Relational Coping Resources: Caregiver Families' Experience of Living with Chronic Illness in Addis Ababa, Ethiopia: A Phenomenological Study

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Abstract: Caregiver families of chronically ill members usually experience chaos. They, however, often use strategies to manage, cope with, and mitigate the negative effects of the illness. Therefore, this study aimed at revealing relational coping resources that caregiver families use to cope with and mitigate the effects of living with chronically ill family members. The study was purely qualitative. It employed a phenomenological method. Participants were caregiver families who had a family member with a chronic illness. The data was collected from 20 interviewees using semi-structured interview-guiding questions and analyzed it thematically. The findings revealed that relational resources emanated from a family's religious affiliation and friendships provide opportunities to enhance coping capacities, which in turn facilitated and helped in coping with and mitigating the effects of illness. Moreover, a strong sense of We-ness produced by familial relationships plays an important role in strengthening the family's coping capacity. Relational coping resources enhance maintaining the family's social relationships, obtain social support, and provide a sense of unity within the family. In the absence of formal supports, such as family counseling, this study argues that informal relational coping resources play a critical role in mitigating the effects of the illness. Despite its debilitating effects, the family experiences of chronic illnesses received little attention in hospitals. In conclusion, the study recommends that hospitals need to establish mechanisms to support families living with chronic illness, which could raise their awareness and help them, cope with the challenges that the illness brings.

Keywords: Caregiver; Chronic illness; Families; Family experience; Relational coping resources

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1. Introduction

Chronic illness, such as cancer, diabetes, stroke, asthma, cardiovascular disease, and so on, is a long-term and incurable condition that necessitates lifelong support and care (Dobbie and Mellor, 2008). The global prevalence of chronic illness is increasing (WHO, 2002, 2011, and 2014). Chronic diseases accounted for approximately 60% of the 56.5 million total reported deaths worldwide in 2001, accounting for nearly 46% of the global disease burden (WHO, 2002). By 2020, the burden is expected to increase to 57%. It has posed a serious threat to the global population's health (Bauer, Briss, Goodman, and Bowman, 2014; Nuget, 2008; WHO, 2011). The World Health Organization stated in its 2010 report that chronic diseases, such as diabetes, cancer, cardiovascular, asthma, and arthritis, accounted for nearly two-thirds of deaths worldwide (WHO, 2011). The magnitude of deaths from chronic disease is expected to increase from 38 million in 2012 to 52 million by 2030. (WHO, 2014). Similarly, as WHO stated in its 2011 report, chronic illnesses are the leading causes of death, accounting for 60% of all deaths worldwide.

Chronic diseases have a significant impact in low- and middle-income countries (LMICs), despite their lack of understanding. According to the World Health Organization's 2014 report, only 20% of chronic disease deaths occur in high-income countries, while 80% occur in low and middle-income countries, where the majority of the world's population. Surprisingly, 4 out of 5 chronic illness-related deaths occur in developing countries, making such chronic illness conditions one of the challenges to the health of the population in low- and middle-income countries (Nuget, 2008; WHO, 2011, 2014; Wonde and Boru, 2019). Similarly, Ethiopia is facing challenges as the prevalence of chronic illness grows, putting a double burden on the population and the health system, which is already overburdened by acute diseases (Wonde and Boru, 2019). According to Prevett (2012), the overall prevalence of chronic disease in Ethiopia is 8.9%. Chronic diseases account for 42% of all deaths in Ethiopia (Yosef, 2020). However, as in many developing countries, chronic illness receives insufficient attention in policy and intervention practices in Ethiopia (EPHA, 2012; Kiflie, Jira, and Nigussie, 2011).

Individuals with chronic diseases were unlikely to survive long after diagnosis prior to advances in research, treatments, and medicines for chronic illness. However, advances in modern health care have enabled individuals to survive more health crises, such as chronic illness, and spend less time in medical centers (La Clare, 2013), resulting in the majority of care being provided at home. For example, before the discovery of insulin, patients diagnosed with diabetes were either unlikely to survive or expected to die within a year (Hoard, 2004). Unfortunately, even with new research, treatments, and medicine available, the care required to cope with chronic illness falls under the caregiving responsibility of healthy family members. The majority of medical care and treatments, which are usually provided at health centers and performed by a physician or other health worker, take place at home, leaving healthy family members of the patient to take on a more caregiving role. Dealing with chronic illness takes time and is emotionally and physically exhausting for the patient's caregiver or family members (Murray, Kelley-Soderholm, and Murray, 2007). Caregiving families often feature chaotic emotions and behavior, including shock, anxiety, depression, and fear which could have chaotic impacts on the overall family functions and interactions, usually between the patient and the rest of the family (Abdella and Mohammed, 2013).

