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“Trouble Won’t Last Always”: Religious Coping and Meaning in the Stress Process

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Abstract

Meaning-based coping, particularly religious coping, might lead to positive emotions in stressful situations. Religious coping is common among older adults. We explored the experience of religious coping, organizational religious affiliation, and one’s relationship with God among older adults with advanced chronic illness and their caregivers. Research questions included: How is religious coping experienced in this context? How is a relationship with God experienced in coping? How is meaning experienced in this context? Brief qualitative interviews uncovered descriptions of experiences using the qualitative descriptive method. Three themes were identified: God is a provider, one’s religion and relationship with God when coping are essential, and the God–person relationship is intimate. Care recipients coped through their personal relationship with God, whereas caregivers coped through religious beliefs and support. Meaning was defined as purpose, responsibility, and duty.

Keywords

caregivers / caregiving; coping and adaptation; geriatrics; illness and disease; chronic; older people; religion / spirituality; stress / distress

As people grow older they experience an increased risk of developing an advanced, chronic illness or a combination of chronic illnesses. A substantial proportion of people who provide care to individuals with an advanced, chronic illness in the community are family members (Arno, Levine, & Memmott, 1999; Family Caregiver Alliance, 2006). Providing care to an elderly family member with a chronic illness is often associated with psychological distress (Aneshensel, Pearlin, Mullan, Zarit, & Whitlach, 1995; Family Caregiver Alliance). For example, family caregivers of individuals approaching the end of life are at risk for stress, depression, and health problems (McMillan, 2005; McMillan et al., 2006; Williamson, Shaffer, & Family Relations in Late Life Project, 2001).

In contrast to the negative outlook for both caregivers and their chronically ill care recipients, research suggests that there are beneficial aspects of facing adversity (Folkman,

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1997). During the course of physical illness, care recipients experience positive emotional outcomes such as the attainment of growth through coping with adversity. Stress-related growth, defined as positive changes in the aftermath of stressful life situations (Park, Cohen, & Murch, 1996), has been reported by medically ill individuals (Pargament, Koenig, Tarakeshwar, & Hahn, 2004; Pargament, Smith, Koenig, & Perez, 1998; Park, 2006).

In the current study we explored the meaning-based and religious coping practices of people living with advanced, chronic illness and their caregivers in the community. A primary area of inquiry concerned how these individuals experienced and related their religious coping practices with their emotional well-being. Folkman's (1997) stress process model provides a useful theoretical lens to explore how a burdensome situation might lead to positive emotional experiences. If the situation is appraised as burdensome, a coping strategy will be used to deal with the negative appraisal. The coping strategy leads to a favorable resolution or an unfavorable resolution. Favorable resolutions lead to positive emotions and unfavorable resolutions lead to distress. If an unfavorable resolution is met and distress results, then the cycle will be repeated. A state of chronic stress arises if the process repeatedly ends with unfavorable resolutions.

Folkman (1997) revised this model to include meaning-based coping as a resource that is used when individuals face an unfavorable resolution or no resolution to a problem, as when a situation such as advanced, chronic illness cannot be changed. In a study of caregiving partners of men with HIV/AIDS, Folkman (1997) discovered that in stressful situations, people often seek out events that are meaningful or create positive meaningful experience out of ordinary, neutral life events.

Folkman (2008) reported that research supports the distinction of meaning-based coping from other forms of coping, and supports the primary association of meaning-based coping with the creation of positive emotions rather than the regulation of distress. The model suggests that creation of meaning through meaning-based coping is the mechanism by which people experience positive emotions in stressful situations. As a consequence, the coping process is sustained and distress is ameliorated. Creating positive appraisals and interpreting a negative situation with a positive valence lies at the core of meaning-based coping. One's value/belief system—including religiosity—is a salient factor in both one's ability to reappraise the situation and the manner in which one reappraises it.

Religion is an important aspect of meaning-based coping within the Folkman (1997) model. Folkman (1997) stated that positive emotions in the coping process are often tied to one's values and beliefs. Often a reaffirmation of values and beliefs through meaning-based coping results in positive emotions (Folkman & Moskowitz, 2004). For many, the structure of one's value/belief system is determined by religion. A substantial proportion of people in stressful situations use religion to cope with hardships (Pargament, 1997). Among the elderly and minorities, religion is cited more frequently than any other form of coping (Koenig, 1998).

