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Increased Congregational Support for Parents of Children with Cystic Fibrosis

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Abstract

Positive health outcomes are related to adults' religious congregational participation. For parents of children with chronic disease, structured daily care routines and or strict infection-control precautions may limit participation. For this exploratory study, we examined the relationship between congregational support and religious coping by parents of children with cystic fibrosis (CF) compared to parents for whom child health issues were not significant stressors. CF parents reported higher levels of emotional support from congregation members and use of religious coping. Within-group differences were found for CF parents by denominational affiliation. Congregational support for parents dealing with child chronic disease is important.

Keywords

Congregational support; religious coping; cystic fibrosis; religion; parents

Religious congregations are an important part of life for many Americans. Half of Americans reported being a member of a church or synagogue in 2013, 37% reported attending a church or synagogue at least every week or almost every week, and 56% reported that religion is "very important" in their own life (Gallup, 2008). Belonging to a community of people with shared values and beliefs has been deemed to be very important for 49% of adults in the general US population (Lugo & Cooperman, 2012). People for whom religious identity is very important are likely to attend church more often and more likely to have close friends in the place where they worship (Lim & Putnam, 2010). Participation in the life of a congregation offers various benefits, including developing one's faith, as well as social, emotional and instrumental support.

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Participation in religious congregations also may provide health benefits. In a study of over 550 older adults, attending religious services more than once weekly was determined to be a significant predictor of lower subsequent 12-year mortality compared with never attending religious services (Lutgendorf, Russell, Ullrich, Harris, & Wallace, 2004). In a study of over 2000 African Americans, 37% went to church at least monthly and church attendance was associated with increased likelihood of positive health-care practices, including dental visits and blood-pressure measurements. Based on the results, the authors concluded that church attendance is an important correlate of positive health-care practices and that community- and faith-based organizations present additional opportunities to improve health (Aaron, Levine, & Burstin, 2003). Findings derived from a nationwide survey of members of the Presbyterian Church (USA) revealed that, 1) although women received more emotional support from church members over time than men, the church-based support that was associated with better self-rated health over time emerged only among men (Krause, Ellison, & Marcum, 2002), 2) church members who received emotional support from fellow church members tended to feel they belonged in their congregation, and individuals with a strong sense of belonging were, in turn, more satisfied with their health (Krause & Wulff, 2005), 3) church members who discussed health matters within informal church-member networks were more likely to have health checkups, at least partially due to doctor recommendations from church members (Ellison et al., 2008), and 4) Benjamins and colleagues found that two aspects of congregational support were relevant to the use of preventive health services (Benjamins, Ellison, Krause, & Marcum, 2011). In that study, church-based health activities were significantly related to the use of cholesterol screenings and flu shots, and discussing health-related issues with fellow church members was significantly associated with having had a cholesterol screening, as well as moderately predictive of colonoscopy use. Based on these findings, congregational support likely fosters increased engagement in healthy practices.

However, congregational participation may be limited for persons with chronic disease and their caregivers due to a variety of reasons, including required daily treatment routines and infection-control practices that may make it more difficult to access congregational support. A prior study of the differential amounts of time mothers of children with cystic fibrosis (CF) and matched controls spent in medical care for their child and other activities suggested that mothers of children with CF spent less time engaged in “church” and “meetings” (Quittner et al., 1998). Ault and colleagues reported on congregational participation and support for children with disabilities and their parents (Ault, Collins, & Carter, 2013). Congregational support was operationalized in that study as the extent to which the child was included in religious activities. Parents reported a general dissatisfaction with this type of support.

For the present study, CF was used as a pediatric chronic disease exemplar. CF is a chronic life-shortening disease affecting the lives of approximately 30,000 persons in the US and is the most-common genetic disease among Caucasians. While primarily thought of as a pulmonary disease, CF also can affect the gastrointestinal, endocrine and genitourinary systems. Slowing disease progression requires an ongoing commitment to a structured daily care routine and stringent infection-control precautions, potentially limiting congregational participation and support for parents of children with CF. These daily routines are complex,

