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Religious and Secular Coping and Family Relationships in the Neonatal Intensive Care Unit

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Abstract

Background—Preterm birth is an unanticipated and stressful event for parents. In addition, the unfamiliar setting of the intensive care nursery necessitates strategies for coping.

Purpose—The primary study objective of this descriptive study was to determine whether secular and religious coping strategies were related to family functioning in the neonatal intensive care unit.

Methods—Fifty-two parents of preterm (25–35 weeks' gestation) infants completed the Brief COPE (secular coping), the Brief RCOPE (religious coping), and the Family Environment Scale within 1 week of their infant's hospital admission.

Findings—This descriptive study found that parents' religious and secular coping was significant in relation to family relationship functioning. Specifically, negative religious coping (ie, feeling abandoned or angry at God) was related to poorer family cohesion and use of denial.

Implications for Practice—These findings have relevance for interventions focused toward enhancing effective coping for families.

Implications for Research—Further study of religious and secular coping strategies for neonatal intensive care unit families is warranted in a larger more diverse sample of family members.

Keywords

coping; family relationships; neonatal intensive care unit; religiousness; spirituality

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BACKGROUND AND SIGNIFICANCE

The birth of a child comes with a multitude of emotions and experiences. In the case of an unexpected preterm birth, the realization that a mother or father's expectations may not be what one has planned can bring on a range of additional challenges including emotional and physical distress[1–4] and relationship difficulties.[5,6] The neonatal intensive care unit (NICU) can be a particularly stressful place for parents due to the unfamiliarity of this setting, making it alarming and emotionally taxing.[5,7] Moreover, in the neonatal intensive care setting, there is often prolonged mother-infant separation, a frequent lack of privacy during infant care (ie, breastfeeding and skin-to-skin contact), and a lack of support for the parental role in care of the neonate.[8]

A focus on individualized family-centered care in the NICU encompasses ways to support families through advocating for parental involvement and unlimited parental presence.[9, 10] This includes making changes to the physical design to reduce noise and dim lighting while also providing adequate private space for families to stay with their infants and offer emotional care and comfort, that is, single family rooms.[11, 12] Although there are barriers related to parental involvement in many NICUs, the focus on breastfeeding support, use of skin-to-skin care, and early bonding can lower parental stress levels,[13] shorten length of stay, and improve long-term neurobehavioral outcomes for infants.[14, 15] Furthermore, increased family-centered care can positively affect emotional outcomes for parents.[16] Indeed, parents may call upon family resources and parenting programs to cope effectively with this traumatic event, which can increase feelings of parenting effectiveness and lessen stress related to having a premature newborn.[10, 17] Parents may also utilize religious and spiritual coping methods to handle the stress related to the unknown outcome of their premature or ill newborn.

The transactional model of coping theorizes that parents must first access primary appraisal of the stressful event.[18] The transactional model of stress emphasizes that the way a person appraises an event, be it benign or highly stressful, leads to ways to control the stressful event, known as secondary appraisals.[18] Thus, the initial assessment of the event as stressful is then reduced to a determination of resources to handle this stressful event, which is salient in understanding psychological outcomes. The appraisal process is dynamic and fluid, resulting in different reactions to stress over time. In the case of the NICU, most parents would likely appraise this event as stressful, which would thrust them into secondary appraisal that focuses on accessing means of coping with their infant's hospitalization.

Common methods of coping with this type of life event may include asking for support from family members or friends, actively problem-solving, or more ineffective strategies such as denial of the problem or choosing not to deal with the problem by focusing on other tasks. Furthermore, mothers and fathers of preterm infants need spousal support, information from healthcare providers, and social support to master the parenting role.[19, 20] Social support includes both emotional and instrumental support and requires an environment conducive to information exchange through personal networks[21] and through caring interactions with others.[22]

These forms of secular coping may be accompanied by religious coping methods, which can include positive and negative avenues of stress management. Positive religious coping often includes a belief that there is meaning in life, feeling connected with others on a spiritual level, and feeling that there is a secure relationship with God.[23] Strategies that accompany positive religious coping include seeking forgiveness, craving and exploring religious or spiritual support, and praying to God. However, negative religious coping, often apprised as spiritual or religious struggles, is a less secure sense of a relationship with God, experiencing an ominous worldview, and having challenges with finding meaning in life through a spiritual lens.[24] Moreover, spiritual discontent and feeling punished or abandoned by God is synonymous with negative religious coping or spiritual struggles.[25]

