"God gives me hope!": Hospitalized children's perception of the influence of religion in coping with chronic illness

Abstract

Purpose: The mechanism of the impact of religion on health is still unclear, especially in children and adolescents with chronic illness who live in religious contexts. This study aimed to understand the influence of religion in coping with chronic diseases from the perspective of hospitalized children and adolescents diagnosed with cancer, type 1 diabetes mellitus and cystic fibrosis. **Design and Methods:** Qualitative descriptive research used photo-elicitation interviews with 35 Brazilian children and adolescents with cancer, diabetes mellitus type 1 and cystic fibrosis, aged between 7 and 17 years old. Thematic analysis approach was used to analyze qualitative data. **Results:** Participants were diagnosed with cystic fibrosis (14.3%), cancer (57.1%), and type 1 diabetes mellitus (28.6%) and 82.9% had a religious affiliation. Three themes were constructed: finding strength and support in the relationship with the divine, religion as an important source of meaning, and religious practice as a promoter of well-being. These themes demonstrate that the children and adolescents themselves perceived their illness as a journey on which their faith grows. **Conclusions:** This research show the influence of religion on the positive coping of chronic illness, being a source of strength and support from the relationship with the divine, as well as offering a source of meaning, purpose and well-being based on religious practices. **Practice Implications:** This study may support clinical practice, based on the recognition of the patient as a religious and spiritualized person who has spiritual beliefs and needs that are capable of influencing treatment.

Keywords

Children, Adolescent, Chronic Disease, Religion, Qualitative Research.

Highlights

- Religion influences children and adolescents coping with chronic diseases.

- Children and adolescents see their chronic disease as part of the purpose of God.
- Religious practices alleviate symptoms of illness.
- Children and adolescents feel their religiosity impaired by being hospitalized.

Background

Religion and spirituality are resources that help families, children, and adolescents to cope with illness due to a chronic condition (Grossoehme et al., 2012; Mazhari et al., 2019). Specifically, for children and adolescents, illness, treatment, and hospitalizations generate fear, anxiety and uncertainty (Motta et al., 2015; Öztürk Şahin & Topan, 2019). Religion can be a source of comfort, hope and acceptance in the diagnosis of a chronic disease (Lima et al., 2013; Mazhari et al., 2019). Therefore, these experiences can be confronted by children and adolescents through religious practices (Damsma Bakker et al., 2018).

Religiosity is characterized by being a subset of the spirituality phenomenon and has as an attribute religious affiliation, the practice of religious activities, religious beliefs, and personal expressions, which can be intrinsic or extrinsic to religiosity (Bjarnason, 2007; Herdman & Kamitsuru, 2018). Religion is considered an organized system of beliefs, practices, rituals and symbols designed to facilitate proximity to the sacred or transcendent (God, mystic, higher power or supreme truth/reality) that arises from a group of people with common beliefs and practices (Koenig, 2012). Moreover, religiosity is the degree to which an individual believes, follows and / or practices a religion with the community, individually or privately (Koenig, 2012).

James Fowler's Theory of Faith Development presents the complexity of faith development in six stages and one pre-stage, with mythic-literal faith and synthetic-conventional faith being the corresponding stages for school children and adolescents (Fowler, 1981). According to this theory, faith is a universal, interactive, social, and dynamic human experience, which in essence is a path

taken to give meaning and maintain meaning in life and is the most fundamental category in the human search for a relationship with the transcendent (Fowler, 1981). Table 1 presents a synthesis of the stages of Fowler's Theory of Faith Development. The stages of Fowler's Theory are sequential, dynamic and need to be interpreted considering the individuality of each child or adolescent and the context in which they are inserted.

Table 1

Synthesis of stages of Fowler's Theory of Faith Development (Fowler, 1981)

Synthesis of stages of Fowler's Theory of Faith Development	
Stage 0 or Pre-stage: Undifferentiated Faith	Birth until two years old: Babies experience the environment and feel trust and assurance in the universe and harmony with the divine. Experience of neglect or abuse generates feelings of mistrust and fear with respect to the universe and the divine, sowing the seeds for later doubt and existential angst.
Stage 1: Inductive-Protective Faith	Early Childhood (3-6 years old): Children at this stage already acquire language skills and are able to use symbols to express thoughts. At this stage, there are no formal religious beliefs, with faith being developed through: stories and images given by their culture, as well as influences from others. At this stage there is still an innocent perception of God.
Stage 2: Mythic-Literal Faith	Middle/late Childhood (7-12 years old): At this stage the children believe in justice and are impartial in religious matters. God is related to an anthropomorphic image, and religious metaphors