time-consuming (Marciel, Saiman, Quittell, Dawkins, & Quittner, 2010; Ziaian et al., 2006). They typically include at least twice-daily airway-clearance treatments, administration of nebulized medications often several times a day, pancreatic enzyme replacement with all meals and snacks, insulin (if diabetic), and supplemental nutrition. Infection control is also necessary to prevent or minimize infections leading to poorer lung function and lower quality of life (Saiman, Siegel, & Cystic Fibrosis Foundation Consensus Conference on Infection Control, 2003). As such, infection control considerations may influence decisions regarding participation in religious congregations or other social events. In addition, public settings where exposure to pollution, cigarette smoke, and other respiratory tract irritants are common also may be avoided. Religious congregations that include the use of incense, practice baptism of children by full immersion, or baptize multiple children in a single font, may increase the possibility of exposure to a variety of infectious agents. Therefore, parents of children with CF might be tempted to avoid such places due to infection-control concerns for their child's health.

Religious coping has been shown to be an important source of parental coping during the first two years after a child's CF diagnosis (Grossoehme et al., 2010; Grossoehme, Ragsdale, Wooldridge, Cotton, & Seid, 2010; Grossoehme, Ragsdale, Snow, & Seid, 2011). Parents reframed their experience in religious terms, moving through feeling "devastated" to a task that "we can handle" and, after two years, to understand parenting a child with CF as a vocation for which "we were chosen." Pargament and colleagues terms such reframing of experience as "benevolent religious reappraisal" (Pargament, Koenig, & Perez, 2000). Understanding the role of faith in pediatric health care is important because parental beliefs contribute to determining parental health behaviors for their children. A qualitative study by Grossoehme and colleagues presented a model in which, for parents who used faith, parents who were more adherent to following their child's prescribed treatment plan used faith differently than those who were less adherent (Grossoehme et al., 2013). More-adherent parents used prayer to gain a sense of empowerment so that they could take care of their child, while less-adherent parents used prayer to ask God to take care of their child.

Previously published literature on congregational support has focused on adults as individuals, and the congregational support literature on adults as parents or on families is underdeveloped. Therefore, the purpose of this exploratory study was to identify factors that may be associated with either receiving less support or receiving more support from fellow church members.

Research Questions

1. Do parents of children with CF report receiving less congregational support than parents of children for whom health issues are not a significant concern?
2. How are forms of religious coping used differently by parents of children with CF and parents of children for whom health issues are not a significant concern?

Methods

Participants

CF parent group—In the context of a larger study of parental spiritual, religious and psychosocial characteristics and their potential relationship to health behaviors, data was collected from 141 parents of children diagnosed with CF who were being followed at one of two sites. Both sites are academic pediatric health centers; Site 1 is a 525-bed facility in the Midwest and Site 2 is a 332-bed facility in the South. Parents of children with CF between the ages of 3 months and 13 years (N=116, Site 1 and N=183, Site 2) were eligible to participate in this study. This age range was selected because they are the ages during which parents have begun to adjust to their child's CF diagnosis and yet are still at least 70% responsible for completing their child's treatments (Drotar & Levers, 1994). Parents were informed of their eligibility by a letter from their child's pulmonologist followed by either a phone call or outpatient clinic encounter to have questions answered, decline, or complete informed consent and enrollment processes if interested. Study data, including the scales described below, were collected and managed using REDCap (Research Electronic Data Capture) hosted at Site1 (Harris et al., 2009). REDCap is a secure, web-based application designed to support data capture for research studies, providing 1) an intuitive interface for validated data entry, 2) audit trails for tracking data manipulation and export procedures, 3) automated export procedures for seamless data downloads to common statistical packages, and 4) procedures for importing data from external sources. The study was approved by the institutional review board (IRB) at each of the two sites where informed consent was obtained and data was collected for the CF parent group.

Comparison group—Data for a comparison sample for the present study were derived from an existing database from the February 1997 Presbyterian Panel survey focused on perceptions of spirituality and health (Marcum, 1997). Data were collected by self-administered mail surveys that included responses to part of the same Congregational Support scale used for the CF parent group. The main goal of the Presbyterian survey was to gather broad information about church members in terms of their faith (beliefs, church background, and levels of church involvement) and their social, economic and demographic characteristics (e.g., age, sex, marital status, living arrangements). For comparison with the CF parent group in our study, data from respondents for the Presbyterian survey was a subset of the whole, which was generated in the following way. Data were included for survey participants who had children, and who did not indicate that a family health problem was one of the most significant things they dealt with in the past year. To make the Comparison group comparable with CF parent group, the survey data also was restricted to participants who resided in the American South or Midwest. We found that there were no statistically significant differences between South and Midwest participants, compared to the rest of the cohort, on the congregational support variables within the survey data. This process led to a Comparison group consisting of 156 persons who were as closely matched to the CF parent group of parents of children with CF as possible with respect to the available data. Data from the Comparison group included only the Emotional support from members and Religious coping subscales of the Congregational Support scale, and certain items from the Brief R-COPE scale (Collaborative, Self-directed, Spiritual discontent,

Benevolent religious reappraisal, Seeking spiritual support, Spiritual connection, Religious forgiving, and Punishing God reappraisal).

