Exploring the role of perceived religiosity on daily life, coping, and parenting for Jewish parents of children with autism

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Exploring the Role of Perceived Religiosity on Daily Life, Coping, and Parenting for Jewish Parents of Children with Autism

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A dissertation submitted to Graduate Faculty in Developmental Psychology in partial fulfillment of the requirement for the degree of Doctor of Philosophy

City University of New York, New York

2014
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Abstract

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This two-part study (a) explores the multi-dimensional aspects of religious and psychosocial experience of Jewish mothers and fathers with and without a child with autism; and (b) uses a multi-method design to examine the influence of perceived religious beliefs, ritual practices, and community context on daily life, parenting, and coping processes for these parents. The first study included 20 fathers and 34 mothers of typically developing children. Participants were affiliated with Reform, Conservative, and Modern Orthodox Judaism. They completed three online q sorts and five open-ended questions. The three q sorts focused on the perceptions of religious beliefs, ritual practices, and community context on daily life, parenting, and coping. Results of the q sorts highlighted five religious community contexts and seven daily life and coping statements that were most applicable to Jewish mothers and fathers. In addition, themes from participants’ open-ended responses were used to explain why these statements were appropriate for this particular population.

The second study further examined previous results by comparing the responses of Jewish parents of children with and without autism. Participants included 12 mothers and eight fathers of children with autism and seven mothers and seven fathers of typically developing children. All parents completed online surveys and a phone interview. The surveys and interview questions addressed areas such as parental stress, coping, and the perceived influential role of religious beliefs, ritual practices, and community context.
Results highlighted some themes that were specific to Judaism, and other findings exemplified the perceived role of religious beliefs, ritual practices, and community context on parents of children with and without autism. Forty-five percent of all participants stated that their religious ritual practices connected them to their family history, cultural history, and Jewish identity. Participants with typically developing children discussed how the frequency with which they completed religious activities had either increased or stayed the same since their children were born. In contrast, mothers and fathers of children with autism described very different experiences as they tried to incorporate Judaism into their family life. Although these parents may not have been able to complete certain ritual practices, such as lighting Shabbat candles and participating in Passover Seders, their religious beliefs remained strong and shaped their Jewish identity. This study demonstrates the importance of: (1) clinicians’ being sensitive and knowledgeable about the influential role of various religions and cultures on parents of children with special needs; and (2) professionals and clergy members building a relationship, so that together they can support parents on their journey toward acceptance of their child’s diagnosis.
To my beloved grandmother

Your strength has inspired me through the toughest times.

Your wisdom and love for Judaism will always be missed.
Acknowledgments

I owe my deepest gratitude to the parents who participated in my dissertation research. These men and women took the time out of their busy and stressful lives to tell me their stories. They face so many challenges, yet maintain such a positive energy and sense of strength. I hope that I have done justice in describing their lives.

I would like to express the deepest appreciation to my committee chair, Dr. Martin Ruck. Without his excellent guidance, encouragement, and patience this dissertation would not have been possible. Many thanks to my other committee members, Dr. Herbert Saltzstein, Dr. Michael Siller, Dr. Kristen Gillespie-Lynch, and Rabbi Dr. Martin Schloss for their insightful suggestions and contributions to my dissertation. I would also like to thank, Dr. Deborah Vietze for her assistance, valuable feedback, and support during the beginning stages of my research. Dr. Brett Stoudt’s patience has been an enormous support as he has helped me understand various statistical issues.

Finally, I would like to thank my parents, older brother, and friends. Their love, encouragement, and patience have been vital in my ability to finish this dissertation and graduate school.
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Chapter 1: Theoretical Background

The purpose of this study is to apply cultural and developmental theories to the study of religiosity’s impact on daily life, coping, and parenting for Modern Orthodox, Conservative, and Reform Jewish parents. This study is based on the following theories: Rogoff’s cultural community context theory (Rogoff, 2003); bidirectional model (Kuczynski, 2003); Lazarus and Folkman’s theory of stress and coping (Lazarus & Folkman, 1984); and Pargament’s religious coping theory (Pargament, 1997).

Cultural Community Context

Rogoff (2003) noted that “people develop as participants in cultural communities. Their development can be understood only in light of the cultural practices and circumstance of their communities which also change” (p. 3). A cultural community context is part of the nurturing environment required for human development. This environment cultivates the growth of each family member by using available education system, parental care, family system, and cultural resources. This context also includes various interpersonal relationships and participation in different cultural practices. Each of these connections and rituals influence how people perceive the world around them, behave in different situations, and cope with challenges (Rogoff, 2003).

Bi-directional Model

The relationship between parents and children and the outcomes of these connections can best be understood using a bidirectional model. The circular causality bidirectional model states that “parents and children are involved in a recursive interactional loop in which there is no distinct beginning or end” (Kuczynski, 2003, p. 10). This circular relationship is defined by the ongoing cycle of cause and effect between both parties. Parents and children are embedded within an influential family, cultural, and ecological system; therefore, research may be unable to
predict any outcomes of this cycle (Kuczynski, 2003). A bidirectional model would allow an examination of the “responses of each participant serving not only as the stimuli for the other but also changing as a result of the same stimulus exchange, leading to the possibility of altered response on the part of the other” (Bell, 1979, p. 822). These inter-relationships affect the development of parents’ and children’s feelings, attitudes, behaviors, and response to stressors (Bell, 1979).

**Coping with Family Challenges and Stress**

According to Dougall and Baum (2001), theorists agree and disagree about the definition of stress. These inconsistencies can create some difficulty when researchers try to study how a person or family exhibits stress and adjusts to coping outcomes. Stress involves a person expressing feelings and emotions when they are being forced to adapt to a stimulus. Coping involves successful adaptation to a stressor. This process is multidimensional and occurs within a community context. A person does not cope alone but is influenced by family, institution, community, cultural resources, guiding beliefs, values, and relationships, (Pargament, 1997).

**Lazarus and Folkman’s (1984) theory of stress and coping.** Lazarus and Folkman’s (1984) well-known stress and coping theory focused on three main processes that occurred when a person experienced stress. First, they theorized that people categorize an event as stressful, and then he or she must determine the meaning and importance of the stressful event. An event may be perceived as resulting in one or more of the following: (a) harm or loss; (b) threat, and/or (c) challenge. These categories influence whether or not a situation is viewed as stressful. Lastly, the person chooses and implements a coping method to reduce the impact of the stressful event (Lazarus & Folkman, 1984).
Influence of religion on coping. Hill et al. (2000) identified the following three criteria of religion:

(A) The feelings, thoughts, experiences, and behaviors that arise from a search for the sacred. The term “search” refers to attempts to identify, articulate, maintain, or transform. The term ‘sacred’ refers to divine being, divine objects, Ultimate Reality, or Ultimate Truth as perceived by the individual; and/or (B) A search for non-sacred goals (such as identity, belongingness, meaning, health, or wellness) in a context that has its primary goal the facilitation of (A); and (C) The means and methods (e.g., rituals or prescribed behaviors) of the search that receive validation and support from within an identifiable group of people (p. 66).

Religiosity can be defined as the influence of religion on a person’s life. This definition specifically focuses on the relationship between the individual and a certain worldview (Verbit, 1970). Pargament, Koenig & Perez (2000) summarized the five main functions of religion as: (a) meaning, (b) control, (c) comfort and spirituality, (c) intimacy and spirituality, and (e) life transformation. When individuals face challenges, they may use religion as a framework from which to search for meaning. This understood meaning will help with the interpretation of any future possible changes that the person may need to make to adjust to the stressor. Even though people may comprehend the challenge, they may feel that they have no control over the unfolding of events. Religion offers various methods, such as prayer and ritual practices, to help people achieve a sense of control. In addition to dealing with personal challenges, people often use religion to help understand stressful situations in the world around them. They may feel comforted and less anxious when thinking about the unexpectedness of a potential stressor. Religion also helps develop a sense of intimacy, closeness, and connection to others (Pargament et al., 2000).

Ritual practices can offer a sense of purification to those who have transgressed. The practices also may be a type of punishment, sacrifice, isolation, or repentance that serves various functions. Individuals may feel comforted, accepted, or a relief from the challenges faced
(Pargament, 1996). Other examples of how religion can help one cope and find meaning in stressful events include gaining mastery and control, obtaining comfort and closeness to G-d, and achieving life transformations. Dimensions of religiosity can be used to reframe stressful situations. Negative events may be seen as positive and having a different meaning (Pargament, 1996). For example, a stressor may be redefined as beneficial, a punishment from G-d, an act of the devil, or testament to G-d’s influential power. A person or family can seek control by collaborating with G-d, passively deferring to G-d to manage the stressor, or actively allowing G-d to control the situation. In addition, mothers and fathers may indirectly ask G-d to control the stressor or individually manage the stressful circumstance rather than seeking G-d’s assistance (Pargament, 2011).

The religious coping process is completed within a contextual environment that includes the individual’s beliefs, practices, goals, and values. These aspects of religion may aid a person or family with limited resources to deal with a stressful event (Pargament & Raiya, 2007). Religious coping has various possible spiritual, psychological, social, and physical outcomes such as anxiety reduction, peace of mind, self-development, and a search for meaning. In addition, religious coping can help individuals increase desire for social intimacy and have a better understanding of G-d (Pargament, 2011; Pargament & Raiya, 2007).

Pargament (1997) defined religion as “the search for significance related to the sacred” (p. 32). Any materialistic, psychological, social, physical, or spiritual object or variable can be evaluated for its sacred and significant properties. People are motivated to search so they can better understand the object’s significance (Pargament, 1997). To cope with a stressful life event was defined as a search for significance in the effort to attain and maximize the sacred. This search offers two possible coping mechanisms: (1) conservational; and (2) transformational
Conservation of religious significance occurs when a person attempts to protect his or her religious beliefs, practices, or community context whose significance may be threatened, harmed or challenged. When the strength of people’s religious beliefs, frequency of religious ritual practice participation, and relationship with their community context has been maintained, in spite of danger and challenges, they are conserving the significance of important aspects of religion. Religious beliefs, ritual practices, and community context offer a sense of comfort and intimacy with G-d. Transformation of religious significance transpires when a person decides that they should modify the strength of his or her religious beliefs, frequency of participation in ritual practices, and involvement within a community context because perhaps these aspects seem inadequate and an invalid source of significance. The individuals begin to search for or modify aspects of their religiosity. Once a new sense of religiosity is established, the person must conserve and protect religious beliefs, ritual practices, and community context (Pargament, 1996; 1997). Pargament (1996) noted, “Conservation and transformation are complementary interdependent processes that help guide and sustain the person throughout the life span” (p. 217).

**Theoretical Summary**

The purpose of this chapter was to present a theoretical foundation of the studies. The theories discussed include: Rogoff’s (2003) cultural community context theory; the bidirectional model (Kuczynski, 2003), Lazarus and Folkman’s (1984) theory of stress and coping, and Pargament’s (1997) religious coping theory. This dissertation examined how men and women’s perceived religiosity influence their daily life, parenting, and coping within a very distinct community, ecological, and family context. Chapter 2 presents empirical research that has been completed examining these different areas.
Chapter 2: Empirical Literature Review

This chapter presents a description and critique of some of the major categories of variables involved in this study: (a) religious beliefs, ritual practices, and community context; (b) family and parenting processes; (c) autism; and (4) stress and coping. This review of the literature spans a period of 22 years from 1990 to 2012. Research from journals concerning the inter-relationships among religiosity, family, and parenting; the influence of a child’s diagnosis of autism on parents and family; and the influence of religious beliefs, community context, and ritual practices on parents of children with special needs was included. All articles were found by searching JSTOR and PSYCHINFO databases using the following keywords: family, parenting, mothers, fathers, religion, religiosity, prayer, forgiveness, autism, autism spectrum disorders, special needs, stress, coping, parenting stress, coping styles, support, financial needs. Two to three of the key words needed to co-occur for the article to be included in this literature review.

Influence of Parenting on Religious Attitudes and Ritual Practices

Research has examined the inter-relationships among dimensions of religiosity, parenting, and family. Parenthood and family lifecycle stage were two specific milestones that shaped the way dimensions of religiosity impacted a person or couple’s life (Becker & Hofmeister, 2001; Davey, Fish, & Robila, 2001; Mackey & O’Brien, 2005; Petts, 2007; Semans & Fish, 2000). Becoming a parent influenced whether or not some adults attend church. In a 2007 study by Petts, the house of worship attendance for first-time fathers stayed the same or increased after their baby was born (Petts, 2007). An increase in religious participation was related to more paternal engagement. Paternal engagement was measured by the average number of days per week that the fathers spent playing games, singing songs, and reading stories with their child. Petts (2007) speculated that church attendance may have been the beneficial resource
these men needed when faced with the challenge of a newborn baby (Petts, 2007), or providing their child with a social environment and exposure to religious messages (Davey et al., 2001; Mackey & O’Brien, 2005; Semans & Fish, 2000).

Influence of Religiosity on Family and Parenting Outcomes

This section explores the: (a) influence of religious beliefs and ritual practices on a person’s communication and interpersonal skills; and (b) effects of religious beliefs, ritual practices, and community context on aspects of family and parenting such as communication skills and parent-child relationships.

Influence of religious beliefs and ritual practices on communication skills.
Engagement in consistent ritual practices, such as prayer together or separately, was beneficial for couples who faced a crisis (Lambert & Dollahite, 2006) or who tried to maintain positive relationships with others (Lambert & Dollahite, 2006; Mahoney, Pargament, Murray, Swank, & Swank, 2003). Prayer helped couples calm emotions, improve communication skills, develop a bond, and avoid any feelings of anger toward each other (Lambert & Dollahite, 2006; Mahoney et al., 1999).

When facing a crisis, couples often searched for answers within their holy scriptures. These books offered examples of how to maintain any relationship and solve obstacles (Lambert & Dollahite, 2006). Messages in scriptural teachings of religious beliefs also encouraged followers to be selfless, nonjudgmental, and to love others unconditionally (Lambert & Dollahite, 2006). These lessons are important because they facilitated perspective taking and taught couples to overcome challenges by discussing problems in a rational manner (Lambert & Dollahite, 2006; Mahoney et al., 2003).
**Parent-child relationship influenced by dimensions of religiosity.** For many mothers and fathers, participation in religious ritual practices influenced their parent-child relationship (Cain, 2007; Marks, 2006; Semans & Fish, 2000). These ritual practices encouraged the belief that children must be cherished (Semans & Fish, 2000). Religious messages also taught parents the importance of focusing on the needs of others and actively engaging in their children’s lives. Religious communities organized social programs that promote unification within families and the opportunity to teach children about religion (King, 2003).

A father’s involvement with his faith community promoted the importance accepting responsibility for his actions (King, 2003; Marks, 2006). In 2003, Bollinger and Palkovitz studied the relationship between paternal involvement and the spiritual faith of 65 fathers. These fathers identified with Christianity, the Church of Jesus Christ of Latter Day Saints, or no religious faith. Adults noted how often they participated in various behaviors such as reading scripture, attending church services, and prayer. Fathers who attended church regularly demonstrated more paternal involvement than fathers who were not church members (Bollinger & Palkovitz, 2003). For mothers, engagement in private religious ritual practices such as prayer or mediation predicts parental involvement, acceptance, and the ability to present their child with healthier emotional and verbal responses. Mothers in the study who were more involved in the child’s life were less likely to exhibit negative emotions related to parenting (Cain, 2007).

**The Influence of Religiosity on the Ability to Cope with Challenges**

When faced with a difficult challenge, people and families use religion as a coping mechanism (Lambert & Dollahite, 2006, 2008; Marks, 2005; Marterella & Brock, 2008; Wiley, Warren, & Montanelli, 2002). Prayer can be a guiding and supportive tool that helped couples bond (Lambert & Dollahite, 2006; Marterella & Brock, 2008; Marks, 2005). Religious texts
identified examples of how to connect with others (Lambert & Dollahite, 2006). For some families, religious ritual practices were a tool to help them confront stressful life challenges (Marks, 2005). Prayer, attendance at church, and the study of religious texts helped families resolve conflicts (Lambert & Dollahite, 2006; Marks, 2005), promoted love (Marks, 2005) and the willingness to forgive, and encourages open communication (Lambert & Dollahite, 2006). Adults also learned how to lessen feelings of anger, find inner strength, and connect with others (Lambert & Dollahite, 2006).

Research on the influence of religious dimensions on adults who faced challenges such as poverty demonstrated conflicting results. Wiley et al. (2002) and Cain (2007) evaluated the impact of religion on poor African-American mothers. Cain’s (2007) findings demonstrated that the parental stress of highly religious, African-American, single mothers was not influenced by engagement in religious activities. This relationship was surprising because many of the mothers lived in poverty and thus faced the stressful experience of daily survival (Cain, 2007). Wiley et al. (2002) studied the role of regular church attendance on African-American mothers who faced stressful life events such as unemployment and debt. Although a higher rate of church attendance was associated with these women being more concerned about their financial status, they also identified their house of worship as a significant resource or co-parent. By providing support such as respite care and mentoring, the church community ameliorated many of the participants’ daily life and parenting struggles (Wiley et al., 2002).

**Influence of a Child’s Diagnosis of Autism on Parental Stress**

A child’s diagnosis of autism is a specific, challenging event faced by many parents. Important background information about autism and the significance of diagnosis as a major critical point for parents are provided in Appendix A. This section explores the influence of
children’s autism diagnosis on their parents’ levels of stress. The exact effect of certain variables such as child’s disability, child age, and parent’s gender are discussed.

**Comparisons of parental stress level based on child’s disability.** Researchers have investigated the influential role of a child’s disability on parental stress and coping. Dabrowska and Pisula (2010); Eisenhower, Baker, and Blacher (2005); and Sanders and Morgan (1997) demonstrated that mothers of children with autism exhibit the highest levels of stress compared to parents of children with other developmental delays such as Down syndrome or cerebral palsy. These studies used survey measures and included parents of children with no disabilities as a control group. When making comparisons among different groups, a well-designed study should contain a comparison group to demonstrate the influence of a child without disabilities on parental stress when compared to the other groups.

The stress and coping ability of married parents are experienced together as well as separately. Parents jointly face the trials and tribulations of the child’s diagnosis. For this reason, the stress of having a child with a developmental diagnosis and parental coping with the diagnosis should be examined as an individual and a collaborative experience (Dabrowska & Pisula, 2010; Sanders & Morgan, 1997). Dabrowska and Pisula (2010) examined parental stress and coping styles in parents of children with autism, Down syndrome, and children developing according to typical pattern. Parental stress was measured using the Questionnaire of Resources and Stress (QRS) Scale. The 11 subscales addressed the parents’ perceptions of the child’s problems and personal and family’s problems. Child problems were identified as those related to dependency and behavioral management, cognitive impairment, and physical limitations. The personal problems were related to lifespan care, lack of personal reward, terminal illness stress, preferences for institutional care, and other personal burdens of the parent. Limits on family
opportunities, family disharmony, and financial stress were categorized as family problems (Dabrowska & Pisula, 2010). The coping styles of parents were also explored using three subscales of the Coping Inventory for Stressful Situations (CISS). Emotion-oriented coping focused on reduction of emotional tension. The use of social diversion or distraction to avoid stressful situations was categorized as avoidance-oriented coping. Task-oriented coping involved cognitive restructuring to resolve any given situation (Dabrowska & Pisula, 2010).

Parental stress level and coping methods are influenced by the child’s particular disability and parent gender. Parents of children with autism in Dabrowska and Pisula’s 2010 study exhibited the highest levels of stress on 8 of the 11 parental stress subscales and used emotion-focused coping more often and social diversion less often than other parents. Mothers demonstrated more emotional coping and social diversion than fathers. When examining the interaction between parent gender and child disability, mothers of children with autism exhibited the most stress related to their child’s sense of dependency and management and limits on family opportunities. Fathers of children with autism exhibited significantly less parental stress than their spouses. However, no difference was found between mothers and fathers of children with Down syndrome or those with typically developing children (Dabrowska & Pisula, 2010).

**Child age and parent gender predict parental stress and coping.** Child age can influence parental stress, coping, and the experience of adjusting to a child’s disability. Parents of preschool children with autism were more likely to use problem-focused coping strategies than mothers and fathers of older children with autism (Hastings et al., 2005; Smith, Seltzer, Tager-Flusberg, Greenberg, & Carter, 2008). Some studies compared parents of children from two different age groups. Hastings et al. (2005) studied the main effects of parental gender and child age on parental style of coping in parents of preschool (n = 89) and school aged (n = 46)
children with autism. Coping was measured using the brief version of the Coping to Problem Experienced (COPE) Scale. Four coping styles were assessed: (a) active avoidance; (b) problem-focused; (c) positive; and (d) religious/denial (Hastings et al., 2005).

Hastings et al. (2005) found that mothers engaged in more problem-focused coping than fathers. The researchers speculated that gender differences may influence parental experience and interpretation of their child’s disability, thus affecting parental coping style. Parents of preschool children engaged in more problem-focused coping than parents of school-aged children with autism. Half of the school-aged children did not live at home, so parents may have had a different caregiving experience than the mothers and fathers of the preschool children with autism. This difference in living situation could be a confounding variable that influences whether or not child age is a factor that affected parental coping style (Hastings et al., 2005).

The relationship among parental coping style and maternal depression, psychological well-being, and child autism was also studied in 2008 by Smith and colleagues. The Coping Orientations to Problem Experienced (COPE) scale was used to measure problem-focused and emotion-focused coping styles. Problem-focused coping was assessed as actively reducing the results of a stressor, planning how to deal with a stressor, and positively interpreting a stressful situation. Emotion-focused coping was defined by whether or not mothers and fathers denied the existence of a stressor, vented their emotions, or reduced their efforts and ability to deal with a stressor. Researchers hypothesized that mothers of adolescents with autism used emotion-focused coping because they were psychologically and physically worn out. Mothers may have felt that they were losing control and unable to handle the child’s disability (Smith et al., 2008). A follow-up interview that asked parents why they had chosen a particular coping mechanism might have prevented Smith and colleagues from making such speculations.
Specific Factors Associated with Autism that May Affect Parental Stress Level

Parental stress can be influenced by child-related factors such as (a) amount of time it takes for child to be diagnosed; (b) financial cost of diagnosis; (c) the kinds of interactions with professionals; (d) the large number of treatment options available for children with autism; and (e) the child’s social and communication skills.

Diagnosis process as an influence on parental stress level. The amount of time it takes to complete the diagnosis process for a child with autism can vary depending on a family’s experience with medical and social service systems. Hutton and Caron (2005) found that the majority of children were diagnosed with autism within three years of the parents’ initial recognition of possible behavioral signs. Some mothers and fathers were immediately referred to a psychologist or neurologist for evaluation. Other parents were told by their doctor not to be concerned because their child’s development was simply slower than that of others (Hutton & Carron, 2005). Whether or not caregivers used a publicly or privately funded professional to assess the child also affected the amount of time for the diagnosis process to be completed. Keenan et al. (2010) found that it took 57% of the families in the study about a year to obtain a diagnosis of autism from publicly funded organizations. Parents who used private professionals to assess the child received their diagnosis on average within two and a half months. Mothers and fathers may not have the money to pay for a private assessment; therefore, this great time difference also illustrates the costs of obtaining a diagnosis.

Cost of diagnosis process as an influence on parental stress level. Parents of children with autism face many costs for services such as educational interventions, doctors’ examinations, and medication. To raise a child with autism has been estimated to cost four to six times as much as raising a typically developing child (Shimabukuro, Grosse, & Rice, 2007).
Sharpe and Baker (2007) identified the factors that influence the financial difficulties in families with a child with autism. Parents of children with autism reported on the financial difficulties related to caring for their son or daughter. Results indicated that parents that identified financial concerns within the last 12 months reported having an income less than $40,000 per year and a significantly larger percentage of medical bills that were not reimbursed by insurance companies (Sharpe & Baker, 2007).

Mothers and fathers often feared that a child’s treatment costs will hinder the family’s financial security (Papageorgiou & Kalyva, 2010; Sharpe & Baker, 2007). These parents faced the tasks of reprioritizing, reorganizing, and redefining future goals (Papageorgiou & Kalyva, 2010). Couples who felt desperate about the situation may decide that expensive childcare should be replaced with one parent’s staying home with the child. The mother is the parent who usually sacrificed her career to take care of the child (Cassidy et al., 2008), resulting in her often resenting her family (Gray, 2003; Hutton & Caron, 2005). Families may benefit financially from not paying for a costly specialized therapist or expensive educational facility because one parent stays at home, but, on the other hand, as a result they may need to manage a sudden decrease in family income.

**Interaction with professionals as a factor in parental stress level.** Throughout the diagnosis and treatment process, parents of children with autism interact with numerous professionals. Parents of two- to four-year-old children with autism communicated with an average of four professionals per year (Cassidy et al., 2008). These relationships can be stressful because mothers and fathers must maintain continuous communication with and between each professional (Hutton & Caron, 2005; Nissenbaum, Tollefson, & Reese, 2002). Clinicians educated parents about the cause of the child’s disability (Hutton & Caron, 2005) and influenced
whether they perceived the child’s diagnosis as helpless or hopeful (Nissenbaum et al., 2002). Parents are negatively affected by professionals who insinuate that the child’s disability is the mother or father’s fault (Hutton & Caron, 2005).

**Available treatment options as a factor in parental stress level.** A variety of treatment options (e.g., behavioral interventions, occupational therapy, physical therapy, educational intervention, social skills training, speech therapy, neurosensory therapy, and medication) are available for people with autism (Hutton & Caron, 2005; Sharpe & Baker, 2007). Parents of children with autism have slightly different experiences raising their child than mothers and fathers of children with other disabilities because there is no consensus among researchers and professionals about the best treatment for children with autism (Groden, Baron, Groden, & Lipsitt, 2006). Although parents are often excited to know that a large number of options are available to help the child, they nevertheless face stressful decisions in choosing the appropriate treatment for their son or daughter (Kabot, Masi, & Segal, 2003; Hutton & Caron, 2005; Sharpe & Baker, 2007) and determining whether or not an intervention is successful (Hutton & Caron, 2005; Nissenbaum et al., 2002; Sharpe & Baker, 2007). Parents must also complete large amounts of paperwork, travel to and from appointments, and attend numerous mandatory meetings at their child’s school to discuss his or her progress (Hutton & Caron, 2005).

**Child’s social and communication abilities as a factor in parental stress level.** Treatment options address various areas, such as language ability. A child’s limited social-emotional and communication skills associated with autism can be a factor that causes parents to exhibit high levels of stress (Cassidy et al., 2008; Davis & Carter, 2008; Howlin & Asgharian, 1999; Papageorgiou & Kalvya, 2010; Tarkeshwar & Pargament, 2001). Howlin and Asgharian (1999) reported that 53% of parents identify the child’s limited speech and communication
abilities as the biggest stressor. The child’s language skills also hindered parents from developing a relationship with their autistic children or understanding their thoughts and needs (Cassidy et al., 2008; Papageorgiou & Kalvya, 2010). Davis and Carter (2008) reported that 39% of fathers and mothers in their study were frustrated by the difficulty of relating to their child. Parents may also be stressed because of their inability to receive any sense of reinforcement from their son or daughter, such as a hug or verbal gratitude (Cassidy et al., 2008; Papageorgiou & Kalvya, 2010). This sense of frustration may cause parents to become pessimistic about their child’s future (Hutton & Carron, 2005; Sanders & Morgan, 1997).

**Parental Coping with a Child’s Diagnosis**

Parent gender can influence how mothers and fathers cope with the child’s diagnosis. This coping process may in turn affect a couple’s marital status and the way they socialize with others.

