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Religious Coping Among Adults Caring for Family Members with Serious Mental Illness

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Abstract

This cross-sectional study investigated the use of religious coping strategies among family members of adults with serious mental illness. A sample of 436 individuals caring for a family member with serious mental illness were recruited into a randomized clinical trial for the National Alliance on Mental Illness Family to Family Education Program. Relationships are reported between religious coping and caregiving, care recipient, and mental health services outcomes. Religious coping was associated with more objective caregiving burden, greater care recipient need, less mental health knowledge, and less receipt of mental health services after adjusting for non-religious types of coping. At the same time, religious coping was associated with a positive caregiving experience and greater religious support. Religious coping plays an important role for many caregivers of persons with serious mental illness. Caregivers who use more religious coping may have an especially high need for mental health education and mental health services.

Keywords

Religious coping; Serious mental illness; Caregivers; Coping; Family members

Introduction

Caregivers of adults with serious mental illness often turn to a variety of resources for help and support. Some of these caregivers turn to organizations like the National Alliance on Mental Illness (NAMI). NAMI offers the Family-to-Family Education Program (FFEP), which was created to provide caregivers with information about mental illness and skill-building for self-care, problem solving, and advocacy. Previous research has found that this program improved problem-focused and emotion-focused coping, increased knowledge and empowerment, improved family functioning and reduced distress among family members (Dixon et al. 2011).

This program was built upon stress and coping theory (Lazarus and Folkman 1984), which is a useful conceptual framework for understanding why the experience of care-giving is regarded as more stressful and results in more negative outcomes for some caregivers, but not for others. There are a variety of coping methods. Some of the most widely studied are acceptance, denial, emotion-focused, and problem-focused (Carver et al. 1989). Religious coping is another commonly used coping method for difficult life experiences, which often incorporates the coping styles just mentioned, while also having some distinct elements (Pargament 1997). Relatively little is known about its use among family members of adults with mental illness.

Religiosity and Religious Coping

Religion has many facets, some of which may provide individuals with cognitive schemas to guide their attention, actions, and interpretations of experiences (e.g., Ganzevoort 1998; McIntosh et al. 1993). Religion also provides adherents familiar ways to respond to events, such as praying, seeking spiritual support, and engaging in religious rituals. These religious schemas and behaviors may, in turn, facilitate positive coping outcomes by helping caregivers to process negative events, find meaning, develop positive or hopeful expectations, and execute coping plans (Pargament 2007; Pearce 2005). Of note, when these internalized constructs are automatized, they serve an advantageous heuristic function, but if they are biased, inappropriate, or incomplete they may lead to psychopathology. As with other coping strategies, such as problem focused strategies, religious coping has been found to mediate and moderate the relationship between stress and physical and psychological health (e.g., Pargament et al. 1990, 1998).

Religious Coping and Caregiving

Religion and religious coping methods may be particularly relevant and adaptive for dealing with the stress of caring for a person with a mental illness. In general, caregivers report high levels of religious involvement and frequent use and perceived helpfulness of religious coping strategies (For a review, see Pearce 2005). Among caregivers, religiousness is associated with improved mood, caregiving experience, and spiritual well-being; and sometimes with burden and distress (e.g., Kaye and Robinson 1994; Pearce et al. 2006; Tarakeshwar and Pargament 2001; Whitlatch et al. 1992). Persons who care for a loved one with a serious mental illness also frequently turn to religion and spirituality for support (Maunu and Stein 2010; Murray-Swank et al. 2006). For example, in a study of Hindu family members of patients with schizophrenia, 90 % of the participants reported praying to God to cope and half saw religion as a source of comfort, strength, and guidance in coping with caregiving demands (Rammohan et al. 2002). Some previous work suggests that these family caregivers who turn to religion to cope seem to have a more positive outlook (Johnson 2000) and have reported greater wellbeing, after controlling for other types of coping and demographic factors (Mohamad et al. 2012). Another study suggested that family members of persons with serious mental illness who had higher levels of personal religiosity (i.e., importance of religion and finding comfort and strength from God) also reported higher levels of mastery, self-esteem, and self-care and lower levels of depression (Murray-Swank et al. 2006), suggesting that religiosity may be an important contributor to caregiver adjustment.