Procedure

Congregational Support scale—This is an 11-item scale presented by Krause and colleagues to measure church-based social support and religious coping (Krause, Ellison, Shaw, Marcum, & Boardman, 2001). The items themselves were developed by an expert working group gathered under the auspices of the Fetzer Institute/National Institute on Aging Working Group (Krause, 2003). There are four subscales: Emotional support from members (two items); Spiritual support from members (three items); Emotional support from the pastor (two items); and Religious coping (four items). The two items from the Emotional support from members subscale are: “How often have members of your congregation made you feel loved and cared for?” and “How often have members of your congregation listened to you talk about your private problems and concerns?” The first three subscales have four-point responses ranging from never (1), once in a while (2), fairly often (3) and very often (4), and the score for each subscale is the sum of the response values.

Brief R-COPE scale—Participants in the CF parent group also completed the Brief R-COPE (Pargament, et al., 2000). This 18-item scale included two subscales for positive and negative religious coping. In addition, four items that address forms of religious coping for control (Self-directed, Active surrender, Deferral, and Pleading) were added (the positive subscale already included the fifth form of religious coping for control, Collaborative). Responses on the Brief R-COPE scale are coded 1 (not at all), 2 (somewhat), 3 (quite a bit), and 4 (a great deal). The Religious coping items in the Congregational Support scale were taken from the Brief R-COPE scale. These items inquire about the use of Spiritual connection (Thought about how my life is part of a larger life force), Seeking spiritual support (Looked to God for strength, support and guidance), Benevolent religious reappraisal (Tried to find a lesson from God in this problem), and Religious forgiving (Sought help from God in letting go of my anger). Responses on the Religious coping subscale are coded 1 (not at all), 2 (somewhat), 3 (quite a bit), and 4 (a great deal).

Duke University Religion Index—The Duke University Religion Index (DUREL) was used to measure religiosity (Koenig, Koenig, Parkerson, & Meador, 1997). This five-item scale measures organizational, non-organizational and intrinsic religiosity. The first two constructs are measured with one item each concerning frequency of religious practices, and intrinsic religiosity is measured with three items about religious belief and experience. For this preliminary study, only the first item that measures frequency of attendance at public worship, was used.

Analyses

Descriptive analyses were performed for demographic characteristics and outcome variables. Summaries are reported as n (%) for categorical variables and median (IQR) for continuous variables. The key outcome variables to compare between the two study groups (emotional support from members and religious coping) had intrinsic ordering, but did not meet the assumptions necessary to perform a valid ordinary least-squares regression. Since

each outcome's distribution was highly non-normal, we employed ordinal multinomial logistic regression. The odds ratio (OR) of interest in each regression represents the odds that an outcome will occur given the parent has a child with CF. $OR > 1$ implies that being a parent of a child with CF is associated with increased odds of the outcome, while $OR < 1$ indicates being a parent of a child with CF is associated with lower odds of the outcome. To use ordinal multinomial logistic regression, the assumption that the OR for each predictor is taken to be constant across all possible collapsed values of the outcome variable was checked. This was done by a standard test called the "Score test" (Hosmer & Lemeshow, 2000). If the test was significant, then additional graphical methods were used to determine whether the logit surfaces were actually parallel. If this assumption was unmet, some of the values of the ordinal outcome were dichotomized or combined until the proportional odds assumption was satisfied. Ordinal multinomial logistic regression models were used in a similar manner for data from the CF parent group, in order to assess differences between religious affiliations for each of the outcome variables. For those regressions, the OR of interest corresponds to comparisons of religious affiliations. Potential confounders that were statistically significant at $P < 0.05$ were retained in regression models as covariates. Results are expressed as OR (95% CI) except where noted. All analyses were implemented using SAS 9.3 (SAS Institute, Cary, NC).