**Parental gender influences parental coping.** I examined 20 studies for this literature review. None of these studies solely included fathers. Twenty-five percent of the studies examined only mothers of children with a disability. Seventy-five percent of these studies included a mother-father dyad of a child with a disability. For many of these studies, the article title contained the term parents or families. However, these terms are not accurate given that the inclusion of fathers in these studies ranged from only 8% to 39% of the total sample.

Mothers and fathers often have different experiences in terms of parenting a child with autism. Mothers are usually more responsible for maintaining relationships with doctors and relaying important information to their husbands (Gray, 2003), which may cause them to rate parenting as most stressful (Sanders & Morgan, 1997). Hastings et al. (2005) demonstrated that mothers of children with autism are more likely than fathers to use problem-focused coping
strategies. This difference may have resulted from the mothers’ being responsible for seeking and maintaining communication with professionals. Mothers also were more likely to seek formal and informal social support, such as interaction with other parents of children with autism (Lee, 2009). Maternal stress also resulted from the child’s inability to sleep, and limited emotional regulation issues, or selective eating habits; and paternal stress, in general, was caused by the child’s behavioral problems (Davis & Carter, 2008).

Gray (2003) studied the parental coping process. Thirty-three families of children with only high-functioning autism were interviewed. The study focused on parents of children with one disability and one functioning level. These two characteristics of the study strengthened the study’s internal validity. Interviews addressed practical actions parents took to cope with child-related problems, how emotions were involved in the coping process, and general coping strategies that helped manage the child’s disability. Fathers kept the child busy at home or avoided their family by maintaining longer hours at work. Mothers focused on separating their son or daughter with autism from their typically developing children and worked on implementing the child’s therapeutic regimen. Mothers were more likely than fathers to rely on friends and family as a method of dealing with their emotions related to their child’s diagnosis (Gray, 2003).

**Higher divorce rates among parents of children with autism.** The way parents cope with the child’s disability can have different effects on their family. In a five-year longitudinal study, Hartley et al. (2010) compared families with and without a child with autism. The two groups were matched on demographic variables such as ethnicity, education, mother’s age, child’s gender, age, and birth order. Five years later, 24% of the parents who had a child with autism were divorced, compared to 14% of parents with a typically developing child. Hartley et
al. (2010) hypothesized that a higher divorce rate among parents of children with autism may have been a result of higher levels of stress.

**Influence of a child’s diagnosis on families’** Friends and family can be a great resource to help parents of children with autism deal with the many stressors they face. Parents of children with autism felt that the child affected their ability to engage in social activities with others, such as planning a family vacation or spending time away from their children (Dabrowska & Pisula, 2010; Gray, 2003; Hutton & Caron, 2005; Luong, Yoder, & Canham, 2009; Sanders & Morgan, 1997). Parents felt uncomfortable bringing their often-disruptive autistic child to the home of others or with leaving the child with a baby-sitter (Cassidy et al., 2008). Some mothers and fathers also felt stigmatized by their child’s behavior. Mothers may have perceived more stigma than fathers because they are more likely to be responsible for communicating with the child’s clinicians and other daily issues. The child’s functioning level and age may also be factors that influenced parents’ perceived level of stigmatization (Gray, 1993).

The behaviors of a child with autism also may cause family life to become restricted, routine and too predictable (Cassidy et al., 2008; Gray, 2003; Hutton & Caron, 2005). For example, boys and girls with autism need to maintain routines; therefore, they are most comfortable staying in their own home (Luong et al., 2009). Some parents viewed social support groups as a feasible method of social interaction because such groups allow them to maintain relationships with other families who are experiencing a similar situation (Hutton & Caron, 2005). However, according to Luong et al. (2009), support groups did not help all mothers and fathers of children with autism. Parents in the study mentioned that they did not want to burden others with their problems or noted that others do not want to hear about the concerns of another mother or father of a child with autism (Luong et al., 2009).
Influence of Dimensions of Religiosity on Parents of Children with Developmental Delays

This section explores the influence of religious beliefs, ritual practices, and community context on parents of children with developmental delays. Various aspects of parenting, such as abilities, sense of responsibility, and role, are influenced by religious beliefs. Religious ritual practices may influence mothers’ and fathers’ ability to handle challenges. Families’ ability to participate in their house of worship depended on available resources.

Influence of religious beliefs on parenting. Parents of children with disabilities often gained feelings of support based on religious beliefs and institutions. Bennett, Deluca, and Allen (1995) interviewed parents of children with disabilities to explore the overall influence of religion as a supportive resource and how a child’s age mediates this relationship. The five disabilities included in the study were Down syndrome, developmental delay, mental retardation, autism, and hearing impairment. These disabilities significantly vary in the behaviors exhibited, treatments available, and influence on parental stress and experience. The children with disabilities ranged from 15 months to 30 years old. The inclusion of children within such a range of ages is a potentially confounding factor that may have affected the study’s internal validity. Mothers and fathers identified prayer, attendance at church, and religious beliefs as dimensions of religion that helped them cope with the stress of the child’s disability. In addition, regardless of the child’s age, religious support was an effective coping strategy for parents (Bennett et al., 1995).

Marks and Dollahite (2001) explored the relationships among religion, father’s beliefs and experiences, and the meaning-making process. Fathers from the Church of Jesus Christ of Latter Day Saints were specifically chosen because of the religion’s emphasis on parental responsibility, the importance of being involved with the church, consistent prayer, and use of
religious texts for inspiration (Marks & Dollahite, 2001). Marks and Dollahite (2001) and Dollahite (2003) used qualitative narrative research to address how religious beliefs, ritual practices, and community context influence parenting experiences and help males to make sense of fathering a child with a disability or chronic illness. Religious community context referred to the interactions of fathers with members of their congregation. Formal and informal expressions of faith, such as prayer, were categorized as religious ritual practices. Religious beliefs were identified as a participant’s personal and internal beliefs shaped by religion (Marks & Dollahite, 2001). In addition to religious dimensions, Marks and Dollahite (2001) included three contextual factors that may influence how religious beliefs, ritual practices, and community context influence fathers’ lives. The contextual aspects were: (a) challenges fathers faced because of religious beliefs, ritual practices, and community context; (b) relationship with the child; and (c) beliefs about responsibility to the child (Marks & Dollahite, 2001).

The disabilities and medical diseases in the study included developmental delay, Tourette’s syndrome, autism, scoliosis, heart disease, and learning disability. The ages of the children covered 16-year range (Marks & Dollahite, 2001; Dollahite, 2003). A major potentially confounding variable in this study was the large variability in children’s special needs and ages. This variability makes it difficult to isolate the influences on parents’ experiences and ability to make meaning of their experiences; thus weakening the internal validity of the study. These confounding variables were common in the studies discussed in this literature review. Only nine of the 14 studies included information about the children’s age. Only 22% of the nine studies included parents of children within an age gap of less than 10 years. Fifty-seven percent of the studies included parents of children with various disabilities. On average, each study included
approximately six different disabilities, thus making it difficult to associate the responses of parents by disability.

The results of this thorough, in-depth examination demonstrate the mediating role of contextual context on the extent to which the three dimensions of religion influence parenting. Marks and Dollahite (2001) reported that participants indicated that being a father gave their lives special meaning. They also felt a sacred responsibility to G-d for their actions as a caregiver and believed that parental choices would later be judged by G-d. These religious beliefs inspired fathers to be the best parent and to share the church’s teachings with their children. The church was viewed as a designated community context in which fathers could consistently and continuously spend quality time with their children (Marks & Dollahite, 2001).

**Influence of religious ritual practices on parents’ handling of challenges.** Religions often emphasize the importance of engaging in various religious ritual practices. Rituals include but are not limited to attending classes or programs within the community (Ekas et al., 2009; Poston & Turnbull, 2004; Skinner et al., 2001; Weisner, Beizer, & Stolze, 1991); reciting stories from a religious text (Weisner et al., 1991); making a pilgrimage to a holy site (Coulthard & Fitzgerald, 1999; Skinner, et al., 2001); meditating (Poston & Turnbull, 2004); and making a religious vow on a child’s behalf (Skinner et al., 2001). One of the most common religious ritual practices involved parents’ praying for guidance and strength (Bennett et al., 1995; Coulthard & Fitzgerald, 1999; Poston & Turnbull, 2004; Skinner et al., 2001; Weisner et al., 1991). Many parents feel that prayer is a method of communicating with G-d (Poston & Turnbull, 2004) and that it can help a person to stay positive about a child’s future (Bennett et al., 1995). Prayer also can assist parents to cope and accept challenges they face when caring for a disabled child (Coulthard & Fitzgerald, 1999).
Influence of religious community context on parents’ coping. Fewell and Vadasy (1986) discussed the four types of support provided by religious organizations to families of children with disabilities, including: (a) instrumental; (b) emotional or social; (c) educational; and (d) structural. Instrumental support includes provision of helpful material resources, such as money and food. The congregation can also provide emotional and social support, such as supporting others in happiness and grief. Some religious organizations also offered educational supports that help families find suitable treatment opportunities for the child and resources about the diagnosis for the sibling (Fewell & Vadasy, 1986).

Families engage in religious ritual practices within their community or religious context. When families have a child with special needs and attend a house of worship or participate in their religious community, they hope that the child’s differences will be accepted (Bennett et al., 1995; Poston & Turnbull, 2004). Fathers recognized the church as a contextual environment in which they can strengthen their parent-child relationship by engaging in activities such as teaching children about religious ritual practices (Dollahite, 2003).

Parents of children with various disabilities identified their house of worship as a supportive environment that provided a place to pray, to interact with G-d (Skinner et al., 2001), and to feel stronger about handling any conflict related to their child (Poston & Turnbull, 2004; Skinner et al., 2001). Mothers and fathers also felt that they were able to develop relationships with other congregants and community members (Dollahite, 2003; Poston & Turnbull, 2004). Church members often offered to help parents feel less burdened by the challenges related to their child’s disability (Marks & Dollahite, 2001; Skinner et al., 2001). Families whose needs were met identified their clergy and religious community as important coping resources (Bennett et al., 1995). Unfortunately, churches and religious communities did not always provide families
with the support needed, which may result in parents feeling abandoned and alone (Tarakeshwar & Pargament, 2001). However, regardless of whether or not the family and child are welcomed in the religious community context, parents identified the church as a place where they could find love and acceptance (Poston & Turnbull, 2004).

Tarakeshwar and Pargament (2001) examined the influential role of religion on families’ coping with stressors related to a child with autism. It is difficult to understand these families’ coping processes, when 96% of the total sample was mothers. Researchers noted that a flaw of previous studies was the constant usage of global religious measurements to assess the influence of religion on families’ coping process. However, Tarakeshwar and Pargament measured parents’ religiosity based on three global measurements: (a) frequency of church attendance; (b) frequency of prayer, and (c) self-rated religiosity. Each item was rated on a Likert scale and did not refer to a specific time period. It is unclear how the Tarakeshwar and Pargament’s study, which also included a global measure, differed from the limitations cited.

Tarakeshwar and Pargament’s (2001) study used a mixed methods design. Parents were presented with a list of 25 child-related stressors. The Brief Coping Orientations to Problem Experienced (COPE) scale examined how parents used religion to cope with the three most stressful aspects of raising a child with autism. Parents also completed questionnaires that examined the parents’ psychological adjustment, stress-related and spiritual growth, and how the child’s disability influenced their perceived change in closeness to G-d and church. Thirty percent of interviewed parents noted that they felt “abandoned by their church or were dissatisfied with their clergy” (p. 255). These parental narratives provided researchers with supplementary information not addressed by the surveys.
Religious house of worship supports of families. Parents of children with autism identified their child’s disability as a reason why their church attendance had decreased (Coulthard & Fitzgerald, 1999; Tarakeshwar & Pargament, 2001). Ten percent of the parents interviewed by Tarkeshwar and Pargament (2001) felt that it was too stressful for their child to remain quiet and seated during the sermon. As a result, a decline in the frequency of church attendance resulted in several families’ feeling upset and isolated (Coulthard & Fitzgerald, 1999; Tarakeshwar & Pargament, 2001); overburdened; and unable to balance the responsibility associated with family, home, religion, and occupation (Marks & Dollahite, 2001; Skinner et al., 2001). Parents of children with autism also needed specific practical supports, such as respite care so they may attend their house of worship (Tarakeshwar & Pargament, 2001). Those caregivers who still tried to attend services adapted to the challenge by alternating which parent attended services while the other stayed home with the child (Skinner et al., 2001).

Influence of Religiosity on Parents’ Interpretation of a Child’s Disability

This section explores how dimensions of religiosity can influence parents’ understanding of the child’s developmental delays. Some mothers and fathers believed that a child with a developmental delay was a gift from G-d (Bennett et al., 1995; Dollahite, 2003; Jegatheesan, Miller, & Fowler, 2010; Pollak, 2005; Poston & Turnbull, 2004; Shaked & Bilu, 2006; Skinner et al., 2001; Tarakeshwar & Pargament, 2001; Weisner et al., 1991). Other parents were concerned that such children’s capabilities might prevent them from performing religious duties (Dollahite, 2003; Jegatheesan et al., 2010; Leyser & Dekel, 1991; Marks & Dollahite, 2001; Skinner et al., 2001).

Belief that a child with a disability is a gift from G-d. Parents of children with disabilities often develop a strong connection with G-d. This connection provided parents with
the strength needed to cope (Poston & Turnbull, 2004); a deeper understanding of their son’s or daughter’s disability (Jegatheesan et al., 2010; Poston & Turnbull, 2004); and the resources to face the challenges of a child’s special needs (Tarakeshwar & Pargament, 2001). Other parents felt the opposite: that G-d was malicious and did not care about them, which resulted in their disengagement from religion (Tarakeshwar & Pargament, 2001).

Some mothers and fathers believed that G-d would never abandon them, perhaps expressing the conclusion that they should not question G-d’s actions. Jewish mothers and fathers, in one study completed in Israel, believed that the special-needs child was a gift from G-d and that a form of suffering would help strengthen their family’s moral development (Shaked & Bilu, 2006). The disability was seen as a part of G-d’s special plan for these families (Weisner et al., 1991). The child also was seen as either a blessing, a test of faith (Poston & Turnbull, 2004; Skinner et al., 2001), an earned reward (Skinner et al., 2001), or a gift (Bennett et al., 1995; Dollahite, 2003; Poston & Turnbull, 2004; Skinner et al., 2001) from G-d. Forty-eight Jewish parents in Pollak’s (2005) research were asked about G-d’s responsibility for the child’s having special needs. Seventy-percent believed that G-d had purposely selected their family, 20% of parents felt that the child’s disability was a result of the laws of genetics that were developed by G-d, and 10% stated that the child’s disability was not related to G-d’s actions (Pollak, 2005). When faced with financial difficulties related to the child with special needs, parents often began to doubt G-d’s intentions (Bennett et al., 1995).

**Interpretation of diagnosis by Saudi Arabian parents of children with autism.**

Alqahtani (2012) interviewed Saudi Arabian mothers and fathers of children with autism or a pervasive developmental disorder-not otherwise specified (PDD-NOS). They were asked to identify what they believed caused their child’s developmental disability. Examples of possible
reasons included: (a) frequent medical investigations such as ultrasounds during pregnancy; (b) vitamin deficiency during pregnancy; (c) mothers’ feeling guilty because they believed they were emotionally frigid to their children during their early years; (d) early childhood psychological trauma such as the death of the father; or (e) child was not adequately breastfed.

A majority of participants identified vaccinations, evil eye, or black magic as the root of their son or daughter’s diagnosis. Researchers explained the cultural reasons:

According to Muslim beliefs, an evil eye emanates from another person, or rather from the bad soul, which inhabits that individual. Belief that disease comes from the “evil eye” is common across all ethnic and religious groups in Asia, the Middle East and in some parts of Europe. Black magic was reported less commonly comparing with evil eye. This could be a result of that different cultural understanding about each intervention. Culturally, evil eye is thought to be emanated from humans, black magic, on the other hand, thought to be emanated from supernatural power. As it could be seen, all of these beliefs about autism could be associated with the cultural understanding and explanations (Alqahtani, 2012, p.17)

Parents also discussed their child’s treatments. The most frequent cultural intervention included mothers and fathers reading the Koran or visiting religious healers. The authors emphasized the importance of professionals’ being knowledgeable and sensitive to various religious and cultural beliefs that may influence how mothers and fathers interpret their child’s diagnosis and subsequently search for treatments.

Conclusion

The stressful event examined in this study is a child’s diagnosis of autism. A child’s diagnosis may threaten the strength of the marital and parent-child relationships within a family system (Cassidy, McConkey, Kennedy, & Slevin, 2008; Hartley et al., 2010; Hutton & Caron, 2005; Papageorgiou & Kalvya, 2010; Sharpe & Baker, 2007). Parents may use religious beliefs, ritual practices, and community context as coping resources to handle the different stressors related to the child’s diagnosis (Bennett et al., 1995; Coulthard & Fitzgerald, 1999; Ekas,
Whitman, & Shivers, 2009; Poston & Turnbull, 2004; Skinner, Correa, Skinner & Bailey, 2001; Tarakeshwar & Pargament, 2001; Weisner, Beizer, & Stolze, 1991). The influence of a couple’s religious beliefs, ritual practices, and community context on how they cope is based on the extent to which these three dimensions of religiosity play a role in shaping their nurturing, ecological environment.

**Limitations of Previous Studies**

**Use of global variables in research to examine the influence of religion.** Research that examines the inter-relationships among religious beliefs, ritual practices, community context, parenting, and family most often uses a specific global criterion, such as frequency of church attendance, to measure a participant’s religiosity. This variable does not accurately capture a person’s religious background nor does it take into consideration the interplay between the various dimensions of religions, such as identity, practice, belief, and community. In addition, global variables do not allow researchers to examine the influence of other, extraneous variables, such as the family lifecycle stage. For example, a couple’s frequency of church attendance may reflect factors such as the age of the child. They may only attend their house of worship because they want the child to engage in a religious experience. It is important to remember that religious experience is ongoing and therefore should be examined as a dynamic variable. Frequency of attendance does not explain why the person attends church and if there has been any changes through the years (Becker & Hofmeister, 2001; Bollinger & Palkovitz, 2003).

**Research that examines parents of children with many disabilities.** A major confounding variable in the sections of this literature review that examine parenting and developmental disabilities; and religion, parents, and developmental disabilities was that the children were diagnosed with a variety of disabilities and diseases. Forty-one percent of these 34
studies included parent(s) of children with a range of disabilities or illnesses. Each illness or
disability varies in the symptoms and behaviors that children exhibit and the number and type of
treatments that are available. This range of possibilities can therefore influence the amount of
stress experienced by parents.

**Limited research that uses a multi-method research design.** The method chosen by
researchers to design a study can influence the extent to which findings thoroughly demonstrate
the role of religion or exactly how a child’s disability influences a parent. Quantitative and
qualitative research designs have different costs and benefits. Quantitative methods allowed
Dabrowska and Pisula (2010) and Smith et al. (2008) to identify parental coping styles.
However, the use of these standardized measures did not explain why participants chose
particular coping mechanisms. Other researchers used data from large, national longitudinal
studies that included quantitative-based measures to address areas such as the influence of
religious dimensions on family formation (Eggeben & Dew, 2009) or how aspects of religion are
affected by a person’s views and perceptions (Petts, 2009). These studies identified various
relationships among dimensions of religiosity, family, and parenting; however, they are unable to
explain why these relationships occur.

Qualitative methods better allow researchers to capture the influence of religious beliefs,
ritual practices, and community context, such as the nuances of the various dimension(s), and to
portray religion as a dynamic variable (e.g., Dollahite, 2003; Marks & Dollahite, 2001; Marks &
O’Brien, 2005). On the other hand, qualitative studies do not include scores on standardized
measures which would allow researchers to identify how adults score on constructs that are
reliable and valid. The inclusion of quantitative and qualitative measures allows open-ended
responses to supplement and further explain participants’ numerical answers. This combination
has the potential to explain more thoroughly men and women’s views, perceptions, and behaviors.

**Limited research on the perceptions and behaviors of diverse populations.** In addition to the methods used by researcher, the diversity of participants’ religious background can influence findings about the role of religion. For example, Tarakeshwar and Pargament (2001) included 45 mothers and fathers as participants. More than 50% of the sample was Protestant or Catholic. The rest of the adults identified with another religion such as Judaism. Samples with limited diversity may exclude religions or ethnic groups, leaving them under-studied in the literature. Examination of the influence of religious beliefs, ritual practices, and community context in adults affiliated with certain religions may prevent an understanding of whether or not these results reflect all religions or are specific to certain affiliations. Measures are often not standardized on these under-studied racial, ethnic, and religious groups; therefore, researchers are sometimes forced to make modifications on these surveys.

**Limited research that includes the viewpoints and attitudes of fathers.** Fathers are a group of participants that is under-studied in all areas of research. Two sections of this literature review discussed research that addresses the beliefs, perceptions, and attitudes of parents: (a) parents and developmental disabilities; and (b) religion, parents, and developmental disabilities. Thirty-four of these studies included information about the parental gender. Seventy percent of these studies included both parents. Twenty-four percent of these studies included only mothers, and 6% included solely fathers. For those studies that included both parents, the article title included the terms *parents or families.* However, that is inaccurate given that fathers often ranged from 8% to 39% of the sample.
Rationale and Purpose of the Present Studies

Research on families that face a stressful event such as raising a child with autism may provide further insight into how the influence of religion can differ depending on the family’s functioning level (Ekas et al., 2009; Hastings et al., 2005; Tarakeshwar & Pargament, 2001). Religion, parenting, and autism research has mainly focused on the mother’s viewpoint and relationship with her child (King et al., 2009; Marks & Dollahite, 2001; Sanders & Morgan, 1997; Tarakeshwar & Pargament, 2001). Studies that include both the fathers’ and mothers’ perceptions and the parent-child relationship would provide significant insight into the multiple perspectives within a family system (e.g., Agate et al., 2007; Ambert, 1992; Baron et al., 2006; Bennett et al., 1995; Boyd, 2002; Davis & Carter, 2009). Psychology of religion research would benefit from the study of non-Christian communities (e.g., Coulthard & Fitzgerald, 1999; Dollahite & Tomcho, 2001; Jegatheesan et al., 2010; Lambert & Dollahite, 2006, 2008; Park & Ecklund, 2007). Research that examines the religious coping mechanisms of such under-studied populations is still in the very early stages (Pargament & Abu Raiya, 2007).

The present studies address the five limitations of previous research in religion, parenting, and parental stress and coping with autism discussed above. Many of the studies in literature included a quantitative or qualitative design and global variables to capture the role of religion. Research that examines the influence of autism on parental stress and coping included children with a variety of disabilities and a very large age range. In addition, there is limited research that has investigated the perceptions, viewpoints, attitudes, and behaviors of fathers and under-studied religious populations such as Jewish parents.

To address these discussed limitations, this two-part study (a) explores and develops a thorough understanding of the multidimensional aspects of religious and psychosocial experience
of Jewish mothers and fathers with and without a child with autism; (b) uses a multi-method design to examine the influence of perceived religiosity on daily life, parenting, and coping processes of Jewish parents of children with and without autism.

Research Questions

1. **Daily life** - How do perceptions of their religious beliefs, ritual practices, and community context influence the daily life of Jewish mothers and fathers of children with and without autism?

2. **Stress and coping** - How do Jewish mothers and fathers of children with and without autism use their perceptions of their religious beliefs, ritual practices, and community context to cope with parenting stressors?

3. **Parenting** - How do Jewish mothers and fathers of children with and without autism use their perceptions of their religious beliefs, ritual practices, and community context to parent their child?

4. **Interpretation of diagnosis** - How do the perceptions of their religious beliefs, ritual practices, and community context influence the way Jewish parents of children with autism interpret the cause of their child’s diagnosis?
Chapter 3: Study One

Summary

The first study used a multi-method research design to examine the influence of perceived religious beliefs, ritual practices, and community context on daily life, parenting, and coping processes and to explore the multidimensional aspects of religious and psychosocial experience of 20 fathers and 34 mothers of typically developing children. Participants were affiliated with Reform, Conservative, and Modern Orthodox Judaism. They completed three online q-sorts and five open-ended questions. The three q-sorts focused on the inter-relationships among daily life, parenting, and coping and perceptions of religious: (a) beliefs, (b) ritual practices, and (c) community context.

The q-sort statements were chosen from the literature review, which was based on samples of men and women who were not Jewish. The responses of participants’ in this study helped to narrow down those items that were also most applicable to Jewish parents. In addition, their open-ended responses provided some insight into why these statements were appropriate for this population. The next study further examined these results by comparing the responses of Jewish mothers and fathers of children with and without autism. The validity of the second study was strengthened by first testing these items on Jewish participants of children without autism.

Participants

Participants’ background information. Reform, Conservative, and Modern Orthodox Jewish young married adults participated in both studies. Modern Orthodox Jews wear clothing similar to that of non-Jews and non-religious Jews. However, Orthodox men wear a yarmulke on their head and women wear modest garments and often cover their hair. There are six main practices and beliefs followed by modern Orthodox Jews: (a) men and women must sit separately
during religious services in a synagogue; (b) religious services should be conducted in Hebrew; (c) the Torah is the word of G-d; (d) the importance of Jewish dietary laws; (e) the importance of observing Shabbat; and (f) a woman must visit a ritualistic bath to purify herself after her menstrual cycle is completed. Aspects of secular society, such as learning and culture, also have a significant influence on the lives of modern Orthodox people (Schlosser, 2006).

Conservative Jewish men and women will sit next to each other during synagogue services. Prayers are mainly recited in Hebrew. They are also more likely to follow dietary laws and complete Sabbath rituals than Reform Jews. Conservative Jews maintain a strong relationship with modern secular culture and the religious teachings of Judaism. Reform Jews believe that societal changes must be taken into consideration; therefore, they view Judaism as constantly evolving. There are four elements of Reform Judaism: (a) women may become ordained as rabbis; (b) synagogues allow men and women to sit next to each other during religious services; (c) services are conducted in Hebrew and English; and (d) choices are guided by decisions and individual conscience rather than the Torah. Some, but not all, Reform Jews keep Jewish dietary practices, observe Shabbat, and follow family purity laws (Scholsser, 2006).

**Study 1 recruitment strategies.** Mothers and fathers were recruited by way of friends and family, and students at CUNY Graduate Center using flyers and departmental list-servs. In addition, methods of social networking such as Facebook™ and Craigslist™ were used. Contacts were based on the principal investigator’s previous research studies and from various networking events also were employed. Flyers were posted at Jewish community centers and synagogues. All adults who participated were politely encouraged to recommend another person who fit the recruitment requirements.
Study 1 sample demographics. Twenty men and 34 women participated in this study. Adults were aged between 25 and 35 years (n = 33) and 36 and 45 years (n = 18). Participants’ average age was 33.4 years. Religious affiliations included Modern Orthodoxy (n = 21), Conservative (n = 13), and Reform Judaism (n = 17). Three men and women did not disclose their age and religious affiliation.

Fifty-four participants completed the first q-sort (perceptions of religious beliefs). Only 47 of the 54 adults finished the second (perceptions of religious ritual practices) and third (perceptions of religious community context) q Sorts. Both spouses were not required to participate in the study. Participants were married an average of six and half years and their family size ranged from one to four children. The child’s average age was four years and all children were typically developing. The adults were from all over the United States. Tables 1 and 2 provide information about participants’ religious ritual practices and the types of schools their children attended.