Families can be burdened by a caregiving role as a result of a family member's diagnosis of chronic disease. It often alters the family system in areas such as role relationships, family lifestyle, and family-values priorities (Lee *et al*., 2004). The diagnosis of a family member with a chronic illness usually disrupts overall family functioning because family members must assume the roles previously carried out by the chronic patient (Deist, 2013). However, families often use various coping strategies and resources available through their social networks to provide the best care the patient requires while maintaining the family's overall functions. As a result, according to Family Resilience theory, families must be able to mobilize and tap into resources in order to adapt and respond to such situations (Walsh, 1996).

Nonetheless, studies in the area of chronic illness have usually emphasized the deficit model. The deficit model focuses on the burden of chronic disease on caregiver families of a chronically ill family member. Caregivers are often viewed as burdened, passive victims of chronic crises (Deist, 2013; Hoard, 2004). Caregivers, however, always demonstrate their resilience by mitigating the adversities of living with a chronically ill person. In contrast to the deficit model, this study model the concept of resilience, emphasizing the caregiving family's resiliency gained through social relations or associations in mitigating the effects of living with chronic illness. What relational coping resources do the patient's caregiver families use to cope with the challenges? The question reveals the relational coping strategies used by chronic patients' caregiving families to mitigate the challenges and changes brought on by a family member's diagnosis with chronic health conditions. In this study, relational coping resources are social relations or associations that allow caregiver families to access relational resources that can help them adapt to and mitigate the challenges and changes brought on by a family member's chronic health conditions. The social relations or associations this study includes are family members' religious affiliation, family members' social relationships with people who have or have had the same chronic health condition, and family members' relations within a family. Understanding the factors that would assist families in coping with the negative aspects of chronic health crises could be critical to developing effective coping strategies.

This study was based on the concept of family resilience, which explains how patient's caregiver families cope and were resilient in the face of challenges and changes brought on by a family member's diagnosis with a chronic health condition. The concept of resilience focuses on the roles that coping resources play in determining a patient's caregiver family's ability to adapt to chronic health conditions. The Family Resilience Framework is a theoretical framework used to identify and explore factors associated with the caregiver families' ability in dealing with a family member diagnosed with chronic health conditions to adjust and adapt to their situation (Walsh, 1996; Patterson and McCubbin, 1983). Thus, this study focuses on the relational coping resources that caregiver families use to mitigate the challenges of living with and caring for chronically ill family members. In doing so, the study reveals the roles of relational coping resources that may contribute to mitigating the effects of living with a chronically ill person.

2. Research Methods

2.1. Study Approach

This study was based on a phenomenological study approach with a qualitative research method. A phenomenological research approach provides an in-depth and interpreted understanding of the social world (including experiences, perspectives, and histories) of the research participants (van Manen, 2016). Thus, the phenomenological research approach was used to investigate the caregiver family experiences of living with a chronically ill family member. The method was used to extract the essence of the human experience about the phenomenon of living with chronic illness. The approach was used specifically to uncover the relational coping resources that caregiver families used in their social environment to mitigate the negative effects of living with a chronically ill family member.

2.2. Participants and Sampling Procedures

The study recruited the participants from Black Lion Specialized Referral Hospital (BLSRH), Addis Ababa, Ethiopia. BLSRH was selected because it was the only public hospital in the country during the study period to treat chronic illnesses. The study participants were the caregiver families of a family member who had received a diagnosis of cancer, diabetes, and hypertension. The following were the inclusion criteria for participation: (1) a family living with a chronic disease; (2) the person must have been diagnosed with a chronic disease for at least three months; and (3) the participants must be families, including housemaid, who are still living in the home. The study contacted a nurse at the health care center to initiate contact with families of chronic patients who met the eligibility criteria and expressed an interest in participating. To plan and conduct the interviews, the researcher called each participant directly.