Parents can experience both positive and negative forms of both secular and religious coping in relation to NICU admission, as they are typically not dichotomous forms of coping. However, experiences of negative religious coping tend to evoke more deleterious results for most individuals.[23]

Indeed, parents who find themselves in the NICU after their child's preterm birth may find that religious and spiritual aspects of their lives are tested or strengthened through this stressful time. The field of the psychology of religion and spirituality has a depth of knowledge on how religion and spirituality affect individual well-being[26, 27] and has made significant advances in studying religiousness, spirituality, and family relationships in the recent decade.[28] However, the extant medical and psychological literature remains scant when exploring distressed families or families who are struggling with a significant life event.[28] The birth of an infant who must be admitted to the NICU is one of these stressful situations in family life. In particular, parents may call upon spiritual resources to handle challenging decisions about their babies' health or to deal with their expectations of parenting that have been tested as a result of having a baby admitted to the NICU. The existing literature finds that, in particular, mothers tend to struggle with higher levels of anxiety and depression while their baby is in the NICU[29] and may even display symptoms of posttraumatic stress following their infant's NICU experience.[2]

Undeniably, families of preterm infants are especially vulnerable to isolation and ineffective interactions as they have infants with unique healthcare needs and present particular challenges for successful parenting.[30] Moreover, parents may be coping with their own feelings of anxiety, grief, fear, helplessness, guilt, and depression.[31] These emotions also may inhibit successful interactions with their infants and role transitioning to being a first time parent or the parent of a premature infant, which is a salient reason to fortify efficacious coping.

As previously indicated, to date, a dearth of research exists on parents' religious and spiritual mechanisms and their relationship to mental health and relational functioning in the NICU. Thus, our descriptive study will assess through self-report measures mothers' and fathers' use of religious and secular coping strategies in relation to family functioning. We hypothesize that parents who utilize positive forms of secular coping, such as seeking emotional support from family members, will be more likely to use positive religious coping strategies. It was also hypothesized the greater use of positive religious and secular coping

strategies in the NICU would be associated with lower levels of family conflict, higher levels of family cohesion, and greater family expressiveness. Conversely, we hypothesize that when parents report using negative religious coping, they will experience greater levels of denial and behavioral disengagement that may relate to less cohesion and more conflict with their families.

METHODS

We enrolled 52 adult parents of preterm infants born at the Penn State Milton S. Hershey Medical Center whose infants were admitted to the NICU of Penn State Children's Hospital during 2012–2014 in a cross-sectional, descriptive, cohort study. The Penn State Hershey institutional review board approved the study protocol and parental consent was obtained prior to subject enrollment. Parents were approached to enroll in this study within 1 week after their child's admission to the NICU. We did not approach parents immediately after birth but felt that the week of the birth was an important time for capturing parents' views on coping and family relationships in proximity to this salient event. The inclusion criteria were parents older than 18 years with English fluency who had singleton or twin preterm infants born at 25 to 35 weeks of gestation and admitted to the NICU within 48 hours of delivery. Parents were not approached to participate if their infants were born with severe/life-threatening illnesses, congenital syndromes, or significant deformational abnormalities, or if maternal illness prevented the ability to obtain informed consent.

Statistical Analysis Methods

After calculation of psychometric properties of the instruments' subscales (see Table 1), we computed participant demographics, bivariate correlations between aspects of the family environment while in the NICU, secular coping strategies, and religious coping strategies using SPSS (version 21). Correlations were followed by hierarchical regression analyses to determine whether unique variance was associated with religious coping in relation to family outcomes above that of secular coping.

Materials

Demographics—The survey contained questions regarding general demographic information including age, gender, race/ethnicity, marital status, income, level of education, and employment status. In addition, questions designed to assess religious and spiritual demographics were included. These questions included, "To what extent do you consider yourself a religious person?" and "To what extent do you consider yourself a spiritual person?", responses included 1 (*not at all religious/spiritual*), 2 (*slightly religious/spiritual*), 3 (*moderately religious/spiritual*), and 4 (*very religious/spiritual*). Two questions were also employed to assess frequency of prayer and religious service attendance, which asked, "How often do you go to religious services?" and "How often do you pray?". These 4 questions along with a question asking current religious affiliation are the crux of ascertaining parents' religious demographics.