Measures

Q-sort. According to Westwood and Griffiths (2010), a q-sort is the best way to study a population of viewpoints; this is in contrast to the use of instruments such as surveys that measure a population of people. A q-sort involves presentation of a small number of people with numerous items. These participants are then asked to express their beliefs, attitudes, or feelings about the statements. A well-structured q-sort that includes a full range of viewpoints about one or more topics can be generalized to a larger population because the results are not based on the percentage of participants that agreed or disagreed with that viewpoint (Westwood & Griffiths, 2010). Q-sort methods are ipsative rather than normative. This method allows evaluation of how
Table 1

*Frequency of Study 1 Participants’ Religious Ritual Practices (n = 54)*

<table>
<thead>
<tr>
<th>Religious Ritual Practices</th>
<th>Participants’ Responses</th>
<th>n</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kosher</td>
<td>Ate only kosher meat and dairy at home and outside</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Did not keep kosher</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ate only dairy outside</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Did not eat seafood, pig, or mixed dairy and meat</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>N/A</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Frequency of Synagogue</td>
<td>Once a week</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>Attendance</td>
<td>Once a month</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Holidays and special events</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Two to three times a month</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Every Day</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Never attended services</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>N/A</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Frequency of Prayer at</td>
<td>Every day</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>Home</td>
<td>Once a week</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Once a month</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Never</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td></td>
<td>N/A</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>
Table 2

Frequency of the Type of Schools Attended by Study 1 Participant’s Children

<table>
<thead>
<tr>
<th>Type of School</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jewish-based schools</td>
<td>35</td>
</tr>
<tr>
<td>Private school</td>
<td>6</td>
</tr>
<tr>
<td>Public school or private school and Hebrew after-school</td>
<td>4</td>
</tr>
<tr>
<td>Public school</td>
<td>3</td>
</tr>
<tr>
<td>No information provided</td>
<td>11</td>
</tr>
</tbody>
</table>

*Some participants sent their children to different types of schools.*

and why people think a certain way rather than a determination of how many people think a particular way. The items are therefore viewed as the sample (Ozer, 1993).

The items for the three $q$-sorts were based on information collected while reviewing the literature for this study. In addition, Reform and Modern Orthodox rabbis and young married adults with children were consulted about the accuracy of the items. These experts were recruited using the principal investigator’s previously developed contacts, friends, and family. They also were asked to suggest additional items they believed would describe the role of religiosity on the marriage, coping, and daily life of a Modern Orthodox or Reform married adult with children. The collected statements were revised based on these consultations. A full list of all items and open-ended questions are provided in Appendix B.

$Q$-sort items were rated on a Likert scale from -5 (extremely unimportant) to 5 (extremely important). Adults sorted the statements in each $q$-sort to reflect the extent to which they agreed that it represented their experience during the last six months as a Jewish adult married with children. The statements were presented to each participant online in a random order. The first $q$-sort included items that assess the adult’s perceptions of their religious beliefs. Individuals’
views of their religious ritual practices were evaluated in the second q-sort. The third q-sort included items that refer to perceptions of the religious community context.

A total of 78 statements were equally divided among three q sorts. Twenty-nine percent of the items were repeated in two or more of the q-sorts. This repetition allowed for a comparison of participants’ responses across three different religious dimensions. Daily life was mentioned in 31 items. Nineteen statements referred to coping and 28 items discussed aspects of marriage. Information about the marriage statements was not included in this results section or in study 2 because the purpose of both studies had been modified after participants completed the q-sorts.

The q-sorts also included five open-ended questions. The questions asked each adult to explain why they gave particular statements the highest and lowest rankings. Participants were asked to suggest any additional statements that they felt reflected their experiences related to the content of each q-sort. The final three open-ended questions asked adults to state in their own words the role of their religious beliefs, religious ritual practices, and community context on their daily lives. Table 3 provides information about the statements and open-ended questions included in all three q-sorts.

Table 3

*Information Describing the Three Q-sorts*

<table>
<thead>
<tr>
<th>Q sort #1: Religious Beliefs (n = 54)</th>
<th>Q-sort #2: Religious Ritual Practices: (n = 47)</th>
<th>Q-sort #3: Religious Community Context (n = 47)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- 26 total statements</td>
<td>- 26 total statements</td>
<td>- 26 total statements</td>
</tr>
<tr>
<td>o 7 coping</td>
<td>o 6 coping</td>
<td>o 6 coping</td>
</tr>
<tr>
<td>o 9 marriage</td>
<td>o 10 marriage</td>
<td>o 11 daily life</td>
</tr>
<tr>
<td>o 10 daily life</td>
<td>o 10 daily life</td>
<td>o 9 marriage</td>
</tr>
</tbody>
</table>

- Please explain all highest and lowest ratings.
- Please suggest other (a) beliefs; (b) ritual practices; and (c) community context statements
- Please describe in your own words the role of your Jewish religious (a) community context; (b) ritual practices; and (c) beliefs in your daily life.
Demographic variables and religious rituals questionnaire for study 1. Participants were asked about their gender, age, number of years married, age and gender of their children, and the type of school their child attended. The religious rituals included the extent to which they kept kosher, prayed, and attended synagogue within the past six months. A copy of these questions is provided in Appendix B.

Procedure

Participants completed each of the three q sorts. The participants were emailed a link to access the three online q sorts, a demographic questionnaire, and five open-ended questions using the personal computer of their choice. After signing on to the Web site, all participants were given an automatic user ID and password so that they had the option to complete the online activities in more than one sitting.

Participants first read and agreed to an online consent form. Consent was affirmed by clicking the, “I agree” button at the bottom of their computer screen. Then, statements for the first q-sort were presented followed by the next two. The following instructions were presented to each adult prior to beginning each q-sort:

“(Step 1). Please read each statement. Think about your religious beliefs/ practices/ community context for the last six months. After you have read each statement, decide whether you agree or disagree. If you agree, please drag the statement into the, “AGREE” column. If you disagree, please drag the statement into the “DISAGREE” column. If you find you cannot agree or disagree, please drag the statement into the “UNSURE” column”.

“(Step 2). Now divide the statements into 11 categories to show exactly how much you agree or disagree. Use the categories, “1” to “5” to rate the level of agreement for each statement and “-1” and “-5” to show how much you disagree with a statement. If you are somewhat unsure of a statement, you can place this statement in the “-1”, “0”, “1” categories. On the screen, you will see a limited number of boxes for each of the eleven number categories. For example, for category “-5” you will see one box. This means you can drag one statement in this “-5” category, that you want to rate as “I strongly disagree with this statement, to one of the boxes”.
Participants were only allowed to use each Likert scale score to rate a certain number of statements: extremely important (n = 1), very important (n = 2); moderately important (n = 2); somewhat important (n = 3); slightly important (n = 3); neither important nor unimportant (n = 4); slightly unimportant (n = 3); somewhat unimportant (n = 3); moderately unimportant (n = 2); very unimportant (n = 2); and extremely unimportant (n = 1). This distribution was suggested by the computer consultant who developed the online q-sort.

The final step in each q-sort allowed parents to check their answers and make any changes to their responses. Two open-ended questions between each q-sort asked participants to suggest additional statements and explain why they gave certain statements the highest and lowest ranking. After all three q sorts and five open-ended questions were completed, each adult was asked to complete demographic questions, provide information about participation in selected Jewish rituals, and answer three additional open-ended questions asking them to describe the role of their religious beliefs, religious ritual practices, and community context. Participants received a $10 Starbucks™ gift card for completing the online q sorts. Statements were presented in a random order to each participant.

**Data Analysis**

**Exploratory data analysis.** Exploratory data analysis (EDA) emphasizes the importance of “listening to the data in as many ways as possible until a plausible story is clear” (Behrens, 1997, p. 139). Furthermore, EDA involves the use of a particular sense of flexibility to search for distinct patterns (Behrens, 1997; Tukey, 1980). Three EDA methods were used in this study: (a) re-expression of the scales; (b) examination of outliers; and (c) graphical representations. Re-expression of the original scale allowed the researcher to “represent the phenomenon in a meaningful way therefore facilitating interpretation of the data in a natural way” (Behrens, 1997,
p. 140). Outliers can be visually identified with graphical representations of the data (Behrens, 1997; Tukey, 1980).

**Q-sort analysis.** Participants completed three q sorts using an 11-point Likert scale that ranged from -5 (extremely unimportant) to 5 (extremely important). Six points were added to all responses to allow re-expression of the scale by removing the negative numbers and creating a positive scale that ranged from one to 11. The following is a breakdown of the 11-point Likert scale: (1) extremely unimportant; (2) very unimportant; (3) moderately unimportant; (4) somewhat unimportant; (5) slightly unimportant; (6) neither unimportant or important; (7) slightly important; (8) somewhat important; (9) moderately important; (10) very important; and (11) extremely important.

Q-sort quantitative analysis focused on examining the distribution of the data. The minimum value, 25th percentile, 50th percentile (median), 75th percentile, and maximum value for each statement were identified. In addition, men’s and women’s responses to each q-sort statement were categorized as low, neutral, or high. Any response between one and four was identified as low. Neutral included any answer between 5 and 7. Participants’ responses between 8 and 11 were categorized as high. The percentages of men and women who responded low, neutral, and high also were calculated. These three categories were developed to help analyze the data in a succinct and concise manner.

**Open-ended response analysis.** Participants completed five open-ended questions. A list of these questions is located in Appendix B. Their responses were analyzed thematically. The purpose of this analysis was to: (a) supplement and further explain the q-sort quantitative ratings; and (b) identify any new statements or rewording of items.
Results

This results section is organized based on the following themes: (a) five religious community context items; (b) seven daily life and coping fill-in-the-blank statements; and (c) understanding the coping process: daily life hassles versus major life crises.

**Community context.** The following section discusses the q-sort answers and open-ended responses for 5 of the 26 items that refer to the participants’ perceptions of their religious community context. These statements were chosen because they demonstrated a distinct pattern of results. Men and women whose q-sort ratings did not align with this pattern were visually identified by examining histograms of the data. Two particular outliers’ background information and q-sort answers were presented.

**Community context q-sort answers.** Two of the five items were positively worded. Sixty percent or more of men and women responded “high” to both statements. “Engaging in our religious community has: (a) allowed my spouse and I to make many valuable friendships (n = 34); and (b) provided my spouse and I with a welcoming environment (n = 32)”.

The other three statements were negatively worded. Twenty percent or less of adults scored these statements as “high”. “My spouse and I: (a) are often frustrated because we feel as though we have to conform to the expectations of our religious community (n = 7); (b) have nothing in common with people in our religious community besides our religious background (n = 3); and (c) find it hard to connect with people in our religious community (n = 9). Table 4 summarizes the distribution of data for these five community context statements.

**Community context open-ended responses.** The religious community was considered an environment that offered comfort, support, structure, stability, trust, acceptance, strength and
### Table 4

<table>
<thead>
<tr>
<th>Distribution of Data</th>
<th>Engaging in our religious community has allowed my spouse and I to make many valuable friendships.</th>
<th>Engaging in our religious community has provided my spouse and I with a welcoming environment.</th>
<th>My spouse and I are often frustrated because we feel as though we have to conform to the expectations of our religious community.</th>
<th>My spouse and I have nothing in common with people in our religious community besides our religious background.</th>
<th>My spouse and I find it hard to connect with people in our religious community.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low (1-4)</td>
<td>10.6</td>
<td>4.3</td>
<td>63.8</td>
<td>70.2</td>
<td>72.3</td>
</tr>
<tr>
<td>Neutral (5-7)</td>
<td>17</td>
<td>27.7</td>
<td>21.3</td>
<td>23.4</td>
<td>8.6</td>
</tr>
<tr>
<td>High (8-11)</td>
<td>72.3</td>
<td>68.1</td>
<td>14.9</td>
<td>6.4</td>
<td>19.1</td>
</tr>
<tr>
<td>Minimum</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>25&lt;sup&gt;th&lt;/sup&gt; Percentile</td>
<td>7</td>
<td>7</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Median (50&lt;sup&gt;th&lt;/sup&gt; Percentile)</td>
<td>9</td>
<td>8</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>75&lt;sup&gt;th&lt;/sup&gt; Percentile</td>
<td>10</td>
<td>10</td>
<td>6</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Maximum</td>
<td>11</td>
<td>11</td>
<td>11</td>
<td>11</td>
<td>11</td>
</tr>
</tbody>
</table>
guidance. Participants were able to meet men and women who had similar religious beliefs, family values, lifestyle, experiences, and political and social views. Maintaining these relationships also offered close friends to share different ritual practices and playmates for their children. Factors such as busy schedules, a recent move to a new neighborhood, and different political views prevented some men and women from being able to participate fully in community activities. These negative perceptions caused them to avoid some congregants or maintain superficial friendships using social media.

**Community context outliers.** The q-sort answers and open-ended responses of two selected outliers are presented in-depth. Participants’ names were changed to protect their anonymity. A summary of their demographics and q-sort ratings are located in Table 5.

Participant #1 was a 33-year-old Reform female named Isabelle. She had been married for seven years and had one daughter. She indicated that her making valuable friendships within her community were “somewhat unimportant” and her being part of a welcoming environment was “extremely unimportant” for her and her spouse. Isabelle was: (a) unable to connect with her community; (b) frustrated because she felt that she had to conform; and (c) felt that she had nothing in common with others.

Isabelle and her husband did not enjoy their congregation and tried to avoid others as much as possible. She felt that they were not welcoming and had little in common with her family’s interests. She often purposely disengaged herself from her community because she felt other men and women were closed-minded. Isabelle mentioned that she felt “very disconnected from the strong social aspect of my religion.” In addition, she did not want her daughter to be part of such an environment.
Table 5  
*Two of Study 1 Outliers’ Demographic Variables and Religious Community Context Statement Q-Sort Responses (n = 47)*

<table>
<thead>
<tr>
<th>Participant’s Name*</th>
<th>Affiliation</th>
<th>Age</th>
<th># of years married</th>
<th>Age of children</th>
<th>Engaging in our religious community has allowed my spouse and I to make many valuable friendships.</th>
<th>Engaging in our religious community has provided my spouse and I with a welcoming environment.</th>
<th>My spouse and I are often frustrated because we feel as though we have to conform to the expectations of our religious community.</th>
<th>My spouse and I have nothing in common with people in our religious community besides our religious background.</th>
<th>My spouse and I find it hard to connect with people in our religious community.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Isabelle</td>
<td>Reform</td>
<td>33</td>
<td>7</td>
<td>2-year-old girl</td>
<td>4</td>
<td>1</td>
<td>10</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td>Rebecca</td>
<td>Modern Orthodox</td>
<td>36</td>
<td>3</td>
<td>1-year-old boy</td>
<td>1</td>
<td>8</td>
<td>6</td>
<td>2</td>
<td>11</td>
</tr>
</tbody>
</table>

*Participants’ names have been changed to maintain their privacy.*
Religious ritual practices and maintenance of a cultural connection to Judaism seemed to be more important than community inter-relationships for Isabelle and her family. They occasionally participated in religious ritual practices at home, such as lighting Shabbat candles, fasting for Yom Kippur, singing Jewish songs, and celebrating holidays such as Hanukkah and Passover. Although Judaism was not “very important” on a day-to-day basis for Isabelle, she still felt connected to religion because of her family history. Although she did not believe in many Jewish teachings, Isabelle felt that she still retained her “religious identity because I feel like it is the primary connection to my family and ancestors.” Furthermore, she also wanted to make sure her daughter maintained a strong religious identity and connection to ancestors.

Participant #2 was a 30-year-old Modern Orthodox female named Rebecca. She had been married for three years and had one son. Although Rebecca indicated that it was “very unimportant” to make valuable friendships in the community, she believed that it was “somewhat important” to be provided with a welcoming environment. Furthermore, Rebecca demonstrated neutral feelings about whether or not she felt she was expected to conform to any particular community expectations. Although Rebecca believed that she did not have much in common with other community members besides their similar religious background, she still found it easy to connect with them. After she had lived in her community for a year and a half, Rebecca was frustrated that she still had not “formed any genuine friendships with anyone in our community.” She felt that other aspects of Judaism, such as her identity and beliefs, were more important because “they inform who I am and how I act.” Furthermore, Jewish ritual practices also were a significant part of her daily life and marriage, as they gave her life “structure and a day-to-day map.”
These outliers’ q-sort responses demonstrated the importance of understanding the perceptions of individuals who may not align with general patterns of results, and the causes and effects of these alternative views. For example, in contrast to most of the other participants, Isabelle mainly presented negative perceptions of her religious community. In addition, she was concerned about the effect of the environment on her young daughter. Rebecca’s responses exhibited a mixed pattern of strong positive and negative views toward her religious community. She noted that she had lived in her community for only a short while and had been unable to form any genuine friendships. Therefore; this limited amount of time may have influenced her perceptions.

**Daily life and coping.** Six of the q-sort statements were chosen to be included in the fill-in-the-blank section of Study 2. These items were chosen because 75% or more of the participants selected neutral (slightly unimportant to slightly important) or high (somewhat to extremely important) for all six statements within each of the three q sorts. Tables 6, 7, 8, and 9 show results for each item. The seventh statement, “________ connects me to my family history, Jewish history, and culture identity,” was based on a theme that was repeated throughout the open-ended responses. Three statements focused on daily life and four items referred to coping with challenges. The following sections include participants’ q-sort quantitative answers and any applicable open-ended responses.

**Experiencing G-d in day-to-day life.** Religious beliefs reinforce the idea that there is only one G-d who manages the world and strengthens a person’s relationship with something “greater than” themselves. In addition, religious beliefs reinforce the importance of prayer and other traditions. Prayer is a ritual practice that provides one the opportunity to become closer to G-d by communicating one’s needs. Religious obligations such as the performance of various
ritual practices are perceived as comforting. Men and women feel that their belief in G-d and His teachings are incorporated into their daily lives. An individual’s religious community is a context in which to experience G-d through prayer. Religious beliefs (n = 48), ritual practices (n = 39), and community context (n = 35) were rated “slightly unimportant” to “extremely important” in allowing participants to experience G-d in their daily lives.

**Provision of order and structure.** Participants’ daily life, week, month, and year were shaped by their religious ritual practices. This structure offered a sense of solace and reassurance. More than 55% (n = 26) of participants rated their ritual practices as high in provision of order and structure. Some men and women perceived these traditions as an obligation, therefore ensuring aspects of their life, such as work and family, did not interfere with their ability to complete these rituals.

Almost 50% (n = 26) of participants rated their beliefs as “somewhat to extremely important” in structuring their lives. These men and women explained that they perceived this religious dimension as providing guidance, balance, and direction. It also was comforting for participants to know that the teachings inspired by these religious beliefs were included in their everyday routines.

The religious community was identified by 32% (n = 15) of men and women as high in shaping and structuring daily life. This was an environment in which adults felt that they could participate in various holiday events with their families and develop relationships with others. One female participant described these relationships as a “part of our lives and daily routines and we all share the same common religious beliefs, family values, and experiences, which enhance our lives and provide structure and order.”
**Connection to family history, cultural history, and Jewish identity.** A reoccurring theme in participants’ open-ended responses was the connections among religious beliefs, ritual practices, community context, family history, cultural history, and Jewish identity. Religious practices and communal special events were perceived as offering the opportunity to experience Jewish cultural heritage and family traditions within a specific environmental context. Spending time with friends and family added to the richness and significance of the holidays. Even though these ritual practices were often completed infrequently, they still offered a sense of belonging. In addition, maintaining certain religious beliefs allowed men and women to connect with their ancestors, Jewish history, and culture.

**Establishment of meaning in life.** Religious beliefs and ritual practices assisted in the search for meaning in life. Performing various religious ritual practices offered the opportunity to reflect on the significance of Judaism. Religious beliefs (n = 34) and ritual practices (n = 26) were “somewhat to extremely important” in helping them find meaning in their lives. The religious community context q-sort did not include a statement which referred to the process of searching for life’s significance.

**Acceptance of challenging life situations while knowing there are uncontrollable factors.** Certain religious beliefs teach people always to remember that some stressful situations and difficult people cannot be changed. More than 50% (n = 29) of participants rated their religious beliefs as “somewhat to extremely important” in their ability to accept challenging life situations even when all aspects of the crisis cannot be controlled. Thirty six percent (n = 17) of the participants identified their religious practices and 21% (n = 10) scored their religious community with similar high ratings.
**Assistance in coping with stress and challenges.** Men and women used their religious beliefs, ritual practices, and community to cope with certain stressors and challenges. About 85% (n = 46) of adults rated their religious beliefs as neutral or high in their value as a coping resource. Participants’ perceived their religious beliefs as helping to guide their actions, decision-making, and values. Men and women used prayer to communicate with G-d and ask for what they needed to cope. Participants also felt a sense of comfort and acceptance because they believed that they could always rely on other people in their community. Fifty percent (n = 24) of the participants scored their religious practices and 53% (n = 25) of men and women scored their religious community as neutral or high in the extent to which they identified it as a coping resource.
Table 6

*Distribution of Data and Percentage of Study 1 Participants’ Responses to Six Religious Beliefs Q-sort Statements (n = 54)*

<table>
<thead>
<tr>
<th>Six Religious Beliefs Q-sort Statements</th>
<th>Low (1-4)</th>
<th>Neutral (5-7)</th>
<th>High (8-11)</th>
<th>Minimum</th>
<th>25th Percentile</th>
<th>Median (50%)</th>
<th>75th Percentile</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>My religious beliefs allow me to experience G-d in my day to day life.</td>
<td>11.1</td>
<td>33.3</td>
<td>55.6</td>
<td>2</td>
<td>6</td>
<td>8</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>My religious beliefs provide order and structure to my life.</td>
<td>14.8</td>
<td>37</td>
<td>48.2</td>
<td>1</td>
<td>5</td>
<td>7</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>My religious beliefs connect me to my family history, cultural history, and Jewish identity.</td>
<td>9.2</td>
<td>27.8</td>
<td>63</td>
<td>2</td>
<td>6.75</td>
<td>8</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>Based on participants’ responses to the open-ended questions.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My religious beliefs help me find meaning in life.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My religious beliefs help me to accept challenging life situations while knowing many factors I cannot control play a role such as resources and coping ability.</td>
<td>14.8</td>
<td>31.5</td>
<td>53.7</td>
<td>1</td>
<td>6</td>
<td>8</td>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td>My religious beliefs are a resource that helps cope with stress and challenges.</td>
<td>14.8</td>
<td>57.4</td>
<td>27.8</td>
<td>1</td>
<td>5</td>
<td>6</td>
<td>8</td>
<td>10</td>
</tr>
</tbody>
</table>
Table 7

Distribution of Data and Percentage of Study 1 Participants’ Responses to Six Religious Ritual Practice Q-sort Statements (n = 47)

<table>
<thead>
<tr>
<th>Six Religious Ritual Practices Q-sort Statements</th>
<th>Low (1-4)</th>
<th>Neutral (5-7)</th>
<th>High (8-11)</th>
<th>Minimum</th>
<th>25th Percentile</th>
<th>Median (50%)</th>
<th>75th Percentile</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>My religious ritual practices allow me to experience G-d in my day to day life.</td>
<td>17</td>
<td>25.5</td>
<td>57.5</td>
<td>2</td>
<td>6</td>
<td>8</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>My religious ritual practices provide order and structure to my daily life.</td>
<td>10.6</td>
<td>34.1</td>
<td>55.3</td>
<td>2</td>
<td>6</td>
<td>8</td>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td>My religious ritual practices connect me to my family history, cultural history, and Jewish identity.</td>
<td>12.8</td>
<td>31.9</td>
<td>55.3</td>
<td>1</td>
<td>6</td>
<td>8</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>My religious ritual practices help me find meaning in life.</td>
<td>25.5</td>
<td>38.3</td>
<td>36.2</td>
<td>2</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>11</td>
</tr>
<tr>
<td>My religious ritual practices help me to accept challenging life situations while knowing many factors I cannot control play a role such as resources and coping ability.</td>
<td>17</td>
<td>51.1</td>
<td>31.9</td>
<td>1</td>
<td>5</td>
<td>6</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>My religious ritual practices are a resource that helps cope with stress and challenges.</td>
<td>Based on participants’ responses to the open-ended questions.</td>
<td>Based on participants’ responses to the open-ended questions.</td>
<td>Based on participants’ responses to the open-ended questions.</td>
<td>Based on participants’ responses to the open-ended questions.</td>
<td>Based on participants’ responses to the open-ended questions.</td>
<td>Based on participants’ responses to the open-ended questions.</td>
<td>Based on participants’ responses to the open-ended questions.</td>
<td>Based on participants’ responses to the open-ended questions.</td>
</tr>
</tbody>
</table>
### Table 8

**Distribution of Data and Percentage of Study 1 Participants’ Responses to Six Religious Community Context Q-sort Statements (n = 47)**

<table>
<thead>
<tr>
<th>Six Religious Community Context Q-sort Statements</th>
<th>Low (1-4)</th>
<th>Neutral (5-7)</th>
<th>High (8-11)</th>
<th>Minimum</th>
<th>25&lt;sup&gt;th&lt;/sup&gt; Percentile</th>
<th>Median (50%)</th>
<th>75&lt;sup&gt;th&lt;/sup&gt; Percentile</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>My religious community context allows me to experience G-d in my day to day life.</td>
<td>25.5</td>
<td>27.7</td>
<td>46.8</td>
<td>1</td>
<td>4</td>
<td>7</td>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td>My religious community context provides order and structure to my daily life.</td>
<td>14.9</td>
<td>53.2</td>
<td>31.9</td>
<td>1</td>
<td>5</td>
<td>6</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>My religious community context connects me to my family history, cultural history, and Jewish identity.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Based on participants’ responses to the open-ended questions.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My religious community context helps me find meaning in life.</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>My religious community context helps me to accept challenging life situations while knowing many factors I cannot control play a role such as resources and coping ability.</td>
<td>25.5</td>
<td>53.2</td>
<td>21.3</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>7</td>
<td>11</td>
</tr>
<tr>
<td>My religious community context is a resource that helps cope with stress and challenges</td>
<td>14.9</td>
<td>53.2</td>
<td>31.9</td>
<td>2</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>11</td>
</tr>
</tbody>
</table>

*Note. N/A means not applicable.*
**Provision of guidance and comfort when facing challenges: Coping with major life crises versus daily life hassles.** When facing challenges, religious beliefs, ritual practices, and community offered comfort and guidance. Forty six percent (n = 25) of participants scored their religious beliefs as high in providing support when faced with a crisis. Religious beliefs helped men and women make better decisions and answer difficult questions. The extent to which participants felt that their religious beliefs were comforting and supportive differed depending on whether they faced a major crisis or a daily life stressor. When facing everyday struggles, parents’ belief in G-d offered the hope, strength, and support they needed. In times of crisis and challenge, religious beliefs inspired the question “why would G-d put these obstacles in front of me and how would He want me to overcome such challenges?”

When facing misfortunes and suffering, 70% (n = 38) of participants rarely questioned their own religious beliefs. They rated this religious dimension as extremely to somewhat unimportant. Any experienced stressful event did not cause them to doubt their religious beliefs but instead gave them hope, support, and strength. One mother noted,

*It is actually these hard times that cause me to turn to these beliefs. This is probably one of the most critical times that I rely on my beliefs to help guide me through any hard or painful experience. I would never doubt myself in those kinds of situations because that is when those beliefs matter the most.*

One father said, “I think G-d puts us here for a reason and everything he does is for a reason. Whether I have a good day or bad, I always have to think this is for the best.”

Performing various religious ritual practices were perceived as offering a sense of comfort, structure, support, and belonging. These religious obligations also connected individuals to Judaism, resulting in the guidance and strength they need to help make important decisions. When facing daily hassles, religious ritual practices helped the person stay grounded and remember that these challenges are a passing inconvenience. Thirty-eight percent (n = 18) of
the participants rated their religious practices as high in providing guidance and comfort when the participant faced a challenge.