	are interpreted literally.
Stage 3: Synthetic-Conventional Faith	Early Adolescence: At this stage there is the growth of a religious or spiritual identity, which is accompanied by spiritual questioning. There is also a possible identification with a religious institution or belief system.
Stage 4: Individuative-Reflective Faith	Late adolescence and Early Adulthood: At this stage the individual takes responsibility for their beliefs and feelings. Spiritual and religious beliefs are more complex, and conflicts can be experienced if beliefs and traditions collide.
Stage 5: Conjunctive Faith	Middle Adulthood: The person recognizes the paradoxes and mysteries of their transcendent values, which can lead them to reflections that go beyond the religious traditions or beliefs obtained in the previous stages.
Stage 6: Universalizing Faith	Middle and Late Adulthood At this stage, the transcendent belief system is used to achieve a sense of oneness with all beings. The person at this stage is limited by differences in religious or spiritual beliefs among people in the world but considers all beings to be worthy of compassion and deep understanding.

In the stage of mythic-literal faith, children's narratives are composed of literal terms, and their descriptions of God are related to the images or stories to which they have been exposed. Also in this stage, children present the concept of fairness in separating right and wrong behaviors. The

synthetic-conventional faith stage is influenced by puberty. Adolescents are developing their self-image, related to their own and others' opinions. Although adolescents have some consistent values and beliefs, these are still being evaluated. For example, their conceptions of faith have various influences from their own context and their own reflections, so this phase is characterized by questioning and immense changes (Fowler, 1981).

The literature presents several studies related to the spirituality of children and adolescents with chronic diseases (Damsma Bakker et al., 2018; Drutchas & Anandarajah, 2014; Espinha & Lima, 2012; Lima et al., 2013; Schaefer et al, 2021; Scott et al., 2023). Although religion is integrated with spirituality, it is a complex and multidimensional phenomenon (Bjarnason, 2007; Herdman & Kamitsuru, 2018). The mechanism of the impact of religion on health is still unclear, especially in children who live in cultural contexts of religious practices. Religion is an important aspect in the life of Brazilians, and most people consider themselves Christians, mainly affiliated with the Catholic or Protestant religion (Peres et al., 2018). This socio-religious context impacts the experience of Brazilian children, who consider the expression of religious beliefs and practices to be an important spiritual need in the experience of chronic illness (Blinded for peer review). Understanding the role of religion in Brazilian children with chronic illnesses highlights an important gap in research that may help researchers understand this phenomenon and health professionals when proposing future interventions.

This study aimed to answer the question: How does religion influence the coping with chronic illness and the experience of hospitalization from the perspective of chronically ill children and adolescents? In this way, it would be possible to explore a phenomenon that is relevant to patients (Bravin et al., 2019), but which health professionals still report difficulty in dealing with in their clinical practice (Arrieira et al., 2018). Thus, the aim of this study was to understand the

influence of religion in coping with chronic diseases from the perspective of hospitalized children and adolescents diagnosed with cancer, type 1 diabetes mellitus and cystic fibrosis.

Methods

Type of study

This is descriptive qualitative research (Glaw et al., 2017), which used photo-elicitation interviews and thematic analysis approach (Braun & Clarke, 2019). The Standards for Reporting Qualitative Research (SRQR) was used as a guide to report this research (O'Brien et al., 2014).

Setting of data collection

Data collection was developed between August 2017 and January 2020, in the pediatric wards of a public hospital, located in the southwest of Brazil. This hospital performs treatments for highly complex diseases of children and adolescents from all over the country. Brazil has different spiritual and religious beliefs, intrinsically related to the historical issues of colonization and immigration. The last Brazilian census indicated the following religious affiliations: Catholic, Protestant (Evangelical, Pentecostal and Neo-Pentecostal), Spiritist, Jehovah's witness, Afro-Brazilian religion (Umbanda and Candomblé), Buddhist, Jewish and Islamist. Other religious minorities are also present in Brazilian culture (Instituto Brasileiro de Geografia e Estatística, 2012). Furthermore, there is also 8% of the Brazilians, around 15 million, who declare themselves irreligious, atheist or agnostic (Instituto Brasileiro de Geografia e Estatística, 2012).