Goals of the Present Study

Little is known about which individuals turn to religion to cope in the context of caring for a family member diagnosed with serious mental illness. Do these individuals tend to have less professional support, more objective challenges/ burden in caring, and/or fewer resources to draw upon? If so, it may be that mobilizing religious resources and support becomes a primary method for coping with their caregiving situation. Do caregivers of persons with severe mental illness who use religious coping resemble the general population of individuals who report higher levels of religiousness and religious coping; namely women, minorities, and older adults? Another question that remains to be answered is whether religious coping is associated with caregivers' experiences and service use outcomes, after adjusting for other forms of coping such as positive, emotional, acceptance, and denial methods of coping.

To elucidate the impact of religious coping among family members caring for a person with serious mental illness, this study examined the use of religious and non-religious coping, dimensions of adjustment, caregiving burden, and mental health service use in a sample of participants in the NAMI Family to Family Education Program. The aim of this study was to test whether religious coping is associated with caregivers' experiences and utilization of mental health services. Demographic correlates of religious coping were also measured in this sample of caregivers of persons with serious mental illness.

Methods

Procedures and Participants

Individuals were eligible for participation in the study if they were 21 years old or older, desired enrollment in the FFEP class as a family member or significant other, and spoke English. Out of the 1532 individuals who contacted one of the five NAMI-Maryland affiliates, expressed interest in the FFEP program, and screened for the study, 1168 were determined to be eligible for participation in the randomized trial. Of this group 322 individuals consented to be randomized. Participants were either randomized to take the FFEP class immediately or to be wait-listed to the next available class. A second group of participants ($N = 124$) consisted of individuals who declined randomization in the RCT but who were planning to take the class and who consented to be a part of a nonrandomized arm (Marcus et al. 2013). Thus, we had a final sample of 436 individuals. Both cohorts were recruited from five Maryland NAMI affiliates: Baltimore Metropolitan region and Howard, Frederick, Montgomery, and Prince George's Counties. All participants provided informed consent and were assessed at baseline (before FFEP started) with a structured telephone interview that lasted approximately 60 min. Study participants were recruited between March 15, 2006, and September 23, 2009. FFEP is a 12-week course with a highly structured standardized curriculum, developed and conducted by trained family members. Family members receive information about mental illness, medication, rehabilitation, problem-solving, and self-care, among other topics, during 2–3 h weekly classes. (See Dixon et al. 2011; Marcus et al. 2013 for a more detailed description of the recruitment process, randomized sample, and non-randomized sample.) Only the baseline data from the parent study were used for this investigation. This study was approved by the University of

Maryland Institutional Review Board. The authors have no known conflicts of interests and all certify responsibility for the manuscript.

Assessments and Variables

A variety of structured scales were used to assess coping strategies and caregiver's experiences.

Religious and Emotion-Focused Coping—Religious coping and emotion-focused coping were measured with five subscales from the COPE, a coping inventory: religiosity, emotional social support, positive reinterpretation and growth, acceptance, and denial (Carver et al. 1989). The religious coping scale consists of four items: "I put my trust in God," "I seek God," "I try to find comfort in my religion," and "I pray more than usual." Answer choices were: 1 "I usually don't do this at all;" 2 "I usually do this a little bit;" 3 "I usually do this a medium amount;" and 4 "I usually do this a lot." The COPE has good reliability and validity and has been adapted for family members of individuals with a severe mental illness (Solomon and Draine 1995).

Caregiver Involvement—We obtained information about caregiver involvement using the Family Experiences Interview Schedule (FEIS) (Tessler and Gamache 1995). This instrument elicits information about the level of involvement, the type of relationship, and the extent of contact between the caregiver and the care recipient.

Caregiver Burden—Objective caregiver burden was measured by the care recipient's need for daily living assistance and supervision as measured by the FEIS. Subjective illness burden was evaluated with the FEIS worry and displeasure scales (Tessler and Gamache 1995). The worry and displeasure subscales have been found to be internally consistent, with Cronbach's alphas of .89 and .85, respectively (Tessler and Gamache 1995).

Care Recipient Need Factors—Care recipient need was measured using the number of times the care recipient was hospitalized for mental health issues in the last 6 months, and whether the care recipient was homeless during the past 12 months.