Results

Demographic data for the two samples are presented in Table 1. The Comparison group had a larger percentage of persons over age 40 than the CF parent group. The CF parent group's religious breakdown included roughly equal numbers of (mainline) Protestants and non-denominational Christians (30% each) and roughly equal percentages of persons who indicated they were Roman Catholic or Other (20%). Age group, marital status and religious affiliation significantly differed between the CF parent and Comparison groups. Since all participants within the Comparison group had a Protestant religious affiliation, this variable was not included as a covariate in the statistical models. Cronbach's alpha for the Brief R-COPE scale was 0.80.

Worship attendance by participants from the CF parents group was 43% attending at least weekly, which is similar to Gallup data for the US average of 41% (Newport, 2010). Frequent attenders reported higher levels of receiving Emotional support from members of their congregations than the less-frequent attenders (Chi-square=50.7; $df=24$; $P=0.001$).

Ordinal multinomial logistic regression was used to assess whether parents of children with CF have more, less, or similar levels of congregational support compared to parents who are not parents of children with a chronic illness, controlling for age group and marital status. The only variables that failed to meet the proportional odds assumption were Emotional support from members, Spiritual support from members, and Spiritual discontent. The Emotional support variable was recoded into three levels, the Spiritual support variable was dichotomized into "seldom" and "often", and Spiritual discontent was dichotomized into "not used" and "used" (at any of the three frequencies, from used "somewhat" to "a great deal") to obtain an approximately equal number of people in each level of the newly-created variables. The probability of a higher score was modeled for each outcome, and the

corresponding odds ratios were determined (Table 2). Model results obtained within the CF parent group are reported in Table 3.

Compared with parents who are not parents of children with a chronic illness from the survey data, parents of children with CF who were affiliated with a congregation had increased odds of higher scores of Emotional support from congregation members (OR=4.96; CI: 2.59–9.52). Feeling cared for by members of the congregation was more likely among parents of children with CF than among the Comparison group of parents (OR=27.32; CI: 13.11–56.95). The CF parents group had significantly increased odds of having higher levels of Benevolent religious reappraisal, Spiritual connection, and Religious forgiving. The Comparison group had increased odds of having higher scores for Collaborative religious coping (OR=0.43; CI: 0.25–0.74) and decreased odds of higher scores of Self-directed religious coping (OR=2.13; CI: 1.19–3.84) than parents of children with CF. The Comparison group parents had decreased odds of having a higher score for Spiritual discontent than the parents of children with CF (OR=2.48; CI: 1.22–5.04). No significant differences were found between the two groups of parents for having someone to talk about their problems within their congregation.

Model results obtained within the CF parent group are reported in Table 3. Within this group, Protestants and non-denominational Christians had increased odds of higher scores of Collaborative religious coping than all others (OR=5.03; CI: 2.00–12.62 and OR=3.69; CI: 1.53–8.94, respectively). Furthermore, Protestants were more likely to have increased Collaborative religious coping than Roman Catholics (OR=2.85; CI: 1.13–7.17). On the other hand, Protestants were less likely to have higher scores of Self-directed religious coping than those subjects with other religious affiliations (OR=0.29; CI: 0.11–0.73). Feeling cared for by members of the congregation was more likely among CF parents who were non-denominational Christians than parents who were Roman Catholics (OR=0.17; CI: 0.037–0.80), while these findings were similar for Protestants and Roman Catholics (OR=7.47; CI: 1.62–34.40). CF parents who were non-denominational Christians felt that members in their congregations listened to them talk about their problems more often than parents who were Roman Catholics (OR=0.17; CI: 0.044–0.63). With regard to Emotional support from congregation members, parents who were non-denominational Christians, Protestants and parents with other religious affiliations had increased odds of higher scores than Roman Catholics (OR=0.095; CI: 0.025–0.351, OR=7.19; CI: 2.18–23.73 and OR=0.13; CI: 0.019, 0.87, respectively). Protestants had significantly increased odds of having higher levels of Benevolent religious reappraisal than their counterparts who were Roman Catholic or had another affiliation (OR=4.06; CI: 1.37–11.99 and OR=5.65; CI: 1.25–25.46, respectively). Protestants had significantly increased odds of having higher levels of Religious forgiving than both Roman Catholics and non-denominational Christians (OR=4.6; CI: 1.31–16.14 and OR=3.45; CI: 1.22–9.78, respectively).

