Possibility:* Religious coping strategies offer a 'Sense of possibility' in parents of disabled children when all other remedies are lost. For believers, it translates in engaging/attending religious activities or services and in approaching God to provide a new direction in life.
- *Spiritual and Social Support:* Parents recognize the value of Spiritual and social support in coping with their children's disability. It is expressed in several ways, such as asking others to pray for the recovery of their children, providing spiritual support, seeking social support from family or friends, and seeking support from religious instructors.

4.3. Procedure

A relationship was established with the parents prior to being exposed to the research study. The researcher first introduced him/herself and then explained the purpose of the research to the respondents. The participants were assured that their responses were strictly confidential and were thus used exclusively for the research purpose. A scheduled questionnaire was used in this study. The respondents were told to listen to the instructions carefully before responding to the questions. Each respondent took about 10-15 minutes to fill in the questionnaire.

5. Data analysis

The data was analyzed by using the SPSS 20 version. Welch's test, followed by a Post-hoc analysis (Games-Howell), were used to analyse the data. The level of significance was set at or below .05.

6. Results and discussion

The purpose of the study was to examine the difference on religious coping among caregivers of differently-abled children that could be explained by the age of the caregivers and type of child disability. A total of 200 caregivers, 108 fathers (54%) and 92 mothers (46%), was selected from various rehabilitation centers and special schools of the Kashmir Valley by applying a purposive sampling technique.

Table 3 highlights the significant differences on religious coping between the younger (27-39 years old) and older caregivers (40-52 years old).

Table 3 – *Comparison of younger (27-39 years old) and older (40-52 years old) caregivers on religious coping and its dimensions*

		Sum of Squares	*df*	Mean Square	*F*	*Sig.*
Divinely Seeking	Between Groups	15.52	1	15.52	5.98	.01
	Within Groups	513.50	198	2.59		
Coping Attitude	Between Groups	10.83	1	10.83	2.31	.13
	Within Groups	929.79	198	4.69		
Religious Faith	Between Groups	.60	1	.60	.61	.44
	Within Groups	195.15	198	.98		
Sense of Possibility	Between Groups	6.19	1	6.19	1.44	.23
	Within Groups	849.20	198	4.29		
Spiritual & Soc. Support	Between Groups	34.76	1	34.76	5.04	.02
	Within Groups	1364.99	198	6.89		
Religious Coping Scale	Between Groups	268.64	1	268.64	6.24	.01
	Within Groups	8518.95	198	43.02		

Table 4 – *Robust tests of equality of means*

		Statistic[a]	*df*1	*df*2	*Sig.*
Divinely Seeking	Welch	3.46	1	51.92	.07
Coping Attitude	Welch	2.25	1	67.68	.14
Religious Faith	Welch	.49	1	60.34	.49
Sense of Possibility	Welch	1.60	1	74.73	.21
Spiritual and Social Support	Welch	3.74	1	57.86	.06
Religious Coping Scale	Welch	5.16	1	61.31	.02

[a] Asymptotically *F* distributed.

As the results of the table suggest, significant differences were found among the caregivers concerning overall religious coping ($F_{(1,198)} = 6.24$, $p = .01$) and its two dimensions, divinely seeking ($F_{(1,198)} = 5.98$, $p = .01$) and spiritual and social support ($F_{(1,198)} = 5.04$, $p = .02$). Welch's test was further conducted due to the substantial difference in variance and small sample size between the two groups (Tab. 4). The results from Welch's test indicate a significant difference between the two groups but only concerning overall religious coping ($Fw = 5.16$, $p = .02$). The mean score of the older caregivers was higher as compared to the younger caregivers. This can be explained by the fact that younger caregivers are less religious as compared to older caregivers. When a child is diagnosed as disabled, young couples believe more on the expertise of professionals working in the field of disability for the recovery of their child besides having a religious faith. At a first stage, these young couples hope for their child's recovery but when they become aware of the fact that the chances of recovery are very low and that their child presents a lifelong disability, they become more religious and resort to praying to God for the well-being of their children. These religious practices increase with an increase in age. Our results are in line with the literature on psychology of religion, which shows a positive relationship between age and religiousness (Bengtson, Silverstein, Putney, & Harris, 2015; Murat, 2017).

Table 5 – *One way analysis of variance*

	Sum of Squares	*df*	Mean Square	*F*	*Sig.*
Between Groups	1138.48	9	126.49	3.14	.00**
Within Groups	7649.11	190	40.26		
Total	8787.59	199			

$^{**}p < .01$

Table 6 – *Robust tests of equality of means*

	Statistic[a]	*df*1	*df*2	*Sig.*
Welch	9.40	9	30.92	.00

[a] Asymptotically *F* distributed.

The results of the one way ANOVA, as presented in Table 5, also revealed a significant difference on religious coping among the caregivers of differently-abled children with respect to the type of child disability. The *p* value (*sig.*) was .00, i.e. less than the minimum assumed level of

significance (p = .01). Therefore, there was enough evidence to reject the null hypothesis number 2. Welch's robust formula was used to check the homogeneity of variance considering that the 10 child disability groups varied in terms of sample size (Tab. 6). The results from Welch's test also confirmed a statistically significant difference among the groups. A further pair-wise comparison was carried out by using the Games-Howell Post-hoc analysis (Field, 2009), as the sample size among the groups was very different (Tab. 7).