When confronted with misfortunes and suffering, 66% (n = 31) of participants hardly questioned their religious ritual practices. They rated this religious dimension as “extremely to somewhat unimportant” and were actually motivated to complete more ritual practices because they felt that these traditions brought them one step closer to G-d. One woman said,

*Negativity in the world or even just in my own life should be no reason to ignore my obligations to G-d and to my community. Instead, unpleasantness that I experience should be more motivation for me to do good and take steps to come closer to the Divine through my practice.*

The belief in G-d taught the importance of communication with the Divine using prayer and other ritual practices. Prayer strengthens an individual’s relationship with G-d and provides an opportunity for individuals to ask for what they need. When facing a misfortune, one female participant was inspired “to ask why G-d put these obstacles in front of me and how would he want me to overcome them.” The religious community offered men and women a sense of structure, stability, support, strength, trust, and guidance. Thirty-six percent (n = 17) of participants indicated that the religious community context was “somewhat to extremely important” in providing guidance and comfort when the participant faced a crisis.
Table 9

Distribution of Data and Percentage of Study 1 Participants’ Responses to Two Coping Q-sort Statements

<table>
<thead>
<tr>
<th>Coping Statements</th>
<th>Low (1-4)</th>
<th>Neutral (5-7)</th>
<th>High (8-11)</th>
<th>Minimum</th>
<th>25&lt;sup&gt;th&lt;/sup&gt; Percentile</th>
<th>Median (50%)</th>
<th>75&lt;sup&gt;th&lt;/sup&gt; Percentile</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>When faced with challenges I find that my religious beliefs provide me with guidance and comfort. (n = 54)</td>
<td>25.9</td>
<td>27.8</td>
<td>46.3</td>
<td>1</td>
<td>4</td>
<td>7</td>
<td>8.25</td>
<td>11</td>
</tr>
<tr>
<td>When faced with challenges I find that my religious ritual practices provide me with guidance and comfort. (n = 47)</td>
<td>23.4</td>
<td>38.3</td>
<td>38.3</td>
<td>2</td>
<td>5</td>
<td>7</td>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td>When faced with challenges I find that my religious community context provides me with guidance and comfort. (n = 47)</td>
<td>14.9</td>
<td>48.9</td>
<td>36.2</td>
<td>1</td>
<td>5</td>
<td>6</td>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td>Misfortunes and suffering cause me to question my religious beliefs. (n = 54)*</td>
<td>70.4</td>
<td>14.8</td>
<td>14.8</td>
<td>1</td>
<td>1.75</td>
<td>3.5</td>
<td>5.25</td>
<td>10</td>
</tr>
<tr>
<td>Misfortunes and suffering cause me to question my religious ritual practices. (n = 47)*</td>
<td>66</td>
<td>17</td>
<td>17</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>6</td>
<td>10</td>
</tr>
</tbody>
</table>

*Statement not included in study 2.
Summary of Results

The q-sort findings identified five statements that described Jewish mothers and fathers’ perceptions of their community context. Themes included: (1) valuable friendships; (2) welcoming environment; (3) connecting with others; (4) conforming to expectations; and (5) finding commonalities with others. The community was a context that offered opportunities to complete rituals with other families who shared the same religious beliefs. Not all participants had the same patterns of opinions about their community; therefore these outliers demonstrated the importance of examining the causes and effects of possible alternative views.

Daily life and coping was also explored using q-sort findings. Participants’ ratings narrowed down six different areas that were influenced by the perceptions of their beliefs, practices, or community. Seventy five percent of men and women rated the following themes as slightly unimportant to extremely important: (1) experiencing G-d in daily life; (2) providing order and structure in life; (3) establishing meaning in life; (4) accepting challenging life situations; (5) assisting in coping with stress and challenges; and (6) offering guidance and comfort. Participants’ open-ended responses identified an additional important theme: family, cultural and Jewish identity. The extent to which some participants found comfort in their religious beliefs or practices differed depending on whether they were faced with a major crisis or daily life stressor.
Discussion

The first objective of this study was to explore the multidimensional aspects of religious and psychosocial experience for Jewish parents. The use of a specific global variable or criterion to measure a participant’s religiosity does not accurately capture a person’s religious background, take into consideration the interplay between the various dimensions of religion, nor examine the influence of the family lifecycle stage. Therefore, the present study examined religious experience as a dynamic variable. This dynamic variable relates to one’s understanding participants’ perceptions of their religious beliefs, ritual practices, or community context.

The second goal was to use a multi-method design to investigate the inter-relationships among perceived religious beliefs, ritual practices, community context, daily life, and coping processes for Jewish mothers and fathers. A combination of qualitative and quantitative methods allowed a thorough analysis of the influence of three religious dimensions on participants’ daily lives and coping abilities. The third aim was to supplement current research that has focused on the psychology of religion by focusing on non-Christian or Catholic communities (Coulthard & Fitzgerald, 1999; Dollahite & Tomcho, 2001) and including both the fathers’ and mothers’ perceptions to provide significant insight into the multiple perspectives within a family system (Agate et al., 2007; Ambert, 1992; Baron et al., 2006; Bennett et al., 1995; Boyd, 2002).

Results demonstrated an inter-relationship among all three dimensions of Judaism. When facing a challenge, participants felt that their religious beliefs, ritual practices, and community offered a sense of guidance and comfort. The extent to which these three religious dimensions influence how individuals handle stressors differed depending on whether they faced a daily challenge or major life crisis. Religious beliefs emphasize the importance of communication with G-d, and ritual practices such as prayer provide a specific opportunity to ask for assistance.
Previous research also noted that prayer can help parents communicate with G-d (Poston & Turnbull, 2004) and ask for guidance and strength (Bennett et al., 1995; Coulthard & Fitzgerald, 1999; Poston & Turnbull, 2004; Skinner et al., 2001; Weisner et al., 1991). Participation in community events, performance of various holiday traditions, and observance of the teachings inspired by religious beliefs structured mothers’ and fathers’ daily lives. Participants maintained their family history, cultural history, and Jewish identity by taking part in community events and remembering that they shared the same religious beliefs and ritual practices as previous generations of Jews.

The religious community context had positive and negative influences on participants’ psychosocial development. This environment allowed some men and women to develop valuable friendships and feel that they were a part of a welcoming environment. Other participants mentioned that they had experienced a sense of conformity, minimal commonalities, and difficulty connecting with some individuals in their religious community.

The q sorts in study 1 included statements from the literature review that were based on samples of men and women who were not Jewish. Participants’ responses in this study helped to narrow down those items that were most applicable to Jewish mothers and fathers. In addition, their open-ended answers: (1) identified a new theme that had not been accounted for when examining the literature; and (2) provided some insight into understanding why these statements were appropriate for this particular religious population. The next study examined the results of study 1 by comparing the responses of Jewish parents of children with and without autism. The validity of the second study was strengthened by first testing these items on Jewish mothers and fathers of typically developing children.
Chapter Four: Study Two

Summary

The second study utilized a multi-method design to examine how Jewish mothers and fathers of children with and without autism use their perceptions of religious beliefs, ritual practices, and community context in their daily life, to cope with parenting stressors related to having a child with autism, and raising their son or daughter. In addition, this second study contributes to the understanding of how Jewish parents of children with autism’s perceptions of their religious beliefs, ritual practices, and community context influence the way they interpret the cause of their child’s diagnosis. Twelve mothers and eight fathers of children with autism and seven mothers and seven fathers of typically developing children completed online surveys and a phone interview. This study also aimed to examine further the results of the previous study; therefore, some of the surveys were based on results from study one. The surveys and interview questions addressed areas such as parental stress; coping; and the perceived influential role of religious beliefs, ritual practices, and community context. Quantitative results from an independent samples t-test indicated that parents of children with autism scored statistically significantly higher mean parental stress scale scores than parents of typically developing children. These results suggest that child’s diagnosis can have an effect on a parent’s stress level. In addition, parental gender was identified as a possible partial moderator influencing the relationship between parental stress and child’s diagnosis. Qualitative responses highlight some themes that are specific to Judaism and other findings demonstrate the role of religious beliefs, ritual practices, and community context on parents of children with and without autism.
Participants

**Recruitment strategies.** Reform, Conservative, and Modern Orthodox Jewish couples with a young child diagnosed with autism or a typically developing young child were recruited using social networking Web sites, Jewish day schools, community centers, synagogues, CUNY posted flyers, and list-servs. In addition, caregivers were recruited using early intervention centers, organizations that assist families of children with autism, and Jewish-based preschools. Potential participants were provided with an email address so that they could contact the principal investigator to receive more information about participation.

**Demographics.** Twelve mothers and eight fathers of children with autism participated in this study. In addition, seven mothers and seven fathers of typically developing children completed the same survey and interview process. Participants’ ages ranged from 26 to 54 years. The mean age of parents was 38.4 years. Husbands and wives’ marriages ranged from 5.5 to 20 years. Couples were married for an average of 12.05 years. Family size ranged from 1 to 4 children. Each mother and father received $25 for their participation. Additional demographic information is presented in Table 10.

Participants followed religious-based dietary, dress code, and family purity laws to a varying extent. Eleven mothers and fathers did not keep kosher. Seven parents maintained all dietary kosher laws inside and outside of their homes. Other participants did not eat non-kosher foods such as seafood, pig products, or mix meat and dairy foods (n = 6), consumed only non-kosher dairy foods outside of their homes (n = 5), or ate kosher food at home but non-kosher food in other locations (n = 2). Two participants were vegetarians and one father did not provide information about the degree to which he followed dietary laws.
Table 10

*Frequency of Study 2 Participants' Demographic Background Information*

<table>
<thead>
<tr>
<th>Demographic Variable</th>
<th>Answer Choices</th>
<th>n Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant Education (n = 34)</td>
<td>Less than a Bachelor</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Bachelor</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Masters</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Ph.D., MD, JD</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Two degrees</td>
<td>1</td>
</tr>
<tr>
<td>Participant’s Self-Affiliation and Child’s Diagnosis (n = 34)</td>
<td>Modern Orthodox Autism</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Conservative Autism</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Reform Autism</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Other Autism</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Modern Orthodox Typical</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Conservative Typical</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Reform Typical</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Other Typical</td>
<td>2</td>
</tr>
<tr>
<td>Number of Spouses per Household Interviewed (n = 19)</td>
<td>Both spouses</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Only one spouse</td>
<td>4</td>
</tr>
<tr>
<td>Family Income per Household (n = 19)</td>
<td>$15,000 to $45,000</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>$45,001 to $75,000</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>$75,001+</td>
<td>16</td>
</tr>
<tr>
<td>Number of Households Receiving Financial Support from Extend Family (n = 19)</td>
<td>Yes</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>10</td>
</tr>
<tr>
<td>Community Type (n = 19)</td>
<td>Suburban</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Urban</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Rural</td>
<td>1</td>
</tr>
<tr>
<td>Recruitment (n = 19)</td>
<td>Synagogue or disability organization list-serv</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Facebook</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Advertisement at child’s school</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>P.I.’s personal contacts</td>
<td>2</td>
</tr>
</tbody>
</table>
Four male participants wore a yarmulke on a daily basis. Other men (n = 11) only wore this head covering when they were inside a synagogue. Some women covered their hair with a wig, scarf, or hat (n = 2). Several female participants never covered their hair (n = 10) or only did so when they attended synagogue (n = 10). In addition, several women did not follow a particular dress code (n = 9), and other females only wore modest clothing attire when they went to synagogue services (n = 8). Two women followed a strict dress code and therefore never wore pants. Five of the 19 couples followed family purity laws. Table 11 provides information about the frequency with which participants’ performed various religious ritual practices.

Nine boys and three girls were diagnosed with autism. This gender division aligns with the literature which states that boys are more likely to be diagnosed with autism than girls (Gernsbacher, Dawson & Goldsmith, 2005). They ranged from 4.9 to 14 years old. Three of the 12 special-needs children had a history of seizures. Eight children scored severe, moderate (n = 3), and mild (n = 1) on the Social Responsiveness Scale (2nd ed.). The study also included 3 boys and 4 girls who were typically developing. These children ranged from 2.5 to 6 years old and were all within normal limits on the Social Responsiveness Scale (2nd ed.). None of the typically developing children ever had a seizure. The children with autism were chronologically younger than the comparison group to account for possible mental age and developmental level differences. Table 12 includes more information about the children’s education and medical and therapeutic histories. The Vineland Adaptive Behavior Scale was only completed for eight of the children with autism and six of the typically developing children. The average age and standard deviation for the three domain categories are shown in Table 13.
Table 11

*Frequency of Study 2 Participants’ Religious Ritual Practices*

<table>
<thead>
<tr>
<th>Religious Ritual Practice</th>
<th>Answer Choices</th>
<th>n Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Synagogue Attendance (n= 34)</td>
<td>Sometimes on Shabbat and holidays</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>Only high holidays</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Every Shabbat and most/all holidays</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Never</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>When I feel religiously inspired</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Only Shabbat</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Every day, every Shabbat, and all holidays</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Weddings/funerals/bar mitzvah</td>
<td>1</td>
</tr>
<tr>
<td>Travel During Shabbat (n = 34)</td>
<td>Travel all the time</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>No, I walk everywhere</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Yes, but try not long distance</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Synagogue is too far away to walk</td>
<td>1</td>
</tr>
<tr>
<td>Electrical Appliances During Shabbat (n = 34)</td>
<td>Touch all appliances</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>Touch certain appliances</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Home is on a timer</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Leave one light on in a room</td>
<td>2</td>
</tr>
<tr>
<td>Religious Program Online, Web site, Book, Magazine, Newspaper Article (n = 34)</td>
<td>A couple times a month</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>Never</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>When I feel religiously or spiritually inspired</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>A couple times a week</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Every day</td>
<td>3</td>
</tr>
<tr>
<td>Gave Money to Charity (n = 34)</td>
<td>A couple times a month</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>When I feel religiously or spiritually inspired</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>A couple times a week</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Never</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Every day</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Holidays</td>
<td>2</td>
</tr>
<tr>
<td>Attended a Jewish or Israeli Festival or Event (n = 34)</td>
<td>When I feel religiously inspired</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Never</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>A couple times a month</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Only holidays</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>A couple times a week</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Every day</td>
<td>2</td>
</tr>
<tr>
<td>Fasting (n = 34)</td>
<td>Only Yom Kippur</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>Never</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Every Jewish Fast</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Yom Kippur and Tis B’Av</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>When I feel religiously inspired</td>
<td>2</td>
</tr>
<tr>
<td>Number of Households Eating a Formal Sit-Down Dinner with a Large Group of People (e.g., Friends and Family) (n = 19)</td>
<td>Sometimes on Shabbat and Holidays</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Every Shabbat and Holiday</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Holidays only</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Never</td>
<td>2</td>
</tr>
</tbody>
</table>
Table 12
Frequency of Study 2 Children’s Demographic Information

<table>
<thead>
<tr>
<th>Child’s Demographic Variable</th>
<th>Answer Choices</th>
<th>n Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s Diagnoses (n = 19)</td>
<td>Typical</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Autism</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Asperger’s</td>
<td>3</td>
</tr>
<tr>
<td>Number of Medications (n = 19)</td>
<td>None</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>One</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Two</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Three or more</td>
<td>2</td>
</tr>
<tr>
<td>Child’s School (n = 19)</td>
<td>Public special education classroom</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Public inclusion classroom</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Private school</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Private Jewish school</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Private ABA school</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Private special needs school</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Public school and Hebrew school</td>
<td>1</td>
</tr>
<tr>
<td>Co-diagnoses*</td>
<td>Sensory Problems</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>ADD/ADHD</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Seizures</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Mental Retardation</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Abnormal MRI/Cat Scan</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>OCD</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Nonverbal Learning Disorder</td>
<td>1</td>
</tr>
</tbody>
</table>

Types of Therapy Sessions* | Speech Therapy | 12 |
|                            | Occupational Therapy | 10 |
|                            | Physical Therapy | 3 |
|                            | Miscellaneous (Karate, Horseback riding, Gymnastics) | 3 |
|                            | Art Therapy | 2 |
|                            | Music Therapy | 2 |
|                            | Swimming Therapy | 2 |
|                            | Social Skills Program | 2 |
|                            | Sunday Respite program | 2 |
|                            | Home Health Aide (Medicaid Voucher) | 1 |
|                            | Psychologist (Stress and Anxiety) | 1 |

*Some children with autism may have had more than one diagnosis or therapy session.

Table 13
Children’s Vineland Mean Age and Standard Deviations for Three Domains

<table>
<thead>
<tr>
<th></th>
<th>Autism (n = 6)</th>
<th>Typical (n = 8)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Communication</td>
<td>3.63</td>
<td>1.15</td>
</tr>
<tr>
<td>Daily Living Skills</td>
<td>4.04</td>
<td>1.84</td>
</tr>
<tr>
<td>Socialization</td>
<td>3.02</td>
<td>1.36</td>
</tr>
</tbody>
</table>
Measures

Copies of the first seven measures are located in Appendix C.

Coping orientations to problem experienced (COPE; Carver, Scheier, & Weintraub, 1989). The measure included 52 items and focused on assessment of cognitive and behavioral problem-focused and emotion-focused coping strategies. The following 13 subscales are included: active coping, planning, suppression of competing activities, seeking instrumental social support, seeking emotional social support, positive reinterpretation and growth, acceptance, turning to religion, focus on and venting of emotions, denial, behavioral disengagement, mental disengagement, and alcohol-drug disengagement. For example, the following items were included in the turning-to-religion subscale, “I seek G-d’s help,” “I put my trust in G-d,” “I try to find comfort in my religion,” and “I pray more than usual.” Adults respond to items on a four-point Likert scale ranging from 1 (I have not been doing this at all) to 4 (I’ve been doing this a lot). Cronbach alpha levels for the 13 subscales ranged from 0.45 to 0.92.

Demographic variables and religious rituals questionnaire. This questionnaire included questions developed by the principal investigator for this study. Examples of demographic questions are participants’ age, gender, income within the past year, education, number of years married, and occupation. Questions referred to the ritual practices completed by the participant at home with and without their spouse. Examples of ritual practices include clothing choices, the extent to which the participant kept kosher, synagogue attendance, following family purity laws, placement of a mezuzah on the doorpost, travel and use of electrical appliances during the Sabbath. Depending on the question, participants responded using multiple choice answers or rated their response on a Likert scale. These items, questions,
and response choices were developed in consultation with rabbis and Jewish parents of typically developing children.

**Jewish religious coping scale (JCOPE; Rosmarin, Pargament, Krumrei, & Flannelly, 2009).** This scale includes 22 items that examine how Jewish adults use religion to cope. Example items include, “I ask G-d to forgive me for things I did wrong,” “I talk to my rabbi,” and “I try to do Mitzvot (good deeds).” Participants responded to the items using a five-point Likert scale ranging from 1 (never) to 5 (always). The following instructions were provided: “This questionnaire asks about different ways in which you might rely on religion to deal with stress. Choose the number that best describes how often you do the following things when you have a stressful problem.” Psychometric information is not available.

**Medical history questionnaire.** This questionnaire included nine questions about participants’ children’s neurological history, medications, possible comorbidity of disabilities, and family medical history.

**Parental stress scale (Berry & Jones, 1995).** This 18-item scale measures the stress level associated with the parenting experience. The following instructions were given to participants:

> The following statements describe feelings and perceptions about the experience of being a parent. Think of each of the items in terms of how your relationship with your child or children typically is. Please indicate the degree to which you agree or disagree with the following items by placing the appropriate number in the space provided. Example items include, “I am satisfied as a parent.” Participants responded to the items using a five-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). The Cronbach alpha level was 0.8.

**Religious dimensions questionnaire.** This is a 12-item scale developed for this study to assess the role of religious beliefs, ritual practices, and community context on the marriage, daily
life, and coping of participants. These statements were narrowed down and chosen from the 
$q$-sort results. The first seven items referred to daily life, coping, and parenting. Six of the 
statements were chosen because 75% or more of the participants in study 1 selected slightly 
unimportant to extremely important. The seventh statement, “_________connects me to my 
family history, Jewish history, and culture identity,” was based on a theme that was repeated 
throughout the open-ended responses. Participants were asked to read the sentence and fill in the 
blank with the religious dimensions that best describe their life or the option of “none of the 
religious dimensions.” An example of an item is: “When faced with challenges related to my 
child’s diagnosis I find that my ______ provides me with strength, support, guidance, belonging 
and comfort.”

The last five items referred only to perceptions of the religious community context and 
daily life. These items were selected because majority of the participants in study one presented 
positive perceptions to these discussed themes; therefore wanted to compare the responses of 
mother and father with and without a child with autism. Participants were asked to rate the items 
on a scale of 1 (strongly disagree) to 5 (strongly agree). The wording of some items was adjusted 
depending on whether or not the parents had a child diagnosed with autism.

**Social responsiveness scale (2nd ed.; Constantino & Gruber, 2012).** The social 
responsiveness scale (2nd edition) is a 65-item scale that examines autistic symptoms across a 
range of severity. Two versions of the instrument were used: (a) preschool form for ages 2.5 to 
4.11 years and (b) school-aged form for ages 5 to 18 years. Each item is rated on a scale of 1 
(never true) to 4 (almost always true). The survey addresses five areas: (a) social awareness; 
(b) social cognition; (c) social communication; (d) social motivation; and (e) restricted interests 
and repetitive behaviors. For example, the following items were included within the social
cognition category: “Has a sense of humor, understands jokes,” “Is overly suspicious,” and “Gives unusual or illogical reasons for doing things.” Accordingly, some of the responses are reverse scored. Cronbach alpha level was 0.83.

**Vineland adaptive behavior scale (Sparrow, Cicchetti, & Balla, 2005).** A standardized, semi-structured parent interview was used to assess the individual’s (birth to 90 years old) current adaptive behavior. Composite scores are given for four domains: (a) communication; (b) daily living skills; (c) socialization; and (d) motor skills. Only the first three domains are used in the present study. Participants were provided with the following response choices: (a) usually; (b) sometimes or partially; (c) never; or (d) don’t know. The score ranges included: (a) high: 130 and above; (b) moderately high: 115-129; (c) adequate: 86-114; (d) moderately low: 71-85; and (e) low: 70 and less. The reliability coefficient for all four domains was 0.89, and the split-half reliability was 0.92 (Hall & Graff, 2011).

**Semi-structured interview.** The semi-structured interview included four categories of questions: (a) background information about the child’s schooling; (b) participants’ religious beliefs, ritual practices, and community context; (c) parenting; and (d) coping. The wording of some interview questions was changed depending on whether or not the couple had a child diagnosed with autism. All interview questions are provided in Appendix D.

**Background information about the child’s schooling.** Parents of a typically developing child were asked to describe the school and types of programs their child attended within the past year. Mothers and fathers of a child with autism were asked the same questions and provided information about the interventions received by their child. Examples of treatments included speech therapy, physical therapy, and behavioral services.
**Religious dimensions.** Participants were asked about the influence of their religious beliefs, ritual practices, and community context on their emotions and daily lives. Mothers and fathers also were asked to discuss their responses to the religious dimensions questionnaire. The principal investigator also asked whether there were any changes to the frequency with which they completed particular religious practices. Parents of a typically developing child were asked to refer to the time since their child(ren) were born. Mothers and fathers of a child with autism were asked to use their child’s time of diagnosis as a reference point.

**Parenting.** Two video clips were emailed to parents. They were asked to watch the clips alone before the scheduled phone interview. These clips were found on the Center for Disease control Web site and included a child with autism. The first video clip presented a child having a temper tantrum, and the second clip concerned a child who was unresponsive to his name being called. Each video clip was followed by various questions, such as how participants felt and thought about the child’s behavior and the way they believed their spouse would respond to the video clip. Mothers and fathers also discussed whether their child presented similar behaviors, how they would respond to the particular behavior, and the way they believed their spouse would react to their child’s actions. The principal investigator also asked participants to explain how their religious beliefs, ritual practices, and community context might have influenced their responses to their child’s behavior and how they believed their spouse would react to their son or daughter’s behavior.

**Coping.** First, mothers and fathers discussed their fears, anxieties, and concerns about their child’s future and parenting. Then, the participants were asked to explain how their religious beliefs, ritual practices, and community context helped or harmed their ability to cope
with these fears, anxieties, and concerns. Last, participants identified nonreligious coping mechanisms they used to cope with these fears, anxieties, and concerns.

**Reaction to diagnosis interview (RDI; Marvin & Pianta, 1996).** Parents of children with autism answered additional interview questions. The interview questions aimed to classify the parents’ current frame of mind regarding their child’s diagnosis. The semi-structured interview protocol included five questions that asked participants to remember the time when they found out about their child’s diagnosis, changes in their thoughts and feelings since the diagnosis, and their search for other reasons that have influenced their experiences. Researchers must use a specific manual to code participants’ responses as resolved or unresolved. The specific coding manual required researchers to video tape parents; therefore this semi-structured interview protocol was solely used to address the topics that are targeted by the questions. Parental responses were analyzed thematically. Table 14 provides a list of the quantitative and qualitative data associated with each research question.

Table 14

*Quantitative and Qualitative Data Associated with Each Research Question*

<table>
<thead>
<tr>
<th>Research Question</th>
<th>Quantitative Data</th>
<th>Qualitative Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1: Daily Life</td>
<td>(1) 4 of the 7 fill-in-the-blank statements; (2) Total community score and 5 rated religious community context statements</td>
<td>Religious Dimensions</td>
</tr>
<tr>
<td>#2: Parental Stress and Coping</td>
<td>(1) 5 of Parental Stress Scale statements; (2) 4 COPE subscales; (3) all JCOPE subscales and 3 chosen statements</td>
<td>Coping Parenting Religious Dimensions</td>
</tr>
<tr>
<td>#3: Parenting</td>
<td>(1) 3 of the 7 fill-in-the-blank statements; (2) COPE Seeking Instrumental Support subscale</td>
<td>Parenting Religious Dimensions</td>
</tr>
<tr>
<td>#4: Interpreting Diagnosis</td>
<td>Not included</td>
<td>Response to Diagnosis Interview question, “Parents sometimes wonder or have ideas about why they have a child with special needs, do you ever wonder anything like that?”</td>
</tr>
</tbody>
</table>
Procedure

A total of 34 Reform, Conservative, and Modern Orthodox Jewish adults were recruited. Once mothers and fathers contacted the principal investigator and agreed to participate, the surveys were sent to them as a link via email. The consent form was the first document they read and agreed to online by clicking the “I agree” button at the bottom of the computer screen. The seven questionnaires were presented to all participants in the same order online: (a) Medical Questionnaire; (b) Demographic and Religious Ritual Questionnaire; (c) Religious Dimension Questionnaire; (d) Parental Stress Scale; (e) JCOPE; (f) COPE; (g) SRS (2nd edition). The participants were asked to complete these survey measures prior to the interview session.

The principal investigator scheduled a phone interview at the time most convenient for each participant. Husbands and wives were interviewed separately. The interview was audi-taped and later transcribed. Each participant first read and agreed to a consent form online. The Reaction to Diagnosis Interview questions were presented only to mothers and fathers of a child with autism. All participants answered the rest of the interview questions regardless of their religious affiliation or child’s diagnosis. The interview was completed in the following order: (a) religious dimensions; (b) parenting; and (c) coping. The parenting questions involved participants also watching two video clips that had been emailed to them. The principal investigator also mailed a copy of the Vineland Adaptive Behavior Scale and a self-addressed stamped envelope to each family to complete and return back. Each participant received a check for $25 when all measures and interview questions were completed.
Data Analysis

The various online measures were quantitatively analyzed by calculating percentages, frequencies, and average scores and examining the distribution of data. Statistical significance was only calculated for the parental stress scale scores because an independent t-test assumes that scores within each group must be independent and not-related to each other (Cramer & Howitt, 2004). For this comparison, there were four distinct groups of participants: (1) mothers of children with autism; (2) mothers of typically developing children; (3) fathers of children with autism; and (4) fathers of typically developing children. Statistical significance was not calculated for the other means presented in this result section because the scores compared parents of children with autism versus mothers and fathers of typically developing children. Therefore, the scores within both groups were related to the scores of the participants in the same group. Results were presented as trends that assessed the patterns between all parents of children with autism versus all mothers and fathers of typically developing children.