Discussion

The purpose of this preliminary study was to explore possible differences in congregational support perceived by parents of children with CF compared to a group of parents whose children did not have a chronic, life-shortening disease. No support was found for the

hypothesis that parents of children with CF experience less emotional support from members of their congregation than the control sample. In fact, in this study, parents of children with CF reported significantly higher levels of emotional support from members of their congregation than did persons in the control sample.

Emotional support from congregation members may facilitate or strengthen a parent's sense of connectedness with others and has been shown to lead to higher levels of purpose and meaning in life among older adults (Krause, 2004). Furthermore, emotional support from members and spiritual support from members are correlated, in that having both contributes to a person's sense of religious meaning, although spiritual support plays the more important role (Krause, 2008).

We also found support for differences in religious coping between parents of children with CF and the parents in the Comparison group. The increased odds that parents of children with CF would experience higher levels of thinking of how their life was part of a larger life force/spirit, which is a benevolent religious reappraisal, is consistent with how parents in other studies have positively reframed their experience of parenting a child with medical issues (Dollahite, Marks, & Olson, 1997; Grosseohme, et al., 2011). The decreased odds that parents of children with CF would report their experience as collaborative religious coping (Working together with God) and increased odds of using self-directed religious coping (Trying to deal with this without God's help) is not surprising given the level of time and skill required to prepare for, administer or supervise, and clean up from, the daily treatment routines.

It may be that the demands of caring for a child with CF lead to the development of self-directed religious coping. In a study of adults with end-stage pulmonary disease, which included adults with CF, Burkner and colleagues found that persons with CF used self-directed religious coping more frequently than did the other adults with end-stage pulmonary diseases (who tended to use passive deferral more frequently than did persons with CF) (Burkner, Evon, Sedway, & Egan, 2004). Self-directed coping has been related to depression and hopelessness (Molock, Puri, Matlin, & Barksdale, 2006; Phillips, Russell, Lynn, Crossley, & Pargament, 2004). Phillips and colleagues suggested that for persons with lower self-efficacy, individuals with the belief in a supportive and non-intervening God might experience higher levels of distress. Therefore, it may matter what belief lies behind self-directed religious coping. Providing the daily CF treatment routine may cultivate a sense of self-efficacy in parents that influences their use of religious coping for control. Phillips and colleagues found that self-directed religious coping that is related to a sense of abandonment by God was related to poorer self-esteem, whereas belief in abandonment by God was itself related to high anxiety and lower spiritual well-being (Phillips, et al., 2004).

Based on our results, congregations might think intentionally about how to foster an emotionally safe space for persons with CF, and potentially other chronic health conditions. While the stigma related to having CF is lower compared to other chronic disease (Oliver, 2011), it is nonetheless present and is related to poorer psychological outcomes. Disclosing that one has CF is an individual choice, and Modi and colleagues have shown that adults with CF are more likely to disclose to relatives and close friends compared to dating

partners, bosses/supervisors, co-workers or acquaintances, which would likely include congregational members (Modi, Quittner, & Boyle, 2010). To the extent that receiving emotional support from members is correlated with receiving spiritual support from them also, it could be helpful to equip members to talk about illness and disease in religious or spiritual language. Parents of children with chronic conditions have been shown to reframe their experience in religious terms (Dollahite, et al., 1997; Grosseohme, et al., 2011). Therefore, facilitating the ability of adults to provide spiritual support may enable increased ability or likelihood of providing emotional support. Another aspect of this is to reframe how congregations think about parents of children with CF or other chronic conditions. Rather than look for ways to “help” these parents, parents of children with CF could be perceived as relative experts in framing experiences in religious language—experts who could provide knowledge to people in the congregation about how to reflect theologically on brokenness.

This preliminary study has the following limitations. The Comparison group dataset did not include items dealing with other dimensions of congregational support, such as Receiving spiritual support from members and Emotional support from clergy. The time period between data acquisitions for the two study groups may have an influence, and while steps were taken to subset the Comparison group database to be as similar as possible to the CF parent group participants, the samples will have differences. The nature of CF as a disease that affects primarily Caucasians limits the generalizability to other chronic diseases of childhood. The majority of participants in this study were mothers, limiting generalizability to fathers of children with CF. However, important conclusions still can be drawn from the results of this study. The differences in emotional support perceived by parents of children with CF and the differences in religious coping suggest the need for a more robust, in-depth study of all dimensions of congregational support experienced by both fathers and mothers of children with a variety of chronic physical and mental health conditions.