A purposive sample of 10 families living with a chronically ill family member participated. To achieve variation and maintain an in-depth understanding of the phenomena investigated, two members of each successfully contacted family were included in the study. Thus, 20 participants took part (13 women and 7 men). The study's participants ranged in age from 19 to 31. Twelve of the participants were students at the time, with the remaining eight workings. After conducting 20 interviews, the researcher concluded that the data was saturated with descriptions of chronic illness experiences.

2.3. Data Collection

The study conducted semi-structured interviews using guiding questions to collect data from 20 interviewees. The purpose of the interviews was to ensure that participants had a chance to voice their experiences and further explore their insight and knowledge of particular phenomena. During the interview, participants were encouraged to recount their experiences. According to Kvale and Brinkmann (2014), a qualitative research interview is a specific form of conversation that aims at understanding the dimensions of the interviewees’ life world. The study used interview-guiding questions that the study prepared ahead of the fieldwork. Each interview lasted 40 to 60 minutes. The interviews were held in mutually agreeable locations to ensure the convenience and comfort of the interview participants. The interviews were conducted by the researcher and were taped and transcribed verbatim.

2.4. Data Analysis

In this study, data analysis occurred concurrently with data collection. The researcher transcribed and translated Amharic interviews from tapes into English. The data gathered was thoroughly processed and examined. The collected data was thoroughly processed and examined. As a result, this study made use of transcribing, translations, coding, categorizing and generating themes and subthemes, and interpretation.

2.5. Ethical Issues

The study received ethical approval from Addis Ababa University's Department of Sociology before beginning fieldwork. All participants completed an informed consent form to confirm their willingness to partake in the study. The participants were assured that their participation was voluntary and that they could opt out at any time. The study carefully maintained each participant’s privacy during the interviews by maintaining the confidentiality of data and keeping records in a safely locked personal computer.

3. Results

3.1. Relational Coping Resources

Regardless of illness-related crises, caregiver families of chronically ill family members can tap into and mobilize coping resources to adapt to or mitigate disease-related challenges and changes. Even though some characteristics of specific illnesses differ, there are several similarities among families caring for chronically ill family members, such as their coping resources (strategies). This study only looks at a few of the relational coping resources that caregiver family members were able to access, obtain, and use to help them cope with the challenges of chronic illness.

Themes and subthemes

List of themes	*Subthemes*
Benefits of family's religious affiliation	• Hope to get a complete healing • Emotional support • Social support
Socially accrued information or knowledge about chronic illness	• Information or knowledge crises • Knowledge about chronic illness • Socially accrued information and its benefits
A family's strong sense of unity, We- nesses	• Quality time spent and open communication • Role divisions

3.1.1. Family's religious affiliation

This study identified religious affiliations as an essential relational coping resource. It is central to the family's experiences of living with and caring for a chronically ill member. Caregiving families usually accrue the benefits through their affiliation with the congregation. The religious belief and spiritual practices of the caregiver families of the chronically ill member contribute as a valuable relational coping resource that facilitates the family's coping strategies in three ways.

First, religious affiliation was a way to practice and use religious services with the hope of finding religious healing services. Participants revealed that religious beliefs and spiritual practices such as faith, prayer, meditation, visiting holy places, and fathers provide hope in the face of a family member's illness. Religious practices had an impact on giving families with chronic patients hope and optimism. It was founded on the central religious belief system that faith in God and spiritual practices can provide relief from all forms of suffering, including illness.

> The only solution we have is faith in God. Our only source of comfort is the almighty God and his providence. That is why we frequently pay visits to religious fathers in order to receive their healing services. We believe we will be able to solve our problem. We have faith in God. We rely on our faith in God (Participant 2, Male, 27).

Participant five described her family's experiences in the same way:

> We believe in St. Virgin Merry and her son, Jesus Christ. They can help us get out of our current health situation. Therefore, we often visit holy places and holy fathers to get their spiritual healing services and drink holy water. We have faith in God (Participant 5, Female, 25).

As findings revealed, during chronic health crisis conditions, faith in God was believed to be the highest more vital solution to the chronic health condition. According to the findings of this study, spiritual belief, trust, and hope in God through spiritual activities such as prayer were believed as critical for receiving healing and relief from health crises. It was founded on the belief that families can be strengthened by putting their trust in God and His willingness to heal the family's health crisis because He is ultimately in control of everything. Caregivers usually gain access to religious coping resources such as father's prayer and holy water sprays through their affiliation with the religion and congregation.