Participants

The participants in this study were 35 children and adolescents with cancer, diabetes mellitus type 1 and cystic fibrosis, aged between 7 and 17 years old. They were included if they had experienced the disease for at least three months and were hospitalized for clinical treatment in the pediatric ward. The time of diagnosis was determined by considering the time needed to experience the disease and to reflect on aspects of religious coping during this phase. The types of

chronic diseases included in the study were chosen due to epidemiology and high need for utilization of healthcare resources, and that fact that there is an increase in the number of children hospitalized due to cancer, type 1 diabetes mellitus, and cystic fibrosis (Blinded for peer review). The perspective of the non-categorical approach was used (Stein & Jessop, 1989), and allowed for the inclusion of children and adolescents with different chronic illnesses and age groups so as to identify the common characteristics and diversity of experiences. This was due to the fact that the focus of this approach is to analyze a phenomenon considering the similarities of experiences in the context of living with the diagnosis of chronic illness. Children and adolescents were excluded if they: were unaware of their diagnosis; had a level of development below seven years or not compatible with age; had language problems that impaired speech or visual deficiencies that would impair the viewing of the photographs.

Data collection

A convenience sample was interviewed with a data collection technique that consisted of a set of photographs and guiding questions to conduct individual, audio-recorded, and semi-structured interviews. These interviews generated a reflective conversation about religious beliefs and practices and explored the influence of religion in hospitalized children and adolescents when coping with chronic illness. The choice of the 10 photos (Table 2) that comprised the interviews were based on a conversation model of spirituality/religiosity developed from a literature review and which was evaluated by a committee of experts and tested with children and adolescents with cancer (Blinded for peer review). The photographs used did not have a connotation to a specific religious belief. They were selected by researchers based on the related theme and their potential to explore the participants' religious experience or beliefs. We used photos in high-resolution colored printing, dimensions of 10 × 15 cm and laminated. The interviewer used a nondirective approach, in which the children and adolescents have the chance to choose the photograph and the

sequence in which they would like to follow during the interview. The interview questions were asked verbally after the photo presented was chosen by the child. The child was free to explore the photo and other questions were asked depending on what she/he thinks and feels during the interview. It was emphasized that there were no right or wrong answers and that he/she could interrupt the interview at any time.

Table 2

Photographs and guiding questions used in the photo-elicitation interviews

Description of the photos used	**Principal related topics**	**Initial guiding questions**
Photo 1: A girl alone, looking at a long road that is behind her	Meaning of life and the path of the disease	"What do you think she's thinking about?" "How would you describe what you've been experiencing so far?"
Photo 2: A girl looking at the stars through her bedroom window	Main worries and faith	"What do you think she's thinking about?" "What do you usually think about?"
Photo 3: An adult's hand holding the hand of a child	Relationship with the significant other and religious beliefs	"Who would you like to be holding hands with?"
Photo 4: An open child's hand with a butterfly at rest	Relationship with the significant other and religious beliefs	"If you were this little butterfly, whose hand would this be?" "How important is this person to you and why?"
Photo 5: A teenager walking alone on the train tracks, towards a bend with bright light	Future worries and hope	"What do you think she will find after the bend?"

Photo 6: A man looking up with his hands outstretched with an expression as if he is asking 'Why me?'	Existential questions and the meaning of life	"Have you ever asked yourself 'why me'?"
Photo 7: A girl crying and hugging her dead pet cat	Experience with treatment	"What would you say to her about facing her loss?" "What do you think about death?"
Photo 8: The shadow of a hand showing a monster on the wall	Fears and concerns	"Tell me about your fears"
Photo 9: A very happy man, staring at his hands full of money	Belief and values	“What do you think is the most important thing in life?”
Photo 10: Image of the universe and planet Earth	Belief and questions about the meaning of life	"Have you ever asked yourself about the creation of the world or about life?"

Source: Adapted from (Omitted for blinded review).

The data were collected by two undergraduate students, which were supervised and trained by two nurses and Ph.D. students experienced in this type of data collection. The Ph.D. students implemented the first three interviews to demonstrate to undergraduate students how they should be conducted. The other interviews were developed by the undergraduate students, while in the presence and under supervision of the Ph.D. students. Participants were informed and agreed to how the interview dynamic was to be conducted. None of the researchers had previous contact with the participants or were involved in their care. As they are pediatric patients, caregivers could accompany the participants during the interview, and this option was offered to the child/adolescent. When there was the presence of caregivers, it was not perceived as an influence on the interview (Spratling et al., 2012). Data collection came to end when the conceptual

complexity and stability of the compiled codes reached code saturation as well as the complexity and depth of the phenomenon reached saturation of meaning (Hennink et al., 2017).

