

In God We Trust?

Organised Religion and Personal Beliefs as Resources and Coping Strategies, and their implications for Health, in Parents with a Child on the Autistic Spectrum

Strategies and resources for coping are important for all parents. They are vital for parents raising a child with autistic spectrum disorder. These parents have devised many, often ingenious, ways to deal with the challenging behaviour of their offspring. The strategies employed would seem to be dependent on the resources available.

Resources can be classified as internal, such as personality characteristics, health, intelligence, personal beliefs, parenting skills, previous coping experience, and external, support received from others. External sources of support comprise the social support system as defined by Schilling, Gilchrist, & Schinke (1984). Their model consists of three levels of support. The first level of support comes from close family members and friends. The second level includes neighbours, more distant friends and self help support groups. These two levels form the informal social support system. The third level, known as the formal support system, is the help received from professionals. This can include people in the health, social work, organised religion, and education areas, and also politicians and policy-makers.

The larger study, of which this paper is a part, aims to approach the family from an ecological point of view. This means looking at the family as nested in its environment and taking into account the different systems that impinge on it. Organised religion and personal beliefs dwell within these nested systems. Therefore in-keeping with this ecological approach it seemed important to explore these areas. Previous research has recognised the contribution that organised religion and personal beliefs have made to family life. In 1984 Bronfenbrenner, Moen, and Garbarino said that "researchers concerned with the well-being of families would do well to attend to the part played by religious institutions within the community." (p.30). Fewell, (1986) felt that some people derive important support from their inner resources, personal belief systems, and religious affiliation. In 1994 Beresford published a paper which examined the research looking at the resources and strategies used by families caring for disabled children. These included support from organised religion and personal beliefs, which she felt were a potential resource during the continuing process of caring for the disabled child.

Organised religion can be seen as fulfilling a number of roles for its' members. It may provide education, emotional support and sometimes financial and material help. Bennett, Delucca & Allen, (1995) suggested that people involved with religious organisations should be sensitive to the needs of families who have children with disabilities and be aware of the ways they can serve as sources of

support. However, Turnbull, Brotherson, & Summers, (1985), reported that some families found that churches hindered family adaptation because they did not incorporate the needs of disabled children into their activities. Fewell (1986) reported that families were not always supported by their churches. Within organised religions there are many rites and rituals. These may provide a framework for life, as they mark life's milestones and act as rites of passage. Beit-Hallahmi & Argyle, (1997) stated that rites of passage are "universal to mankind, suggesting that they do have an important function." (p53). Fewell,(1986) felt that the rituals and corporate acts of worship may also provide a supportive structure that some people find meaningful.

Organised religion, represented by its' churches, is part of the nested system of society. It therefore follows, as Young, (1990), suggested that the church is a human institution and that, as such, it can only reflect the society in which it exists. She continued that society generally does not want to know about handicap, and it is only interested in achievers. Therefore society cannot cope with those whose handicap is lack of achievement. Middleton (1995) expanded this theme, feeling that it is clear that as a society we do not want to include disabled children. She suggested that society did its' best to prevent their birth, and if this failed it sought seek to 'normalise' them. Finally if this failed they were rendered invisible by an elaborate system of segregation.

Personal beliefs may or may not have religious connotations. These beliefs may help in two main ways. Firstly, they could aid parents to focus on the positive aspects of their disabled child, and encourage them to cope from day to day, rather than planning for the future. Secondly, personal beliefs could also help the parents to interpret and redefine their child's disability. Copeland (1988) found that parents needed to be able to alter their previous life philosophies to cope with the impact of their disabled child on family life. They may feel that they were specially selected for this task, and that they would be given the strength to cope. Hepple, (1988) found that despite the pressures on them, most families held a set of beliefs that helped them adjust to their child's handicap. Consequently they had turned a potentially negative situation into a positive one.