Second, another key subtheme that emerged from the analysis was the emotional support that the caregiver families accrue. The findings revealed that religious affiliation is a valuable coping resource that facilitates *emotional support* for caregiver families of chronically ill family members. Since the onset of the chronic disease, the patients' families have usually experienced various emotional tolls or chaotic emotions, such as shock, anxiety, fear, depression, confusion, desperateness, or hopelessness about life, God, and everything. These emotions are often triggered by the presence of the illness, as well as the related challenges and changes. Here are two examples:

> When the doctor confirmed Mom's cancer diagnosis, the family was filled with tears, anxiety, confusion, and unstable emotions. We knew nothing about the illness and saw no way to restore Mom's health. As a result, we usually experience anxious moments (Participant 1, Male, 25).

> At first, none of us knew anything about the disease that mom was suffering from. As a result, we become anxious when we learn of mom's diagnosis, anticipating the future hassle. We assumed she would die sooner (Participant 8, Male, 28).

The families living with a member with chronic illness also experience chaotic emotions due to the absence of easy treatment for the disease. Family members often put their eyes on the medical treatments hoping to get the patient's health back. However, this does not work for chronic diseases like cancer, which could expose family members to experiencing chaotic emotions.

Families who have a member with a chronic illness experience chaotic emotions as a result of the absence of easy treatment for the disease. Family members often put their eyes on medical medicines in the hope of restoring the loved one's health. This, however, does not usually work for chronic diseases such as cancer, which may expose family members to face chaotic emotions.

Describing his experience, Participant 2 also said:

> The lack of a simple cure for the illness has increased our anxiety. Moreover, when you want to see your mother back to normal health status, and when things go wrong, it can make you feel a mix of emotions: upset, frustrated, and angry (Participant 2, Male, 27).

Furthermore, the patient's frequent changes in emotions and behavior contributed also to the chaotic emotions that the family members experiences. As a caregiver, the family is often involved in a compulsory caregiving burden. However, despite their efforts, the chronic patient's changing emotions often create an uneasy family environment, usually between the patient and the rest of the family. Describing his experiences gained, participant 1 said:

> Despite our best efforts to provide the required care, mother's unceasing complaints have made our lives more straining than usual. Sometimes we have no idea what to do. It is downing and depressing. I am not sure how we could live this way (Participant 1, Male, 25).

The absence of family counseling services and psychosocial therapy at health centers may aggravate family members' situations. However, the study identified religious affiliation as a valuable relational coping resource to find emotional support and comfort. Religion fathers were often the ones who counseled caregiver families living with family members facing chronic health hardship. Religious fathers usually serve in the role of meaning-making situations indicating God's goodwill and purpose. For example, a participant described her experience as *"*We often consult our spiritual fathers and get their comforting words*"* (Participant 11, Female, 21).

In addition to their prayers, religious fathers' emotional support provides caregiving families with meaning and purpose beyond their situations to create a feeling of hope by developing a belief that God would not allow without reason. The experience gained from participants eleven and seventeen read as:

> My sister sometimes takes mom to holy places to get holy water and hopes to get mom healed. Religious fathers also visit and comfort us with their uplifting words. I would say that emotional support allows the family to take a breather and take a break from stressful situations (Participant 11, Female, 21).
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> We often discuss our chaotic situations with church fathers. Church fathers come to our home to comfort us with their words and God's words indicating his purpose. It also offers genuine comfort. They sometimes pray and spray holy water on family members (Participant 17, Female, 26).

According to the findings, in the absence of professional family counseling services, support obtained from religious affiliation provides a variety of relational coping resources that may help at least to mitigate the chaotic emotions brought on by a family member's chronic illness diagnosis. According to the findings, spiritual services, such as the father's prayer and counseling, provide the patient's caregiving family with strong guidance, comfort, and strengths that help to understand and mitigate the effects of illness-related crises. It allows the patient's family members to take a break from the emotional strains and stress caused by the illness.