In a review of religion and coping Pargament (1997) indicated that religious coping is an important predictor of well-being that extends beyond the effects of nonreligious coping. In addition, measures of religious coping are stronger predictors of psychological outcomes of stressful situations than are global measures of religiosity (e.g., prayer, church attendance, and so forth). A meta-analysis of the effect of religiosity on psychological health conducted by Hackney and Sanders (2003) revealed that personal devotion (e.g., intrinsic religious orientation, relationship with God) was more closely related to emotional health than was institutional religion (e.g., church attendance, participation in church activities). The associations of religious coping with indicators of well-being have been shown even when controlling for sociodemographic variables and global religious measures (Pargament, Koenig, & Perez, 2000).

One's relationship with God/a higher power has been shown to be an important aspect of the association of religion/spirituality and health (Holt, Lewellyn, & Rathweg, 2005; Holt & McClure, 2006; Krause, 2006; McAuley, Pecchioni, & Grant, 2000; Polzer & Miles, 2007). The ways people relate to God and understand their interactions with God/a higher power might play a significant role in their value/belief structure and might direct the ways they engage in meaning-based coping. Consequently, how one interprets and experiences one's relationship with God might have a strong effect on the coping process.

Their relationship with God represents an important aspect of the coping process for many older adults. Qualitative inquiry in this area has provided insights regarding people's experiences of interacting with God to solve problems and gain control (Gall & Cornblat, 2002; Polzer & Miles, 2007). Although this manner of coping occurs frequently, little is known about the direct experience of relationship with God/a higher power. Thus, one aim of our study was to describe this experience. What is it like to interact with God when coping? Findings from qualitative inquiry in this area would increase understanding of a complex and dynamic relationship. What are older adults' experiences with this relationship within the context of coping?

In addition, we were interested in exploring the direct experience of relationship with God/a higher power among older adults who were ill and their family caregivers. These experiences among caregivers were heretofore ill-defined. Most research that has examined caregivers' relationships with God when coping has been conducted among dementia caregivers. In this study, we explored the experience of religious/spiritual coping among palliative caregivers. Research indicates that this group regards meaning making and relating to God to be important needs (Taylor, 2006).

Need for the Study

Older adults' engagement in religious coping practices, including those that involve God, has been discussed in relation to Folkman's (1997) meaning-based coping. Qualitative methods have been useful in exploring religious coping methods among diverse groups in previous research (Gall & Cornblat, 2002; Polzer & Miles, 2007). Previously, investigators concluded that specific assessment of one's religious coping style affords a powerful predictor of physical and emotional adjustment when coping with stressful situations. Specifically, understanding religious coping that involves one's relationship and style of interaction with God is important. In addition, according to the Folkman (1997) model, meaning-based coping plays an important part in the coping process. Current understanding of the experience of one's relationship with God when coping and the experience of meaning is underdeveloped, as is understanding of the experience of these phenomena among palliative caregivers. The research questions guiding the study were as follows. First, within the context of coping with advanced, chronic illness or providing care to someone with such illness, how is religious/spiritual coping experienced? How is a relationship with God/a higher power experienced in coping? What is one's experience of meaning in this context?

Method

Participants

Qualitative descriptive methods were used to explore the experience of religious/spiritual coping, one's relationship with God when coping, and meaning among older adults with advanced, chronic illness and family caregivers providing care to this group. This study was part of a baseline inquiry for a randomized controlled trial assessing the effectiveness of a reminiscence-based activity on the quality of life of older adults with advanced, chronic illness and their familial caregivers. A convenience sample was used to gather data on care recipient/caregiver dyads. The care recipients were community-dwelling older adults with advanced, chronic illnesses and functional decline indicative of increased risk of mortality within 2 years. Care recipients and their family caregivers were recruited from within a 60-mile radius of Tuscaloosa and Birmingham, Alabama.