Emergent themes approach. This method of qualitative analysis involves the use of inductive reasoning to examine interview findings in a nondiscriminatory manner. Data are organized into categories and patterns by checking each finding and explanation against “other sources of data until a point of saturation is reached, thus completing the analysis” (Strauss & Corbin, 1990, p. 132). Themes emerge as the data do not add further meaningful information to the category, and “linkages between them become more sensible” (p. 133). By first reviewing the various interview transcripts and examining reoccurring patterns, the researcher can consider all possible directions in data analysis. Themes are considered when numerous codes that identify patterns are observed and organized into broader categories of findings. Coding ends when the
data do not enhance the information already identified about the category, subcategories, or relationship between groups (Strauss & Corbin, 1990).

Interview transcripts were reviewed for similarities and differences between the responses of parents of children with autism compared to mothers and fathers of typically developing children. According to Strauss and Corbin (1990), it is important always to think critically about the qualitative data. This process involves: (a) open coding; (b) axial coding; and (c) memo-writing. During open coding, the researcher names and develops categories by closely examining the data. The transcripts are compared, the information is questioned, and the data are conceptualized. Axial coding involves “putting back the data in new ways after open coding by making connections between categories” (p. 155). The relationships between these categories and subcategories are verified and related to each other by memo-writing. These memos help organize ideas related to the qualitative data and conceptualize each established theme (Strauss and Corbin, 1990).
Table 15

*Percentage of Study 2 Participants’ Fill-in-the-Blank Statement Responses Categorized by Child’s Diagnosis*

<table>
<thead>
<tr>
<th>Fill-in-the-Blank Statement</th>
<th>Autism (n = 20)</th>
<th>Typical (n = 14)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Beliefs</td>
<td>Ritual Practices</td>
</tr>
<tr>
<td>___ allows me to experience God in my day-to-day life.</td>
<td>45</td>
<td>0</td>
</tr>
<tr>
<td>___ provides order and structure to my life.</td>
<td>35</td>
<td>15</td>
</tr>
<tr>
<td>___ helps me to find meaning in my life.</td>
<td>45</td>
<td>25</td>
</tr>
<tr>
<td>___ connects me to my family history, cultural history, and Jewish identity.</td>
<td>25</td>
<td>45</td>
</tr>
</tbody>
</table>
Results

Influence of religious beliefs, rituals practices, and community context on daily life. The following section includes information about the one religious dimension mothers and fathers selected most often to complete 4 of the 7 statements that were presented to them. The religious dimension choices were: beliefs, ritual practices, community context or none. By choosing one response, participants were asked to prioritize dimensions of their religious background. Table 15 presents the percentage of participants who chose a particular religious dimension to complete the statements. In addition, participants’ total religious community context score and ratings of the five religious community context statements are discussed. All of the parents’ answer choices are supplemented with applicable segments of their interview responses.

*Experience G-d in daily life.* On a daily basis, more than 35% of all participants experienced G-d through their religious beliefs. Parents of children with autism noted that they felt their religious beliefs taught them the importance of their appreciating everything because it had been created by G-d. When facing challenging child-related situations, it was important to realize that “life could be worse.” These participants also tried to remember that enjoyable moments were a precious gift from G-d and that He would help them handle any stressors.

Religious beliefs helped caregivers of typically developing children shape their views and perceptions of the world, how they treated others, and the way they presented themselves in public. One male participant discussed experiencing G-d in the positive inter-relationships with his friends and family. When facing challenges, this group of parents believed that it was important to stay optimistic and remember that everything is part of G-d’s plan. Mothers and fathers from both groups of participants were often unable to complete practices or actively take
part in their community. Therefore, caregivers emphasized the importance of their maintaining the strong and constant religious beliefs that ultimately shaped their Jewish identity.

**Provides order and structure.** Fifteen percent (n = 3) of the parents of children with autism stated that their religious ritual practices organized their lives. Half of the comparison group (n = 7) responded similarly. Both groups of caregivers felt that their religious ritual practices organized their day, week, month and year. More than one-third (n = 7) of parents of children with autism believed that their religious beliefs structured their life. They felt that their beliefs taught them that everything happens for a reason and inspired them to make the best decisions for their child and family. Twenty-five percent (n = 5) of mothers and fathers of children with autism described their daily lives as being organized by events at their synagogue, child’s school, or Hebrew after-school program. Only one participant from the comparison group responded similarly. Twenty-five percent of all participants noted that they did not find order in any religious dimension. Instead, their job, children’s schedule, and their spending time with their friends and family organized their daily lives.

**Helps to find meaning in life.** Religious beliefs helped 45% (n = 9) of parents of children with autism find meaning in their lives. These beliefs shaped their sense of identity, helped them to appreciate life, and inspired the belief that G-d wanted them to be the caregiver of a child with special needs. Twenty percent (n = 4) of parents of children with autism and half of the comparison group (n = 7) perceived neither of the religious dimensions as helping them to discover the importance of life. These mothers and fathers instead found significance in spending time with their family, partaking in their hobbies, and supporting social and political issues.

**Connection to my family history, cultural history, and Jewish identity.** Almost 45% of all participants described their religious ritual practices as a way to connect to their family
history, cultural history, and Jewish identity. Participants felt a sense of belonging as they realized that other Jews also were performing the same practices. In addition, mothers and fathers recalled performance of rituals with their family from their own childhood. Adults wanted to make sure their children were given the same Jewish experiences.

Specific political and historical events influenced how often some parents completed ritual practices. They believed that because the world was filled with anti-Semitism, it was even more important to carry on traditions and honor their Jewish identity. One father of a typically developing child demonstrated a sense of guilt when he was unable to follow ritual practices. He felt it was important to complete rituals because “we were persecuted people and our ancestors sacrificed to continue their practices so I think it is important for our family to carry that on.”

Two parents of children with autism discussed the Holocaust. One mother noted that her grandparents were survivors who remained religious throughout their experience. She then realized “G-d took care of them and they were in a much worse place so we are going to be okay.” Another female participant found strength in remembering that “Jews have had hardships but we overcome things. It is just a different thing that sets us apart.” She also felt that caregivers of children with special needs are “separated even more. You are filtered into a different group. If my daughter was around during the Holocaust she would have been killed right there. People like that didn’t survive.”

**Sole influence of religious community context on aspects of daily life.** Participants were asked to rate the extent to which they agreed with five presented statements about their religious community context. Three of the items were negatively worded; therefore, they were reverse scored to calculate a total religious community context score. Table 16 shows that parents of typically developing children’s total community scores were higher than were those of
mothers and fathers of children with autism. Lower scores mean that parents of children with autism demonstrated a pattern of views about their religious community that was less positive.

Table 16

*Distribution of Data for Study 2 Participants’ Total Community Score Categorized by Child’s Diagnosis*

<table>
<thead>
<tr>
<th>Distribution of Data</th>
<th>Autism (n = 20)</th>
<th>Typical (n = 14)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Score</td>
<td>17.25</td>
<td>21.21</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>3.81</td>
<td>3.70</td>
</tr>
<tr>
<td>Range</td>
<td>11-25</td>
<td>14-25</td>
</tr>
</tbody>
</table>

than that of the comparison group. A variety of religious community contexts, such as synagogue, Jewish community center, Jewish special needs organizations, and the companionship of other Jewish families who may or may not have lived nearby were included in parents’ interview responses. Some mothers and fathers held specific leadership roles, such as a replacement cantor, usher, Hebrew school teacher, or social worker at a Jewish community center. These roles and responsibilities increased their opportunities to build friendships with other young families.

Participants’ responses to three of the five statements demonstrate an interesting pattern of results between the two groups of participants. Engagement in a religious community context failed to provide a welcoming environment for 10% (n = 2) of parents of children with autism. Twenty-five percent (n = 5) of caregivers from this group often felt frustrated because they had to conform to the expectations of their religious community. Furthermore, 30% (n = 6) of these mothers and fathers found it difficult to connect with people in their religious community. On the
other hand, neither of the parents in the comparison group responded similarly to any of the three statements. Table 17 presents both groups of participants’ ratings for each of the five religious community context statements.

**Development of valuable friendships and being part of a welcoming environment.** The religious community context helped parents from both groups of participants to create valuable friendships and belong to a welcoming environment. One Modern Orthodox father of a typically developing child described “a two-way link between their friendships that encourage the religious engagement and religious engagement reinforces the friendships.” These relationships were described as “an extended family.” Many participants mentioned that their own families lived far away, which meant that they celebrated birthdays, holidays, and special events with friends they made in their religious community context. Other community members offered help by providing concrete supports such as assistance with emergency childcare, help to find a new job, support for each other’s businesses, and completion of errands.

Families of children with autism described varying experiences when they attended synagogue services. Two parents were amazed when their rabbi or cantor sat down with their son or daughter after services to sing songs they knew that the child would enjoy. Congregation members also demonstrated a sense of acceptance. For example, they accommodated the child who needed to sit in a certain section of synagogue and were not judgmental when a boy or girl randomly started to dance in the synagogue aisle.

Unfortunately, not all of these mothers and fathers described such a positive experience when attending synagogue services. For one mother, the child’s diagnosis was a distinct point at which other congregants became less welcoming and accepting. She noted, “Before my son had autism, I would say they were super welcoming and now less so. Some people are so nice and so
understanding and then when we get dirty look from people and that feels not welcoming.” This unwelcoming feeling was not only directed toward parents of children with autism. Another female participant mentioned that she had met other caregivers of children with various special needs at her synagogue.

*When you are parenting, it is all the same when your kid doesn’t fit in. Doesn’t matter what the label is. I am able to connect with them, but like I said, it is more of the disappointment of your kid not fitting in. Someone else can understand your feelings. Know what you are going through.*

**Conforming to expectations.** Mothers and fathers of children with autism discussed their feelings about the various religious and non-religious expectations from members of their community. One Modern Orthodox male described this ritual of following a specific modest dress code as being “primarily about conformity not about individuality and not about sincerity.” Another father from the same religious group discussed his feeling that he had to be observant; therefore completing rituals for “appearance’s sake."

**Parents (n = 7)** also discussed nonreligious expectations, such as their child behaving in a particular manner. One couple described in detail that they felt as though others judged them when they had to restrain their child during synagogue services. They were trained to respond to their son’s outbursts and therefore wished that others would be more supportive. The mother also noted,

*If my child had a physical illness, there would be a lot of people asking if I needed to talk, hey, ‘can I help in this way or that way’. But when your child is perceived as a having a mental illness, which is an organic issue, people scurry away. I should not be judged, deemed to be a lazy parent or have a bratty kid.*

Feelings of conformity may have based on a parent’s own insecurities as a mother discussed her belief that “conformity is coming from me.”
Table 17

Percentage of Study 2 Participants’ Responses to Religious Community Context Statement Categorized by Child’s Diagnosis

<table>
<thead>
<tr>
<th>Religious Community Context Statements</th>
<th>Autism (n = 20)</th>
<th>Typical (n = 14)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engaging in our religious community has allowed my spouse and I to make many valuable friendships.</td>
<td>60 Strongly Disagree/Disagree, 25 Neutral, 15 Strongly Agree/Agree</td>
<td>78.6 Strongly Disagree/Disagree, 7.1 Neutral, 14.2 Strongly Agree/Agree</td>
</tr>
<tr>
<td>Engaging in our religious community has provided my spouse and I with a welcoming environment.</td>
<td>60 Strongly Disagree/Disagree, 30 Neutral, 10 Strongly Agree/Agree</td>
<td>78.6 Strongly Disagree/Disagree, 21.4 Neutral, 0 Strongly Agree/Agree</td>
</tr>
<tr>
<td>My spouse and I are often frustrated because we feel as though we have to conform to the expectations of our religious community.</td>
<td>25 Strongly Disagree/Disagree, 40 Neutral, 35 Strongly Agree/Agree</td>
<td>0 Strongly Disagree/Disagree, 21.4 Neutral, 78.6 Strongly Agree/Agree</td>
</tr>
<tr>
<td>My spouse and I have nothing in common with people in our religious community besides our religious background.</td>
<td>10 Strongly Disagree/Disagree, 45 Neutral, 45 Strongly Agree/Agree</td>
<td>7.1 Strongly Disagree/Disagree, 7.1 Neutral, 86 Strongly Agree/Agree</td>
</tr>
<tr>
<td>My spouse and I find it hard to connect with people in our religious community.</td>
<td>30 Strongly Disagree/Disagree, 10 Neutral, 60 Strongly Agree/Agree</td>
<td>0 Strongly Disagree/Disagree, 21.4 Neutral, 78.6 Strongly Agree/Agree</td>
</tr>
</tbody>
</table>
Hard to connect but parents try to find commonality with other caregivers. Parents of children with and without autism discussed the similarities and differences they had with other families in their religious community context. They shared basic commonalities, such as being young Jewish families living in the same community and following the same religious laws, beliefs, and values. In addition, their children tended to be of a similar age and attended the same schools. A father of a typically developing child mentioned “parents of young kids relate to each other whether or not they have stuff in common.”

Mothers and fathers of children with autism noted that although they faced various challenges related to their child’s diagnosis, they could always try to find something in common with another family. A female participant said,

*I have plenty of things in common with them. One of the things that I don’t share is having to raise a child with special needs. . . . I think there are plenty of other things that we find to connect with people in our community. It is just that there are other things that make it difficult to make long lasting meaningful connections.*

Some of the participants’ friendships started prior to their child’s diagnosis. Events and support groups hosted by Jewish special needs organizations allowed families to meet other parents and to share experiences and emotions related to their child’s not fitting in with the rest of society.

When socializing with other families in their religious community, mothers (n = 2) experienced many child-related obstacles. One female participant talked about the influence of her son’s obsessions and routines on her ability to spend time with her friends.

*His behaviors don’t allow the flexibility to suggest to others, “Hey, let’s meet up at the park and do this, that or the other thing.” Then there are the extreme meltdowns. It is really hard to have a conversation when you are being kicked and making a hasty exit out the front door. We don’t really get to relax 100%. We are sort of always waiting for it either to get too loud or get too quiet. Other parents can chillax at the table a little more than we can.*
Another mother also talked about how she always had to focus on her child. “I don’t have the luxury of parents of typically developing kids. When they can go to the playground and sit back and watch their kid plays and just completely ignore them.”

**Religious beliefs, rituals practices, and community context influencing parenting.** Mothers and fathers discussed how their religious beliefs, ritual practices, and community context influenced the way they raised their children. Aspects of parenting that participants most often mentioned included: (a) seeking instrumental and social support for parenting challenges and (b) providing their children with religious experiences. The following measures were included in this section: (a) responses from 3 of the 7 statements completed by parents and (b) the COPE Seeking Instrumental Support subscale. All of participants’ answer choices are supplemented with applicable segments of their interview responses.

**The search for instrumental and social support for parenting challenges.** This section includes information about the religious dimension participants selected most often to complete statements presented to them. Thirty percent of mothers and fathers of children with autism perceived their religious beliefs as providing them with strength, support, belonging, guidance, and comfort when faced with challenges related to parenting. More than one-third of the comparison group believed that their religious community context assisted them in the same way. Table 18 provides quantitative information about participants’ responses to the fill-in-the-blank statement responses.

The Coping Orientations to Problem Experienced (COPE) Seeking Instrumental Support subscale refers to the frequency with which participants’ talked to other individuals about similar, challenging experiences and exchanged concrete solutions. Table 19 shows that parents of children with autism were slightly less likely than the comparison group to discuss and seek
Table 18

*Percentage of Study 2 Participants’ Fill-in-the-Blank Statement Responses Categorized by Child’s Diagnosis*

<table>
<thead>
<tr>
<th>Fill-in-the-Blank Statement</th>
<th>Autism (n = 20)</th>
<th>Typical (n = 14)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Beliefs</td>
<td>Rituals Practices</td>
</tr>
<tr>
<td>When faced with challenges related to parenting, I find that my ___provides me with strength, support, belonging, guidance, and comfort.</td>
<td>30</td>
<td>15</td>
</tr>
<tr>
<td>___is a resource that helps me cope with stressors and challenges related to parenting.</td>
<td>25</td>
<td>15</td>
</tr>
<tr>
<td>___helps me to accept challenging life situations while knowing that there are many factors I cannot control play a role on my life such as available resources and general coping ability.</td>
<td>45</td>
<td>25</td>
</tr>
</tbody>
</table>
advice from others. Synagogues and Jewish community centers offered parenting programs for many families of typically developing children and the opportunity to connect with other caregivers. In contrast, parents of children with autism exchanged ideas with other mothers and fathers they met at Jewish special needs organization’s support groups and events, synagogue, and online forums.

Table 19

_Distribution of Study 2 Participants’ Coping Orientations to Problem Experienced (COPE) Seeking Instrumental Support Subscale Scores Responses Categorized by Child’s Diagnosis_

<table>
<thead>
<tr>
<th>Distribution of Data</th>
<th>Autism (n = 20)</th>
<th>Typical (n =14)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average score</td>
<td>7.85</td>
<td>8.43</td>
</tr>
<tr>
<td>Standard deviation</td>
<td>2.66</td>
<td>2.28</td>
</tr>
<tr>
<td>Range</td>
<td>2-11</td>
<td>4-11</td>
</tr>
</tbody>
</table>

_Mothers of children with autism start social support groups. Three mothers organized_ their own social support group. They hoped that in a small group, parents would be “more comfortable speaking and really getting out what they need.” They believed that it was important for everyone to share their experiences, educate each other about possible treatments, and develop an environment in which they could socialize with other caregivers. A havera, social group organized within a synagogue, was started by another mother to “do things that parents of autistic children would like to do. For example, sit on a bench and watch their kids run around in circles.”
Mothers of children with autism supporting other parents of children with autism. Four female participants often felt the need to help other parents.

When I do see a mom with a young child with autism, I try to get her email. I try to mentor her. The new ones. Give them ideas and tell them what they need to do. No need for anybody to reinvent the wheel.

Earlier, this mother mentioned that she was not active in the community because of her son’s therapy schedule and her feeling that she “did not fit in” with other congregants. However, her religious beliefs were strong and taught her the importance of “paying it forward” and helping to educate other parents about autism and available resources for their children. In addition, assisting other parents improved another mother’s sense of self-confidence. These experiences made her realize the extent to which she had helped her daughter and “say, well, there are people that we can help so maybe it won’t be as hard for them. Other people did that for me and I definitely see that as a very Jewish way.”

Parents providing children with religious experiences. All parents of typically developing children mentioned that the frequency with which they completed religious activities had either increased or stayed the same since their children were born. Those who were raised in a religious environment continued to maintain their observant lifestyle as an adult. Other parents felt that prior to having children, ritual practices seemed like obligations and community events were perceived as not important. As mothers or fathers, they believed it was their duty to provide their children with positive and meaningful experiences and to expose them to rituals and Jewish communal events. A few families had even developed new traditions and synagogue routines in hopes that their child would become excited about attending services. Provision of his children with various Jewish opportunities allowed one father to “experience the religion and values through their eyes as they go through it the first time.”
In contrast, parents of children with autism presented very different experiences as they discussed their attempts to incorporate Judaism into their family life. Some mothers and fathers noted that their child’s therapy sessions were often scheduled on Friday night or Saturday morning, therefore conflicting with synagogue services. In addition, parents did not attend services for a number of other reasons, such as their synagogue’s being over-stimulating for their child, not wanting to answer congregants’ questions, or encountering “dirty looks” because of their son or daughter’s disruptive behavior. One couple mentioned that their son with autism had an unpredictable sleep schedule and often ran away in the middle of the night. They decided that to manage daily life, the husband and wife needed to reassess their family’s priorities. Therefore, the couple chose to decrease their synagogue attendance.

Although families of a child with autism may not have been able to participate fully in their religious community, many tried to maintain a Jewish home by performing some or all rituals. One Modern Orthodox mother discussed that she kept her son busy with therapy sessions or by allowing him to use their computer. However, she was stressed because the family was unable to touch electricity or schedule therapy sessions on the Sabbath and holidays. Therefore, this religious restriction meant that she needed always to have activities planned for her son.

Families lighting Shabbat and holiday candles. More than 50% (n = 7) of households that included a child with autism responded that they sometimes light candles on Shabbat and holidays. A similar percentage (n = 4) of the comparison group completed the same ritual every Shabbat and holiday. Table 20 provides the frequency of households that light ritual candles throughout the year. Mothers of typically developing children discussed the importance of their lighting Shabbat candles. This ritual connected them to previous generations and structured their week. They appreciated the opportunity to complete such a meaningful experience with their son.
or daughter because it reminded the parents of lighting candles during their own childhoods. In addition, the women felt a sense of belonging in knowing that on that day, other Jewish families were engaging in the same ritual.

Table 20

*Frequency of Study 2 Households that Light Shabbat and Holiday Candles Categorized by Child’s Diagnosis*

<table>
<thead>
<tr>
<th>Frequency of Lighting Shabbat and Holiday Candles</th>
<th>Autism (n = 12)</th>
<th>Typical (n = 7)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Every Shabbat and Holiday</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Sometimes on Shabbat and Holidays</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Sometimes on Shabbat</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Holidays only</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Not all participants who were interested in lighting candles on Shabbat and holidays were able to complete this ritual practice. Four mothers of children with autism noted that they were unable to perform this ritual because they believed it was “too dangerous.” They feared that their child would “play with it, blow it out, touch it, or throw things at it.” A few families had found a way to make necessary adjustments. They would light candles, say the blessing, and then the child with autism would blow out the flame.

*Ritual of Passover Seders.* Mothers and fathers of typically developing children portrayed Passover as a time to spend with extended family and friends. It was an opportunity to participate in a formalized ritual, the Seder, and for parents to teach their children about Jewish history. Children were also given the exciting responsibility of finding the hidden matzah (*afikonman*).
Participants whose children were diagnosed with autism described various Passover experiences. Four families were unable to attend a Seder at someone else’s home because it was often too crowded and noisy. Extended family and friends also were concerned that the child with autism would damage valuable items in their homes. Instead, families hosted small autism-friendly Seders. One mother described her family’s Passover experience:

*Actually, we make an activity schedule on his whiteboard, which a Seder really lends itself to. The word Seder means order, and there is a nice order for everything, which works well for autism. We write out all parts of the Seder, and I might not have previously written in the middle of a Seder or holidays. But I will check it off as we go because that is helpful for my son.*

Those families who were unable to organize a Seder that was geared to the needs of their child opted to not share the ritual experience with their son or daughter.

**Parental stress, secular and religious coping mechanisms.** Mothers and fathers of children with and without autism faced a variety of parenting challenges. Various religious and secular coping mechanisms helped parents deal with these stressful experiences. The following measures are included in this section: (a) five Parental Stress Scale statements; (b) four Coping Orientations to Problem Experienced (COPE) subscales; and (c) all Jewish Religious Coping Scale (JCOPE) subscales and three chosen statements. All of the parents’ answer choices are supplemented with relevant segments of their interview responses.

Results from an independent samples t-test indicated that mothers of children with autism (M = 46.8, SD = 11.39) received statistically significantly higher mean parental stress scale scores than mothers of typically developing children (M = 36.6, SD = 5.62), t (17) = -2.194, p < .05, η² = .18. There was also a statistically significant difference in the scores of fathers of children with autism (M=45.9, SD=10.08) versus fathers of typically developing children (M=34.3, SD=4.46), t (13) = 4.136, p < .05, η² = .33. These results suggest that child’s diagnosis
can have an effect on parent’s stress level. Specifically, partial eta squared \( (\eta^2) \) predicts that 18% of maternal stress and 33% of paternal stress is associated with their child’s diagnosis. Table 21 includes distribution data for Parental Stress Scale scores.

Table 21

*Distribution of Data for Parental Stress Scale Score Categorized by Parental Gender and Child’s Diagnosis in Study 2*

<table>
<thead>
<tr>
<th>Distribution of Data</th>
<th>Mother Autism (n = 12)</th>
<th>Father Autism (n = 8)</th>
<th>Mother Typical (n = 7)</th>
<th>Father Typical (n = 7)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Score</td>
<td>46.8</td>
<td>45.9</td>
<td>36.6</td>
<td>34.3</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>11.39</td>
<td>10.08</td>
<td>5.62</td>
<td>4.46</td>
</tr>
<tr>
<td>Skewness</td>
<td>1.11</td>
<td>-1.20</td>
<td>-0.68</td>
<td>-0.56</td>
</tr>
<tr>
<td>Standard Error</td>
<td>.64</td>
<td>.75</td>
<td>.79</td>
<td>.79</td>
</tr>
<tr>
<td>Skewness/Standard Error</td>
<td>1.73</td>
<td>-1.60</td>
<td>-0.86</td>
<td>-0.71</td>
</tr>
<tr>
<td>Kurtosis</td>
<td>.419</td>
<td>2.53</td>
<td>-.97</td>
<td>-.73</td>
</tr>
<tr>
<td>Standard Error</td>
<td>1.23</td>
<td>1.48</td>
<td>1.59</td>
<td>1.59</td>
</tr>
<tr>
<td>Kurtosis/Standard Error</td>
<td>0.34</td>
<td>1.71</td>
<td>-0.61</td>
<td>-0.46</td>
</tr>
</tbody>
</table>

When dividing the skewness or kurtosis value by the appropriate standard error, each of the responses was between -1.96 and +1.96. Therefore; the parental stress scale scores can be identified as approximately normally distributed for all participants. This information was also verified by the visual inspection of histograms (Cramer & Howitt, 2004).
Thirty percent (n = 6) of mothers and fathers of children with autism agreed or strongly agreed that they had too few choices and too little control over their lives. A similar number of the same group of participants also felt overwhelmed by the responsibility of being a caregiver and pessimistic about the future. Neither of the parents of typically developing children responded similarly to any of the three statements. These stressful feelings may have been caused by participants’ financial difficulties or their being uncomfortable with their child’s behaviors. Money was a stressor for 65% (n = 13) of parents of children with autism and 50% (n = 7) of the mothers and fathers of typically developing children. About half (n = 9) of the caregivers of children with autism agreed or strongly agreed that they were embarrassed by their child’s behavior. In contrast, only one participant from the comparison group responded similarly.

**Stressors identified by parents of children with autism.** The following section focuses on interview responses of parents of children with autism related to the five selected Parental Stress Scale stressors. Four of the items were chosen because the two groups of parents demonstrated an interesting pattern of responses. Financial stressors related to raising a child with autism has been frequently discussed in the literature (Cassidy et al., 2008; Gray, 2003; Hutton & Caron, 2005; Papageorgiou & Kalyva, 2010; Sharpe & Baker, 2007; Shimabukuro, Grosse, & Rice, 2007); therefore, the last statement referred to this challenge. Parental ratings for these five statements are presented in Table 22. Other challenging factors such as the child’s skill level also are discussed. Participants identified as outliers are highlighted.
### Table 22

**Percentage of Study 2 Parental Responses for Five Selected Parental Stress Scale Statements Categorized by Child’s Diagnosis**

<table>
<thead>
<tr>
<th>Selected Parental Stress Scale Statements</th>
<th>Autism (n = 20)</th>
<th>Typical (n = 14)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly Disagree/Disagree</td>
<td>Neutral</td>
</tr>
<tr>
<td>Having a child(ren) has meant having too few choices and too little control over my life</td>
<td>50</td>
<td>20</td>
</tr>
<tr>
<td>I feel overwhelmed by the responsibility of being a parent</td>
<td>35</td>
<td>35</td>
</tr>
<tr>
<td>The behavior of my child(ren) is often embarrassing or stressful to me</td>
<td>25</td>
<td>30</td>
</tr>
<tr>
<td>Having a child(ren) has been a financial burden</td>
<td>10</td>
<td>25</td>
</tr>
<tr>
<td>Having a child(ren) gives me a more certain and optimistic view of the future</td>
<td>30</td>
<td>15</td>
</tr>
</tbody>
</table>
Feeling overwhelmed and having too few choices and too little control. One couple described the overwhelming feelings of managing their child on a daily basis.