Prayer plays an important part in religious belief. Here it is explored as part of the personal belief system, rather than the corporate or group prayers that might take place in a church. Prayer may take many forms. Common types of prayer include petitionary prayer i.e., asking for help for oneself, thanksgiving prayer and intercessory prayer, asking for help for others. Prayer was seen as a coping strategy for problem solving by Parker & Brown, (1982) and by Lazarus & Folkman, (1984). It was felt by Loewenthal, (1995) that research into prayer may have been thrown off track by Galton's theologically naive study. Francis Galton, (1883), claimed that the British Royal Family were prayed for more than anyone else in Britain, yet they fared no better than the general population in regard to health or longevity. Fewell, (1986) investigated the use of prayer by mothers of children with Down's Syndrome. She found that belief in the efficacy of prayer may have given comfort to such mothers. Argyle & Beit-Hallahmi, (1975), found that prayer was reported as the most helpful cognitive strategy for military personnel in battle, particularly for those who were frightened. They concluded that "there are no atheists in foxholes". Bennett, Delucca & Allen, (1995) found that

prayer, church attendance, and specific religious beliefs were identified as sources of support which helped some parents of disabled children feel a growing sense of hope and strength. However, in their study of depression, Parker & Brown, (1986), found that prayer was not associated with any improvement.

There is also evidence that religious beliefs can lead to vulnerability in parents of children with disabilities, (Knussen & Cunningham, 1988). Sometimes parents of disabled children may question their previously held beliefs, and feel guilty and to blame,

(Copeland, 1988).

Previous research findings on the support carers gain from their religiosity had mixed results. Some studies felt it had a buffering effect against stress, whilst others suggested it caused stress. Byrne & Cunningham (1985) considered previous research findings were equivocal. Unless studies use the same measures it is difficult to draw satisfactory comparisons. There is also a problem with different definitions of religiosity. Beresford, (1994), felt it was important to distinguish between support from personal beliefs, and support gained through membership of a religious organisation. When Fewell (1986) used this distinction, she found that personal beliefs were more important than organised religion as a support for those caring for children with Down's Syndrome.

Life with a child on the autistic spectrum is not easy, and so the health status of the participants was of particular interest. Harris, (1994), found that parents of children with autism did not "exhibit greater degrees of psychopathology than the population as a whole". Koegel, Schreibman, O'Neill and Burke, (1983) had a similar finding. In the Eastern Health Board area of the Republic of Ireland, Fitzgerald, Matthews, Birkbeck and O'Connor, (1997) found that there was no significant difference between the GHQ-30 scores of mothers of a child with autism and mothers of control children. In a UK National Population Survey, Cox, Blaxter, Buckle et al., (1987) found that 32% of cases scored at or above the cut-off of 5 on the GHQ-30. The GHQ-28 was chosen for the main study, of which this is a part, rather than the GHQ-30. It was used because in addition to a general health score, it also yields 4 sub-scales. It was felt unnecessary to use these in this paper. Carr, Roseingrave, Fitzgerald, (1996) reported that the GHQ-30 and the GHQ-28 have been shown to yield similar results when used as a screening instrument. Therefore it would seem valid to compare the results of this study with those studies mentioned above.

This paper investigates the possibility of a relationship between reported support from organised religion, personal beliefs and health status. Loewenthal (1995, p 155) stated that "There is some evidence that there are overall positive effects on mental health, but more investigation is often required." In a study of 52 African American caregivers of children with mental retardation, Rogers-

Dulan, J., (1998), found that religion in personal and family life, and church support, were related to positive outcomes in adjustment. In other studies religiosity has been shown to have benefits during negative life events. Shams and Jackson (1993) found that religiosity buffered the effect of unemployment in a sample of British Asians. Their research replicated findings for white subjects. They quoted the meta analysis of Bergin (1983) which indicated that not only could religiosity could be associated with good health, but also that the strength of religious commitment may predict psychological well being.

Personal beliefs are internal coping resources. Organised religion is an institutional resource, and therefore part of the third level of social support, the formal system.

This paper has two main aims:

(1) to explore these two sources of support in these parents of children with autistic spectrum disorder, using Fewell's (1986) model of religiosity.

(2) to investigate the possibility of a relationship between reported support from organised religion, personal beliefs and health status.

Method

Participants

A sample of prime carers, N=60, 56 mothers, and 4 fathers took part in the study. They all availed of services in the Eastern Health Board area in the Republic of Ireland. They had a mean age 47.3yrs. and a median age of 46.5yrs., with a standard deviation of 10yrs. The age range was 27 -71yrs. Age was normally distributed. Forty nine were married or in long term relationships. Seven were separated from their spouses. Four were widows or widowers.