Secular Coping—To assess participants' nonreligious methods of coping with stress, the 28-item Brief COPE was used.[32] This measure has participants respond to items from 1 (*I*

did not do this at all) to 4 (*I did this a lot*), such as "I've been criticizing myself" and "I've been making jokes about it." The Brief COPE represents 14 coping strategies, 5 of which were utilized for this study including instrumental support that focuses on getting help and advice from other people, behavioral disengagement that stresses giving up the ability to cope, emotional support that emphasizes getting comfort and support from others, denial that focuses on refusing to believe that the stressor has happened, and active coping that focuses on taking action to make the situation better. Of the 14 subscales, 5 subscales with a total of 2 items per subscale (a total of 10 items) were chosen because of the other 8 subscales (2 items per subscale) having Cronbach αs that were below 0.60, and one 2-item subscale assesses religious coping, which was deemed redundant due to our use of the more detailed brief Religious Coping Scale (Brief RCOPE). For this study, all subscales utilized in further analyses exhibited adequate internal consistencies of more than 0.60. In previous studies, the Brief COPE has been employed to understand how people cope with a variety of difficulties including mental illness[33] and physical illnesses such as breast cancer[34] and Huntington disease[35] but has not been used with families of ill neonates.

Religious Coping—Participant's religious coping was assessed using the Brief RCOPE.[24] The Brief RCOPE is a 14-item measure of positive (7-item subscale) and negative (7-item subscale) forms of religious coping. Positive religious coping is comprises feeling as though God is supporting one through a difficult time or praying to God for love and grace.[23] Negative religious coping is feeling though God has abandoned the individual or feeling anger at God.[23] Participants rate how frequently they used different strategies to cope with a stressful situation on a scale from 1 (*Not at all*) to 4 (*A great deal*), for example, asking God for forgiveness or feeling punished by God. This scale has previously been used in a variety of samples exposed to high-stress or traumatic situations (eg, patients undergoing surgery and 10 years after 9/11.[36, 37] Both subscales, positive and negative religious coping, have demonstrated high internal consistency of 0.90 and 0.81, respectively.[24] In addition, both positive and negative religious coping have been shown to have high levels of incremental validity over measures of general religiousness and secular factors, such as mood, and social support.[38]

Family Environment—The Family Environment Scale was used to assess the social-environmental characteristics of participants' families.[39] In the Family Environment Scale, participants rate the extent to which they agree on 40 items that describe their family. Specifically, 3 of the Family Environment Scale subscales comprise a family relationship index that encompasses family cohesion, family conflict, and family expressiveness. Family cohesion includes items that assess togetherness in the family and getting along well with each other whereas the family conflict subscale inquires about expression of anger and arguing in the family. Finally, family expressiveness centers on talking about difficult problems and having open discussions in the family.[40] Previously, these subscales have demonstrated adequate to high internal consistencies, with α values of .78, .75, and .69, respectively[40] and have been used in a variety of populations for differing challenges.

RESULTS

Participant Demographics

Participants comprised equally of males (26) and females (26), with the mean age of 29.40 years (range: 20–43 years). Approximately 3.5% of parents reported that they had 1 previous experience in the NICU and 11.5% were currently admitted with twin preterm infants. Breakdown of mothers' and fathers' ethnic background was 73.1% Caucasian, 13.5% Latino/a, 5.8% African American, 5.8% Asian American, and 1.9% Multiethnic. Most parents were married (61.5%), but a large number were single (34.6%) and a small percentage was separated (3.8%). There were 24 couples who both completed surveys, 3 partners elected not to complete the survey, 2 of whom were separated from their spouse, and 1 participant was a single mother without partner involvement. Parents tended to have either a bachelor's or professional degree (38.8%), but some parents obtained some college or an associate's degree (30.8%), whereas others received a high school diploma (17.3%) and others had only a 9th-to 12th grade education (15.4%). Most individuals were employed full-time (63.5%), but 13.5% reported being unemployed, 11.5% being stay at home parents, and 5.8% reported being either a student or employed part-time, respectively (see Table 2).

Parents in our sample were not overly religious or spiritual, but 11.5% reported being very religious and 21.6% as very spiritual. The remainder of mothers and fathers reported being moderately religious (28.8%), slightly religious (30.8%), or not at all religious (28.8%). Furthermore, 41.2% of parents reported being moderately spiritual, 21.6% indicated being slightly spiritual, and 15.7% reported not being spiritual. Most parents were either Catholic (23.1%) or Protestant (36.5%), with 7.7% reporting being atheist and 3.8% being agnostic, and 11.5% reporting other religious affiliation (such as Jewish, Buddhist, or Muslim; see Table 2).