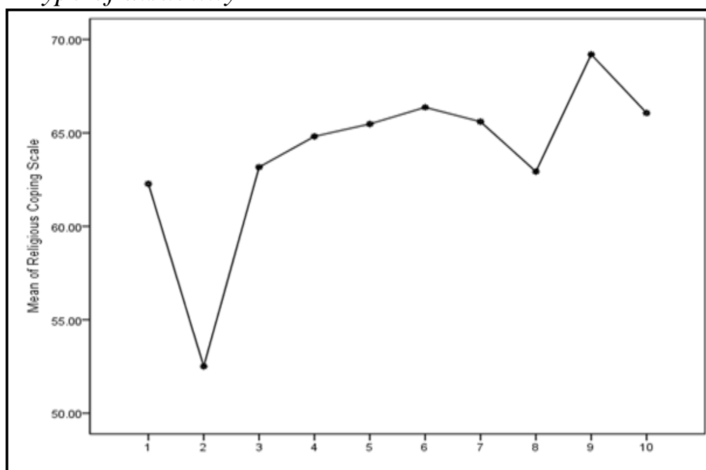
Table 7 – *Post-hoc analysis (Games-Howell). dependent variable: Religious Coping Scale*

(I) Type of disability	(J) Type of disability	(I-J) Mean difference	Std. error	*Sig.*	95% Confidence interval	
					Lower bound	Upper bound
Autism	Visual Impairment	9.77*	2.18	.02	1.20	18.34
Down Syndrome	Visual Impairment	12.31**	2.47	.00	3.20	21.41
Intellectual Disability	Visual Impairment	12.97**	1.61	.00	4.76	21.19
Locomotor Disability	Visual Impairment	13.86**	2.04	.00	5.82	21.91
Microcephaly	Visual Impairment	13.10*	2.81	.04	.37	25.82
Multiple Disability	Visual Impairment	10.42*	1.76	.01	2.59	18.26
Seizure Disorder	Visual Impairment	16.70**	1.76	.00	8.69	24.70
Seizure Disorder	Multiple Disability	6.27**	1.44	.00	1.33	11.20
Speech Problems	Visual Impairment	13.56**	2.27	.00	4.99	22.12

* The mean difference is significant at the .05 level; ** The mean difference is significant at the .01 level

The Post-hoc test revealed that religious coping among the caregivers with Autistic children or children with Cerebral Palsy, Down Syndrome, Intellectual Disability, Locomotor Disability, Microcephaly, Multiple Disability, Seizure Disorder and Speech Problems was higher as compared to caregivers with visually-impaired children (Tab. 7 and Fig. 1).

Figure 1 – *Type of disability*



Autism = 1; Visual Impairment = 2; Cerebral Palsy = 3; Down Syndrome = 4; Intellectual Disability = 5; Locomotor Disability = 6; Microcephaly = 7; Multiple Disability = 8; Seizure Disorder = 9; Speech Problems = 10

The mean score of caregivers of autistic children was higher on religious practices as compared to the mean score of caregivers having visually-impaired children (MI = 62.27; MJ = 52.50). The difference between the two groups was statistically significant (MD = 9.77; $p < .05$). Likewise, the mean score of caregivers of children with down syndrome (MI = 64.81; MJ = 52.50), intellectual disability (MI = 65.48; MJ = 52.50), locomotor disability (MI = 66.36; MJ = 52.50), microcephaly (MI = 65.60; MJ = 52.50), multiple disability (MI = 62.92; MJ = 52.50), seizure disorder (MI = 69.20; MJ = 52.50) and speech problems (MI = 66.06; MJ = 52.50) was higher as compared to the mean score of caregivers of children with visual impairment. The differences between the groups were statistically significant (Tab. 7). The caregivers of visually-impaired children scored less on religious coping as compared to their counterparts. Moreover, a significant mean difference was found between the caregivers having children with seizure disorder and with multiple disabilities (MI = 69.20; MJ = 62.92). The former group scored higher on religious coping as compared to the latter.

Our results show that religious coping was a strategy applied by caregivers with children affected by all the kinds of disability tested here (9 out of 10 child disability groups), with the exception of caregivers having visually-impaired children who scored less. The results suggest that the former caregivers are more religious as compared to caregivers of children

with visual impairment. They perceive trusting in God and gathering in prayer as an effective coping strategy, which helps them to go through difficult caregiving situations. This may be due to the fact that children with such types of disabilities are more dependent on their caregivers as compared to children having a visual impairment. These results are in line with previous research (Stolley *et al.*, 1999; Leung & Li-Tsang, 2003; Malhotra & Thapa, 2015). Also depression was found to be significantly different between caregivers of differently-abled children and caregivers of normal children. Caregivers of children with disability scored a significantly higher mean score on depression as compared to caregivers having normal children (Roach, Orsmond, & Barratt, 1999; Hedov, Annere´n, & Wikblad, 2000). Further research should be promoted to explore if significant differences on depression occur among the caregivers of differently-abled children with respect to the type of child disability just as the results presented in this research appear to suggest for religious coping.

7. Conclusions

Caregiving in general is a very difficult task. Caregivers of differently-abled children worry about the future of their children. These caregivers can experience a range of emotions in response to their child’s disability, which may include ambivalence, anger, denial, depression, hopelessness, fear of stigma, grief, guilt, shock, and even withdrawal. Most of these children are dependent on their caregivers for their “activities of daily living” and are subjected to “behavioral problems”, which lead them to long-term cyclic physical and mental health problems. However, the quality and quantity of the problems incurred vary from caregiver to caregiver, depending on the type and level of severity of the child’s disability. Caregivers use different strategies in order to buffer against the stressors and stressful life events of having a child with a disability, like emotional coping strategies, problem-focused coping strategies and religious coping strategies. Religious coping strategies, in particular, play a significant role when caregivers lose the hope for their child’s recovery so that gathering in prayer and praying to God seem the ideal solution for the well-being of their children and to reach an inner peace for themselves.

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