Third, in addition to the emotional support, congregational associations or affiliation provides families with *social support* during illness brought crisis. Because of their caring roles, caregiver families usually spend time with chronically ill family members, leaving them feeling isolated. However, social support from fellow friends from religious congregations, as demonstrated by the participants' excerpt, means a great deal to the families of the chronically ill in order to keep and maintain their social bond. Sharing his feelings towards his friend’s support, participant two said:

> When you see your friends helping you with your troubling moments, you feel loved and not left alone. It means a lot to us amid such traumatic illness experiences. My friends are thoughtful, considerate, and supportive (Participant 2, Male, 27).

According to the findings, social support was important for enhancing the coping abilities of family members. Families living with chronic illness who have become more integrated into the religious congregation regularly receive help (emotional, social, and sometimes material) from their fellow. In general, the findings reveal that religious affiliation and spiritual practices usually provide families living with and caring for a person with chronic illness with relational coping resources, which have a significant positive impact on mitigating the effects of chronic disease.

3.1.2. Socially accrued information or knowledge and its benefit

Knowledge or information crises: According to the participants’ disruption, lack of knowledge or information about the disease diagnosed, its symptoms, and its treatments usually cause chaos for caregiver families of the chronically ill family members. According to the findings, regardless of literacy status, a lack of knowledge and information posed a serious challenge. The caregiver families usually have difficulty understanding the chronic patients’ struggles and become unable to provide the best care required to help the patient to cope with painful health experiences. Describing their early experiences of living with a chronic health condition, participants one and fifteen said:

> We had no information or knowledge about the disease when the doctor confirmed mom’s diagnosis with cancer, and we were unaware of the treatments used to manage the situation. We did not believe that treatments were possible. As a result, we frequently face difficulties in understanding her situation and providing the best support or care that our mother requires. We even thought she would die right away (Participant 1, Male, 25).
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> Our father is diabetic, and when we heard his diagnosis, we were confused because we were perplexed because we had no idea how to help him. Furthermore, we had no idea whom to consult about the everyday situations we faced because we never even managed to get support from health workers (Participant 15, Female, 24).

A lack of knowledge has more effects, such as causing unhealthy relationships within the family, usually between the patient and the rest of the family members, which results in chaotic emotional experiences for both the patient and the rest of the family members. Participant two described his and his brother's relationship with their mother as follows:

> We have many hard times, especially when Mom is in pain. Mom’s pain usually causes her to become hot-tempered and verbally inconsiderate. We are not sure how we can help her. As a result, we sometimes stay away until she calms down (Participant 2, Male, 27).

Improvements in modern health care have enabled people to survive more health crises and spend less time in medical centers. Consequently, chronic patients often receive their treatments at home under their family members' care. In other words, the roles provided by health centers and health experts were taken on by the families of people with chronic health conditions. As a result, knowledge about the illness, its symptoms, and treatment become even more important for families who take on and perform caregiving roles.

Information or knowledge: Understanding the illness, its symptoms, and the methods used to manage the symptoms is critical to understanding the patient's painful experiences and providing the best care possible for the chronic patient. Participants described how information or knowledge about the illness provides opportunities to learn and practice or play roles at home, which are usually provided at health centers by people with medical expertise, such as injections. A female respondent (participant twelve), whose age was 21, described her experiences as “…I have even learned how to give an injection.”

The study identified the various ways caregiver families empowered themselves to provide the best care for a family member and managed to learn about the illness, its symptoms, and treatment over time, which strengthened their commitment to providing the best care that the patient requires.

Despite the fact that it was uncommon among study participants, a caregiver family member used scientific articles as a source of information to better understand the chronic illness and cope with its challenges. Understanding the illness was important for participants because it allowed them to recognize the patient's experiences, making it easier to adapt and adjust to illness situations. This study identified scientific articles as a source of information and knowledge that could help caregivers in empathizing with and understanding the struggles of a person with chronic illness. Participant 2 (Male, 27) described his experience reading scientific articles to learn about his mother's illness: "I have read scientific articles about mom's illness. So that I could feel her pain and understand her struggle.*"*

Socially acquired information and its benefit: as most participants described, the most important source of information or knowledge for families living with chronic illness was people or friends who had gone through similar experiences. The study's findings indicated that the information enabled caregiving families to better understand the illness, symptoms, and treatment. Caregivers used to learn through their informal social relationships. In this regard, people or friends who had prior exposure to chronic health experiences and friends who currently have a person with chronic illness were the most used sources of information in the absence of family support, such as counseling or family therapy in hospital settings. The information gleaned or heard is usually used as necessary coping resources for families to empower themselves and manage or mitigate the effects chronic illness may have on the patient and other family members. Describing the benefits of the information accrued from people who have been through with the same experiences, participant nine said:

> I am pleased with my friends. We usually talk and share our experiences. They are always available to us. Following their advice, we were even able to understand the behavior of the illness and its treatments (Participant 9, Male, 21). (Participant 9, Male, 21).