Participants were recruited from several areas using multiple methods. Palliative care patients and their family caregivers were recruited from a university medical center, a center for palliative care, various community agencies and associations, assisted living facilities, and a home health care provider. We advertised our project through media campaigns designed by students in the local university's advertising and public relations department; we also used local media. Moreover, we recruited through a community recruiter and used snowball recruitment methods such that participants could refer other friends and family into the study. Graduate and undergraduate student research assistants worked as community recruiters and visited each site to discuss with staff how to recruit participants. They gave presentations to groups of potential participants at each site if needed.

The eligibility criteria for care recipients were created primarily to ensure that these individuals received palliative care for an advanced chronic illness and did not have moderate to severe dementia. Thus, participants meeting the eligibility criteria comprised a sample that likely used religious coping and created the context of interest within which the study phenomena were experienced. Care recipients were eligible for participation if they (a) were age 55 or older;(b) were living in the community; (c) had an advanced, chronic illness or combination of chronic illnesses; (d) received a score of 3 or greater on the Vulnerable Elders Survey-13 (VES-13; Saliba et al., 2001); (e) had no more than mild cognitive impairment or mild dementia as measured by a score of 17 or greater on the Modified Telephone Interview of Cognitive Status (TICS-m; Brandt, Spencer, & Folstein, 1988); (f) received at least 4 hours per week of instrumental or basic daily care from a family caregiver; and (g) read and spoke English.

The eligibility criteria for caregivers were created primarily to ensure that these participants were providing enough care to be considered a caregiver and were not cognitively impaired. Family caregivers were eligible if they (a) were age 19 years or older and were a family member or fictive kin of an eligible care recipient; (b) were currently providing at least 4 hours per week of instrumental or basic daily care for the patient; (c) were cognitively intact as measured by a score of 28 or greater on the TICS-m (Brandt et al., 1988); (d) lived close enough to participate in interviews at the care recipient's home; (e) read and spoke English; and (f) were accessible by telephone.

Screening Measures

Vulnerable elders survey.—The VES-13 (Saliba et al., 2001) is a 13-item measure with a function-based scoring system that considers age, self-rated health, limitations in physical function, and functional disabilities in the identification of older community-dwelling adults at risk of functional decline and death. Validation of the VES-13 has shown that the estimated combined risk of death and functional decline within 11 months rose from 23% among older adults with VES = 3 to 60% among older adults with VES = 10 (Min, Elliott, Wenger, & Saliba, 2006). Thus, the VES-13 is a promising tool for identifying community-dwelling older adults at risk of death or functional decline within 1 to 2 years.

Modified telephone interview for cognitive status.—The TICS-m (Brandt et al., 1988) is a 21-item measure administered over the phone and is designed to detect cognitive decline (Breitner et al., 1990). Although a standard cutoff point indicating cognitive impairment has not yet been established, scores of < 21 have been compared to scores of < 25 (de Jager, Budge, & Clarke, 2003) on the Mini Mental State Exam (Folstein, Folstein, & McHugh, 1975). In a study of poststroke individuals, a cutoff score of 20 or lower provided sensitivity of 92% and specificity of 80% for detecting cognitive decline (Barber & Stott, 2004).

Data Collection Method

Approval for this study was granted by the institutional review boards at the University of Alabama and the University of Alabama at Birmingham. Informed consent forms were read to participants, they indicated understanding, and then provided consent to be in the study prior to beginning study procedures. Information on age, gender, and race were obtained from the care recipients and the caregivers. In addition, participants were asked, "How are you involved in the church?" For care recipients, religious denomination was also collected.

Brief semistructured interviews with the care recipient and caregiver were digitally recorded. In all cases, interviews were conducted at the residence of the care recipient (e.g., home, assisted living facility), because the care recipient/caregiver dyad deemed this most convenient. Each participant was asked four open-ended questions with subsequent follow-up questions. The initial questions included: How does your religious/spiritual life help you cope? How would you describe your relationship with God/a higher power or your lack of relationship with God/a higher power? How does church help you cope? What does meaning mean to you? The caregivers were asked an additional question: Does caregiving provide you with meaning? If so, how? Care recipients and caregivers were interviewed concurrently, in separate rooms, to decrease distraction and interference. These interview recordings were transcribed verbatim by a professional transcriptionist for analysis.