Data analysis

Reflexive thematic analysis in a more inductive way was used to analyze qualitative data (Braun & Clarke, 2019). This consisted of six phases which entailed familiarization with the dataset, coding, generating initial codes, searching for and then reviewing themes. The coding and themes development were carried out jointly by two researchers experienced in qualitative research and the theme of the study. Both researchers made sense of the data and selected the analysis units related to religion. All data were independently coded by two researchers and reviewed by a third. All researchers agreed on the final themes. Field notes helped the authors to perform data analysis.

The results are described through the themes that describe the influence of religion in coping with chronic illness and hospitalization, and a discussion was performed according to the literature and Fowler's Faith Development Theory. The theoretical framework of Fowler's Theory of Faith Development (Fowler, 1981) was used to address the children and adolescents properly, respecting their potential religious development, and to understand the religious experience of the participants, for example, manifestations of faith and belief-forming context.

To achieve trustworthiness and validity, we invested in prolonged engagement with the data and the influence of the findings was decreased by multiple coders who conducted the data collection and analysis, and who hold an interpretivist research position and different religious affiliations (Catholic, Evangelical, Spiritist, and Nonreligious).

Ethical approval

This research was approved by the Human Research Ethics Committee (nº 2.592.553 and 2.600.524). Written informed consent was obtained from parents or caregivers. Subsequently, the

study was explained to the children and adolescents and their signed assent was obtained. The researchers only included children and adolescents who gave their own assent and the consent of their parents or caregivers. Considering that participants were pediatric patients, caregivers could be present during the interview, and the child/adolescent was given this option. All participants chose to carry out the interview in the presence of parents or caregivers. This presence was not perceived as an influence on the interview.

Results

Forty-two children and adolescents were invited to participate in this study, but seven refused to participate for reasons related to their clinical condition, or because of shyness due to being recorded. Therefore, the participants in this study were fifteen children and twenty adolescents (Table 3), with a mean age of 13 years (± 2.5), diagnosed with cystic fibrosis (n = 5; 14.3%), cancer (n = 20; 57.1%), and type 1 diabetes mellitus (n = 10; 28.6%). Most were diagnosed more than a year ago (n = 18; 51.4%), had a religious affiliation (n = 29; 82.9%) and were practicing their religion (80%), whether Catholic or Evangelical. Most attended religious ceremonies one or more times a week (n = 16; 45.7%) and practiced prayer (n = 28; 80%). Children and adolescents had similar results to their parents, with regard to religious practice and type of religion (see table 3 for further details). Only 2 participants (5.7%) did not have the same religious affiliations as their parents, thus showing the influence of the family context on religiosity.

Table 3

Characterization of participants

Characteristics	Frequency	Percent (%)
Age range (in years)		
7 – 12	15	42,9
13 – 18	20	57,1