My comment to my wife on more than one occasion has been lots of children will give you an argument about doing something. A lot of children will make it difficult to do step a or b. Every single day we go through with my son is a fight and argument. It doesn’t always end up in a tantrum but it is never a smooth transition. It is never a simple task. It makes every day that you spend with him mentally and physically exhausting.

His wife constantly questioned herself about how she responded to her son’s current and future needs.

All the time, I feel like I don’t know what to do. Like I don’t know how to deal with him on a day to day basis when he is having temper tantrums. Like I said, we are getting training but a lot of times, I have no idea what to do, especially when we are in public. Do I let him have a tantrum and everyone is looking at us or do I get into it so that we can just move on to the next thing? What do we do with him on the weekends when there is unstructured time? There is a day next week when I am going to be home alone with him. What do I do with him? Do I let him sit and watch television and run back and forth and put on the Ipad™ and rock back and forth? When he is engaging in stereotypic behaviors do I let him do that or do fight him on it? How do I get him to do the right things? On a day to day . . . hour to hour when I am with him. When I am not with him, I think about what I should be doing. Do I have him in the right school? Is it okay that I have him going 1.5 hours each way on the bus? If he is sick, should I keep him home from school so that he is resting or is it better for him to be in school so that he can get therapy? What is going to happen to him in the future? How long is he going to have to stay at this school? When can he be in a less restrictive environment? Is he ever going to be in a less restrictive environment? Like everything all the time, I am thinking about it.

Another mother described having limited amounts of choice and power over her family’s social life. For example, she described entertaining guests as challenging because of her child’s special needs. This woman and her husband were trying to search for a family that would be “a good match”:

Some people you can tell they would be okay with whatever my daughter would be doing. For example, they would be okay with us allowing her to watch TV while we all eat dinner because it is just too hard to get her to sit at the table for a long time. It is more work for me, and you know, there are some people who I don’t know if they would be acceptant of that. . . . My son wants to play. He doesn’t necessarily want three girls to come over and play. He might play with one of them. The other girl is going to feel left out because my daughter is not going to play with her. From a social point of view, it needs to be a family that matches well.
A daily task such as grocery shopping was stressful for another female participant as she was unable to predict whether or not her daughter would have “a potential outburst” in public.

**Stressed because of child’s particular skill level.** A child with autism’s behavioral, emotional, communication, and social skills may have influenced parents’ stress levels. Some children are unable to manage their anger and frustration. However, mothers and fathers mentioned that they observed a decrease in these violent behaviors because of factors such as improvements in language, therapy sessions, and their finding specific ways to help children transition from task to task. Participants also were worried about their child’s social skills, ability to make friends, and being bullied. Other social issues that caused concern included the children’s inability to make eye contact, respond to their name, and maintain a conversation.

**Embarrassed by child’s behaviors.** Parents (n = 9) were uncomfortable with their child’s tantrums, phobias, inappropriate personal habits, lack of organization, and inability to maintain proper social cues during conversation. One mother mentioned that she had learned how to manage her son’s tantrums, “I have gotten over my embarrassment. If my son is having a tantrum, I will pick him up and carry him like a football. I don’t deal with that at all anymore.”

**Seven participants** also talked about feeling like other congregants were judging their child’s behaviors. One mother noted, “People are looking because he is stuffing food in his mouth. Some don’t know he has autism and they just think he is a badly behaved boy.” Another father was clearly frustrated by having to explain his daughter’s behaviors.

*There are some days that I can say to people, “Oh she has special needs.” But there are some days that I just don’t feel like explaining it to you. It is just so frustrating when people have an opinion and they express it to you.*

Community members often changed their body language around a child with autism. One female participant wished “they would see what a great kid that he really is. I guess I feel sad that
especially people who are not accepting of him to begin with don’t have had the opportunity to see him in that light.”

**Child-related financial stressors.** Parents worried about their child’s current and future financial status. They discussed their reliance on financial support from extended family, government agencies, and Jewish special needs funding organizations. One mother talked in detail about her fear that her family would go bankrupt because of expenses related to her son’s therapies. Furthermore, she also noted, “No one gets these figures and I am certainly not putting my bank statement on the ground for them to see. You are comparing apples and oranges. Regular expenses and special needs expenses. Two completely different worlds.” Caregivers also worried about how their children would support themselves once they became adults. Mothers and fathers (n = 4) feared that when they died, their typically developing children would be left with the financial burden of the sibling with autism.

**Not optimistic about the future. Some mothers and fathers (n = 9)** were pessimistic about their child’s future. A female participant described how she was determined to cure her son with autism:

*We were just determined to figure out how we could treat this. We thought if there was no cure at the time, it was because people were lazy. They hadn’t done their due diligence or whatever. We didn’t think at the time that this was a life sentence.*

Another couple noted that through the years, the perception of their daughter’s diagnosis and capabilities had changed. The wife stated,

*When she was younger, we were much hopeful of a recovery. But now we are just trying to focus on getting her to her maximum potential. So not that we are less hopeful, but we now acknowledge more that this is who she is. We will always have a special needs kid.*

In addition, her husband mentioned,
Actually for both of us, our concern is that she’s not going to get to a place where she is “better.” I mean we both pretty firmly believe now that’s not going to happen, and the question is to what extent is she going to lead at least somewhat of a normal life.

Other parents were concerned with specific issues such as their child with autism would soon be an adolescent with hormones. One mother talked about wanting to sterilize her daughter but her medical insurance and state regulations would not allow it. She asked, “How do you deal with someone who is like a baby but is going into puberty?” Another father worried about the effect of his son’s possible increase in size on his becoming more aggressive and violent toward others.

**Stressors identified by parents of typically developing children.** Parents of typically developing children described a variety of different child-related stressors. They faced challenges such as convincing their children to brush their teeth, potty training, or maintaining a regular sleep schedule. Furthermore, certain children were at the developmental stage at which they wanted to exert their independence and constantly negotiate everything with adults. Although parents were frustrated by this behavior, they also were proud that their child was able to communicate their wishes and needs. Mothers and fathers were quick to justify any of their typically developing child’s noncompliant behaviors. They emphasized that the child was probably tired, hungry, sick, overstimulated, or still young and therefore throwing tantrums was part of their natural developmental process.

**Stress because of providing child with a Jewish education.** Some parents of children (n = 5) with and without autism were concerned about their children’s future religious development. They felt that if their child was attending a public school, then he or she would be exposed to non-Jewish holidays, such as Christmas and Halloween. One mother of a son with autism described in great detail the challenges she experienced as she tried to find the most
appropriate educational environment for her son. She realized that a Jewish school did not have the resources to educate her son.

I had to sacrificed his Jewish education because I realized at the moment he has to learn one language at least to talk to me, and then I thought I will try everything else later on to bring him back and raise him as a Jewish child. I am now kinda paying a heavy price for that because he is constantly talking about Santa Claus. They taught him about this in public school.

A female participant with a typically developing daughter described her children’s school as “definitely more of a Christian-dominated culture.” She and her husband therefore decided to supplement their children’s public school education by enrolling them in a Hebrew after-school program.

**Secular coping mechanisms identified by both groups of parents.** Both groups of participants described similar secular coping mechanisms they used when they faced parenting concerns, fears, and challenges. For example, parents saved money for their child’s future, read books, researched Web sites, mediated and exercised. The distribution of data for three COPE subscales is presented in Table 23. These particular subscales were chosen because many of the participants’ interviews included recurring themes related to these areas. Therefore, quantitative data were included to supplement the interview responses. Parents of children with autism exhibited a slightly higher average level of alcohol and drug use and denial as a coping mechanism. The comparison group demonstrated higher levels of seeking social support for emotional reasons.
Table 23

_Distribution of Data for Study 2 Parental Responses to Three Coping Orientations to Problem Experienced (COPE) Subscales Categorized by Child’s Diagnosis_

<table>
<thead>
<tr>
<th>COPE Subscale</th>
<th>Autism (n = 20)</th>
<th>Typical (n =14)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Average Score</td>
<td>Standard Deviation</td>
</tr>
<tr>
<td>COPE: Denial</td>
<td>5.35</td>
<td>2.87</td>
</tr>
<tr>
<td>COPE: Alcohol/Drugs</td>
<td>1.30</td>
<td>.57</td>
</tr>
</tbody>
</table>

The following highlights the interview responses of participants with a child with autism who had the highest scores in any of the three subscales and lowest Coping Orientations to Problem Experienced (COPE) Seeking Social Support for Emotional Reasons subscale score.

_Parents of children with autism: Denial._ Some mothers and fathers’ (n = 9) talked about finding it difficult to adjust to their child’s diagnosis. One father mentioned that he thought his son’s special needs were “going to get fixed at some point. I am sort of coming around to the idea that this is not the case.” Another mother believed that she could cure her son’s developmental disability. After a series of unorthodox treatments, she realized that she needed immediately to find an appropriate clinician. Although her son’s behaviors had changed through the years, the mother still felt that she was slightly in denial.

*I am personally probably still in denial because I do not believe that my kid is going to end up in a group home flapping his arms for the rest of his life. I believe there is more out there for him and we will figure it out.*
During the interviews, participants were presented with video tapes of other children with autism interacting with their caregivers. The video tapes changed one mother’s perception of her son’s diagnosis:

*Like I said, always in the back of my mind from the beginning, I was always in denial. Okay, it is autism, but it is the good autism. It is the temporary autism, and it was a slow realization that made me realize, no, it is not. It is real autism. But the little part in the back of my head thinks now that he is in the right school, he is going to snap out of it.*

The tapes helped her realize that her child had special needs and “that this is real.”

*Parents of children with autism: Use of alcohol and drugs.* Drugs helped one mother forget about her child-related challenges. She often smoked marijuana before she went to sleep but soon realized her problems stayed the same. Three fathers sought psychiatric care and prescription antidepressant medication when their child was diagnosed. They hoped this treatment would help them remain “mentally healthy” and strong enough to advocate for their child’s needs.

*Identified religious coping mechanism.* The religious community context was identified as a coping mechanism for both groups of caregivers. Organizations that focused on helping Jewish families of children with special needs provided respite services, parent training resources, support groups, and social events. Participants met other mothers and fathers who had similar child-related stressors and talked about their experiences and exchanged advice. In addition, parents of older children with autism offered potential insight into the future of their child’s developmental disability. Meeting other families at synagogue services provided members of the comparison group with parenting resources to help with child-related challenges. This context was perceived as an environment that allowed caregivers to support each other by exchanging advice and ideas.
The extent to which parents use religion as a coping mechanism was quantitatively measured using the Coping Orientations to Problem Experienced (COPE) Turning to Religion subscale and the Jewish Religious Coping Scale (JCOPE) survey. As shown in Table 24, mothers and fathers of typically developing children exhibited a slightly higher score for the COPE Turning to Religion subscale. Mothers and fathers of children with autism, however, exhibited higher scores on the JCOPE positive and JCOPE negative subscales. The distribution of data for two JCOPE subscales and JCOPE total is presented in Table 25.

Table 24

*Distribution of Data for Study 2 Parental Responses to Coping Orientations to Problem Experienced (COPE) Turning to Religion Subscale Categorized by Child’s Diagnosis*

<table>
<thead>
<tr>
<th>Distribution of Data</th>
<th>Autism (n = 20)</th>
<th>Typical (n = 14)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Score</td>
<td>7.75</td>
<td>8.43</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>3.16</td>
<td>3.74</td>
</tr>
<tr>
<td>Range</td>
<td>4-15</td>
<td>4-16</td>
</tr>
</tbody>
</table>

Table 25

*Distribution of Data for Study 2 Parental Responses to Jewish Religious Coping Scale (JCOPE) Subscales Categorized by Child’s Diagnosis*

<table>
<thead>
<tr>
<th>JCOPE Subscale</th>
<th>Autism (n = 20)</th>
<th>Typical (n =14)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Score</td>
<td>Standard Deviation</td>
<td>Range</td>
</tr>
<tr>
<td>JCOPE Positive</td>
<td>10.80</td>
<td>3.17</td>
</tr>
<tr>
<td>JCOPE Negative</td>
<td>39.55</td>
<td>8.56</td>
</tr>
<tr>
<td>JCOPE Total</td>
<td>50.35</td>
<td>9.65</td>
</tr>
</tbody>
</table>
Parents of children with autism: Relationship with G-d. The belief in G-d helped mothers and fathers of children with autism cope with their child’s diagnosis and to feel as though they were not alone. One female participant stated that G-d “was watching over me and making sure that I am okay. Allows me to live that happy life even though I have challenges.” The diagnosis also was perceived as a particular plan from G-d; however, one father believed he had to “accept it and deal with it. I don’t ask the reason.” Another mother thought that G-d was using her son’s special needs to try and teach her and her husband the importance of “patience and unconditional love.”

Other participants demonstrated a different relationship with G-d. They believed that it was ineffective to think that G-d or a higher power would solve a particular situation. Any child-related stressor would only be alleviated by mothers and fathers who remained proactive in helping their son or daughter. A female caregiver noted, “I don’t ask G-d for things. I am not praying to G-d to stop this or anything like that because it is not what I believe. I think it is more just talking to the doctors.” When faced with a challenging situation, one father mentioned that he did not relate to G-d because of practical reasons, “You have woken up in a puddle of urine that anyone of three children could have inflicted on you. At that point my relationship with G-d or Judaism is not going to help.”

Some of the statements on the JCOPE referred to participants’ relationship with G-d. Three specific JCOPE items were examined. These statements demonstrated a noteworthy pattern of results between the two groups of participants. Parents with a diagnosed child stated that they always or most of the time got mad at G-d (n = 3), argued with G-d (n = 2), or wondered whether G-d cared about them (n = 4). Neither of the parents in the comparison group
responded similarly to any of the three items. Table 26 provides further information about parents’ responses to three highlighted JCOPE statements.

Table 26

*Percentage of Study 2 Parental Ratings for Three Jewish Religious Coping Scale (JCOPE) Statements Categorized by Child’s Diagnosis*

<table>
<thead>
<tr>
<th>JCOPE Statement</th>
<th>Autism (n = 20)</th>
<th>Typical (n = 14)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Never, Hardly Ever, Sometimes</td>
<td>Most of the time, Always</td>
</tr>
<tr>
<td>I get mad at G-d</td>
<td>85</td>
<td>15</td>
</tr>
<tr>
<td>I argue with G-d</td>
<td>90</td>
<td>10</td>
</tr>
<tr>
<td>I wonder whether G-d cares about me</td>
<td>80</td>
<td>20</td>
</tr>
</tbody>
</table>

The interview responses of parents of children with autism, who negatively responded to these JCOPE statements, were examined. One of the participants who noted that she was mad at G-d was a mother who mentioned in her interview that she did not perceive him as “somebody that I can turn to.” One father thought about his own upbringing and discussed his being the perfect child, yet one of his sons died and another was diagnosed with autism. He may have argued with G-d as he did not understand how his young brother caused trouble yet later had a typically developing daughter. Another father wondered whether G-d cared about him. These
thoughts may have been resulted from his child’s diagnosis and other discussed life challenges, therefore causing him to become “less spiritual and less of a believer.”

Parents’ Interpretation of Child’s Diagnosis Inspired by Religious Beliefs, Ritual Practices, and Community Context

Mothers and fathers of children with autism were asked during the Reaction to Diagnosis Interview, “Parents sometimes wonder or have ideas about why they have a child with special needs, do you ever wonder anything like that?” Their responses were organized into the following four categories: (a) religious-based; (b) medical/environmental; (b) wondering and confused; and (d) focused on helping their child. Participants’ responses may have aligned with one or more groups.

Religious-based reasons. A total of four mothers and fathers mentioned religious reasons for their child’s diagnosis. Two mothers discussed the belief that given their previous failed pregnancies, G-d had chosen them to be the caregiver of a child with autism.

My initial answer is that is because G-d wanted me to have a kid with autism. I don’t understand why He wanted me to have a kid with autism, but He wanted me to have a kid with autism. Everything is for a reason, and I believe that this is who I am supposed to be. I am supposed to be a mother of a kid with autism.

Another female participant mentioned that she questioned her religious faith; however, she believed that the diagnosis had not influenced the extent to which her family completed ritual practices. Her husband said that he perceived the diagnosis as a punishment from G-d, yet was unsure why he was being punished.

Medical and environmental reasons. Not all parents felt that there was any merit to a religious-based interpretation. Nine parents discussed different possible medical and environmental reasons for their child’s autism diagnosis. A female caregiver emphasized the extent to which she believed that autism is caused by environmental factors:
I believe autism was created by man. We screwed up something along the way. What is it? I don’t know. Maybe we have too many cell towers? I don’t know, but I definitely don’t think this came from G-d. The only negative part is when someone is telling me this is through G-d. Because that, I won’t believe.

Mothers and fathers suggested many possible medical reasons that they thought their child was diagnosed with autism. Examples include inadequate prenatal care, medications mothers took during their pregnancy, the child’s being born prematurely, damage to the baby’s brain during birth, and the child’s immunization shots. Parents also stated genetic causes for their child’s special needs, such as “old sperm and eggs” or recognized adults in their extended family who they believed should have been diagnosed with a developmental disability.

Environmental factors were also identified by participants as another possible cause of their child’s diagnosis. One mother noted that she was supposed to have had twins, but one of her babies died. The woman had read that the toxicity of the dead fetus may cause the surviving baby to be later diagnosed with a developmental or physical disability. Therefore, she believed her son’s prenatal environment had caused his diagnosis. In addition, the child’s early years were believed to perhaps have influenced the onset of autism. Many participants thought that the child’s main caregiver may have shaped an inadequate setting where the child was constantly spoiled, under stimulated, never frustrated, and never forced to communicate his or her needs.

Wondering and confused. Although some parents could clearly identify and interpret what they thought was the cause of their child’s special needs, other caregivers (n = 4) exhibited confusion and posed numerous questions. A father stated that during his religious education and upbringing, he learned that any sinful behavior would be immediately punished. His raising a child with autism and being exposed to the special needs community had made him question the validity of this lesson. He states,

I am sure there are plenty of people who don’t have disabled kids and have sinned just as much. Or there were people pure as snow and never sinned a day in their life and they
are afflicted with numerous disabled kids. What did they do wrong? It is a very, very unproductive and dangerous road to go down. The alternative is G-d works in mysterious ways and we have no idea.

When his son was diagnosed, he sought the assistance of a rabbi. The rabbi told him, “I have no idea what G-d wants from you.” The male participant noted that this answer was honest and comforting because it confirmed his belief that people are not necessarily punished nor rewarded for their behavior. He also talked about the importance of religious community leaders and members supporting and helping to reassure parents that they did nothing to deserve their child’s diagnosis.

Interpersonal relationships within the community context made one couple wonder about the possible causes of their daughter’s diagnosis. Other congregants had told them that “G-d gives special children to special people.” Although the husband believed there was some merit to this reasoning, he also wondered whether there was anything the couple could have done differently to prevent their child’s developmental disability. His wife did not think that there was much value to this explanation, which resulted in her ongoing search for the hidden lesson behind their child’s diagnosis.

**Focused on helping their child.** Not all participants focused on identifying the possible cause of their child’s diagnosis. Three females discussed that they believed it was instead more important to provide for their child’s needs. One mother specifically mentioned that when her son was diagnosed at three and a half years of age, she was “in denial, shock, and grief all at the same time.” Upon hearing of the diagnosis, a woman in her community advised her to focus on helping her son because his brain would develop until age five. This advice “set the tone for me not to grieve too long. . . . I think this woman just pulled me out of it. She said stop it. You have to do something.” The mother then decided to concentrate on taking immediate action to help her
son and to teach other parents of children with autism the importance of not denying their child’s developmental disability.

**Summary of Results**

Findings from study 1 were further examined by comparing Jewish parents of children with and without autism perceptions of their religiosity. All parents identified the religious dimension they believed most influenced aspects of their daily life, coping, and parenting. Participants’ explanations of their choices identified different themes; however distinct similarities and differences could not be identified because of a small sample size.

Parents of children with autism’s total community scores were lower than those of the comparison group. These lower scores demonstrated a less positive perception of their community. Both groups of parents described their community as a context where they exchanged parenting suggestions with other mothers and fathers. Mothers of children with autism were inspired to start social support groups or offer advice to parents with newly diagnosed children. Both groups also mentioned wanting to provide their child with religious experiences within their community; however it may have been more difficult for parents of children with autism because of scheduling conflicts with different therapy sessions.

Parents of children with autism demonstrated statistically significant higher parental stress scale scores than parents of typically developing children. Eighteen percent of maternal stress and 33% of paternal stress was associated with their child’s diagnosis. Thirty percent of parents of children with autism felt they had too few choices and too little control over life, overwhelmed by the responsibility of being a parent, or did not believe having children gave them an optimistic view of future. Neither of the comparison group responded similarly to any of the three statements. A variety of non–religious mechanisms such as saving money and reading
books were used to cope with the challenges of raising children with and without a diagnosis. Parents of children with autism presented slightly higher JCOPE scores than the comparison group who scored higher on the COPE Turning to Religion subscale. A child’s diagnosis may have influenced parents’ to get mad at G-d, argue with G-d, or wonder whether G-d cared about them. Participants from this group mentioned four different themes when interpreting their child’s diagnosis: (1) religious-based reasons; (2) medical and environmental reasons; (3) wondering and confused; or (4) focused on help their child.

Discussion

Study 2 explored the multidimensional aspects of religious experience for Jewish parents of children with and without autism. A multi-method design was utilized to examine the interrelationships among religious beliefs, ritual practices, community context, daily life, parenting, and coping processes for a unique religious population: Jewish mothers and fathers. A child with a disability or illness exhibits varying symptoms and behaviors that may influence their parents’ stress levels. Therefore, study 2 focused on parents of children with only one developmental disability: autism.

The study examined the influence of religious beliefs, ritual practices, and community context on how participants experienced G-d, organized their life, found meaning in daily experiences, and connected to their history and identity. Five patterns of findings from both groups of participants were revealed: (a) Religious beliefs influenced the ritual practices they completed and the extent to which they participated in their community context; (b) Religious community was a place to learn various Jewish beliefs and perform ritual practices; (c) Performances of ritual practices and engagement in a community context were some families’ main priorities because they wanted to provide their child with a Jewish cultural experience;
(d) Because of certain limitations, the family was unable to perform religious ritual practices or participate frequently in their community; therefore, their religious beliefs mainly inspired their life; and (e) an aspect of secular life was more influential than one or more of the three religious dimensions.

When specifically focused on the influence of the religious community context, results demonstrated that Jewish parents of typically developing children attained slightly higher total scores than Jewish mothers and fathers of children with autism. These trends demonstrated that parents of children without a diagnosis may have a more positive view and perception of their religious community. Patterns of results show that compared to mothers and fathers of children with autism, the comparison group seemed to feel: (a) more welcomed; (b) that they did not have to conform; and (c) that they were able to connect with others. During the interviews, parents of children with autism described mixed feelings toward how other families in their community viewed their son or daughter. Results aligned with previous research, which noted that the parents’ house of worship attendance changed because of their child’s autism diagnosis (Coulthard & Fitzgerald, 1999; Tarakeshwar & Pargament, 2001). In addition, churches and religious communities do not always provide families with the support they need, causing parents to feel isolated, abandoned, and alone (Poston & Turnbull, 2004; Tarakeshwar & Pargament, 2001).

Parents of children with autism also noted that they bonded with other families they met at events hosted by Jewish special needs organizations. These friendships provided parents with social support and allowed them to share advice with other mothers and fathers who had similar experiences. Hutton and Carron (2005) noted that parents viewed social support groups as possible methods of social interaction because these groups allow them to develop relationships
with other families who were experiencing similar situations. Both groups of participants in this study mentioned that they had sought caregiving advice from other mothers and fathers; however, parents of children with autism demonstrated slightly lower scores on the COPE Seeking Instrumental and Social Support subscale. They may have felt that because everyone did not share the same experiences parenting a child with autism, there was limited opportunity to seek support from others. Some mothers of children with autism started small support groups within their religious community or were inspired by their religious beliefs to help educate other caregivers who face similar challenges. These results demonstrate how the religious community can be a possible supportive resource for parents of children with autism.

Parents of typically developing children noted that they believed it was their duty to provide their children with positive and meaningful Jewish experiences and exposure to communal events. Parents’ synagogue attendance and religious beliefs were often based on whether or not they had young children (Becker & Hofmeister, 2001; Mackey & O’Brien, 2005; Petts, 2007). In contrast, mothers and fathers of children with autism had some difficulty in maintaining Jewish experiences because of issues related to their child’s diagnosis. For example, therapy sessions were often scheduled during the Sabbath or families felt it was too dangerous to complete the ritual practice of lighting Sabbath or holiday candles. To socialize with friends and family during the holidays was also difficult because of their child’s disruptive behaviors. Cassidy et. al., (2008) also highlighted parents of children with autism can be uncomfortable when they bring their son or daughter to their friends’ and families’ homes.

Participants also mentioned the influence of their child’s diagnosis on their social experiences. For example, some mothers and fathers felt uncomfortable attending community events because of their child’s behaviors and inflexibility. They were searching for other families
with whom to spend time in their own homes. These individuals would have to be understanding and sensitive to their child’s special needs. A child with autism has a history of influencing families’ social relationships and ability to develop plans (Cassidy et al., 2008; Dabrowska & Pisula, 2010; Gray, 2003; Hutton & Caron, 2005; Luong et al., 2009; Sanders & Morgan, 1997).

Earlier research also identified mothers of children with autism as having the highest stress rate (Dabrowska & Pisula, 2010; Eisenhower et al., 2005; Sanders & Morgan, 1997). Parents of children with autism in this research study presented the highest parental stress scores, therefore demonstrating more stress than the comparison group. Results of the present study also showed that parents of children with autism are stressed by many different issues, such as their child’s and family’s financial future. These findings align with Shimabukuro et al. (2007), who noted that to raise a child with autism is challenging for parents because it is estimated to cost 4 to 6 times more than raising a typically developing child.

Parents of children with autism were slightly more likely than mothers and fathers of typically developing children to get mad at G-d, argue with G-d, and wonder whether G-d cared about them. Although some parents thought that their child was a particular lesson from G-d, others believed that it was ineffective to think G-d would take care of everything. Children with special needs can influence their parents’ relationships with G-d in many different ways (Bennett et al., 1995; Dollahite, 2003; Jegatheesan et al., 2010; Poston & Turnbull, 2004; Shaked & Bilu, 2006; Skinner et al., 2001; Tarakeshwar & Pargament, 2001).