Analysis

Participant narratives were analyzed by the first two authors. A total of 63 transcripts were available for analysis. Narratives were analyzed using the descriptive and thematic analysis approaches (Lincoln & Guba, 1985; Sandelowski, 2000). This analysis was fractured into three separate phases: one phase for approximately each third of the data. Each of the first two phases comprised 20 transcripts chosen at random (without replacement): 10 care recipients and 10 caregivers. The final phase consisted of 23 transcripts: 10 care recipients and 13 caregivers. Within each phase, the coders separately read each transcript fully and then read each question across transcripts. Throughout the coding process, comparative methods were used to illuminate similarities and differences between data. New themes and refinements to identified ones were discussed by the coding team at regularly scheduled meetings. Once all three phases of data collection and coding were complete, the coders reviewed all transcripts and discussed their findings, resolving any inconsistencies across coders.

Transcripts for caregivers and care recipients were coded separately; however, the analysis was the same. In this way, areas of convergence and divergence in experience between caregivers and care recipients could be explored. Independent review and coding was followed by consensus during analysis meetings. In addition, the analysis team kept detailed notes as part of an audit trail, documenting each and every step of the research process to help document analytic decisions (Bradley, Curry, & Kelley, 2007). These procedures helped facilitate qualitative research evaluative criteria (Cohen & Crabtree, 2006; Lincoln & Guba, 1985).

Results

Sample Characteristics

Care recipients were primarily women (77%) and White (63%), with a mean age of 78.2 years. Care recipients had a mean TICS-m (Brandt et al., 1988) score of 25.3 and a mean VES-13 (Saliba et al., 2001) score of 7.5. This score is predictive of a combined probability of death or functional decline of .4 within the next 8 to 14 months (Min et al., 2006). Caregivers were primarily women (69%) and White (53%), with a mean age of 61.1 years. Caregivers had a mean TICS-m score of 32.0.

Religious denominations of the White care recipients were as follows: 9 Baptists, 4 Methodists, 3 Roman Catholics, and 1 each of Church of God, Presbyterian, and Unitarian Universalist. Among African Americans, there were 7 Baptists and 4 Methodists. With respect to church involvement, care recipients noted not being involved; not attending because they were not interested; not attending because of illness or involvement from home (e.g., listening to services on the radio, watching services on the television); and regular attendance. Some care recipients reported serving many roles in the church (e.g., being a deacon, serving on committees). Care recipients noted that sometimes their ability to attend and/or be active in church was limited because of illness. Caregivers also noted that being a caregiver hindered their ability to be involved in church.

Thematic Findings

God is a provider.—When discussing their relationship with God when coping or discussing how their religious life helped them cope, participants reported that God was a provider. The thing they described most as being provided by God was strength, followed by perspective and hope. A caregiver stated, “It provides a basis for comfort, for strength, for encouragement.” Another caregiver reported,

> I believe that there is a God, and I believe that there is a person who watches over me and guides me and gives me the strength and the knowledge and the willpower to do the things that I know that I need to do.

A care recipient noted, “He’s my king. He’s my strength. He is my everything.” Another care recipient said, “Because of my faith in God, there’s always, I don’t know what I want to say. I know there’s always hope.” Across participants, God and religious beliefs were noted as providers of tools and resources to deal with their respective situation.

There were varied responses regarding the manner in which God provides. The nature of participants’ relationships with God as they related to God being a provider encompassed several patterns of provision. Some care recipients noted that the relationship was bidirectional. A care recipient said,

> Well, we know that we have a God that we can call on and He will answer. One scripture that comes to mind is “Call upon me in the day of trouble”—and I’ve had some trouble [laugh]; everybody has—“and I will answer thee.”

This pattern of provision within their relationship with God was discussed in terms of their having to ask for assistance before assistance was provided. Others noted that the relationship was more unidirectional. A care recipient noted, “He’ll carry me a long way, and through Him and His strength, I believe, I’m a strong believer that the Lord will pull me outta this illness I have.” These individuals talked about God providing something without their praying for or asking for help. Faith replaced the necessity of asking for help.