Instruments

The following instruments were used in this study.

1. Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, (APA 1994) Axis 1: Clinical Disorders 299.00 Autistic Disorder. To be included in the study carers had to have a child that met these criteria. One author (MF) trained the other (PC) to use DSM-IV to confirm this.

2. Childhood Autism Rating Scale (CARS) (Schopler, Reicher, & Renner, 1988). This is a fifteen item behavioural rating scale developed to identify children with autism, and so distinguish them from developmentally handicapped children without the autism syndrome. It further distinguishes children with autism in the mild to moderate range from children with autism in the moderate to severe range. The emphasis of the CARS is on behavioural and empirical data, rather than on clinical intuition, makes it possible to move the diagnosis from the private domain of the clinically initiated to the less restrictive domain of appropriately informed persons from different professions. The ratings are extremely useful for identification of behavioural symptoms, for research purposes, or for classification purposes. The CARS was used to indicate the severity of autism. Parents' reports can be used for this rating. The CARS is also thought to be a useful screening device for adolescents and adults with autism, (Mesibov, Schopler, Schaffer, & Michal, 1989). One author (PC) was trained to use this by the head teacher of a special school who was an experienced user.

3. The General Health Questionnaire, Scaled-28, (GHQ-28) (Goldberg, D. 1978) This is a well-known and extensively validated screening questionnaire. It inquires about various aspects of present physical and mental health and also assesses stress responses in the health domain. It provides a single total score for the purpose of case identification using a threshold score of 5 or greater to fall into the clinical range. Responses were made on a four point scale, and they were scored 0,0,1,1 to obtain the total and sub-scale scores.

4. Support from Religious Organisations and Personal Beliefs Scale, (SROPB Scale) It has 12 items, and was based on the Religion Scale (Fewell, 1986). Fewell investigated this type of support in 80 mothers of children with Down's Syndrome. The study was done in the United States of America. Her scale had 12 statements; six were on support from organised religion; and six on support from personal beliefs. They were scored on five point Likert scales with higher scores reflecting stronger agreement with the statements. Fewell's (1986) results showed the mothers' responses. They distinguished between the two different types of support. An insight was given into the role that both played in the support and coping systems of the families. The authors felt that the Religion Scale (Fewell, 1986), as it stood, was not suitable for this study. The wording was for an American setting and it was used for parents of children with Down's Syndrome. The wording was changed in this study, however all but one of the changed statements had the same enquiry as the originals. That one statement was changed from "Our clergyman was helpful when our handicapped child was born", Fewell (1986) p300, to "My clergyman was helpful to me when our disabled child was diagnosed". This reflects the fact that Down's syndrome is recognisable and diagnosed at birth, whereas autistic spectrum disorders are developmental and not diagnosed until later in the child's life.

5. A semi structured interview schedule was developed for the larger study. The data reported here is a part of a larger data set collected using this interview schedule. It reports on the use of prayer as a coping strategy in more detail. It also recorded statements with a religious or ideological connotation made by the participants.

The interviews were recorded with field notes and a tape recorder.

Design

This part of the study investigated the present time. Data is quantitative and qualitative.

Procedure

Professionals in various institutions, special schools, clinics, workshops, residential care homes, were asked if they could help to find subjects for the research. They were sent details of the study, and letters to send out to the carers. The letters invited carers to take part. They also gave information on the study, and what taking part involved. All were assured of confidentiality. Carers sent back reply slips if they were willing to take part. They were then phoned and appointments arranged. All but one of the participants were interviewed in their own homes. That one person, who lived in the country, was interviewed in the Dublin offices of the Irish Society for Autism. One author, (PC), arranged and conducted the interviews. Each interview took between two and a half and three and a half hours. The data used here is only part of that collected for the larger study. Permission was sought at the start of each session to tape the interviews. Tapes were unavailable in three cases. DSM-IV, CARS., and the SROPB Scale and the original semi-structured interview schedule were administered to participants. Instructions were given for completing the GHQ-28. This was left for them to complete in their own time, and return in a stamped addressed envelope. There was a 92% response rate. This resulted in 54 complete data sets for this paper.