Parents' reports on engagement in prayer on a scale from 1 (*not at all*) to 7 (*more than once a day*) ranged from 25% indicating that they never prayed, 9.6% reported praying once or less a month, 7.7% indicated a few times a month, 7.7% reported use of prayer a few times a week, 19.2% reportedly daily prayer, and 30.8% reported more than once a day engagement in prayer. Furthermore, for religious service attendance on a scale from 1 (never) to 6 (more than once a week), 25% of parents reported never attending religious services, 38.5% reported attendance 1 to 2 times a year, 7.7% reported attending every month or so, 11.5% reported attending once or twice a month, 15.4% reported every week or more attendance, and 1.9% reported more than once a week religious service attendance (see Table 2).

Primary Bivariate Correlations

Two-tailed Pearson correlations were derived to examine relationships between mothers' and fathers' reports of religious coping, secular coping, and family relationship quality while in the NICU (see Table 3 for all intercorrelations). Positive religious coping and negative religious coping were significantly positively correlated in this sample ($r = 0.51$, $P < .01$). As predicted, results also revealed a significant inverse correlation between use of negative religious coping and family cohesion ($r = -0.43$, $P < .001$). Significant correlations were also found between negative religious coping and instrumental support ($r = 0.32$, $P < .05$)

and denial ($r = 0.40$, $P < .01$) for NICU parents. Hierarchical regressions were computed following exploration of significant correlations but did not yield significant results likely due to low sample size and the number of predictors included in each model.

DISCUSSION

Medical and psychological literatures are scant when assessing religiousness and spirituality of family members in the NICU. Specifically, no studies to date have focused directly on the link between parents' views of religiousness and spirituality as an aspect of coping with an infant being admitted to the neonatal nursery. This descriptive study was aimed at the beginning to fill this dearth of information by exploring whether there was a link between religious coping, secular coping, and family relationship quality in parents who have a preterm infant in this setting.

In this study, results indicated that increased use of negative religious coping strategies, such as feeling abandoned or punished by God, was related to higher levels of denial and lower levels of family cohesion. Parents who used negative religious coping tended to have lower levels of feeling connected to their family members even after accounting for use of denial, which tends to be a deleterious long-term coping strategy for some, but for others, it may be functional in the short term before rebounding back to baseline functioning.[41] Surprisingly, use of instrumental coping, which includes getting help or advice from others was also related to higher levels of negative religious coping. This finding may be related to parents who feel angry with God and may also seek others (eg, friends, family) to help deal with and explain this challenging situation, thereby rendering support through instrumental coping. Furthermore, results also supported that parents who utilized positive religious coping (praying to God and feeling supported by God) also tended to use negative religious coping while in the NICU. This finding may be due to the dual process model of coping with stressful situations that highlights the multilevel aspects of coping with grief.[42] Applied to the NICU, parents may find that they vacillate between confronting their hopes and dreams related to having a healthy child coupled with avoiding feelings related to this process, reflecting the roller coaster ride experienced by most parents in the NICU.

Indeed, the prominence of one's religious and spiritual coping is important when discussing palliative care in a hospital setting,[43] but continues to be salient in non–life-threatening hospital situations. Our findings suggest that parents' spiritual lens is relevant in an unfamiliar and unexpected hospital admission for their newborn, even when engaged in nonpalliative care. Families' spiritual lens or worldview may encompass their views on their own religiousness and spirituality and their use of religious or spiritual copings strategies. When family members believe that God is punishing them, as reflected by their newborn being admitted to the hospital, there may be implications for appraising how to cope with a stressful situation. The ability to access effective coping could in part rely on appraising a situation as manageable due to the support from a loving and caring God. If religious parents report feeling angry with God, their secondary appraisal processes may be ineffective, as supported by the results of this study, demonstrating the increased use of denial is employed in concert with negative religious coping.