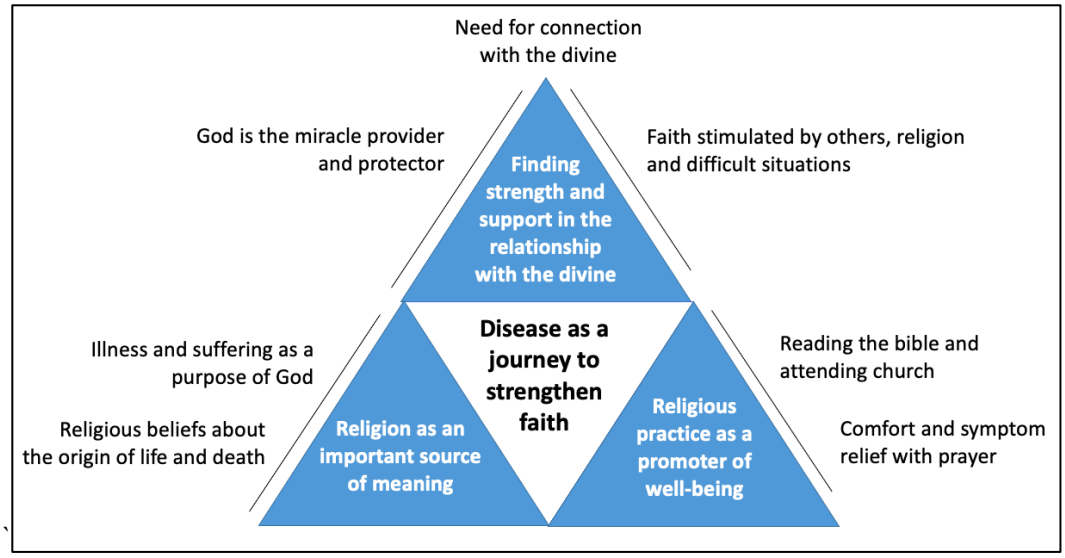
Gender		
Female	17	48,6
Male	18	51,4
Diagnosis		
Cystic fibrosis	5	14,3
Cancer	20	57,1
Type 1 diabetes mellitus	10	28,6
Diagnosis time (months)		
3 – 6	12	34,3
7 – 11	5	14,3
≥ 12	18	51,4
Level of education		
Elementary school	8	22,9
Middle school	19	54,3
High school	8	22,9
Religious affiliation		
Evangelical	14	40,0
Catholic	13	37,1
Spiritist	1	2,9
Umbanda (Afro-Brazilian religion)	1	2,9
No religion, but spiritual (believes in something)	1	2,9
Atheist (does not believe in God)	1	2,9
No information	4	11,4
Religious practice		
Yes	27	77,1
No	4	11,4
No information	4	11,4
Frequency of participation in religious ceremonies		
1 or more times a week	16	45,7
1 or more times a month	4	11,4
Few times a year	3	8,6

Rarely	3	8,6
No information	1	2,9
Prayer practice		
Yes	28	80,0
No	6	17,1
No information	1	2,9
Frequency of prayer practice		
Daily	19	54,3
1 or more times a week	8	22,9
1 or more times a month	1	2,9
No information	1	2,9
Parents' religious affiliation		
Catholic	14	40
Evangelical	14	40
Spiritist	1	2,9
Umbanda (Afro-Brazilian religion)	1	2,9
Evangelical mother and spiritist father	1	2,9
Atheist (does not believe in God)	1	2,9
No information	3	8,6
Parents religion practitioners		
Yes	29	82,8
No	4	11,4
No information	3	8,6
Frequency of parental participation in religious ceremonies		
1 or more times a week	19	54,3
1 or more times a month	6	17,1
Few times a year	2	5,7
Rarely	2	5,7
Practitioner without frequency information	2	5,7

Based on the analysis of the interviews, three themes were constructed: finding strength and support in the relationship with the divine, religion as an important source of meaning, and religious practice as a promoter of well-being. These themes demonstrate how the children and adolescents themselves perceived their illness as a journey on which their faith is strengthened (Figure 1).

Figure 1

Themes on the influence of religion in coping with chronic disease of children and adolescents



Finding strength and support in the relationship with the divine

Children and adolescents showed the need for faith and a positive relationship with God not only as a healing method, but also as a support and relief from suffering, helping them to recover and to live with the disease.

Need for connection with the divine. Children and adolescents demonstrate the need for a closer relationship with God and a deep development of faith after the diagnosis of a chronic disease. The relationship with the divine became more intimate for most of them or unchanged after the illness. The positive relationship with God is a source of well-being, hope and emotional

comfort, as the optimism and the feeling of joy and peace arising from this connection are present in the comments of children and adolescents.

> *God gives me hope, gives me strength, peace and support (Adolescent 30, Male, 16 years old, cancer, Evangelical).*

Even though they had believed in God since childhood, some reported that they had little interest in the church before becoming ill. The illness led them to a religious and spiritual identity, which are characteristic aspects of the synthetic-conventional faith stage generally present in adolescence. A 17-year-old adolescent reported that his relationship with the divine and religion intensified after the disease, as their strong faith became an ally in the fight against the disease.

> *I wanted to find a study of God and the Bible, I want to find God's peace, go to church, follow God's way. I never went to church, I believed inside me, but I was never interested. Then, I discovered I had cancer, I started to be interested in him. Before I prayed, but not every day, now I pray every day. It was something that happened that enabled me to become more attached to God, which made me believe more. Cancer is a life lesson! (Adolescent 3, Male, 17 years old, cancer, No religion, but spiritual).*

God is the miracle provider and protector. Many children and adolescents have believed in the existence of God since childhood and consider him fair, faithful and benevolent. They attribute to God the role of miracle provider and protector, due to the sense of security related to divine omnipresence. A 10-year-old girl describes God as an anthropomorphic and fair image, which are characteristics of the mythic-literal faith stage.