Caregiver Appraisal of Experiences—The Experience of Caregiving Inventory (ECI), a brief self-report measure, was used to assess caregivers' appraisals of their experience of caring for a relative diagnosed with a mental illness. Subscales assessed negative and positive aspects of providing care. The ECI has been validated with a sample of 626 relatives of individuals with severe mental illness, in which all ten subscales were found to be internally consistent, with Cronbach's alphas of 0.74–0.91 for each subscale (Szmukler et al. 1996).

Caregiver Problem-Focused Coping—Indicators of problem-focused coping were evaluated with empowerment and knowledge scales. The Family Empowerment Scale (FES) measures the level of empowerment using three subscales: family (12 items), community (ten items), and service system empowerment (12 items). The FES has been validated with a sample of parents of children with emotional, behavioral or mental disorders, in which the three subscales were found to be internally consistent, with Cronbach's alphas of 0.87–0.88

(Koren et al. 1992). We assessed knowledge about mental illness using a 20-item true–false test of factual information covering material drawn from the FFEP curriculum that assessed general knowledge about mental illnesses (scale available from authors).

Family Functioning—We assessed family functioning with the Family Assessment Device (FAD) and the Family Problem-Solving Communication (FPSC) scales. The FAD evaluates family functioning and family relations (Epstein et al. 1983) and is widely used in studies of family response to medical and physical illness, with well-established reliability and validity (Sawin and Harrigan 1995). We used subscales assessing general functioning (12 items) and problem-solving (five items). The ten-item FPSC scale measures positive and negative aspects of communication (McCubbin et al. 1996).

Psychological Distress—We assessed distress with the Brief Symptom Inventory (BSI-18) and the Center for Epidemiological Studies Depression Scale (CES-D). The BSI-18 is a measure of psychological distress designed for use primarily in nonclinical, community populations. The BSI-18 has well-established reliability and validity (Derogatis 2001). The modified version of the CES-D is a reliable and valid 14-item scale designed to measure depressive symptoms in the general population (Radloff 1977; Radloff and Lock 1986).

Mental Health Services—We adapted a series of structured questions regarding the use of diverse community and clinical family support services, support groups, and attendance at Family to Family classes from our previous studies.

Statistical Analysis

All data were screened for outliers and normality assumptions. Pearson correlations (for continuous variables) and Analysis of Variance (for categorical variables) were used to assess for bivariate relationships between religious coping and demographic variables, and between religious coping and scales assessing caregivers' experiences. When scales describing caregivers' experiences were significantly associated with religious coping, we created multiple regression and logistic regression models to assess whether associations remained significant after adjusting for non-religious coping methods assessed on the COPE scale (emotional social support, positive reinterpretation and growth, acceptance, and denial).

Results

Sample Description

Table 1 shows the demographic characteristics of the sample. Of the 437 caregivers, 332 (76 %) were female, and the average age was 52 years of age. Two-thirds were White (68 %) and one quarter (25 %) were Black. Most caregivers were parents (61 %); 12 % were siblings, and 11 % were spouses or partners. The remaining 15 % were caring for a child, other kin, or non-kin friend. Religious coping was used more often by family members who were female, non-white, with a family income below \$50,000 (Table 2).

Bivariate analyses showed a variety of associations between the frequency of religious coping and caregiver experience scales (Table 3).

After adjusting for non-religious forms of coping (Table 4), there were multiple indicators that caregivers who use religious coping more frequently experience heavier caregiver burden. Caregivers who use more religious coping reported providing more daily living assistance and more supervision. They reported greater care recipient dependency, more hospitalizations in the past 6 months, and more care recipient homelessness. These caregivers were less likely to report that the care recipient lived independently, they were less likely to have received support from mental health programs and services in the past 3 months, and caregivers were less likely to have received counseling or therapy with a private counselor. Additionally, caregivers who use more religious coping had less general knowledge about mental illness.

At the same time, caregivers who use more religious coping received more religious or spiritual informal support, and reported more positive personal experience.