The implications of this study could extend to other family members, including grandparents and other support systems for parents. In addition, NICU staff, particularly nurses and neonatologists, may imbue their work with spiritual or religious significance when coping with challenging circumstances. Specifically, 83% of nurses in a study by Catlin et al[44] reported praying privately for babies in their care. Furthermore, these same populations of 45 neonatal staff all reported that families' religiousness and spirituality had a place in the NICU. Studies focused on neonatal staff support and the importance of assessing spiritual and religious means of coping with this setting, but rarely are there supports in place for parents to access their feelings about religious and spiritual views in relation to their baby being hospitalized. Although family-centered interventions are more commonplace in the NICU,[10, 45, 46] the complex interplay between emotional and spiritual needs of families is minimally addressed in a critical care setting. A lack of addressing religious and spiritual parental needs may result in family members struggling with existential questions and fears that require adequate support not only from therapists but also from spiritual and religious communities or pastoral counselors trained in psychospiritual integration. A study by Snodgrass[47] implemented a psychospiritual, family-centered intervention with one NICU mother, which focused on existential doubts and grief experienced by many parents in the NICU. This intervention is one of the first in the neonatal setting with a spiritual component. In light of the nascent study of religious and spiritual needs of NICU families, more research is needed to uncover the nature of religious and spiritual worldviews of NICU parents and if these parents find their religious backgrounds are strengthened or weakened during times of crisis. This line of research could support psychospiritual interventions to assist these families.

This study has added to the extant NICU literature, but limitations include use of self-report data that may not account for the interaction between parents' use of specific coping strategies and impacts of family relationships. Furthermore, the small sample size comprising largely married Caucasian parents limits generalizability of these findings to more diverse samples.

The results of this study support the need for more research on parents' use of coping with the NICU. In particular, future research is necessary to explore religiousness and spirituality in the NICU to find ways to support parents who may or may not be struggling with their religious and spiritual journeys. Resulting from this information, robust psychospiritual interventions can be developed to support families while in the NICU and upon discharge. If parents feel more psychologically capable of handling a newborn who may have special needs upon hospital discharge, they may be more likely to feel more equipped to handle their child's future medical needs. In addition, if parents are able to cope effectively, they may be able to access supports to assist them in navigating caring for their newborn. However, if foundational core beliefs are shaken and not addressed prior to discharge, parents' ability to access more effective means of coping with stress may be limited, thereby impacting their newborn with potential readmission to the hospital.

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References

1. Montirosso R, Provenzi L, Calciolari G, Borgatti R. Measuring maternal stress and perceived support in 25 Italian NICUs. Acta Paediatr. 2012; 101(2):136–142. [PubMed: 21827551]
2. Greene MM, Rossman B, Patra K, Kratovil AL, Janes JE, Meier PP. Depression, anxiety, and perinatal-specific posttraumatic distress in mothers of very low birth weight infants in the neonatal intensive care unit. J Dev Behav Pediatr. 2015; 36(5):362–370. [PubMed: 26039191]
3. Holditch-Davis D, Miles MS, Weaver MA, et al. Patterns of distress in African-American mothers of preterm infants. J Dev Behav Pediatr. 2009; 30(3):193–205. [PubMed: 19412125]
4. Fransson E, Ortenstrand A, Hjelmstedt A. Antenatal depressive symptoms and preterm birth: a prospective study of a Swedish national sample. Birth. 2011; 38(1):10–16. [PubMed: 21332769]
5. Doucette J, Pinelli J. The effects of family resources, coping, and strains on family adjustment 18 to 24 months after the NICU experience. Adv Neonatal Care. 2004; 4(2):92–104. [PubMed: 15138992]
6. Manning AN. The NICU experience: how does it affect the parents' relationship? J Perinat Neonatal Nurs. 2012; 26(4):353–357. quiz p 358–359. [PubMed: 23111724]
7. Shaw RJ, Deblois T, Ikuta L, Ginzburg K, Fleisher B, Koopman C. Acute stress disorder among parents of infants in the neonatal intensive care nursery. Psychosomatics. 2006; 47(3):206–212. [PubMed: 16684937]
8. Wigert H, Johansson R, Berg M, Hellstrom AL. Mothers' experiences of having their newborn child in a neonatal intensive care unit. Scand J Caring Sci. 2006; 20(1):35–41. [PubMed: 16489958]
9. Cooper LG, Gooding JS, Gallagher J, Sternesky L, Ledsky R, Berns SD. Impact of a family-centered care initiative on NICU care, staff and families. J Perinatol. 2007; 27(suppl 2):S32–S37. [PubMed: 18034178]
10. Gooding JS, Cooper LG, Blaine AI, Franck LS, Howse JL, Berns SD. Family support and family-centered care in the neonatal intensive care unit: origins, advances, impact. Semin Perinatol. 2011; 35(1):20–28. [PubMed: 21255703]
11. White RD. The newborn intensive care unit environment of care: how we got here, where we're headed, and why. Semin Perinatol. 2011; 35(1):2–7. [PubMed: 21255701]
12. White RD, Smith JA, Shepley MM, Committee to Establish Recommended Standards for Newborn ICUD. Recommended standards for newborn ICU design, eighth edition. J Perinatol. 2013; 33(suppl 1):S2–S16.
13. Melnyk BM, Feinstein NF, Alpert-Gillis L, et al. Reducing premature infants' length of stay and improving parents' mental health outcomes with the Creating Opportunities for Parent Empowerment (COPE) neonatal intensive care unit program: a randomized, controlled trial. Pediatrics. 2006; 118(5):e1414–e1427. [PubMed: 17043133]
14. Feldman R, Rosenthal Z, Eidelman AI. Maternal-preterm skin-to-skin contact enhances child physiologic organization and cognitive control across the first 10 years of life. Biol Psychiatry. 2014; 75(1):56–64. [PubMed: 24094511]
15. McAnulty G, Duffy FH, Kosta S, et al. School age effects of the newborn individualized developmental care and assessment program for medically low-risk preterm infants: preliminary findings. J Clin Neonatol. 2012; 1(4):184–194. [PubMed: 23951557]
16. Ortenstrand A. The role of single-patient neonatal intensive care unit rooms for preterm infants. Acta Paediatr. 2014; 103(5):462–463. [PubMed: 24812710]
17. Turner M, Winefield H, Chur-Hansen A. The emotional experiences and supports for parents with babies in a neonatal nursery. Adv Neonatal Care. 2013; 13(6):438–446. [PubMed: 24300964]