Analysis

Scores for support from personal beliefs and organised religion were summed across statements. This gave total scores on both sources of support for each participant. Simple linear regression, correlation, paired and two sample Student t tests were used to investigate the differences and relationships between reported support from organised religion, support from personal beliefs and

health status. The analysis of individual statements on the religion scales followed that of Fewell, (1986). She collapsed the response categories to give more concise results. Strongly disagree and moderately disagree were combined to form one category called disagree. Strongly agree and moderately agree were combined to form one category called agree.

The GHQ-28 scores were examined, and then used to separate the participants into two groups. Those with scores below the cut off criteria of 5 were deemed to have good health. Those with scores at and above the criteria were deemed to have poor health.

Simple linear regression and correlation were used to investigate the possibility of relationships between the participants health status and their age, the severity of their child's autism and age of their child. The same procedures were also used to investigate any possible relationship between support from organised religion and personal beliefs, and participants age, severity of their child's autism and the age of their child.

Results

1. DSM IV It was confirmed that all participants had children which met the criteria for Autistic Disorder.

2. CARS. This showed that 97% of participants had children in the moderate to severe range, and 3% had children in the mild to moderate range.

3. The GHQ-28 indicated that 35% of participants, scored at or above the cut off point of 5, they had a mean 11.84, a standard deviation of 5.71, and a range 5-22. It also showed that 65% of participants scored below the cut off point, with a mean 0.66, a standard deviation of 1.2, and a range of 0-4. This indicates that just over a third of respondents were experiencing clinically significant levels of psychological symptomatology. A two sample Student t test showed that the difference between those with good health and those with poor health was significant, $p < 0.001$.

Correlation offered no significant evidence of a relationship between the age of participants, the severity of the child's autism, or between the ages of their children and their health status. Therefore the severity of their child's autism, the age of their child, and their own age do not seem to effect the health status of the participants.

4. The SROPB Scale showed that participants reported most support from their personal beliefs. They received little support from organised religion. The total score for participants' support from organised religion was 572 with a mean of 9.69 for each individual, and a standard deviation of 4.88. The total score for support from personal beliefs was 1259, with a mean of 21.34 and a standard deviation of 7.44. A paired t test showed that the difference between the scores for these two potential sources of support was significant ($p < 0.001$). Student t tests showed that this difference was significant for those who had good health,

($p < 0.001$), and for those with poor health ($p < 0.001$). Therefore those with good health and those with poor health, both reported more support from their personal beliefs than they did from organised religion. Support from personal beliefs and organised religion scores were correlated with the participants age, severity of their child's autism and their child's age. The only significant relationship was between personal beliefs and participants age when

$r = .3373$, with $p = .009$. This means that the older the participant the more support they reported from their personal beliefs.

Table 1. Responses on support from organised religion.

| Statement | Not applicable | Agreed | Neither agreed/ disagreed | Disagreed |
|---|----------------|--------|---------------------------|-----------|
| 1 My clergyman was helpful to me when our disabled child was diagnosed | 41% | 7% | 10% | 42% |
| 2 I am satisfied with the availability of religious education available for our child | 29% | | | |

46%

15%

10%

3 I am more active in our church since our child was born

9%

5%

24%

64%

4 If I had problems with our child I would seek help from our church

2%

5%

12%

79%

5 The church has been more supportive of me than other agencies

5%

9%

9%

78%

6 Most of my social activities involve members of my church/parish community

2%

12%

3%

83%

Participants disagreed with all but one of the six statements. Apart from religious education they felt unsupported by their organised religion. Forty six percent agreed and 10% disagreed that they were satisfied with the availability of religious education for their child. Twenty eight percent said it did not apply to them because religious education meant nothing to their child. Forty percent said the statement "My clergyman was helpful to me when our disabled child was diagnosed", was not applicable to them, of these 22% had not told their clergyman.