> *I think that to help me in the treatment I need to have a lot of faith in God. Because if you have faith in Him, He will help you. He always helps. He is a great person. He's always right (Child 20, Female, 10 years old, type 1 diabetes mellitus, Catholic).*

Spiritual solutions are also found for solving problems: a collaborative solution, when God helps and prepares them for difficult situations, as well as a style of surrender, giving God complete control over themselves or the situation they are experiencing. Some children and adolescents in this study are in the synthetic-conventional faith and individuative-reflective faith stages, when they demonstrate identifying with a belief system and taking responsibility for their own beliefs, which are more common in late adolescence and early adulthood.

> *We must not only believe in God, we must also do His will and wish, and have trust and faith, because what is a man worth in this world, without having faith, without having God, without having compassion? God is sublime. He's here right now (Adolescent 11, Male, 12 years old, cancer, Catholic).*

Faith stimulated by others, religion, and difficult situations. Faith was stimulated by family, friends, religion and difficult situations and was conceptually considered as a base, serving as a support for coping with the disease as well as a source of hope.

> *My father motivated me to believe in God, even though he was not that religious, except that he always looked at me and said, "Trust God, do the things", then I started (Adolescent 23, Male, 14 years old, type 1 diabetes mellitus, Evangelical).*

Some children and adolescents do not know how to conceptualize religion or have difficulty in conceptualizing it, which is very common in the inductive-protective faith stage in early childhood. Others make a more elaborate discussion and conceptualize religion by relating it to faith or religious practices and doctrines that guide a person's religious behavior and relationship with God.

> *Religion is the church. A place where you go to pray (Adolescent 27, Male, 12 years old, type 1 diabetes mellitus, Spiritist).*

Religion as an important source of meaning

The chronic disease took children and adolescents on a journey of spiritual growth, in which they used religion and its relationship with the divine to make sense of diagnosis, suffering, the origin of life and death.

Illness and suffering as a purpose of God. Children and adolescents give a spiritual interpretation to the disease. They interact with their religious belief systems that guide the interpretation and meaning attributed to chronic illness. They see their situation as part of the purpose of God, so they ask God why, and make sense of their illness based on responses from God and their religion. Reflecting on one's own spiritual and religious beliefs is characteristic of the individuative-reflective faith stage of early adulthood and it was observed in a 10-year-old girl:

> *I ask God: why me? I find an answer by going to church. Because I go there, I pray, I ask God, then God goes and sends the answer to me (Child 19, Female, 10 years old, type 1 diabetes mellitus, Evangelical).*

Regarding illness and suffering as a purpose of God, gives children and adolescents a deep sense of faith, of control of the situation that is managed by God and of justice, because God would not subject them to a situation without a purpose or without preparing them for the challenge. In this way, they attribute a positive meaning to their diagnosis and find in chronic illness the opportunity for growth, learning and change through the reorganization of priorities in their life that was given by God. Recognize the mysteries of their transcendent values that go beyond the religious traditions are characteristics of the conjunctive faith stage, more common in middle adulthood.

> *I think the medicine is necessary and faith too, but the medicine is for me to survive and the belief is to find the reason, the strength for me to know why to survive. My religion helps me. If I don't have faith, I lose my meaning. I read the books there are on my religion, so you see that God does not give you a cross that you cannot carry. So I have the ability to*

carry the cross that he gave me (Adolescent 16, Female, 16 years old, cystic fibrosis, Umbanda).

This disease happened to me so I could start eating better and, also, as I am an evangelical, they say it is a testimony. When I am cured, I will tell the others, and I can find someone who has the same disease so I can give them strength (Adolescent 28, Female, 12 years old, cancer, Evangelical).

Religious beliefs about the origin of life and death. Religious beliefs underpinned a worldview about the origin of life and about death. Most children and adolescents prefer to believe in God as the creator of the universe and in life after death, they believe that heaven is the resting place after death. These beliefs were learned from the family, the school, the church, the internet and the bible. The vast majority of them fear death and find it difficult to talk about the topic. Beliefs in judgment after death, in the existence of heaven and hell, uncertainties and the need to believe in Jesus before dying were aspects that permeated the comments of children and adolescents. Even for the adolescent who considers himself an atheist, death is a mystery and he has a belief related to something more after death.

I think our planet came from God, how did he do it, I don't know. The flowers, the hospitals, the houses, people, everything he made. (Child 9, Female, 7 years old, cancer, Evangelical).