18. Lazarus, RS., Folkman, S. Stress, Appraisal, and Coping. New York, NY: Springer; 1984.
19. Turner M, Chur-Hansen A, Winefield H. The neonatal nurses' view of their role in emotional support of parents and its complexities. J Clin Nurs. 2014; 23(21–22):3156–3165. [PubMed: 24575971]
20. Bracht M, O'Leary L, Lee SK, O'Brien K. Implementing family-integrated care in the NICU: a parent education and support program. Adv Neonatal Care. 2013; 13(2):115–126. [PubMed: 23532031]
21. Finfgeld-Connett D. Clarification of social support. J Nurs Scholarsh. 2005; 37(1):4–9. [PubMed: 15813580]
22. Rossman B, Greene MM, Meier PP. The role of peer support in the development of maternal identity for "NICU Moms". J Obstet Gynecol Neonatal Nurs. 2015; 44(1):3–16.
23. Pargament, KI. Religion and coping: the current state of knowledge. In: Folkman, S., editor. The Oxford Handbook of Stress, Health, and Coping. Vol. 1. New York, NY: Oxford University Press; 2011. p. 269-288.
24. Pargament KI, Smith BW, Koenig HG, Perez L. Patterns of positive and negative religious coping with major life stressors. J Sci Study Religion. 1998; 37(4):710–724.
25. Exline, JJ. Religious and spiritual struggles. In: Pargament, KI.Exline, JJ., Jones, JW., editors. APA Handbook of Psychology, Religion, & Spirituality: Context, Theory, and Research. Vol. 1. Washington, DC: American Psychological Association; 2013. p. 459-475.
26. Emmons RA, Paloutzian RF. The psychology of religion. Annu Rev Psychol. 2003; 54:377–402. [PubMed: 12171998]
27. Pargament KI, Mahoney AM. Sacred matters: Sanctification as a vital topic for the psychology of religion. Int J Psychol Religion. 2005; 15(3):179–198.
28. Mahoney A. Religion in families 1999 to 2009: a relational spirituality framework. J Marriage Fam. 2010; 72(4):805–827. [PubMed: 22102761]
29. Pisoni C, Garofoli F, Tzialla C, et al. Risk and protective factors in maternal-fetal attachment development. Early Hum Dev. 2014; 90(suppl 2):S45–S46.
30. Gray PH, Edwards DM, O'Callaghan MJ, Cuskelly M, Gibbons K. Parenting stress in mothers of very preterm infants—influence of development, temperament and maternal depression. Early Hum Dev. 2013; 89(9):625–629. [PubMed: 23669559]
31. Melnyk BM, Feinstein N, Fairbanks E. Two decades of evidence to support implementation of the COPE program as standard practice with parents of young unexpectedly hospitalized/critically ill children and premature infants. Pediatr Nurs. 2006; 32(5):475–481. [PubMed: 17100079]
32. Carver CS. You want to measure coping but your protocol's too long: consider the brief COPE. Int J Behav Med. 1997; 4(1):92–100. [PubMed: 16250744]
33. Meyer B. Coping with severe mental illness: relations of the Brief COPE with symptoms, functioning, and well-being. J Psychopathol Behav Assess. 2001; 23(4):265–277.
34. Lechner SC, Carver CS, Antoni MH, Weaver KE, Phillips KM. Curvilinear associations between benefit finding and psychosocial adjustment to breast cancer. J Consult Clin Psychol. 2006; 74(5): 828–840. [PubMed: 17032087]
35. Downing NR, Williams JK, Leserman AL, Paulsen JS. Couples' coping in prodromal Huntington disease: a mixed methods study. J Genet Couns. 2012; 21(5):662–670. [PubMed: 22278219]
36. Ai AL, Hall D, Pargament KI, Tice TN. Posttraumatic growth in patients who survived cardiac surgery: the predictive and mediating roles of faith-based factors. J Behav Med. 2013; 36(2):186–198. [PubMed: 22460360]
37. Abu-Raiya H, Pargament KI, Mahoney AM. Examining coping methods with stressful interpersonal events experienced by Muslims living in the United States following the 9/11 attacks. Psychol Religion Spirituality. 2011; 3(1):1–14.
38. Pargament KI, Feuille M, Burdzy D. The Brief RCOPE: current psychometric status of a short measure of religious coping. Religions. 2011; 2(1):51–76.
39. Moos RH. Determinants of physiological responses to symbolic stimuli: the role of the social environment. Int J Psychiatry Med. 1974; 5(4):389–399. [PubMed: 4464279]