Table 2. Responses to statements on support from personal beliefs.

| Statement | Not applicable | Agreed | Neither agreed/ disagreed | Disagreed |
|---|----------------|--------|---------------------------|-----------|
| 7 My personal beliefs, have helped me to understand and accept our disabled child | 0% | 70% | | |

4%

27%

8 I am satisfied that our personal beliefs, are fulfilling our family's spiritual needs

0%

78%

3%

19%

9 Having a disabled child has brought me closer to God and my religion

0%

39%

17%

45%

10 I seek comfort through prayer

0%

66%

0%

34%

11 My personal beliefs, continue to be a source of comfort in coping with our disabled child

0%

73%

5%

22%

12 My personal beliefs, are a source of personal and family strength to me in everyday life

0%

68%

9%

24%

Participants agreed with all but one of the statements. The majority felt supported by their own personal beliefs. However 45% disagreed that having a disabled child had brought them closer to God and their religion.

The total scores of each individual for support from personal beliefs and organised religion were then explored to see if there was evidence of a relationship with their health status. There was no

evidence of a relationship between support from organised religion and health status. However correlation and regression did indicate a significant relationship between support from personal beliefs and health status ($r = -0.417$, $p = .002$), and $F=10.93$, $\text{Signif } F = .0017$. This negative relationship shows that as scores for personal beliefs increased as health scores decreased, therefore better support from personal beliefs may result in better health. Furthermore a t test showed that the difference in scores of support from personal beliefs between those with good health and those with poor health, was significant, $p < 0.0157$. It would seem that those with higher scores on support from personal beliefs had better health. The participants in this study who sought comfort in prayer had significantly better health, ($p < 0.01$), than those who did not.

Discussion

The sample consisted of fathers and mothers which may mean it cannot be compared to other

studies. There were three fathers, two of them were separated from their spouses and were in sole charge of their children. The third father was a widower. Perhaps just three fathers in a final sample size, $N=54$, for this paper did not effect the overall results.

It should be noted that only one of the studies cited, Fitzgerald et al, (1997), had participants whose children had autistic spectrum disorder. Other studies cited here were concerned with various disabilities. Differences between disabilities, and also their severity are other factors that need to be considered when making comparisons with these other studies.

The main findings of this study agreed with the those of Fewell, (1986). Participants reported significantly more support from their personal beliefs than from their organised religion. The formal churches to which they belonged did not help them to cope, and were rarely there as a resource. The mean score for reports on support from organised religion for this study 9.69, is lower than 13.22, that of Fewell, (1986). This indicates that participants in this study reported less support from their organised religion than did those in Fewell, (1986). Personal beliefs were both a resource and a coping strategy. The mean score for support from personal beliefs from this study, 21.34, was similar to the 21.85 of Fewell, (1986). There were two differences in individual items concerned with organised religion on the SPROB Scale. These differences may reflect the difference between autistic spectrum disorder and other disabilities

Support from Organised Religion

The first difference that this study found was that just 7% participants agreed that their clergyman had been helpful at the time of diagnosis, compared to 42% in Fewell's, (1986) study. Fewell's, (1986) subjects had children with Down's Syndrome which is recognised and diagnosed at birth. When disabilities are visible at birth, diagnosis may follow swiftly. The clergy are then likely to know about these disabilities at the time of the child's baptism. Autism reveals itself over the first few years of a child's life. Typically during this time the child presents increasing incidents of challenging and unusual behaviours. These may cause the family to withdraw socially, and also their family and friends to withdraw from them. Coulthard, & Fitzgerald, (1997), found that reports of social withdrawal were highest at the time of diagnosis. This could mean that the clergy and parish community might never know about the disability. Twenty-two per cent of participants had not told their clergy. One said "Why involve the church", another said "They (the clergy) have little understanding", another found that the "priest was positively unhelpful", whilst one said that their clergyman was a "great support".

The second difference concerned parents seeking help from their church. Fewell, (1986) found that 37.7% of her participants would seek help compared to 5% in this study. This maybe related to the fact that the presence of a child on the autistic spectrum seemed to result in families being less active in their churches. One carer felt "autism isolates us from the church", another said they could not be active "because of their child's behaviour", a third was "tired of religion". Three said they "were active as ever". The churches were not more supportive than other agencies. Participants reported that: "They (the priests) just give you sympathy", and "I insisted in taking her to Mass even though people said to leave her in the porch". Some were pleased with that the clergy let parents stand at the church gates to collect money for the Autism Society, but others seemed resentful. They felt that that was the only support they received from their church. Two families, who were members of the Church of Ireland, found their clergy most supportive. This may be because their church is a small, close-knit minority community. One carer said that his clergyman was great, he would collect the whole family and take them to church.