Care recipients and caregivers diverged in the experience of God’s providing. Specifically, caregivers discussed a future-oriented hope being provided. A caregiver reported, “It gives me hope, and it also gives me the strength to carry on, especially with elder care. I don’t worry so much about my tomorrow or her tomorrow.” Another caregiver stated,

> Trouble won’t last always. There’s gonna be good days, bad days. The good days won’t last forever, and neither will the bad days. It’s just a matter of seasons: Just as seasons change, you can look for issues in your life to change also.

One’s religion and relationship with God when coping are essential.—The nature of participants’ experiences with religion and their relationship with God/a higher power when coping were characterized as extremely important. These aspects of coping were experienced as essential among this group. Words used to describe this concept were *utmost importance* (a care recipient) and *absolutely essential* (a care recipient). A caregiver stated, “One hundred percent I depend on my religion.” Another caregiver noted, “I really don’t feel I could make it without my relationship with God.” A care recipient said, “He is my everything. I mean, I have to depend on Him because I can’t depend on nobody but Him.” A caregiver reported, “Uh, religious-wise, it’s great. I mean, if it wasn’t for that, I don’t think I’d be able to do it—truly.”

Across participants, the experience of religion and their respective relationship with God were interpreted as primary aspects of living and coping with illness. When facing a stressful situation, either having an advanced, chronic illness or caring for a loved one with a chronic illness, religion and a relationship with God were noted as fundamental. A relationship with God was discussed as the primary aspect of religion and spirituality when coping. However, experience with organized religion was also identified as an aspect of religious coping. Specifically, participants discussed their experiences with church in terms of social support and experiencing their religion.

Two subthemes were uncovered within the higher-order theme of social support: faith-based social engagement and nonreligious social support. Nonreligious social support, noted most often, was represented in many ways: visits from church members, talking with people about similar difficulties, fellowship with like-minded people, and so forth. A care recipient stated, “They help me by caring and showing concern for my welfare and my well-being.” Another care recipient noted, “I mean, it’s a support group. When you go to church and you have friends there you look forward to seeing ‘em; it’s kind of like a support group.” A caregiver answered, “I guess gathering, gathering together with like-minded people, it helps after you go through whatever you go through during the week.” Faith-based social engagement was represented as knowing others were praying for the participants. A care recipient reported, “Well, they pray with me, you know, and singing and praying and preaching, the preacher preaching, telling us how to live so God can use us.”

In addition to social support, participants reported that attending church helped them cope by providing a venue to experience religion. A caregiver said, “Well, spiritually, they give me the encouragement to go on, and when I hear the Word, it helps me, it gives me strength.” A care recipient noted, “Because that’s the way I know that God is my help, and it helps me to understand His Word more, and from reading the Bible, the knowledge, and reading it in a group and listening to the good sermons.”

The God—person relationship is intimate.—Participants talked about their relationship with God as a true, personal, intimate relationship, which included various interpersonal interactions. Participants noted that they “talk[ed] with God,” that they “walk[ed] with God,” that God was “with” them, and that God was “close.” One participant noted that God was “like a father,” whereas another reported, “We have a lot of arguments.” Participants often described their relationship with God in terms one might use to describe a relationship with another person.

A divergence was noted between descriptions of caregivers’ and care recipients’ experiences of religion and spirituality helping them cope. Specifically, caregivers often spoke of how "it"—to be understood as their religious and spiritual life—helped them cope, whereas care recipients described their experiences directly relating to God. For example, a caregiver stated, "It provides a basis for comfort, for strength, for encouragement." This is in contrast to the care recipients who almost uniformly talked about how God-as-an-entity helped them cope. A care recipient noted, "He's there. He's always there. You can feel Him." Care recipients more frequently discussed their religious coping in terms of their relationship with God. In addition, they talked about their relationship with God with more interpersonal and intimate language.

The experience of meaning.—Participants described meaning in terms of purpose in life. A care recipient reported, "Meaning means do I think I'm here for, do I have purpose, do I still have a purpose, and am I still working on something that's important; is my life important? All of that speaks to meaning." Another care recipient responded, "My biggest plan for the future is not only to construct and publish a Bible, but I wanna put together a scrapbook. So I think those things add to my spiritual growth." By discussing plans she had for the future, this care recipient delineated her continuing purpose in life. A caregiver responded, "It means something that is not shallow or purposeless, but it has a depth and quality in your life." Another stated, "I would like my life to mean something. You know, when I leave here, on this Earth, I would like to know that I will be missed, that I did everything God wanted me to do." This caregiver reported her desire to achieve her purpose to attain meaning.