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Biography

Daniel Grosseohme, DMin, is an Associate Professor of Pediatrics (Pulmonary Medicine) at the University of Cincinnati College of Medicine/Cincinnati Children's Hospital Medical Center and Staff Chaplain III, Department of Pastoral Care, Cincinnati Children's Hospital Medical Center. Dr. Grosseohme's expertise is the role of religion/spirituality in chronic diseases of childhood, with special focus on cystic fibrosis. His current projects focus on the role of spirituality in adherence to prescribed medical therapies.

Table 1

Demographics and characteristics of CF parent and Comparison groups

Variable	Sub-Category	CF parent group (N=141) n (% of group N)	Comparison group (N=156) n (% of group N)	P-value
Age group				<0.001
	<=40 years	114 (81%)	22 (14%)	
	>40 years	27 (19%)	152 (83%)	
Parent gender				0.69
	Female	101 (72%)	105 (67%)	
	Male	40 (28%)	46 (29%)	
Marital status				<0.001
	Married	126 (89%)	129 (83%)	
	Not married	0 (0%)	20 (13%)	
	Other	15 (11%)	7 (4%)	
Geographic region				0.15
	Midwest	84 (60%)	80 (51%)	
	South	57 (40%)	76 (49%)	
Religious affiliation				<0.001
	Protestant	41 (29%)	156 (100.00%)	
	Roman Catholic	25 (19%)	0 (0.00%)	
	Non-denominational Christian	47 (33%)	0 (0.00%)	
	Other	28 (20%)	0 (0.00%)	

Table 2

Predicted differences in congregational support and religious coping between parents of children who have CF and comparison group

Outcome	OR* (95% CI)
Emotional support from members	4.964 (2.589, 9.521)
Spiritual connection	1.888 (1.008, 3.538)
Benevolent religious reappraisal	2.049 (1.092, 3.845)
Religious forgiving	38.102 (15.643, 92.805)
Spiritual discontent	2.479 (1.219, 5.043)
Collaborative religious coping	0.433 (0.253, 0.739)
Self-directed religious coping	2.134 (1.187, 3.837)
Feeling cared for by members of the congregation	27.319 (13.106, 56.945)

* Each Odds Ratio (OR) was constructed as CF parent group versus Comparison group and corresponds to the CF parent group having higher (OR>1) or lower (OR<1) odds of increased score than the Comparison group. Each OR is adjusted for age group and marital status. CI, confidence interval

Table 3

Predicted differences in congregational support and religious coping based on religious affiliation of parents with children who have CF

	P/O	R/O	N/O	P/N	R/N	P/R
Feeling loved and cared for by members of the congregation	1.778	0.238	1.389	1.28	0.171 *	7.466 *
Listened to you talk about your private problems and concerns	1.071	0.313	1.875	0.571	0.167 *	3.429
Emotional support from members	0.928	0.129 *	1.364	0.68	0.095 *	7.193 *
Collaborative religious coping	5.027 *	1.766	3.693 *	1.361	0.478	2.847 *
Self-directed religious coping	0.286 *	0.372	0.423	0.675	0.879	0.768
Spiritual discontent	0.951	0.653	0.385	2.467	1.695	1.456
Punishing God reappraisal	1.612	1.710	1.53	1.054	1.118	0.943
Seeking spiritual connection	4.228	1.363	3.861	1.095	0.353	3.102
Seeking spiritual support	3.444	1.235	2.848	1.209	0.434	2.789
Benevolent religious reappraisal	5.645	1.391	2.646	2.133	0.526	4.059
Religious forgiving	2.556	0.556	0.741	3.45	0.75	4.6

Note:

* indicates significant results.

P: Protestant, R: Roman Catholic, N: Non-denominational Christian, O: Other. Each Odds Ratio (OR) refers to a comparison of two affiliations (affiliation 1/affiliation 2) with respect to measures of congregational support and religious coping. An OR >1 (<1) corresponds to CF parents with religious affiliation 1 having higher (lower) odds of increased score than CF parents with religious affiliation 2.