Forty six percent of participants were satisfied with their child's religious education. Although 29% of respondents felt that religion and it's rituals meant nothing to their children. Many of the children of the parents in this study had made their first communion and had been confirmed. Perhaps this fulfilled the parents' need, a normalising of their situation, observing the rites of passage of their culture. Perhaps as Meske et al in Beit-Hallahmi & Argyle, (1997) felt, these family rituals may be seen as strengthening families by bring them together to share enjoyable occasions. In Ireland these rituals are catered for in the special schools, rather than in the family's parish. In one way this seems good as the child is likely to be happier in a familiar place. However on the other hand this situation may further isolate the families from their local communities. One family were disappointed when they invited the local clergy to attend their child's confirmation and no one came.

Support from Personal Beliefs

Personal beliefs, whether religious or secular, were both a resource and coping strategy for carers. The severity of autism and child's age were not related to reported support from personal beliefs. However as the age of participants increased so did their reported support from Personal Beliefs. This could indicate a developmental maturity, and one might expect this to occur in the population as a whole.

Forty five percent of participants felt that having a disabled child had distanced them from God and their religion. One carer "gave out to God", another asked "God why did you do it". On the other hand a carer of an adult son said "It is easier for me to see God in my autistic son than anyone else, I do believe there is a God up there". This different finding may again be due to the difference between autism and Down's syndrome. Perhaps increasing incidents of challenging behaviour that kept carers physically from their churches also made them feel psychologically distanced from their religion.

Many of the participants' statements reflected the findings of previous studies. They included; "I believe in myself and my own philosophy of life, this helps", and, "Stoicism and my own philosophies have been everything". During ancient times in Ireland disabled people were well cared for, they were seen as special in society; as people of God. This was indicated in another quote "The Lord has his reasons, the role of the handicapped in society is being a person of God". Another carer said "I believed and trusted in God. God takes care of everything". Many parents said that they coped from day to day and did not think about the future.

The vulnerability described by Knussen & Cunningham, (1988) and the feelings of guilt and self blame, (Copeland 1988), were also evident in the participants in this study. One said "If you can't blame God, blame your Mother", many felt guilty and to blame.

Prayer

Prayer was a resource and a coping strategy. One participant said "prayer was the most important strategy, I told him (the diagnostician) I would go home and say my prayers I thought it would be more benefit". Another stated "I always prayed, it helped me cope". Yet another said "I prayed all the time, my faith kept me going". Others were more specific using petitionary prayer e.g. "I prayed for my autistic child more than the rest of the family", "I still pray for a magic cure, I'm still living in hope". To some people prayer was an ongoing support, e.g. "Prayer was the only thing that helped", "Prayer helps, I would have gone crackers if I didn't pray", "Even though I was mad with God I still kept praying", and "Prayer is all we have at the end of the day, there were times when I gave up, sometimes I wonder if He's up there at all". Four families went on pilgrimage to Lourdes, one "found

great peace there". The fact that participants in this study who sought comfort in prayer had significantly better health is interesting, but it does not presume causality. Other factors, such as socio-economic status, are also likely to effect health status. Previous research has been equivocal. Perhaps it is more important to do the praying yourself than have people praying for you, as in Galton (1883). There are many forms of prayer, but all have the acknowledgement of a supreme being common. Therefore not only is the person praying physically carrying out an activity, praying, they are also in some sense handing the problem on, by deferring to a higher authority. A participant said " I trusted and left it to God, God will take care". The latter may lessen feelings of guilt and responsibility. This change of attribution away from the self, combined with the physical activity of doing something may aid the carer to cope more adequately. One person said "prayer helped me to reach acceptance", another said "lately religion has helped me to understand and to accept". Perhaps the participants in the study of Parker & Brown, (1986) were too depressed to have confidence in the efficacy of prayer. The carers in this study would seem to have used prayer as a buffer in times of stress in a similar way to the military personnel of Argyle et al (1975).