Discussion

These data suggest that community mental health providers should give special consideration to caregivers who frequently use religious coping, because these caregivers potentially have something to learn and something to teach. That these caregivers have something to learn is suggested by data showing they have less knowledge about mental health, less contact with community mental health providers, higher caregiver burden, and care recipients who are not doing as well (more hospitalizations, more homelessness). We do not suggest that religious coping is causing these differences. Rather, the data suggest at least the possibility that education and outreach by community mental health providers to these caregivers might improve these outcomes.

At the same time, caregivers who use more religious coping may have something to teach. Despite reporting a higher caregiver burden, these caregivers reported more positive personal experience. The current data cannot explain why this pattern exists (although one might speculate it is related to specific beliefs or practical support within the faith community). However, they do identify a caregiver group that has perhaps developed strategies that could be adapted for more general use in community mental health settings.

In this sample, religious coping was associated with being female, non-white, and earning less income. These findings are comparable to national samples showing higher use of religious coping among more resource-poor demographic segments of the population (Levin et al. 1994).

Although caregivers who used religious coping received more religious support, they used less support from mental health programs and services, after adjusting for other forms of coping. The inverse relationships between religious coping and mental health service use may indicate less need for professional services. Or it may represent an underutilization of services for caregivers who are in need of mental health support. Previous research has shown that religious individuals are less likely to seek secular mental health treatment and

more likely to seek help from a religious professional, such as a pastor or chaplain (Koenig 2012). Caregivers of family members with serious mental illness may be concerned that secular therapists will not support their religious beliefs or understand their world-view (Koenig 2005). Or, these individuals may feel a sense of shame or stigma for seeking mental health services, perhaps thinking that religious or spiritual resources should be sufficient.

Overall, the results of this study are consistent with the view that religious coping is mobilized among persons dealing with difficult situations (Pargament 1997). Many people are particularly inclined to rely on religion when they have reached their own human limitations and when religion is “available and accessible” (Pargament 1997). When this occurs, religion may exert its greatest influence by facilitating and increasing positive emotions and experiences in the midst of feelings of stress and burden, rather than directly protecting caregivers from experiencing negative outcomes. In other words, religion may provide caregivers with the resources they need to find purpose and meaning within difficult and stressful situations (Pearce et al. 2002). For example, research among caregivers of terminally ill cancer patients found that caregivers who relied on religion to cope reported greater caregiving burden, but also higher caregiving satisfaction (Pearce et al. 2006).

This study has limitations. We did not control for multiple comparisons, so these findings need to be replicated in a hypothesis-testing study. The sample was composed of help-seeking individuals who may differ in relevant ways from individuals not seeking caregiving education and support. These data are cross-sectional, which limits conclusions about cause and effect. Caregiving experiences and coping strategies are not static, and some patterns may change over time. We focused on religious coping, while other unmeasured variables, such as social support, could be responsible for the observed relationships.

Future research might include longitudinal studies to examine when and why caregivers mobilize religious coping strategies. Longitudinal studies may also consider how caregivers’ experiences and coping strategies interact and evolve over time; sometimes reinforcing and sometimes reducing each other. Survey research indicates there is a need for partnerships between community mental health providers and religious communities who provide services for underserved populations (Dossett et al. 2005). Future research into the role of religious coping could help to optimize NAMI initiatives such as the Faith Communities Education Project and FaithNet in their efforts to provide mental health support for faith-based communities who are caring for people with serious mental illness (NAMI).

Conclusion

These findings indicate that caregivers who use more religious coping report more objective caregiving burden, they care for recipients with greater needs, they have less knowledge about serious mental illness, and they receive less support from mental health services. However, despite these challenges, these caregivers also reported having a positive caregiving experience and receiving more religious and spiritual support.

Understanding how family members of adults with mental illness experience and cope with stressors is essential to formulating and refining effective clinical and self-help interventions

to assist them, such as the peer-taught Family-to-Family Education Program offered by the National Alliance on mental Illness. Religion provides many individuals with a worldview that informs appraisals of illness and their responsibilities and coping resources. A more sophisticated understanding of caregivers who use religious coping may enhance the effectiveness of community-based interventions.