40. Moos, RH., Moos, BS. The Family Environment Scale Manual. Palo Alto, CA: Consulting Psychologist Press; 1986.
41. Bonanno GA, Westphal M, Mancini AD. Resilience to loss and potential trauma. Annu Rev Clin Psychol. 2011; 7:511–535. [PubMed: 21091190]
42. Stroebe M, Schut H. The dual process model of coping with bereavement: rationale and description. Death Stud. 1999; 23(3):197–224. [PubMed: 10848151]
43. Hexem KR, Mollen CJ, Carroll K, Lanctot DA, Feudtner C. How parents of children receiving pediatric palliative care use religion, spirituality, or life philosophy in tough times. J Palliat Med. 2011; 14(1):39–44. [PubMed: 21244252]
44. Catlin EA, Guillemin JH, Thiel MM, Hammond S, Wang ML, O'Donnell J. Spiritual and religious components of patient care in the neonatal intensive care unit: sacred themes in a secular setting. J Perinatol. 2001; 21(7):426–430. [PubMed: 11894509]
45. Harris GM. Family-centered rounds in the neonatal intensive care unit. Nurs Women's Health. 2014; 18(1):18–27. [PubMed: 24548493]
46. Westrup B. Newborn Individualized Developmental Care and Assessment Program (NIDCAP)—family-centered developmentally supportive care. Early Hum Dev. 2007; 83(7):443–449. [PubMed: 17459617]
47. Snodgrass JL. A psychospiritual, family-centered theory of care for mothers in the NICU. J Pastoral Care Counsel. 2012; 66(1):2.

What This Study Adds

- The results of this descriptive study support the need for more research on parents' use of coping with the NICU. In particular, future research is necessary to explore religiousness and spirituality in the NICU to find ways to support parents who may or may not be struggling with their religious and spiritual journeys.
- Our findings suggest that parents' spiritual lens is relevant in an unfamiliar and unexpected hospital admission for their newborn, even when engaged in nonpalliative care. When family members believe that they are being punished by God, resulting in their newborn being admitted to the hospital, there may be implications for appraising how to cope with a stressful situation.
- The implications of this study could extend to other family members, including grandparents and other support systems for parents. In addition, NICU staff, particularly nurses and neonatologists, may imbue their work with spiritual or religious significance when coping with challenging circumstances.