When discussing their experiences with meaning in the context of caring for their loved ones, caregivers talked about meaning in terms of responsibility and duty. A caregiver noted,

> It provides me with responsibility and a duty to take care or to assist or to guide an individual who has come to rely on my giving them the means that they need to accomplish maybe even just a simple task.

Another said, "Oh yes. Being able to take care of others. That's my calling. That's the calling God gave me. 'Cause I've always been somewhere taking care of somebody."

The notion of meaning being related to a sense of worth and being needed arose. A caregiver said, "I just like to be there for the people that really need me." Another reported, "Growing up in a household like I grew up in taught me a very valuable lesson: Love self but care for others. And once you start doing that, you feel better." Another caregiver noted,

> I see his struggle and I see his growth in learning to cope with it. As a result of our faith, I see that we both are conscious of each other's needs and we are both putting forth an effort to make it easier on each other and to be understanding when each other is going through a weak period or kind of a low day.

Discussion

In this study we explored the experience of coping with advanced, chronic illness and/or providing care to a family member with such an illness. Heretofore, qualitative research regarding one's relationship with God when coping with illness has been conducted mostly with care recipients. Caregivers, particularly palliative caregivers, have rarely been the focus of inquiry. Moreover, persons' relationships with God/a higher power have not been explored frequently in samples similar to that of this study.

Regarding personal, devotion-based religious coping (e.g., intrinsic religious orientation, relationship with God), participants reported that they were provided with resources that facilitated dealing with the situation (e.g., strength, help, positive perspective). In addition, participants reported positive emotions stemming from their coping (e.g., hope, faith). Across care recipients and caregivers, religious life supplied positive emotional experiences that assisted in continued coping. Furthermore, the way coping led to positive emotions, outcomes, and sustained coping was the infusion of the individual's primary values and beliefs into the coping. Once a person integrated his or her values/beliefs (religious) into coping, the coping itself became a reaffirmation of his or her values/beliefs and consequently led to positive emotions. For example, many participants discussed God being of the utmost importance (a value/belief) and indicated a heavy reliance on God (religious coping). In addition, God being a provider was frequently discussed, as was receiving positive benefit from God (positive outcome). It might be that the daily, lived experience of engaging in the coping practice (guided by one's religion/spirituality) is what imparts emotional benefit.

An interesting divergence arose in participants' descriptions of their experiences regarding how religion helped them cope. Care recipients largely stated that God-as-an-entity provided them with resources when coping, whereas caregivers reported that their religious life provided such resources. Why the difference? Both care recipients and caregivers described their relationship with God as interpersonal; however, care recipients tied that relationship into their religious coping description to a greater extent than did caregivers. For care recipients, coping was more being-related than institution-related.

The tenets of Socioemotional Selectivity Theory (SST) might help explain this finding (Carstensen, Isaacowitz, & Charles, 1999). This theory states that people tend to alter their goals as perspective of future time changes. When one begins to perceive time as limited—as might be the case for those with chronic, advanced illness—one shifts from information gathering/knowledge-based goals to more emotion- and present-focused and meaning-based goals. Those with the former set of goals, who perceive that they have more time left to live, might work to spend time forming new relationships. In contrast, those with the latter set of goals, who perceive their time left to live as being limited, might focus more on preestablished partnerships, such as the person–God relationship. In this case, care recipients largely discussed their religious coping as it related to their relationship with God as a separate entity.

With respect to care recipients' and caregivers' discussions of their relationship with God, the overwhelming sentiment was that it was one of importance. Largely, this was described as an essential relationship. God was frequently discussed as both partner and provider. Much work has been done in the creation of Likert-type questionnaires meant to assess one's relationship with God; however, these assessments and their underlying constructs might be lacking a key aspect of the relationship that the people in this study espoused: the interpersonal and intimate nature of the relationship one has with God, on which they rely in times of stress.