It is a little difficult to talk about death because everyone is afraid of dying. After death, there is eternal rest, after the final judgment when God decides whether you are going to hell or heaven, from what you did, if you had a purpose in life to improve the world, if you didn't commit many sins. (Child 34, Male, 11 years old, cystic fibrosis, Evangelical).

I see no sense in believing in God as the great creator. But I think there is something after death, because it would not make sense that just this is our life. So I think there must be

something else, but I don't think it depends on God. (Adolescent 22, Male, 14 years old, cystic fibrosis, Atheist).

Religious practice as a promoter of well-being

Children and adolescents have a relationship with the divine that is expressed by private religious practices, such as prayer and reading the Bible, and by formal religious practices, related to a traditional religious institution, such as attending church and wearing religious adornments.

Reading the bible and attending church. Children and adolescents feel a need to attend church during the hospitalization period and feel that their religiosity is impaired by being hospitalized. Churchgoing enables a feeling of closeness to the divine, while the family helps in adhering to the treatment. The wearing of religious adornments provides a sense of security and protection.

Religion helps me with my treatment. I think it's because I'm going to church (Child 25, Female, 7 years old, cystic fibrosis, Catholic).

Praying helps me. Every night I pray before I go to sleep. Sometimes I also read the bible, it helps me to think a little and gives me a good feeling inside, I don't know how to explain it. At the hospital, I find it kind of difficult to read, because I didn't bring it (the bible), *but when I can, I read it on my cell phone. It's not as frequent as if I were at home (Adolescent 23, Male, 14 years old, type 1 diabetes mellitus, Evangelical).*

I carry small medallions, one is of Saint Rita and the other is of Our Lady. Saint Rita was called the saint of impossible causes. I take her with me because it was a gift and because I believe in her, I feel protected (Adolescent 2, Male, 13 years old, cancer, Catholic).

Some children show regret that they did not prioritize church attendance and a close relationship with God before their illness and now they want to make up for lost time. They talk about the importance of reading the Bible and how often they do it.

Before, I didn't feel like going to church because I kept working, worked a lot, but I regret it so much. Health, love, family, God is what is of value to me today, money is not so valuable (Adolescent 3, Male, 17 years old, cancer; No religion, but spiritual).

Comfort and symptom relief with prayer. They show that they obtain comfort from the practice of prayer, they receive answers that reassure them and give them relief from symptoms. They pray for closeness and intimacy with God and ask for health, protection for themselves and for people close to them such as friends and family, as well as to have strength to face the treatment and the difficulties arising from the chronic disease.

I pray every day for God to give me strength first, to help me and for the people who can sometimes be suffering around me. I pray for Him to help them too (Adolescent 24, Female, 14 years old, type 1 diabetes mellitus, Evangelical).

Discussion

This study investigated the influence of religion on coping with chronic illness from the perspective of hospitalized children and adolescents diagnosed with cancer, type 1 diabetes mellitus and cystic fibrosis. The results show the influence of religion on the positive coping of chronic illness, being a source of strength and support from the relationship with the divine, as well as offering a source of meaning, purpose and well-being based on religious practices.

Children and adolescents showed different patterns of thinking and behavior related to the stages of intuitive-projective faith, mythic-literal faith, synthetic-conventional faith and individuative-reflective faith. This shows that although the stages of Fowler's Theory of Faith Development are sequential and they show a relationship with chronological age (Parker, 2010), the development of faith is not perfectly correlated with age and can be stimulated by the experience of falling ill. In addition, children inserted in a context of spiritual nutrition and practice

can have a faster and deeper development of faith (Fowler & Dell, 2006). In this study, most participants practiced a religion and shared the same religion as their parents.

Aspects of synthetic-conventional faith related to adolescence were very present in this study, and included school children. The image of transcendence had a significant divine characteristic, in which God is resignified and has the qualities of companionship, loyalty, support, wisdom and love in crisis situations (Fowler, 1981). Similarly, the influence of the religious community is perceived in the formation of the "self" and faith, as well as the incorporation of symbols and expressive rituals of faith in the system of meanings, which are particular to synthetic-conventional faith (Fowler, 1981).