Health

Support from personal beliefs and seeking comfort in prayer seemed to be related to good health. Fitzgerald et al. (1997) were surprised to find that there was no significant difference in health status between mothers of children with autism and their control group of mothers. The present authors could not find an Irish population survey on health status. The nearest comparison was the UK National Population Survey, Cox et al., (1987) it found that 32% of cases scored at or above the cut-off of 5 on the GHQ-30. The findings of this study seem similar, 35% of participants scored at or above the cut-off score on the GHQ-28. There was also no relationship between severity of autism, child's age or participants age and health status. Although this result fits in with the above reports it was a surprise. The participants reported many problems in their lives and it was thought that their health would suffer. Beit Hallamhi et al, (1997, p165) stated that "Most studies show a positive association between religiosity and self-esteem". Perhaps these people's personal beliefs helped them to feel secure in themselves, this aided their coping skills, and consequently they had better health. Personal beliefs may be acting as a buffer against the impact of having a child with autism as they seem to have done in parents of children with mental retardation, (Rogers-Dulan, J.,1998). Shams and Jackson, (1993), described a similar effect of religiosity in relation to unemployment. Bergin (1983) felt that the strength of religious commitment may predict psychological well being. Linear regression did give adequate validity to the idea that strength of support from personal beliefs may be an indicator of health status. However more investigation would be required before one could think of claiming this predictive quality.

This paper set out to investigate just one small area in the support systems of these families. It would seem that perhaps the input of organised religion itself is small, but the role played by personal beliefs, whether religious or not, may play a large part in a family's ability to cope with their child on the autistic spectrum. Support systems are often looked at from an external viewpoint

including such as service provision, professionals, and social networks. Future research may perhaps examine further the personal factors that mediate adequate coping, such as beliefs, ideologies, and personality.

The churches to which these participants belonged generally did not have an outreach to these isolated families. Many statutory services for the disabled in Ireland are administered by religious organisations. Perhaps the church feels it is fulfilling its' commitment to the disabled through such bodies. However, society is more than its major organising institutions, it consists of local communities or in church terms - parishes. It could be at this level that clergy might be educated as to the spiritual support they could give to these families in their parish communities. This may be just the occasional visit to acknowledge the existence of the child with autism in that family. These children with autism have been baptised into their church and are just as valid members as the rest of their parish.

Despite the difference in disabilities it is interesting that this study in Ireland had the same main results as Fewell, (1986) in the United States of America. The different disabilities may have effected individual scale items, but it seems debatable whether these differences would change the overall results. One wonders how different the findings might be in other cultures and organised religions, and perhaps what they might learn from each other.

References

American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders (1994). 4th Edition, Washington DC..

Argyle, M., and Beit-Hallahmi, B., (1975). *The Social Psychology of Religion*. London: Routledge & Kegan Paul.

Beit-Hallahmi, B., & Argyle, M., (1997). *The Psychology of Religious Behaviour, Belief and Experience*. London: Routledge.

Bennett, T., Delucca, D.A., & Allen, R.W.. (1995) Religion and children with disabilities, *Journal of Religion and Health*, vol.34, No. 4.

Beresford, B. A. (1994) Resources and Strategies: How parents cope with the care of a disabled child. *Journal of Child Psychology and Psychiatry*, 35, No. 1, 171- 209.

Bergin, A. E., (1983) in Shams M., and Jackson, P. R.. (1993) Religiosity as a predictor of well-being and moderator of the psychological impact of unemployment, *British Journal of Medical Psychology*, 66, 341-52.

Bronfenbrenner, U., Moen, P., & Garbarino, J., (1984). In R. D. Parke, R. N. Emde, H. P. McAdoo, & G. P. Sackett (Eds.), *The Family. Review of Child Development Research, Volume Seven*. Chicago: University of Chicago Press.

Byrne, E. A., & Cunningham, C. C. (1985). The effects of mentally handicapped children on families - a conceptual review. *Journal of Child Psychology and Psychiatry*, 26, 847-864.

Carr, A., Roseingrave, P., & Fitzgerald, M.X..(1996) Factors associated with stress responses in staff caring for patients with cystic fibrosis, *Irish Journal of Psychology*, 17, 3, 241-250

Copeland, D. R. (1988). *Stress and the patient's family*, In Russell, M. L. (ed.) *Stress management for chronic disease*, New York: Pergamon Press.