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Table 1

Demographic characteristics of the sample

N = 437^a	n	%
Female	332	76
Race		
Asian	10	2
Black	107	25
Hispanic	8	2
White	293	68
Other	16	4
Married	278	64
Family Income > \$50,000	302	71
Completed 12 years education	428	98
Relationship to care recipient		
Parent	268	61
Child	30	7
Sibling	52	12
Spouse/partner	50	11
Other kin	31	7
Non-kin friend	6	1

Mean age 52.1 years, SD 10.7

^a Actual N may vary because of missing values

Table 2
Bivariate relationships between sample demographic characteristics and religious coping

Demographics	Religious coping					
	N	%	Mean	Test*	df	p
Age (year)	436			-.04 ^b	435	.383
Gender						
Male	105	24	9.76 (4.37)	22.18 ^a	(1434)	<.001
Female	331	76	12.10 (4.44)			
Race						
White	292	68	10.73 (4.55)	29.94 ^a	(1431)	<.001
Non-white	141	32	13.19 (4.02)			
Completed 12 years of education						
Yes	427	98	11.48 (4.55)	3.52 ^e	(1434)	.061
No	9	2	14.33 (1.94)			
Family income						
>\$50,000	301	71	10.87 (4.62)	21.72 ^a	(1421)	<.001
<=\$50,000	122	29	13.09 (3.92)			
Marital status						
Married (or living as if married)	277	64	11.34 (4.51)	1.46 ^a	(1434)	.228
Not married or widowed	159	46	11.88 (4.57)			
Working status						
Full-time	255	58	11.39 (4.58)	.64 ^a	(1434)	.425
Part-time/not working	181	42	11.74 (4.47)			
Relationship to care recipient						
Parent	267	61	11.47 (4.59)	2.00 ^a	(5430)	.077
Child	30	7	12.33 (4.48)			
Sibling	52	12	10.62 (4.33)			
Spouse/partner	50	11	11.00 (4.52)			
Other kin	31	7	13.23 (4.17)			
Nonkin/friend	6	1	14.00 (3.46)			

Significant at $p < .05$ are given in bold
* Actual N may vary because of missing values
 η^2 ANOVA
 r Pearson Correlations coefficient

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Table 3

Bivariate relationships between caregivers' experiences and religious coping

	Class	N	Mean	Test*	df	p
Caregiver involvement						
Family very involved with care recipient	1-Yes	341	11.77 (4.49)	4.41 ^a	(1434)	.036
	No	95	10.67 (4.61)			
Care recipient live independently	1-Yes	131	10.72 (4.72)	6.36 ^a	(1432)	.012
	No	303	11.90 (4.40)			
Are you the family member providing most support	1-Yes	320	11.87 (4.50)	6.55 ^a	(1433)	.011
	No	115	10.62 (4.53)			
Caregiver burden						
Subjective burden						
FEIS worry scale				.10 ^b	436	.047
FEIS displeasure scale				-.01 ^b	436	.760
Objective burden						
Objective daily living				.16 ^b	436	.001
Objective supervision				.17 ^b	436	<.001
Care recipient need factors						
Any mental health hospitalizations in past 6 months?	1-Yes	158	12.35 (4.50)	8.07	(1430)	.005
	No	274	11.08 (4.47)			
Past 12 months, has care recipient been homeless?	1-Yes	44	13.23 (3.47)	6.84 ^a	(1432)	.009
	No	390	11.36 (4.60)			
Caregiver appraisal						
Difficult behavior scale				.04 ^b	431	.429
Negative symptom scale				.02 ^b	431	.670
Stigma scale				.05 ^b	436	.259
Problem with service scale				.13 ^b	436	.007
Effect on family scale				.07 ^b	436	.128
Need of backup scale				.07 ^b	436	.133

	Class	N	Mean	Test*	df	p
Dependency scale				.12 ^b	436	.010
Loss scale				.02 ^b	436	.720
Positive personal experience scale				.33 ^b	436	<.001
Good relationship scale				.16 ^b	436	<.001
Positive scale				.29 ^b	436	<.001
Negative scale				.10 ^b	436	.033
Caregiver coping						
Problem focused coping						
Fes family scale				.15 ^b	435	.002
Fes service scale				.17 ^b	435	<.001
Fes community scale				.16 ^b	435	<.001
Knowledge				-.18 ^b	436	<.001
Emotion focused coping						
Cope positive scale				.44 ^b	433	<.001
Cope denial scale				.04 ^b	435	.371
Cope emotional scale				.17 ^b	434	<.001
Cope acceptance scale				.11 ^b	434	.023
Family functioning						
General functioning scale				-.07 ^b	424	.166
Problem solving scale				-.07 ^b	421	.145
Affirming communication				.11 ^b	430	.023
Incendiary communication				-.11 ^b	425	.021
Psychological distress						
Depression symptom sum				-.05 ^b	430	.335
Area T Score of BSI				-.04 ^b	428	.365
Area T Score of Somatization				.07 ^b	428	.130
Area T Score of Depression				-.06 ^b	428	.244