TABLE 1

Psychometric Properties of Major Study Variables.[a]

Construct (# of Items)	Range	*M*	SD	α
Secular coping (Brief COPE)				
Instrumental support (2)	2–8	5.31	1.80	80
Behavioral disengagement (2)	2–7	2.19	0.76	87
Emotional support (2)	2–8	6.28	1.57	63
Denial (2)	2–8	2.69	1.21	67
Active coping (2)	2–8	6.11	1.82	65
Religious coping (Brief RCOPE)				
Negative religious coping (7)	7–25	8.90	3.91	88
Positive religious coping (7)	7–28	15.48	7.13	94
Family relationship quality (FES)				
Family cohesion (5)	11–25	21.36	2.97	60
Family conflict (5)	6–22	11.96	3.69	73
Family expressiveness (4)	7–20	15.94	2.82	64

[a]Higher scores indicate higher levels of the corresponding construct. α = Cronbach α is an intercorrelation reliability coefficient. N = 52.

TABLE 2

Parent Demographics (N = 52)

Marital status	**%**	**Extent of religiousness/spirituality**	**%**
Married	61.5	Very religious/spiritual	11.5/21.6
Single	34.6	Moderately religious/spiritual	28.8/41.2
Separated	3.8	Slightly religious/spiritual	30.8/21.6
		Not at all religious/spiritual	28.8/15.7
Ethnic background		Religious affiliation	
Caucasian	73.1	Protestant	36.5
African American	5.8	Catholic	23.1
Latino/a	13.5	Other	11.5
Asian American	5.8	Agnostic/atheist	3.8/7.7
Multiethnic	1.9		
Education		Prayer	
Graduate degree	17.3	Greater than 1X day	30.8
Bachelor's degree	19.2	Daily	19.2
Some college or associate's degree	30.8	A few times a week	7.7
High school diploma	17.3	A few times a month	7.7
Less than a high school diploma	15.4	Less than 1X month	9.6
Employment		Never	25
Full-time	63.5	Religious service attendance	
Part-time or student	5.8	More than 1X week	1.9
Unemployed	13.5	1X week or more	15.4
Stay at home parent	11.5	1–2 times a month	11.5
		Every month or so	7.7
		1–2 times a year	38.5
		Never	25

Abbreviation: 1X, one time per.

TABLE 3

Correlations Between Coping, Family Conflict, Family Cohesion, and Family Expressiveness[a]

	PRC	NRC	FCN	FCH	FEX
Religious coping					
Positive	…				
Negative	0.513[b]	…			
Family environment					
Conflict	0.260	0.221	…		
Cohesion	−0.231	−0.432[b]	−0.621[b]	…	
Expressiveness	−0.046	−0.117	−0.509[b]	0.739[b]	…
Secular coping					
Instrumental support	0.303[c]	0.329[c]	0.066	−0.090	0.146
Behavioral disengagement	−0.085	0.195	0.480[b]	−0.547[b]	−0.525[b]
Emotional support	0.038	−0.043	−0.042	0.086	0.137
Denial	0.124	0.402[b]	0.422[b]	−0.556[b]	−0.527[b]
Active coping	0.016	0.077	0.075	−0.146	−0.139

Abbreviations: FCH, family cohesion; FCN, family conflict; FEX, family expressiveness; NRC, negative religious coping; PRC, positive religious coping.

[a] N = 52.

[b] $P < .01$.

[c] $P < .05$.

Summary Recommendations for Practice and Research

What we know:	• Parental coping with a premature birth resulting in an neonatal intensive care setting can be challenging.[1] • Parents need support in coping in the NICU[10]; this includes supporting religious and spiritual concerns. • Parents' religious and spiritual beliefs can affect their ways of dealing with stress.[23] • Parents who cope more effectively with stress while in the NICU tend to function better after their babies' discharge.[17]
What needs to be studied:	• Means of supporting parents' religious and spiritual challenges during their time in the NICU. • Understanding ways of integrating secular psychological concerns and religious/spiritual worldviews to enhance successful coping with the NICU and after discharge. • How NICU staff can assist parents in accessing psychological and religious supports to facilitate the most effective transition to parenting outside of the NICU.
What we can do today:	• Provide parents with psychological supports through counseling, both individual and through support groups, while in the NICU and after discharge. • Ask parents about their religious and spiritual beliefs to ascertain whether assistance is needed or whether support is gained through their religious worldviews. • Encourage NICU staff to access psychological and religious supports when dealing with stress related to their works and duties in the NICU. • Provide an open forum in the NICU for discussing psychological and religious or spiritual challenges for both parents and NICU staff.