Some adolescents showed the ability to reflect critically on their system of values and meanings to help them find the significance attributed to the disease, which is characteristic of the individuative-reflective stage of faith in young adults (Fowler, 1981). Likewise, aspects of the intuitive-projective faith of preschool children were perceived in school children and adolescents in this study. A sense of identity and worldview originating from culture, such as beliefs about the origin of life and about death, were incorporated into their own set of significant associations that deal with God and the sacred, which are particularities of intuitive-projective faith (Fowler, 1981).

Although the results of this study showed positive aspects in relation to religious and spiritual coping, there was also a negative influence of religion in coping with chronic illness. This occurred when some children showed regret that they did not prioritize church attendance before their illness or when reporting a fear of death due to the meaning of death from their beliefs and religion. A study with nurses showed that religious and spiritual coping facilitated the process of recovery and healing, and increased the support network for the patient, while also highlighting the difference between patients who face pathology through religion and those who do not have support (Siqueira et al., 2017). Adolescents with cleft lip and palate attended more frequently churches or

temples and had greater social interaction in the religious community in comparison to adolescents without cleft (Farinha et al., 2018). Adolescents with cancer consider that their beliefs helped them to cope with the disease and to improve symptoms, mainly with the practice of prayer (Souza et al., 2015).

Similar results were found in other studies with adults (Benites et al., 2017; Bravin et al., 2019) in which religiosity was a source of strength and hope in the acceptance of pathology and adaptation to treatment, as well as being a source of meaning. A review showed that spirituality and religiosity in children and adolescents promoted greater well-being, especially in a psychological and emotional sense, preventing mental disorders such as anxiety and depression by offering greater satisfaction in life, and helping to avoid risky behavior and consumption of alcohol and other drugs (Oliveira & Souza, 2020).

The results of the present study have clinical implications that should be considered by health professionals. Religion influences coping with chronic diseases from the perspective of children and adolescents diagnosed with cancer, diabetes mellitus and cystic fibrosis. Religious beliefs were a way to understand and attribute significance to suffering. The relationship with God and religious practice were sources of strength, well-being, joy, optimism, and improved adherence to treatment. Religion was also an important source of meaning, as well as cultural, social and moral values. The stages of Fowler's Theory of Faith Development proved to be flexible and integrated with one another, since characteristics from different stages from preschool age to young adults were present in the school children and adolescents in this study. Therefore, it is important for healthcare professionals to consider the role of religiosity so as to improve mental health outcomes and decrease symptoms related to the disease. In addition, they could create plans to develop positive religious coping skills in this population.

Limitations and strengths

This research has limitations because most children and adolescents have a religious affiliation of Judeo-Christian origin and came from families where their parents also have a religious affiliation. The majority of people in Brazil are affiliated with a religion, being mainly Catholic and Evangelical (Peres et al., 2018) and the child's socio-cultural environment influences their worldview and behaviors, such as the use of the language of faith, religious practices and symbolisms (Hay & Nye, 2006). It is important to understand the influence of religion on children and adolescents who do not identify with a religious tradition or have a different religious affiliation than their family. Despite criticism of the stages of Fowler's Theory of Faith Development (Coyle, 2011), the use of this theoretical framework offered insights into the religious experience of children and adolescents and showed the fluidity in dynamics of the stages.

The use of interviews with photo-elicitation is considered the strength of this study, since it allowed us to talk and collect detailed data in a playful way with children and adolescents, about their religious dimension, which is an abstract and complex theme. A further strength of this study is the use of a non-categorial approach, which allowed us to analyze the similarities of the experiences of children and adolescents who were influenced by religion in coping with different chronic illnesses.

Practice implications

This study may support clinical practice, based on the recognition of the patient as a religious and spiritualized person who has spiritual beliefs and needs that are capable of influencing treatment. Health professionals are responsible for promoting comprehensive care for an individual, which implies considering the religious beliefs and practices of their patients. Nurses can identify religious beliefs capable of influencing the child's treatment and their understanding of the disease, allow the expression of these beliefs in the hospital context and encourage the practice of prayer, Bible reading and chaplaincy service by children and adolescents who

demonstrate a desire for these practices. Nurses and other health professionals, through care that is sensitive to the cultural beliefs and values of children and adolescents, will be able to offer more efficient assistance, improving the coping with chronic illnesses.

Conclusions

The results show the influence of religion on the positive coping of chronic illness, being a source of strength and support from the relationship with the divine, as well as offering a source of meaning, purpose and well-being based on religious practices. This research expands the field of knowledge in pediatrics about how religiosity can influence coping with chronic illness in childhood and adolescence.

Conflict of interest disclosure

Nothing to declare

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