	Class	N	Mean	Test [*]	df	p
Area T Score of Anxiety				-.01 ^b	428	.918
Caregiver mental health services						
Received support from mental health programs/services in the past 3 months	1-Yes	168	10.72 (4.67)	9.04 ^a	(1429)	.003
	No	263	12.05 (4.37)			
Counseling or therapy with private counselor	1-Yes	137	10.44 (4.61)	12.26 ^a	(1430)	<.001
	No	295	12.06 (4.41)			
Religious or spiritual informal support	1-Yes	168	14.07 (2.92)	106.80 ^a	(1431)	<.001
	No	265	9.92 (4.65)			
The informal support is a lot of help to you	1-Yes	201	12.31 (4.29)	10.93 ^a	(1312)	.001
	No	113	10.58 (4.71)			

Significant at $p < .05$ are given in bold

^{*} Actual N may vary because of missing values

^a ANOVA

^b Pearson correlation

Table 4

Multivariate relationships between caregivers' experiences and religious coping, after adjusting for other methods of coping (positive reinterpretation and growth coping, emotional social support coping, acceptance coping, denial coping)

Caregivers' experiences	Religious coping			
	OR (95 % CI)	β (SE)	Test	<i>p</i>
Caregiver involvement				
Family member very involved with care recipient	1.04 (.98, 1.10)		1.55 ^b	.212
Care recipient lives independently	.95 (.90, 1.00)		4.56 ^b	.033
Are you the family member providing most support	1.03 (.98, 1.09)		1.37 ^b	.242
Caregiver burden				
Subjective burden				
Worry scale		0.01 (0.01)	1.19 ^a	.230
Objective burden				
Objective daily living assistance		0.02 (0.01)	2.08 ^a	.040
Objective supervision		0.02 (0.01)	3.18 ^a	<.001
Care recipient need factors				
Any mental health hospitalizations in past 6 mo.	1.07 (1.02, 1.13)		6.73 ^b	.009
Past 12 mo., care recipient been homeless	1.12 (1.02, 1.22)		6.17 ^b	.013
Appraisal				
Problem with service scale		0.02 (0.01)	1.49 ^a	.140
Dependency scale		0.02 (0.01)	2.12 ^a	.030
Positive personal experience scale		0.02 (0.01)	2.51 ^a	.010
Good relationship scale		0 (0.01)	-.02 ^a	.980
Positive scale		0.02 (0.01)	1.44 ^a	.150
Negative scale		0.09 (0.06)	1.63 ^a	.100
Coping				
Problem-focused coping				
Family scale		0 (0.01)	-.50 ^a	.620
Service scale		0 (0.01)	.49 ^a	.630
Community scale		0 (0.01)	-.35 ^a	.720
Knowledge		-0.84 (0.2)	-4.20 ^a	<.001
Family functioning				
Affirming communication		0 (0.03)	.08 ^a	.940
Incendiary communication		-0.03 (0.04)	-.75 ^a	.460
Caregiver mental health services				
Received support from mental health programs/services in past 3 mo.	.94 (.89, .98)		7.25 ^b	.007
Counseling or therapy with private counselor	.93 (.89, .98)		7.46 ^b	.006

Caregivers' experiences	Religious coping			
	OR (95 % CI)	β (SE)	Test	<i>p</i>
Religious or spiritual informal support	1.30 (1.22, 1.39)		60.66 ^{<i>b</i>}	<.001
The informal support is a lot of help to you	1.05 (.99, 1.12)		3.15 ^{<i>b</i>}	.076

Significant at $p < .05$ are given in bold

^{*a*}Wald Chi square Test, and *p* value

^{*b*}
t test