Likewise, participant fourteen also said:

> When we are down, it is our friends who always come to our help with advice. They try to discuss the illness, its symptoms, and methods for dealing with situations based on their own experiences with the same health condition. To be honest, their advice was immensely helpful to us (Participant 14, Female, 23).

According to the participants' accounts, professional support, such as family therapy or counseling services, was not noticeable in their experiences. As a result, in the absence of professional assistance, informal social networks, such as friendship, presented as an important relational coping resource for caregiver families living with chronic illness. Friends can help by providing information about the disease, its symptoms, and treatments, for example. People or friends who have experienced the same type of illness share information, emotions, and other related chaos of families who have recently been experiencing it. As the participants' excerpts indicate, informal social relations help the families, on the one hand, to maintain their social bond and, on the other hand, to learn and understand the disease and its symptoms. Besides, the information accrued helps to cope and manage the behavior and symptoms when it features and responds or provides the care the patient needs accordingly. Therefore, as the findings, families living with chronic illness have better family coping and mitigation if they can obtain information that can improve their problem-solving ability.

3.1.3. Family's strong sense of unity, we-nesses

According to the findings, another relational coping resource that plays a vital role in mitigating the effects of living with a family member diagnosed with chronic illness is the family's strong sense of unity or we-ness. Even though disease causes stress, sometimes the presence of chronic illness enables family members of the patient to come together, unite, and work together to mitigate the family's challenge, chronic disease. Indicating the importance of a unified move from the family members, an excerpt from a female participant reads "…I think it's good to be together. If not, I do not even imagine how we could manage to cope with all these illnesses brought strains" (Participant 5, 25).

The social relationships between family members usually create a strong sense of unity, or We-ness, in the family. In a family context, members sometimes get together to form a relational bond and share their experiences or challenges of living with family members with chronically ill-health conditions. Several factors can contribute to the formation of an intimate and humorous mood, which makes family members feel a sense of togetherness or we-ness. This study identified a few keys of the features of a family's sense of unity or we-nesses. These include quality time (the time family members spend to discuss and manage their chronic patient's health condition) spent together and effective open communication (smooth and frequent communication about every aspect of the family, including medication, patient's situation, care needs, and any changes), and division of roles that could ease the burden.

Quality time spent and open communication. One of the key features of caregiving families' strong sense of unity or We-nesses was the quality time spent with one another and the communication they develop about their home situations, especially in chaotic health conditions. Describing how their mother's illness helped them to get quality time to see and communicate with each other about their home condition, a female participant said:

> Since mom's cancer diagnosis, we have had the opportunity to see each other and spend quality time talking about mom's situation and other family issues. Now I realize that the communication we developed was the most crucial factor in retaining our family together despite the illness's challenges (Participant 20, Female, 21).

According to the findings, the quality time that family members spend together leads to them finding more time to communicate freely about illness situations at home. The communication usually involves issues concerning the patient's illness, treatments, caregiving roles, and other inside-out activities undertaken to keep the family functioning. However, communication barriers can arise between the patient and the rest of the family members, as well as among caregiving family members, due to issues such as a lack of understanding about the disease, caregiving roles, and responsibilities. However, when the family starts to spend quality time together at home and communicates openly with one another, it helped the family to develop a strong sense of unity, we-ness, or understanding within the family.

> Since our mother's diagnosis, we have spent a lot of time together and talked about how things are at home, such as mom's illness, medication, caregiving role divisions, and other family issues. We have become very close and caring since Mom's diagnosis (Participant 7, Male, 31).

The study realized the significance of family communication as a unit. When caring for a family member with a chronic disease, sharing experiences makes it easier to deal with every aspect of the illness. According to the participants' accounts, communication within the family was critical to achieving understanding because they were aware of each other's feelings. As a result, they were better able to support one another and became emotionally intimate and caring. Sharing experiences and having open discussions about adverse health conditions encourages family members to support and maintain the family's functioning.