Coulthard, P. M., & Fitzgerald, M. (1997) *Friends, Relations and Professionals? - Social Support in Families who have a Child with Autistic Spectrum Disorder*. 5th European Congress of Psychology, Dublin, Ireland.

Cox, B., Blaxter, M.,Buckle, A., et al., (1987). *The Health and Lifestyle Survey*. Cambridge: Health Promotion Research Trust

Fewell, R. R. (1986). Support from religious organisations and personal beliefs. In Fewell, R. R., & Vadasy, P. F. (eds) *Families of handicapped children: Needs and supporters across the life span*. Austin, Texas: Pro-Ed.

Fitzgerald, M., Matthews, P., Birkbeck, G., and O'Connor, J.. (1997) *Irish Families Under Stress*, Vol. 6., *Planning for the Future of Autistic Persons*. Eastern Health Board, Dublin, Ireland

Galton, F. (1883) *Inquiries into Human Faculty and Development*, MacMillan, New York

Goldberg, D. (1978). *Manual of the General Health Questionnaire*, Windsor: NFER-Nelson

Harris, S. (1994) Treatment of family problems in autism. In Schopler, E., Mesibov G. (Eds.). *Behavioural Issues in Autism*, New York, Plenum.

Hepple, S. (1988) *Families and their handicapped children: a study of coping*. Barnardo's Research & Development, Ilford, Essex, England

Koegel, R.L., Schreibman, L., O'Neill, R. E., & Burke, J.C..(1983) The personality and family interaction characteristics of parents of autistic children. *Journal of Consulting and Clinical Psychology*, 51, 683 - 692.

Knussen, C. & Cunningham, C. C. (1988). *Stress, Disability and Handicap*. In Fisher, S., & Reason, J. (eds.) *Handbook of Life Stress, Cognition and Health*, New York: John Wiley and Sons Ltd.

Mesibov, G., Schopler, E., Schaffer, B., & Michal, N. (1989). Use of the childhood autism rating scale with autistic adolescents and adults. *Journal of the American Academy of Child and Adolescent Psychiatry*, 28(4):538-41.

Meske, C., Sanders, G.F. & Meredith, W.H., (1994) in Beit-Hallahmi, B., & Argyle, M., (1997). *The Psychology of Religious Behaviour, Belief and Experience*. London: Routledge.

Middleton, L. (1995). *Making a difference : social work with disabled children*, Birmingham : Venture Press,

Lazarus, R. S. and Folkman, S. (1984). *Stress, Appraisal and Coping*, New York, Spring Publishing Co..

Loewenthal, K. M. (1995). *Mental Health and Religion*, Chapman & Hall, London.

Parker, G. B., & Brown, L. B. (1982). Coping behaviours that mediate between life-events and depression. *Archives of General Psychiatry*, 39,1386-1391.

Parker, G. B., & Brown, L. B. (1986). Coping behaviours as predictors of the course of clinical depression. *Archives of General Psychiatry*, 43, 561-565.

Rogers-Dulan, J. (1998). Religious connectedness among urban African American families who have a child with disabilities. *Journal of Mental Retardation*, 36(2):91-103 1998

Schilling, R.F., Gilchrist, L., & Schinke, S.P (1984). Coping and social support in families of developmentally disabled children. *Family Relations*, 33, 47-54.

Schopler, E., Reichler, R.J., & Renner, B. R.. *Childhood Autism Rating Scale, (CARS)*, (1988). Western Psychological Services, 12031, Wiltshire Boulevard, Los Angeles, California 99025, U.S.A.

Shams M., and Jackson, P. R.(1993). Religiosity as a predictor of well-being and moderator of the psychological impact of unemployment, *British Journal of Medical Psychology*, 66, 341-52.

Turnbull, A. P., Brotherson, M. J. & Summers, J. A. (1985). The impact of deinstitutionalization on families: a family systems approach. In Bruinicks, R.H.. (ed) *Living and Learning in the least restrictive environment*. Paul H. Brooks: Baltimore.

Young, Frances. (1990). *Face to Face: A Narrative Essay in the Theology of Suffering*,

T & T Clarke, Edinburgh.

End.