Mothers and fathers of children with autism were asked why they believed that they have a child with special needs. Some mothers and fathers believed that the diagnosis was based on a particular medical or environmental reason. A few caregivers only focused on helping their child and did not feel the need to spend time or energy thinking about the cause of the diagnosis.
Religion influenced a few mothers and fathers as they interpreted their son’s or daughter’s developmental disability. These parents believed that they were chosen by G-d for this responsibility or punishment. Those who wondered about the cause of their child’s diagnosis also believed that G-d was possibly involved. Alganthani (2012) reported that a majority of parents believe that their son’s or daughter’s special needs were caused by an evil eye or black magic. These results also demonstrate the role of religious beliefs in influencing how parents interpret their child’s diagnosis of autism. Parents often related their child’s diagnosis to G-d (Bennett et al., 1995; Dollahite, 2003; Poston & Turnbull, 2004; Shaked & Bilu, 2006; Skinner et al., 2001; Weisner et al., 1991) or the laws of genetics, which were developed by G-d (Pollak, 2005).

Study 2 enhances previous literature by exploring the multidimensional role of religious beliefs, ritual practices, and community context on a unique religious group: Jewish mothers and fathers. This study provides some insight into patterns that have emerged from this participant group. It is clear that the religious community context and relationship with G-d was a major coping resource for parents of children with autism. Therefore, further examination of the role of these religious dimensions as a resource for families that face the challenges of a child’s diagnosis is warranted.
Chapter 5: General Discussion and Conclusion

The purpose of both studies was to use a multi-method design that included multidimensional aspects of religion to investigate the inter-relationships among Jewish mothers’ and fathers’ with and without a child with autism’s perceptions of their religious beliefs, ritual practices, and community context on their daily life, parenting, and coping processes. Findings from study 1 helped identify the themes that were most applicable to Jewish mothers and fathers. Study 2 compared the responses of Jewish parents of children with and without autism on these topic areas.

The following section discusses: (1) connection between theoretical perspectives and findings; (2) the studies’ limitations; and (3) future research ideas.

Connection between Theoretical Perspectives and Findings

Mothers and fathers in both studies expressed the perceptions of their religious community context. Rogoff (2003) noted that a person’s development is influenced by his or her community participation. Findings demonstrated the different positive and negative ways participants’ daily life, personal and religious development was influenced by their community. Specifically, both groups of parents in study two discussed seeking advice and guidance from other mothers and fathers in their community. This support helped improve their parenting abilities. In addition, their religious community offered the opportunities to structure their child’s religious development.

According to the circular causality bidirectional model, there is an ongoing cycle of cause and effect between parents and children. This inter-relationship influences the thoughts, feelings, attitudes, and actions of both parties (Bell, 1979; Kuczynski, 2003).
The specific way in which mothers and fathers of children with autism in this study interpreted their child’s special needs may have influenced how they responded to these child-related stressors. Parents’ search for appropriate treatments helped improve their son or daughter’s language abilities and decrease any violent behaviors. This ongoing cycle of cause and effect between parental stress and the behaviors of children with autism may have been influenced by these treatment outcomes. Improvement in children’s behaviors as a result of various therapy sessions may have caused a decrease in parents’ stress levels. Findings from this study demonstrated that only 18% of maternal stress and 33% of paternal stress was associated with their child’s diagnosis. Therefore, research must investigate the other possible factors causing parental stress.

Lazarus and Folkman stress and coping theory (Lazaraus & Folkman, 1984) helped further explain this parent-child cycle of events. Another aspect of this continuous chain is the coping mechanisms mothers and fathers select to handle child-related stressors. These coping methods can positively or negatively influence the way parents perceive and respond to their child’s behaviors. Therefore, it is important to identify the stressors related to the child’s diagnosis and then explore the religious and secular ways caregivers chose to handle these challenges. How do they interpret these stressors? How can religious or non–religious coping mechanisms assist them in reducing the impact of these challenges? Are these chosen coping mechanisms helpful or harmful to parents? This information will help further elucidate the ongoing cause-and-effect cycle between parental stress and behaviors of children with autism.

Pargament (1997) defined religion as “the search for significance related to the sacred” (p. 32). Religion can help individuals deal with stressful events by allowing them to reframe the situation into a positive manner. Conservation of religious significance occurs when people
attempt to protect their religious beliefs, practices, or community context whose significance may be challenged. Transformation of religious significance involves an individual’s deciding to modify an aspect of these three religious dimensions as they search for meaning (Pargament, 1996). This religious coping process is completed within a contextual environment that includes the individual’s beliefs, practices, goals, and values (Pargament & Raiya, 2007).

Participants in study 1 mentioned that when faced with any misfortune and suffering, they hardly questioned their religious ritual practices or religious beliefs. Instead, parents performed more religious practices or were inspired to ask why G-d had placed these obstacles before them. These participants’ found positive meaning in a particular challenge. Parents of children with autism in this study demonstrated higher parental stress rates than mothers and fathers of typically developing children. It is evident that the challenges related to raising their child with special needs structured their environment; therefore influencing how they choose to use religion to cope with challenges. Some parents of children with autism demonstrated perceptions of their community and relationship with G-d that was more negative than the comparison group. Further information describing the strength of the person’s religious beliefs, frequency of completing religious practices, and engagement in religious community, prior to the stressor, would identify: (1) whether participants were specifically engaged in conservation or transformation of religious significance; and (2) if a particular challenge influenced men and women’s religious backgrounds in a positive or negative manner.

Limitations

The first study included a small number of participants yet the sample was still large enough for an analysis of q-sort data (Westwood & Griffiths, 2010). Seven participants did not complete the second and third q sorts, which resulted in a difference in the number of men and
women who completed all three online activities. In addition, the research study did not include in-depth religious, demographic, or socioeconomic status questions. These questions would have allowed thorough examination of any patterns between the participants’ religious background and their q-sort ratings. Participants were asked to rate the q-sort statements on a scale of (-5) extremely unimportant to (5) extremely important. However, the difference between each point on the Likert scale may have been unclear for the participants. Furthermore, they may have found the computerized activity and directions to be difficult and time-consuming. Results demonstrated participants’ positive connections to at least one or more aspects of Judaism. Therefore, it should be noted that the study did not include the perceptions and views of individuals who may not have a strong connection to Judaism.

The second study also included a very small sample size (n = 34), therefore limiting any possible in-depth quantitative analysis. The inclusion of a small sample of fathers (n = 15) helped to begin taking into account male participants’ views, perceptions, and beliefs. Some parents did not complete and return the Vineland Adaptive Behavior Scale; therefore the skill level of only 86% (n = 6) of typically developing children and 67% (n = 12) of boys and girls with autism were presented. In addition, the exact diagnosis of children was not verified by a standard diagnostic measure such as the Autism Diagnostic Observation Schedule. All participants completed the Social Responsiveness (2nd ed.) scale but some parents of children with autism mentioned that a few of the items did not apply to their son or daughter. They felt that their child did not have the particular skill level to function or be included in certain social situations.

Parent stress scale score was assessed by comparing four groups of participants: (1) mothers of children with autism (n = 12); (2) mothers of typically developing children (n = 7); (3) fathers of children with autism (n = 8); (4) fathers of typically developing children
(n = 7). Even though the sample size was small, all three assumptions of an independent t-test were met. The assumption of homogeneity of variance was met because the Levene’s test was not significant; therefore the variance of parental stress scores in the two populations is equal. The assumption of independence was demonstrated because each participant was not related to the scores of other participants in the same group. Husbands and wives’ scores were separated from each other. The assumption of normality was partially met when examining the skewness and kurtosis of the data. These values identified the data as approximately normally distributed for all participants (Cramer & Howitt, 2004).

Child’s diagnosis and parental gender were not used as variables to examine other outcomes such as certain COPE subscales and community total score. Independent t-tests which focused on separating the marital dyads were not significant. Therefore, results were presented as trends that assessed the patterns between all parents of children with autism versus all mothers and fathers of typically developing children. Further research which included a larger sample size should separate the role of parental gender and child’s diagnosis to understand any moderating or mediating effect of these two variables.

Only the Reaction to Diagnosis Interview (RDI) questions was based on an already developed interview protocol. The rest of the interview questions were written by the principal investigator and may not have been accurately worded to portray the topic or area of interest. In addition, although a neutral tone of voice was used when interviewing participants, the researcher may have unknowingly upset a participant. Some of the interview questions addressed sensitive topics; therefore, the P.I. did not want to make participants feel uncomfortable by using too many probing follow-up questions. Some participants may have perceived the online surveys as time-consuming, which may have resulted in their not paying complete attention to each
question. Even though the P.I. consulted with different rabbis to develop the religious
demographic and ritual practice questions, they may have also been flawed or may not have
accurately portrayed the experiences of Jewish families. In addition, men and women may have
interpreted the survey questions differently or felt that a particular statement was unclear.

**Future Research**

Some participants noted that they found comfort in sharing similar religious beliefs, ritual
practices, and community with other individuals in their environmental context. These
connections allowed them to develop friendships and share experiences with other men and
women. Mothers and fathers of children with and without a diagnosis face various parenting
challenges. They may share advice with other mothers and fathers who have faced similar
experiences. In addition, parents are able to connect with other caregivers on the basis of their
religiosity. These connections can be a significant resource as men and women realize that they
are not the only parent who is facing a particular challenge. Furthermore, they also can bond and
develop relationships with other mothers and fathers within the comfort of their shared religious
community, while performing religious practices together or discussing similar religious beliefs.
Therefore, it is important to develop intervention programs that aim to bring families together
and allow them to use their religious beliefs, ritual practices, and community context as a way to
support and guide each other through the experiences associated with raising a child with autism
or another diagnosis.

Some men and women did not have a positive view of their religious community context;
however, their religious beliefs and ritual practices played an important role in the development
of their Jewish identity. The responses of these participants exemplified the importance of the
measurement of religiosity as a multidimensional dynamic variable (Mahoney et al., 1999).
Therefore, to fully understand the influence of religious dimensions on any aspect of a person’s secular life, future research should include numerous questions that address various aspects of a man or woman’s religious background.

A number of parents of children with autism discussed various ritual practices that they were unable to complete because of their child’s diagnosis. Examples of these traditions included lighting Shabbat candles, attending or hosting Passover Seders, and the frequency with which they went to synagogue services. Future research can inquire about the ritual practices in which these participants felt they could not engage because of their child’s diagnosis. Participants also should be asked to discuss their feelings about being unable to complete these identified practices and any outside supports that they believe would help change their circumstances.

Mothers and fathers may be stressed by different aspects of raising a child with autism. For example, mothers are often more responsible for maintaining relationships with doctors and relaying important information to their husbands (Gray, 1993; 2003). In addition, Davis and Carter (2008) noted that maternal stress resulted from the child’s inability to sleep, emotionally regulate, or eating habits; and paternal stress was caused by the child’s behavioral problems. This difference in experience can begin to explain results from this study which identified 18% of maternal stress and 33% of paternal stress to be associated with their child’s diagnosis. This difference in effect size shows that parental gender may have a partial moderating effect on the relationship between child’s diagnosis and parental stress scale scores. Therefore, other research studies must examine factors causing such a variance between mother and father’s stress scores. What other challenges besides child’s diagnosis are stressing fathers and mothers? Further examining the marital dyad and how mothers and fathers divide child care responsibilities may reveal the reasons why parental gender can be a partial moderator. These trends demonstrate the
importance of using larger sample sizes to further examine mothers’ and fathers’ stress levels and the influence of parental gender and child’s diagnosis on other outcome variables such as religious coping.

Participants with children with autism discussed the many challenges related to their child’s diagnosis. For example, these parents are focused on helping their children by managing areas such as their medications, diet plans, or educational treatment programs. Given all of the time and energy these parents spend on maintaining their child’s developmental progress, some mothers and fathers felt that they may not have the ability to focus fully on providing their child with an adequate Jewish experience. Future research should address ways in which clergy and community members can help parents who are managing these stressors related to their child’s diagnosis to provide their son or daughter with adequate religious experiences and knowledge.

Mothers and fathers who face any particular challenge, such as their child’s diagnosis of autism, may use their relationship with G-d as a tool to search for the sacred. Future research should include a larger sample size to examine statistical differences between the two groups and investigate parents’ relationships with G-d before and after their child’s diagnosis or any challenging event. It is also important to control for relevant factors which may influence any possible differences between the two groups. This accumulated information would help further explain participants’ positive and negative coping processes and how a challenging event can influence their relationship with G-d. In addition, the use of a multi-method research design would prevent researchers from speculating why participants chose particular survey answers. A possible multi-method study would involve first collecting quantitative data from a large sample of participants, then using qualitative methods such as interviews to further examine a small portion of the men and women.
Patterns that emerged from the results show that more parents of children with autism than those in the comparison group noted that they perceived their community as not welcoming; they felt frustrated from the pressure to conform and believed it was difficult to connect with others. A follow-up research study to observe how individuals interact within a religious community, such as a synagogue, also would provide further objective insight into the role of this contextual environment. How are families who face particular challenges, such as a child diagnosed with autism, perceived by others? Do the responses of others differ depending on the child’s diagnosis? For example, how does the community respond to a child with autism, who does not present any physical characteristics and may therefore be perceived as poorly behaved boy or girl? In comparison to a child with Down Syndrome or cancer, who does demonstrate physical differences and therefore individuals in the community can clearly identify the reason for the child’s behaviors. Are families actually giving them so-called dirty looks and presenting negative body language or are parents of children with autism misinterpreting the behaviors of other congregants? Gray (1993) speculated that parental gender, child’s functioning level and age may influence parents’ perceived level of stigmatization. Therefore, demographic factors which may influence individual differences in parental viewpoints should also be examined.

Parents of children without special needs should be interviewed about their views of families of individuals with any diagnosis. This research would provide further understanding of these inter-relationships. Participants would discuss why they may or may not feel comfortable around other families who face challenges related to their child’s disability or disease. These parents might benefit from community interventions that educate about autism or other diagnoses. Furthermore, clinicians and religious figures could play a fundamental role in working together to develop these educational interventions and helping to mediate relationships
between families of children with and without special needs. Interviews also should inquire about interventions that would be beneficial for families who face various child-related stressors. For example, participants may find particular social events, community programs, or modifications made to the synagogue helpful in bringing families together and building a strong, welcoming, and accepting environmental context.

Ultimately, the findings from this study and other future research can help to develop community and educational intervention programs. Changes to a synagogue can help create a more inclusive environment for families of children with special needs. However, a synagogue’s religious affiliation can influence the extent to which a rabbi may be able to make specific modifications to the congregation. Therefore, it is important for rabbis and other religious leaders who may face similar restrictions to be educated about personable ways in which they can help to build a compassionate, sensitive, cohesive, and welcoming environmental context where all individuals are accepted and supported regardless of the challenges they face. Other professionals in the Jewish community, such as school directors and teachers, also would benefit from these community programs.

Future research investigating the influence of perceived religiosity on how parents interpret their child’s diagnosis can be utilized by professionals to help support parents during the initial time of diagnosis. Professionals may want to build relationships with clergy members so that together they can support mothers and fathers in their journey to acceptance of their child’s diagnosis and begin to search for the most effective treatments in a time-efficient manner. Clinicians should also be sensitive and knowledgeable about the positive and negative influence of various religions and cultures on patients’ views, perceptions, and behaviors (Alganthani, 2012). Religious figures, such as rabbis, may be able to offer the necessary religious guidance
and support to prevent families from thinking that their child’s diagnosis is their fault. In addition, they also may be able to answer any religious-based questions parents have about the reason that their child has been diagnosed with a particular disability or disease.

Further research should also aim to examine the influence of other unique religions (e.g., Mulism and Hindu) on families of a child with autism or any other diagnosis. A longitudinal or cross-sectional study should be used to examine the influence of time since diagnosis on parents’ interpretations. Do mothers and fathers have the same perceptions of their child’s diagnosis at the time of diagnosis compared to a few months or years later? What are some specific factors that may influence their views? What religious and non-religious supports do they believe would have helped them cope when their child was being diagnosed?

The children referred to in study 2 were either typically developing or diagnosed with either autism or Asperger’s syndrome. Further research should accurately account for the extent to which a child’s behaviors may deviate from the so-called norm. For example, these actions may directly influence the extent to which such children are accepted within their religious community context. In addition to autism, researchers should investigate the influential role of other developmental disorders and medical diagnoses on the strength of parents’ religious beliefs, frequency of performing ritual practices, and the extent to which families participate in their community context. It also might be beneficial to compare parents of children with two different diagnoses to examine the particular ways in which specific child-related stressors can influence the strength of a family’s religiosity. Researchers should remember to include a comparison group to allow for a basic understanding of the influence of the religious affiliation when mothers and fathers are not faced with certain child-related challenges. A multi-method research study with a large sample size would allow in-depth statistical analysis to compare
identified subgroups and use open-ended interview questions to provide further insight into any emerging patterns and findings.

**Conclusion**

Both studies included Jewish mothers and fathers of children with or without autism. The purpose of the inclusion of these specific participants was to examine the views and perceptions of an under-studied population that expressed an interest in one or more aspects of Judaism. Results highlights some themes that are specific to Judaism, and other findings simply exemplify the role of religious beliefs, ritual practices, and community context for parents who were and were not facing the challenges of a child with autism. Study 2 demonstrated how the religious community context can provide guidance and support to help mothers and fathers develop their parenting skills. In addition, a child’s diagnosis may influence parents’ perceptions of their community, relationship with G-d, stress levels, and ability to complete certain ritual practices.

The themes identified in this dissertation can be used by future research to further examine the influence of Judaism on families facing challenges such as raising a child with special needs. In addition, these two studies demonstrated the importance of research taking into consideration the: (1) interplay between different religious dimensions and how each aspect can influence a person or family’s daily life, ability to cope with challenges and development of parenting skills; and (2) effect of extraneous variables such as a family’s functioning level being influenced by their child’s diagnosis of autism. Clinicians and clergy members can then use this research to develop community programs that help families deal with the influence of child related challenges on the strength of their religious beliefs, frequency of religious practices, and involvement in their religious community.
Appendix A. Background Information about Autism and Significance of Diagnosis Point

The process of diagnosing a child with autism often begins with parents contacting their pediatrician with concerns about their child’s behaviors and development. Most children are diagnosed between two and three years old when language delays and behavior difficulties become more apparent. Pediatricians then refer families to other professionals such as neurologists or psychiatrists who specialize in diagnosing autism (Kabot, Masi, & Segal, 2003).

According to Diagnostic and Statistical Manual (DSM) IV, a total of six or more behaviors from three different categories must be presented by a person for him or her to be diagnosed with autism. The three categories are: (1) qualitative impairments in social interaction; (2) qualitative impairments in communication; and (3) restricted repetitive and stereotyped patterns of behavior, interests and activities (DSM IV, 2000). Two of the six behaviors must be related to the person’s social interaction. Examples include avoidance in eye contact, failure to develop peer relationships appropriate to developmental level, or a lack of spontaneous seeking to share enjoyment. At least one of the six behaviors must be related to the person’s communication development. Examples include a delay in, or total lack of, the development of spoken language, marked impairment in the ability to initiate or sustain a conversation with others, or stereotyped and repetitive use of language. A minimum of one of the six behaviors must be related to the person’s repetitive or stereotypic behaviors. Examples include persistent preoccupation with parts of objects, stereotyped or inflexible adherence to specific, nonfunctional routines or rituals (DSM IV, 2000).

DSM IV also states that delays in at least one of the three areas must be prior to age 3 years and cannot be accounted by Rett’s Disorder or Childhood Disintegrative Disorder (DSM IV, 2000). Persons with autism often present symptoms and behaviors related to other disabilities
such as mental retardation, seizures, and fragile X. Any co-morbidity of disabilities can influence the person’s prognosis (Kabot et. al, 2003).

DSM V was published in 2013 by the American Psychiatric Association. This new edition combines four separate diagnoses: (1) autistic disorder; (2) Asperger syndrome; (3) pervasive developmental disorder not-otherwise specified; and (4) childhood disintegrative disorder into one diagnosis: Autism Spectrum disorder. An individual will be further diagnosed according to his or her severity level which is assessed based on how much support he or she may need. In addition, individuals must demonstrate signs and symptoms of autism from early childhood. This change influences clinicians to pay attention to a person’s early developmental history (DSM V, 2013).

The Center for Disease Control and Prevention (2012) conducted a research study at 14 Autism and Developmental Disabilities Monitoring Network (ADDM) community sites throughout the United States of America. Findings showed that the current prevalence rate of autism is one out of every 88 children. It was estimated that one in every 54 boys and 252 girls living in these communities were diagnosed with autism (CDC, 2012).

Johnson and Myers (2007) suggest the reason for a higher rate of autism is a “genetic role in the inheritance of autism…but the reason for the male predominance is not completely understood” (p.1187). Gernsbacher e al., (2005) noted that the recent increase in the number of children diagnosed with autism is due to diagnostic criteria becoming more specific, increased public awareness, and improved research (Gernsbacher et al., 2005). Some of the possible genetic and environmental factors which are associated with the increased risk of having a child with autism include a parent’s age, fetus exposure to environmental teratogens during the prenatal period, birth weight and duration of gestation (Johnson & Myers,
Newborn encephalopathy and the Measles Mumps Rubella (MMR) vaccine are also speculated to cause autism. Children with autism present abnormal brain development. The following are four differences that have been found in research: (1) a reduced number of Purkinje cells in the cerebellum; (2) abnormal maturation in the forebrain limbic system, frontal and temporal lobe; (3) changes in cell size within the Broca’s area of the brain; and (4) brain stem abnormalities (Johnson & Myers, 2007).

There are a variety of different intervention options available for people with autism. Bio-medical treatments aim to lessen the severity of behavioral symptoms. Examples of treatments include vitamins, minerals, gluten-casein free diets, and auditory integration therapy. Other intervention approaches include sensory integration, facilitated communication, applied behavioral analysis; and speech, occupational, physical, play, art, drama, or music therapy. Kabot et al. (2003) reported that there is an agreement in research that effective:

“(a) intervention should be provided at the earliest possible age; (b) intervention must be intensive; (c) parent training and support should be a component of the program; (d) the curriculum should focus on the social and communication domains; (e) instruction should be systematic with individualized goals and objectives; and (f) particular emphasis should be put on teaching for generalization” (p. 30).

Kabot et al. (2003) also noted that choosing and evaluating treatment options can be a very stressful experience for parents of children with autism. Recently there has been an increase in public awareness of autism and online websites claiming that certain treatments can cure the developmental disability. These developments have caused parents of children with autism to face additional stressors compared to parents of children with other developmental disabilities (Kabot et al., 2003).
Appendix B. Q-sort Demographic Questions, Directions, and Items

1) What is your gender? ________male ________female

2) What is your age?______________

3) How many years have you been married? ____________

4) Is this your first marriage? ___________yes ___________no

5) What are the ages and gender of your children?
   First born ___ age [ ] male [ ] female
   Second born ___ age[ ] male [ ] female
   Third born ___ age[ ] male [ ] female
   Fourth born ___ age[ ] male [ ] female

6) What kind of school does your child(ren) attend?
   ________Public day school
   ________Public day school & Hebrew afternoon school
   ________Private day school
   ________Private day school & Hebrew afternoon school
   ________Jewish based school

7) To what extent did you keep kosher during the past six months?
   ________Meat and dairy in the home and outside
   ________Only eat dairy outside
   ________Do not eat seafood, pig products, or mix meat and dairy
   ________I do not keep kosher
   ________Other

8) How often did you go to synagogue during the past six months?
   ________Every day
   ________Once a week
   ________Two to three times a month
   ________Once a month
   ________Holidays
   ________Special events
   ________Holidays and special events
   ________Never
   ________Other

9) How often did you pray at home during the past six months? Please check only one:
   ________Every day
   ________Once a week
   ________Two to three times a month
   ________Once a month
   ________Holidays
   ________Special events
   ________Holidays and special events
   ________Never
   ________Other
Step 1: Please read each statement. Think about your religious beliefs for the last six months. After you have read each statement decide whether you agree or disagree with the statement about your religious beliefs. If you agree put the statement in the “AGREE” category. If you disagree put the statement in the “DISAGREE” category. If you find you cannot agree or disagree you may place the statement in the “UNSURE” category.

Step 2: Now divide the statements into 11 categories so that you can make finer distinctions for each statement to show exactly how much you agree that is like you or not like you. Use the number of categories “1” to “5” to rate the level of agreement for each statement and “-1” and “-5” to show how much you disagree with a statement. If you are somewhat unsure of a statement you can place this statement in the “-1” “0” “1” categories. There are a limited number of statements that be placed in each numerical category. On the screen you will see a limited number of boxes for each of the eleven number categories. For example, for category “-5” you will see one box. This means you can put one statement in this “-5” category, so please place one statement in the box, that you want to rate as “I strongly disagree with this statement”, and so on.

Religious Beliefs

1. Allow me to experience G-d in my day to day life.
2. Provide order and structure to my life.
3. Encourage me to stay married and work out difficulties with my spouse.
4. Provide me with a sense of peace and well-being which allows me to be more connected with my spouse.
5. It is often difficult to follow and fulfill my religious beliefs because of my numerous personal, work, and home obligations.
6. Help me to appreciate the importance of forgiveness but still allow me to accept that some wrong-doings are not forgivable or forgettable.
7. I am still working on trying to figure out my exact religious beliefs.
8. Help me facilitate open communication with others.
9. It is important to me that I set aside time to regularly discuss my religious beliefs with my spouse.
10. Sharing my religious beliefs with my spouse strengthens our marriage.
11. Sharing my religious beliefs with my spouse enhances our sense of marital satisfaction.
12. Keep me in good mental health
13. Are a resource that helps me cope with stressors and challenges
14. Help me to accept challenging life situations while knowing that many factors I cannot control play a role in my life such as available resources and general coping ability.
15. Give me the strength to face and resolve any martial conflict.
16. Allow me to take care of my needs while also providing for the needs of my spouse.
17. Allow me to provide my spouse with unconditional love.
18. Help me to cope even though I know that religion cannot be the answer to every problem.
19. Play an important role in strengthening my marriage but other factors also play a role such as a spouse’s personality and needs.
20. When faced with daily hassles I find that my religious beliefs give me guidance and comfort.
21. Help me to maintain good physical health and quality of life.
22. Help me to accept challenging life situations.
23. Help me to find meaning in life.
24. Misfortunes and suffering cause me to question my religious beliefs.
25. Are constantly changing.
26. Are enhanced by my religious ritual practices.

**Religious Ritual Practices**
1. Allow me to experience G-d in my day to day life.
2. Provide order and structure to my life.
3. Encourage me to stay married and work out difficulties with my spouse.
4. Provide me with a sense of peace and well-being which allows me to be more connected with my spouse.
5. It is often difficult to complete all religious ritual practices because of my numerous personal, work, and home obligations.
6. Help me to appreciate the importance of forgiveness but still allow me to accept that some wrong-doings are not forgivable or forgettable.
7. Help me facilitate open communication with other people.
8. It is important to me that I set aside time to regularly complete religious ritual practices with my spouse.
9. Engaging in religious ritual practices with my spouse strengthens our marriage.
10. Engaging in religious ritual practices with my spouse enhances our sense of marital satisfaction.
11. Keep me in good mental health
12. Help me to have a strong spiritual life.
13. Are a resource that helps me cope with stressors and challenges
14. Help me to accept challenging life situations while knowing that many factors I cannot control play a role in my life such as available resources and general coping ability.
15. Give me the strength to face and resolve martial conflict.
16. Allow me to take care of my needs while also providing for the needs of my spouse.
17. Allow me to provide my spouse with unconditional love.
18. Help me to cope even though I know that religion cannot be the answer to every problem.
19. Play an important role in strengthening my marriage but other factors also play a role such as a spouse’s personality and needs.
20. When faced with daily hassles I find that my religious ritual practices give me guidance and comfort.
21. Help me to maintain good physical health and quality of life.
22. Help me to accept challenging life situations.
23. Enhance my religious beliefs.
24. My spouse and I only engage in the religious ritual practices that have the most meaning to us.
25. Misfortunes and suffering cause me to question my religious ritual practices.
26. Help me to find meaning in life.