The subtheme, *role divisions*, was evident in the study participants' accounts. One aspect of chronic illness is the effect it has on role shifts. The presence of chronic disease alters the roles that each member of the family is expected to play. Each family member is expected to take on the role previously held by the chronic patient. In other words, it expects caregiver families to take on more responsibilities to compensate for the activities that the chronic patient is unable to complete. Role shifts often increase the burden on each patient's family member. However, supportive familial relationships or role divisions, according to participants' experts, were essential to ease the burden each family member would bear. Recounting their experiences, two participants said:

> In the beginning, when we heard dad's diagnosis, we were shocked and confused. We had no idea what to do. Things began to improve later on as we began to support one another. As a result of sharing family burdens and supporting one another, the pressure on one person was significantly reduced (Participant 15, Female, 24).

> I believe things are improving because of the understanding we've developed within the family. Each of us plays an important role in keeping the family functioning. Despite the strains, we often share responsibilities, especially when it comes to mom's care and other household chores. The individual's

> burden has now been significantly reduced. The family members are very close, especially since Mom was diagnosed with diabetes (participant fourteen, female, 23).

In general, a strong sense of unity, or we-ness, fosters family strengths and a sense of pleasure in being together. Furthermore, a strong sense of We-ness within the family enables a shared understanding of the illness, its effects, treatments, and potential role shifts. Thus, the illness established a strong sense of unity or we-nesses, which enabled the patient's family members in coping with and mitigating the crises caused by a family member's diagnosis of chronic illness.

4. Discussions

The purpose of this study was to reveal the relational coping resources that caregiver families used to cope with the challenges and changes that come with living with chronic illness. Improvements in modern health care have enabled people to survive more health crises, such as chronic illness, and spend less time in hospitals (Deist, 2013; Hoard, 2004). The majority of care and treatment takes place at home, with patients' families taking on caregiving responsibilities. As a result, caregiver families often have chaotic experiences, which have an impact on the overall family life (Compas, Jaser, Dunn, and Rodriguez, 2012; Murray *et al.*, 2007). Nonetheless, caregiver families of chronic patients usually use a variety of relational coping resources or methods to deal with the challenges and changes brought on by a family member's chronic illness diagnosis.

Walsh's (2003) Family Resilience Framework identified religious affiliations and spirituality as valuable resources that support chronic patient caregiver families in coping with adverse health conditions. Similarly, the findings of this study show that religious affiliations, as expressed through religious belief and spiritual practices, are the most usually used relational coping resource that helps families cope with chronic health situations. Religious beliefs and spiritual practices, such as faith in God, prayer, meditation, visits to holy places and spiritual fathers, and so on, are thought to have a positive effect on dealing with chronic health conditions. Religious affiliations provide support and comfort throughout the family's difficult situations, according to the findings. Through their affiliation with the congregation, the caregiving family easily access religious coping resources. The caregiver family usually used religious beliefs as part of their relationship with God in the hope that God will cure their chronic health problems. Families with chronic illnesses frequently believe that God can heal a family member's health problem. Religious beliefs and practices have an impact on providing hope and developing optimistic beliefs that God is ultimately in control of their difficult circumstances. Spiritual belief, trust, and hope in God are expressed through religious practices such as prayer, visits to spiritual fathers, and holy places, which are regarded as important religious resources to get instant healing and relief from the adverse health crisis.

Furthermore, the study revealed religious affiliation and spiritual practices as critical relational coping resources for providing emotional support to caregiver families. Following a member's diagnosis with a chronic disease, the rest of the family usually suffers from emotional tolls such as anxiety, fear, hopelessness, and so on. However, religious beliefs and spiritual practices play an important role in making sense of situations such as adverse health situations. Similar studies (Greeff and Joubert, 2007; Deist, 2013) argue that relational religious resources, such as congregational affiliation, fathers' prayers, or counseling, provide families with guidance, comfort, strength, and help to understand the problem and cope with crises. Spiritual fathers were often the ones who played the role of counseling and comfort, indicating God's goodwill and purpose. Religious fathers' emotional support provides patient's caregiver families with meaning and purpose beyond their situations, which tend to create feelings of hope by developing a belief that God would not allow without reason. Walsh (2003) showed that religious support empowers families by providing meaning and purposes beyond themselves and their current problems. It is essential for caregiving families when there is no or lack of professional support like family counseling or family therapy. Emotional support provides families to take a break from illness-caused emotional strains. Congregational affiliation also played an immense role in getting social support from people of the same religion. Caregiving families often experience loneliness due to the caregiving burden. Therefore, apart from its contribution to mitigating illness-caused social isolation, religious affiliation helps caregiving families of the chronic patient to get social support, like labor contributions in home chores.