Regarding institutional religious coping (i.e., church attendance, participation in church activities), participants overwhelmingly reported that social support was the primary means by which church helped them cope. Participants discussed both faith-based social engagement and other social support. In addition, church attendance was discussed as a means of experiencing the religion. Faith-based social engagement and social support were not spontaneously reported when asked about the manner in which religiosity helped in coping. Rather, they were discussed in terms of ways the church and/or church attendance helped. It might be that people with an advanced, chronic illness and those caring for members of this group use these coping strategies differently from how they use personal devotion-related coping strategies.

Although faith-based social engagement, social support, and experiencing the religion were reported to lead to positive emotions, faith-based social engagement might have held less value. For this group, experiencing the religion might allow for greater (re)affirmation or reinvigoration of a religious value and belief system. As discussed regarding personal, devotion-based coping, reaffirmation of values and beliefs is one pathway to the experience of the positive in a stressful situation.

Caregivers overwhelmingly acknowledged that caregiving provided them with meaning in life. What is it about caregiving that leads to meaning? Folkman (1997) stated that in stressful situations people might cope by infusing ordinary events with a meaningful salience because the events substantiate their values and beliefs. Caregivers reported that they conceptualized meaning as having purpose, being responsible for the care of others, and being needed. These represented fundamental ideals of how one should behave. Given these perceptions of meaning, caregiving allows one extensive opportunity to realize these ideals and enact these behaviors. Meaning-based coping occurred in these caregivers when the ordinary, mundane, and sometimes stressful tasks of providing care fulfilled an important aspect of their value systems. Caregiving is an innately helping role; consequently, the aspects of caregiving that provided meaning were largely described as relating to values and beliefs that included a helping relationship.

Another divergence between care recipients and caregivers related to meaning and might be understood within the framework of SST. Specifically, caregivers’ experiences indicated that God provided hope. Hope is a future-oriented construct and would be expected to be experienced among people with an expansive future time perspective. Palliative caregivers might have expected that their caregiving duties would be time-limited and that they would have experiences outside the context currently under study. Their experience of witnessing their loved one’s suffering and caring for this person throughout the course of an advanced, chronic illness activated religious coping and a search for meaning. Hence, palliative caregivers might hope for the future while finding meaning in the present; in contrast, care recipients, knowing that their time left to live is limited, might be more likely to focus on the present and the purpose of their life.

Most research on meaning in life among caregivers has focused on caregivers of family members with dementia. This is despite Folkman’s (1997) original study of caregivers of men with HIV/AIDS, which led to the addition of meaning-based coping to the stress process model. Caregivers' descriptions of meaning that arose from the experience of providing care to a loved one with an advanced, chronic illness help us better understand the role of meaning in this context. Specifically, dementia caregiving might be a lengthy commitment, whereas the caregivers in our study were likely to continue this role for only 1 or 2 years.

Limitations and Conclusions

As with any research inquiry, limitations to our approach must be acknowledged. This study was linked to a randomized controlled trial; the semistructured interviews occurred in addition to a baseline assessment. Therefore, brevity was a factor so as not to increase participant burden in this palliative care sample. Some of the structured interview questions might have introduced bias into participant responses. In addition, the nature of the study precluded engaging in multiple interviews with a participant. Eligibility criteria were determined based on the randomized controlled trial; consequently, convenience and not purposeful sampling was used.

Despite certain limitations, our analysis revealed important information regarding respondents' experiences with advanced chronic illness and caring for chronically ill individuals. Participants' experiences were synthesized into three themes in response to our open-ended questions. Specifically, God is a provider, one's religion and relationship with God when coping are essential, and the God–person relationship is intimate. In addition, participants reflected on their experiences with meaning to produce a description; meaning was defined as purpose in life, responsibility, duty, and being needed.

A majority of older adults with advanced, chronic illness used religion to cope with stress. Moreover, the individuals who provided care to this group used religion and spirituality, leading to the experience of meaning in caregiving. There is a growing literature on incorporating religion into therapy with older adults and others who evidence an affinity for this type of coping (Paukert et al., 2009). Researchers who seek to understand religious coping and its outcomes in an in-depth manner could help identify approaches and topic areas that might be useful in therapeutic interventions designed to enhance positive coping practices. The limitations of quantitative research in this area illustrate the value of in-depth qualitative inquiry in the development of interventions to improve positive coping in the face of adversity.

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