**Religious Community Context**
1. Allows me to experience G-d in my day to day life.
2. Provides order and structure to my life.
3. Encourages me to stay married and work out difficulties with my spouse.
4. Provides me with a sense of peace and well-being which allows me to be more connected with my spouse.
5. It is often difficult to be a part of my religious community context because of my numerous personal, work, and home obligations.
6. Helps me to appreciate the importance of forgiveness but still allow me to accept that some wrongdoings are not forgivable or forgettable.
7. It is important to me that I set aside time with my spouse to regularly engage in activities together within our religious community.
8. Engaging in my religious community context with my spouse strengthens our marriage.
9. Engaging in my religious community context with my spouse enhances our sense of marital satisfaction
10. Keeps me in good mental health
11. Is a resource that helps me cope with stressors and challenges
12. Helps me to accept challenging life situations while knowing that many factors I cannot control play a role in my life such as available resources and general coping ability.
13. Gives me the strength to face and resolve any martial conflict.
14. Allows me to take care of my needs while also providing for the needs of my spouse.
15. Allows me to provide my spouse with unconditional love.
16. Plays an important role in strengthening my marriage but other factors also play a role such as a spouse’s personality and needs.
17. When faced with daily hassles I find that my religious community context gives me guidance and comfort.
18. Helps me to maintain good physical health and quality of life.
19. Helps me to accept challenging life situations.
20. Helps me to cope even though I know that religion cannot be the answer to every problem.
21. Teaches me acceptance and making personal sacrifices which are helpful to strengthening my marital relationship.
22. Engaging in our religious community context has allowed my spouse and I to make many valuable friendships.
23. Engaging in our religious community context has provided my spouse and I with a welcoming environment.
24. My spouse and I are often frustrated because we feel as though we have to conform to the expectations of our religious community context.
25. My spouse and I have nothing in common with people in our religious community context besides our religious background.
26. My spouse and I find it hard to connect with people in our religious community context.

**Follow up Questions**

1. Please describe in your own words the role of your Jewish religious beliefs in your daily life.
2. Please describe in your own words the role of your Jewish religious ritual practices in your daily life.
3. Please describe in your own words the role of your Jewish religious community context in your daily life.
4. Please explain why you gave these statements the highest and lowest rankings.
5. Please suggest additional statements describing the importance of religious beliefs in your daily life.
Appendix C. Study Two Survey Measures

DIRECTIONS: Please provide us with the following information. Unless otherwise specified, respond to the questions based on your child who is participating in this evaluation. Thank you.

Today’s Date __________________________

Person completing form (relationship to child)___________________________________________

Child’s Name__________________________

Child’s Date of Birth ________________________________

Child’s Gender _____________________________

A. Neurological:

1. Has your child ever had seizures or convulsions?  
   Yes   No   Don’t know  
   If yes, when? (circle all that apply)  
   First month of life  
   2-12 months  
   13-24 months  
   2-5 years  
   after 5 years

2. Were your child’s seizures ONLY when they had a high fever?  
   Yes   No   Don’t know

3. Has your child ever had a picture of the brain (eg an MRI or CT scan of the head) that you were told was not normal?  
   Yes   No   Don’t know

4. Has your child ever lost consciousness with a head injury?  
   Yes   No   Don’t know

5. Has a medical professional ever told you that your child has cerebral palsy?  
   Yes   No   Don’t know

B. Medications

Has your child taken any medications during the past year?

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Date begin</th>
<th>Date ended</th>
<th>Dosage per day</th>
</tr>
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<tbody>
<tr>
<td></td>
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</tbody>
</table>
### C. Other Disorders

1. Has your child been diagnosed with any of the following disorders?  

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angelman Syndrome</td>
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<tr>
<td>Attention Deficit Hyperactive Disorder</td>
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<tr>
<td>Attention Deficit Disorder</td>
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<tr>
<td>Down Syndrome</td>
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<tr>
<td>Fragile X Syndrome</td>
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<tr>
<td>Neurofibromatosis</td>
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<tr>
<td>Mental retardation</td>
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<tr>
<td>Neuroinflammation and immune disorders</td>
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<td>Nonverbal learning disorder</td>
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<tr>
<td>Motor clumsiness</td>
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<tr>
<td>Obsessive-compulsive disorder</td>
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<tr>
<td>Prader Willi Syndrome</td>
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<tr>
<td>Rett Syndrome</td>
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<tr>
<td>Seizures</td>
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<tr>
<td>Sensory problems</td>
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<tr>
<td>Tourette syndrome</td>
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<tr>
<td>Tuberous Sclerosis</td>
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</tbody>
</table>

### D. Family History

Check if any of your child’s other family members is known to have or has had in the past:

<table>
<thead>
<tr>
<th>Relationship to Child</th>
<th>Autism/PDDNOS/Asperger Syndrome</th>
<th>Mental retardation</th>
<th>Seizures</th>
<th>Tuberous Sclerosis</th>
<th>Speech Delay requiring therapy</th>
<th>Learning Disabilities</th>
<th>Obsessive-Compulsive Disorder</th>
<th>Tics or Tourette Syndrome</th>
<th>Attention Deficit Disorder</th>
<th>Oppositional Defiant/Conduct Disorder</th>
<th>Anxiety or Panic disorder</th>
<th>Depression</th>
<th>Manic Depression or Bipolar Illness</th>
<th>Schizophrenia</th>
<th>A history of being admitted to a hospital for a psychiatric illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
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E. Notes and additional information

Is there any other aspect of your child’s medical history that we did not ask you about today that you think may be important for us to know about?

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Please answer all questions to the best of your ability.

1) What is your date of birth? ________________

2) What is your gender?
   _____ Male
   _____ Female

3) What is your occupation? __________________________

4) What is the best estimate of your yearly total household income (the combined income of everyone living in your house – including any assets such as paychecks, dividends, welfare, social security, and any other money income received by you and any other family member) within the past year?
   _____ Less than $15,000
   _____ $15,000 - $29,999
   _____ $30,000 – $44,999
   _____ $45,000 - $59,999
   _____ $60,000 - $74,999
   _____ $75,000 - $99,999
   _____ More than $100,000
5) Do you receive any financial support from extended family members? (parents, grandparents, sisters, brothers) __________ yes __________ no

6) What is the highest grade in school that you have completed?
   ______ High school diploma
   ______ Associate degree
   ______ Vocational degree
   ______ Bachelor of Arts or Science
   ______ Master’s degree
   ______ Ph.D, J.D., or M.D

7) Do you currently attend school either part-time or full-time?
   ______ Yes (What degree are you completing? ____________________________)
   ______ No

8) Are you currently completing extended training for your graduate work? (Medical Residency, Law Clerkship, Unpaid Internship)?
   ______ Yes (What extended training are you completing? ____________________________)
   ______ No

9) If you are currently in school or completing extending training, do government or bank loans contribute to your yearly total household income?
   __________ yes __________ no

10) How long have you been married? (months & years) ____________________________

11) Beside you, your child, and your spouse, what are the names of all persons living or staying in your household?

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Birth</th>
<th>Gender</th>
<th>Relationship to Child</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>
12) To what extent did you keep kosher during the past year?
   __________ 100% glatt kosher in the home and outside
   __________ Meat and dairy in the home and outside
   __________ Only dairy outside
   __________ Do not eat seafood, pig products, or mix meat and dairy
   __________ I do not keep kosher
   __________ Other (please explain)________________________________________________

13) How often did you go to synagogue during the past year?
   __________ Every day (Every Shabbat & Holidays)
   __________ Sometimes on Shabbat & Holidays
   __________ Only Holidays
   __________ When I feel religious and spiritually inspired
   __________ Never
   __________ Other (please explain)________________________________________________

14) Do you and your spouse follow family purity laws (niddah)(mikvah)?
   __________ Yes
   __________ No

15) Do you have a mezuzah placed on the doorposts of rooms in your home?
   __________ No
   __________ Just the front door of our house or apartment
   __________ Some rooms
   __________ Yes, all rooms

16) In the past year, did you travel during Shabbat?
   ____ No, we only walk to wherever we need to go
   ____ Sometimes, we only drive or take public transportation to Jewish events (synagogue)
   ____ Yes, but we try not to travel long distance on Shabbat via car, airplane, bus or train
   ____ Yes, we travel all the time on Shabbat
   ____ Other (please explain)________________________________________________

17) A) In the past year, did you touch electrical appliances (lights, phone, television, computer, or radio) on Shabbat?
   ____ No, we do not touch any electrical appliances and our home is on a timer
   ____ No, we do not touch any electrical appliances but we leave a light on in one room
   ____ We touch certain electrical appliances on Shabbat (please proceed to 17B & C)
   ____ We touch all electrical appliances on Shabbat.
   ____ Other (please explain)________________________________________________
17) B) If you touch certain electrical appliances on Shabbat, please list the appliances that you WILL touch.

________________________________________________________________________________________
________________________________________________________________________________________

17) C) If you touch certain electrical appliances on Shabbat, please list the appliances that you WILL NOT touch.

________________________________________________________________________________________
________________________________________________________________________________________

18) A) Do you wear a yarmulke? (men)

_____ Yes, daily
_____ Only inside a synagogue on Shabbat, holidays and special events
_____ Never
_____ Other (please explain)

B) Do you cover your hair? (women)

_____ Yes, daily with a scarf or hat
_____ Yes, daily with a wig
_____ Only inside a synagogue on Shabbat, holidays and special events
_____ Never
_____ Other (please explain)

C) Do you wear pants? (women)

_____ Yes, all the time, I do not follow a particular dress code
_____ Yes, but not when inside a synagogue on Shabbat, holidays, and special events
_____ Never
_____ Other (please explain)
19) Within the past year, how often have you completed the following ritual practice? Please respond to the best of your ability. Please circle the most appropriate answer.

1 - Every day
2 – A couple times a week
3 – A couple times a month
4 – Only holidays
5 – When I feel religiously or spiritually inspired
6 - Never
7 - Other (please explain)

a) Said Modeh Ani when waking up and/or said Shema Yisroel before going to sleep

b) Washed hands and said blessing in the morning (Netilat Yadayim)

c) Said blessing before eating any food or drinking any beverage and/or said grace after a meal (Birkat Hamazon)

d) Listened to a religious program online (podcasts), read a Jewish website, book, magazine, or newspaper article about religious topics

e) Attended a religious lecture or class

f) Visited or helped the sick/elderly. Participated in volunteer work

g) Gave money to charity

h) Attended a Jewish or Israeli festival or event (ex: Jewish heritage museum or Israeli Independence Day Parade)
20) Within the past year, how often have you completed the following ritual practices on Shabbat or Holidays? Please respond to the best of your ability. Please circle the most appropriate answer.

1 – Every Shabbat Only
2 – Sometimes on Shabbat
3 - Holidays only
3 – Every Shabbat and Holiday
4 - Sometimes on Shabbat and Holidays
5 - Never
6 – Other (please explain)

a) Said or heard the blessing for Shabbat or Holiday candles

b) Said or heard the blessing over the wine and challah during Shabbat or a holiday

c) Said or heard havdalah after Shabbat

d) Did not bathe using hot water during Shabbat or holiday

e) Did not use money or make any financial transactions during Shabbat or holiday

f) Did not cook – all meals were prepared ahead of time before Shabbat or holiday

g) Did not carry anything on Shabbat or holiday unless there was an eruv
Fill-in the blank with the term that best describes your life within the past year:

(a) My religious beliefs

(b) My religious ritual practices

(c) My religious community

(d) None of the religious dimension, does not apply to my life

21. ____________________________ allows me to experience G-d in my day-to-day life

22. ____________________________ provides order and structure to my life.

23. ____________________________ helps me find meaning in my life.

24. When faced with challenges related to my child’s diagnosis I find that my
   ____________________________ provides me with strength, support, belonging, guidance and comfort.

25. ____________________________ is a resource that helps me cope with stressors and challenges related to my child’s diagnosis.

26. ____________________________ helps me to accept challenging life situations while knowing that many factors I cannot control play a role in my life such as available resources and general coping ability

27. _______________ connects me to my family history, cultural history, and Jewish identity.
Please rate the following statement as it applies to your life within the past year.

1 – Strongly Disagree
2 – Disagree
3 – Neutral
4 – Agree
5 – Strongly Agree

1. Engaging in our religious community has allowed my spouse and I to make many valuable friendships.

2. Engaging in our religious community has provided my spouse and I with a welcoming environment.

3. My spouse and I are often frustrated because we feel as though we have to conform to the expectations of our religious community.

4. My spouse and I have nothing in common with people in our religious community besides our religious background.

5. My spouse and I find it hard to connect with people in our religious community.
Parental Stress Scale (Berry & Jones, 1995)

The following statements describe feelings and perceptions about the experience of being a parent. Think of each of the items in terms of how your relationship with your child or children typically is. Please indicate the degree to which you agree or disagree with the following items by placing the appropriate number in the space provided.

1 – Strongly Disagree
2 – Disagree
3 – Neutral
4 – Agree
5 – Strongly Agree

1. I am happy in my role as a parent. ______________

2. There is little or nothing I wouldn’t do for my child(ren) if it was necessary. ______________

3. Caring for my child(ren) sometimes takes more time and energy than I have to give. __________

4. I sometimes worry whether I am doing enough for my child(ren). __________

5. I feel close to my child(ren). __________

6. I enjoy spending time with my child(ren). __________

7. My child(ren) is an important source of affection for me __________.

8. Having a child(ren) gives me a more certain and optimistic view for the future. __________

9. The major source of stress in my life is my child(ren). __________

10. Having a child(ren) leaves little time and flexibility in my life. ______________

11. Having a child(ren) has been a financial burden. ______________

12. It is difficult to balance different responsibilities because of my child(ren). ______________

13. The behavior of my child(ren) is often embarrassing or stressful to me. __________

14. If I had to do it over again, I might decide not have a child(ren). ______________

15. I feel overwhelmed by the responsibility of being a parent. ______________

16. Having a child(ren) has meaning having too few choices and too little control over my life. _____

17. I am a satisfied as a parent. ______________

18. I find my child(ren) enjoyable. __________
JCOPE
Jewish Religious Coping Scale
(Rosmarin, Pargament, Krumrei, & Flannelly, 2009)

This questionnaire asks about different ways in which you might rely on religion to deal with stress. Choose the number that best describes how often you do the following things when you have a stressful problem. Please circle the number that best represents your experiences within the past year.

a. I ask G-d to forgive me for things I did wrong.

b. I get mad at G-d.

c. I try to be an inspiration to others.

d. I try to see how G-d may be trying to teach me something.

e. I think about what Judaism has to say about how to handle the problem.

f. I do the best I can and know that rest is G-d’s will.

g. I argue with G-d.

h. I look forward to Shabbat.

i. I ask G-d to help me do what I need to do.

j. I talk to my rabbi.

k. I look for a stronger connection with G-d.

l. I look for a sense of spiritual connection with others.

m. I question whether G-d can really do anything

n. I pray for the well-being of others

o. I pray for G-d’s love and care.

p. I wonder if G-d cares about me.

q. I try to do Mitzvot (good deeds)

r. I try to remember that my life is part of a larger spiritual force.

s. I question my religious beliefs, faith, and practices.

1 (never) to 5 (always)
Coping Orientations to Problem Experienced (COPE) Scales
This questionnaire asks about different ways in which you cope with stress. Please choose the answer that best represents your experiences within the past year.

<table>
<thead>
<tr>
<th></th>
<th>I have not been doing this at all.</th>
<th>I have been doing this a lot.</th>
</tr>
</thead>
<tbody>
<tr>
<td>I look for something good in what is happening.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>I try to see it in a different light, to make it seem more positive.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>I learn something from the experience.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>I try to grow as a person as a result of the experience.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>I learn to live with it.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>I accept that this has happened and that it can't be changed.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>I get used to the idea that it happened.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>I accept the reality of the fact that it happened.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>I seek G-d's help.</td>
<td>1 2 3 4</td>
<td></td>
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<tr>
<td>I put my trust in G-d.</td>
<td>1 2 3 4</td>
<td></td>
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<tr>
<td>I try to find comfort in my religion.</td>
<td>1 2 3 4</td>
<td></td>
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<tr>
<td>I pray more than usual</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>I get upset and let my emotions out</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>I let my feelings out.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>I feel a lot of emotional distress and I find myself expressing those feelings a lot.</td>
<td>1 2 3 4</td>
<td></td>
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<tr>
<td>I get upset, and am really aware of it.</td>
<td>1 2 3 4</td>
<td></td>
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<tr>
<td>I take additional action to try to get rid of the problem.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>I concentrate my efforts on doing something about it.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>I do what has to be done, one step at a time.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>Activity</td>
<td>I have not been doing this at all.</td>
<td>I have been doing this a lot.</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>-------------------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>I take direct action to get around the problem.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>I try to come up with a strategy about what to do.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>I make a plan of action.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>I think hard about what steps to take.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>I think about how I might best handle the problem.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>I put aside other activities in order to concentrate on this.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>I focus on dealing with this problem, and if necessary let other things slide a little.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>I keep myself from getting distracted by other thoughts or activities.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>I try hard to prevent other things from interfering with my efforts at dealing with this.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>I force myself to wait for the right time to do something.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>I hold off doing anything about it until the situation permits.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>I make sure not to make matters worse by acting too soon.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>I restrain myself from doing anything too quickly.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>I ask people who have had similar experiences what they did.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>I talk to someone to find out more about the situation.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>I talk to someone who could do something concrete about the problem.</td>
<td>1 2 3 4</td>
<td></td>
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<tr>
<td>I talk to someone about how I feel</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>I try to get emotional support from friends or relatives</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>I discuss my feelings with someone.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>I get sympathy and understanding from someone.</td>
<td>1 2 3 4</td>
<td></td>
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<td>-----------------------------------------------</td>
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<td></td>
</tr>
<tr>
<td>I refuse to believe that it has happened</td>
<td>1 2 3 4</td>
<td></td>
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<tr>
<td>I pretend that it hasn’t really happened</td>
<td>1 2 3 4</td>
<td></td>
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<tr>
<td>I act as though it hasn’t even happened</td>
<td>1 2 3 4</td>
<td></td>
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<tr>
<td>I say to myself “this isn’t real”</td>
<td>1 2 3 4</td>
<td></td>
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<tr>
<td>I give up the attempt to get what I want.</td>
<td>1 2 3 4</td>
<td></td>
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<tr>
<td>I just give up trying to reach my goal</td>
<td>1 2 3 4</td>
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<tr>
<td>I admit to myself that I can’t deal with it, and quit trying.</td>
<td>1 2 3 4</td>
<td></td>
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<tr>
<td>I reduce the amount of effort I’m putting into solving the problem.</td>
<td>1 2 3 4</td>
<td></td>
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<tr>
<td>I turn to work or other substitute activities to take my mind off things</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>I go to movie or watch TV, to think about it less</td>
<td>1 2 3 4</td>
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<tr>
<td>I daydream about things other than this</td>
<td>1 2 3 4</td>
<td></td>
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<tr>
<td>I sleep more than usual</td>
<td>1 2 3 4</td>
<td></td>
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<tr>
<td>I drink alcohol or take drugs, in order to think about it less</td>
<td>1 2 3 4</td>
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</tbody>
</table>
Social Responsiveness Scale (2nd edition) (Constantino & Gruber, 2012)

1) Seems much more fidgety in social situations when alone.
2) Expressions on his or her face don’t match what he or she is saying.
3) Seems self-confident when interacting with others.
4) When under stress, child seems to go on “autopilot” (for example, shows rigid or inflexible patterns of behavior that seem odd).
5) Doesn’t recognize when others are trying to take advantage of him or her.
6) Would rather be alone than with others.
7) Is aware of what others are thinking or feeling.
8) Behaves in ways that seem strange or bizarre.
9) Clings to adults, seems too dependent on them.
10) Unable to pick up on any of the meaning of conversations of older children or adults.
11) Has good self-confidence
12) Is able to communicate his or her feelings to others in words or gestures.
13) Is slow or awkward in turn-taking interactions with peers.
14) Is not well-coordinated in physical activities.
15) Is able to understand the meaning of other people’s tone of voice and facial expressions.
16) Avoids eye contact or has unusual eye contact.
17) Recognizes when something is unfair.
18) When on the playground or in a group with other young children, child does not attempt to interact with other children.
19) Gets frustrated trying to get ideas across in conversations.
20) Has a strange way of playing with a toy.
21) Is able to imitate others’ actions.
22) Plays appropriately with children his or her age.
23) Does not join group activities unless told to do so.
24) Has more difficulty than other children with changes in his or her routine.
25) Doesn’t seem to mind being out of step with or “not on the same wavelength” as others.
26) Offers comfort to others when they are sad.
27) Avoids starting social interactions with peers or adults.
28) Thinks or talks about the same thing over and over.
29) Is regarded by other children as odd or weird.
30) Becomes upset in a situation with lots of things going on.
31) Can’t get his or her mind off something once he or she starts thinking about it.
32) Wants to be changed when diaper or underwear is soiled or wet.
33) Is socially awkward, even when he or she is trying to be polite.
34) Avoids people who want to be emotionally close to him or her.
35) Has trouble keeping up with the flow of normal interaction with other children.
36) Has difficulty relating to adults.
37) Has difficulty relating to peers.
38) Responds appropriately to mood changes in others (For example, when a friend’s or playmate’s mood changes from happy to sad).
39) Has a restricted (or unusually narrow) range of interests.
40) Is imaginative, good at pretending (without losing touch with reality).
41) Wanders aimlessly from one activity to another.
42) Seems overly sensitive to sounds, textures, or smells.
43) Separates easily from caregivers.
44) Doesn’t understand how events are related to one another the way other children his or her age do.
45) Focuses his or her attention to where others are looking or listening.
46) Has overly serious facial expressions.
47) Is too silly or laughs inappropriately.
48) Has a sense of humor, understands jokes.
49) Does extremely well at a few tasks, but does not do as well at most other tasks.
50) Has repetitive, odd behaviors such as hand flapping or rocking.
51) Responds to clear, direct questions in ways that don’t seem to make any sense.
52) Knows when he or she is talking too loud or making too much noise.
53) Talks to people with an unusual tone of voice (for example, talks like a robot or like he or she is giving a lecture).
54) Seems to reach to people as if they are objects.
55) Knows when he or she is too close to someone or is invading someone’s space.
56) Walks in between two people who are talking.
57) Other children do not like to play with him or her.
58) Concentrates too much on parts of things rather than seeing the whole picture. For example, spins the wheels of toy car but doesn’t play with it as a car, or plays with doll’s hair but not with the whole doll.
59) Is overly suspicious.
60) Is emotionally distant, doesn’t show his or her feelings.
61) Is inflexible, has a hard time changing his or her mind.
62) Gives unusual or illogical reasons for doing things.
63) Touches others in an unusual way (for example, he or she may touch someone just to make contact and then walk away without saying anything).
64) Is too tense in social settings.
65) Stares or gazes off into space.

Answer choices**:
(1) Not true
(2) Sometimes true
(3) Often true
(4) Almost always true

**Responses for some statements are reversed when coding.
## Appendix D – Study Two Interview Questions

<table>
<thead>
<tr>
<th>School Term</th>
<th>Name of School</th>
<th>Date began</th>
<th>Date ended</th>
<th>Number of Hours per week</th>
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</thead>
<tbody>
<tr>
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</table>

What programs has your child attended within the past year?

(Regular School Year) vs. (School Break)  (Full Inclusion Classroom, Mainstreamed Classroom, Special Education)

**Does your child(ren) attend:**

- a) Jewish-based school  d) Public day school and Hebrew after-school
- b) Public day school    e) Private day school and Hebrew after-school
- c) Private day school   


What programs has your child attended within the past year?

(Regular School Year) vs. (School Break) (Full Inclusion Classroom, Mainstreamed Classroom, Special Education)

<table>
<thead>
<tr>
<th>Type of Intervention</th>
<th>Date Began</th>
<th>Date Ended</th>
<th>Number of hours received</th>
<th>Intervention done as part of group or individually. (Teacher/Student Ratio for Groups)</th>
<th>Where is the intervention delivered? (Home, School, Clinic)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Intervention Program</td>
<td></td>
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</tr>
<tr>
<td>Behavioral Therapy (ABA, Lovaas, Discrete Trials, Behavior Modification, Adaptive Skill Training)</td>
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<tr>
<td>Occupational Therapy (Sensory Integration)</td>
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<tr>
<td>Physical Therapy</td>
<td></td>
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<td></td>
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<tr>
<td>Speech and Language Therapy</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Type of Intervention</td>
<td>Date Began</td>
<td>Date Ended</td>
<td>Number of hours received</td>
<td>Intervention done as part of group or individually. (Teacher/Student Ratio for Groups)</td>
<td>Where is the intervention delivered? (Home, School, Clinic)</td>
</tr>
<tr>
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</tr>
<tr>
<td>Floor-time Therapy</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Social Skills Training</td>
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<td>Play Groups (Mommy and me, Gymboree, swimming, gymnastics)</td>
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<tr>
<td>Other: (Please specify)</td>
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**Reaction to Diagnosis Interview (Marvin & Pianta, 1996)**

1. When did you first realize that your child had a possible developmental problem? What gave you this concern?

2. What were your feelings at that time of this realization?

3. How have these feelings changed over time?

4. Tell me exactly what happened when you learned of your child's diagnosis. Where were you, who else was there, what were you thinking and feeling at that moment? Have these feelings changed since then?

5. Parents sometimes wonder or have ideas about why they have a child with special needs. Do you have anything like that that you wonder about?

**Religious Beliefs, Ritual Practices, and Community**

1. Can we discuss your responses to the fill-in-the-blank questionnaire you completed? Why did you choose the particular term? Please explain and provide examples.

2. Has the frequency in which you complete the ritual practices discussed in the previous ritual questionnaire increased, decreased, or stayed the same since before you had child (ren)/before your child was diagnosed? Please explain and provide examples.

3. Can we discuss your response to the items about your community that you rated? Why did you choose the particular rating score? Please explain and provide examples.
**Coping**

1) Please identify and describe concerns, fears, and challenges related to raising your child or your child’s future/ related to your child’s diagnosis, raising a child with autism, or your child’s future.

2) Have you used your religious beliefs, ritual practices, or community to cope with these concerns, fears, and challenges? Have you used your relationship with G-d to cope with these fears, concerns, and challenges? Please explain and provide examples.

3) What are some non-religious ways in which you have coped with these concerns, fears, and challenges? Please explain and provide examples.
Parenting

Participant was emailed two video clips:

i. Child with autism having a temper tantrum

ii. Child with autism being unresponsive to his or her parent

A) What are your thoughts and feelings about the child’s behavior in this video clip?

B) How do you think your spouse would think and feel about the child’s behavior in this video clip? Do you think that your spouse would have thought and felt the same or different than you?

C) Does your child present this behavior or a behavior similar to the child in the video? Has he or she presented this behavior in the past month? Please describe.

   1) If so, how did you feel when your child presented this behavior? How did you respond when your child presented this behavior?

   2) If not, how would you feel if your child presented this behavior? How would you respond if your child presented this behavior?

D) How do your religious beliefs, ritual practices, and community influence your feelings and how you respond or would have responded to the presented behavior?

E) How do you think your spouse would have felt and responded to your child’s behavior?
   Do you think that your spouse would have felt and responded similarly or different than you?

F) How do you think your spouse’s religious beliefs, ritual practices, and community influence his/her feelings and how they would respond or would have responded to the presented behavior?

****Any final questions or comments about the survey or interview questions?
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