This finding enjoys theoretical support from the resilience framework. Walsh (1996) believes that resilient families have the strength to admit when they need help and are more likely to utilize the available support when faced with adversity. In the model of resiliency, the family's social support, which is informal, for example, friends, and religious affiliation, viewed as an essential buffer that promotes family stability (McCubbin and Patterson, 1981). The finding indicates that religious affiliation and spiritual practices offer caregiver families with relational coping resources that the family accrues through their affiliation to the religion and the congregation, which also provides them resources to mitigate the effects of chronic illness. Family resilience was significantly better in families that were more integrated into their religion, usually found support in their affiliations, and used resources on a regular basis when caring for a family member diagnosed with chronic health conditions. Studies have shown that a strong sense of spiritual wellness, whether formal religion or other shared beliefs, enables the caregiving families to stay strong when dealing with problems like chronic illness (Deist, 2013).

The resilience Framework explains that the families' ability to accept a crisis influences their competence in selecting a coping response (Walsh, 2003). However, knowledge regarding the illness is the most significant relational resource that could determine families' ability to cope with the health crises. Professional help, like family therapy or family counseling, was not very noticeable in Ethiopia. As per the findings of this study, none of the participants made use of professional support. In the absence of health education regarding chronic health experiences, families with caregiving responsibilities usually learn and empower themselves about the illness and coping strategies through their relations with people or friends who have gone through the same adverse health conditions. People or friends who had gone through the same chronic health experiences were the most sources of information or informal knowledge. The results of this study reveal that knowledge about the illness was significant for caregiving families to cope with the adverse effects of living with chronic health conditions. Participants explained that, by learning from people with the same experiences about the illness, they were better able to understand the behavior of the disease and the patient, thus making it easier to accept and adapt to the situation. The findings of this study indicate that knowledge helps to understand illness-caused chaotic behavior and respond accordingly. By educating themselves through their social or friendship relations, caregiving families develop a better understanding of the behavior of the illness, thus making it manageable to cope when things turn rough.

Concurring with this finding, studies (McCubbin and McCubbin, 1996; Walsh, 2003) indicated that understanding the crises makes caregiving families better able to maintain a sense of control over illness-causing situations, which fosters confidence that their circumstances will ultimately work out positively. Understanding the illness was significant to cognize the patient's experiences, making it easier to adapt and adjust to illness situations. Thus, the finding of this study argues information or knowledge seeking and using it to manage the adverse health experiences of the family as a resilience resource. Similar studies also showed that making sense of unexpected crises and effective response to the rough situation is a key element in the process that could help caregiving families' resilience and normalize and contextualize their situations (Deist, 2013; Walsh, 2003).

Another essential relational coping resource caregiving family members of the patient frequently used to cope and mitigate the effects of a family member's chronic illness diagnosis was a strong sense of unity or we-ness. According to the Family Resilience Framework, families function best when family members develop a strong sense of unity (Walsh, 2003). As resilience resources, the framework identified family characteristics such as practical support, emotional support, mutual respect, and love for one another within a family. The study's findings indicated that chronic illness in a family provides opportunities for families to get together, spend time together, and move forward in the face of disease-related challenges and changes. According to the findings, the caregiver family mitigates the emotional burden of the illness by spending time together and supporting one another. Everyday communications, emotional intimacies and care, and division of roles at home could ease the burden associated with caregiving responsibilities, including cooking and caring for the patient, were among the essential elements that featured family members' strong sense of unity or we-nesses. The time caregiver families spend together causes members to develop effective communication skills about illness-related situations. Communication frequently includes concerns about the patient's health, treatments, caregiving roles, and other activities undertaken to maintain the family functioning.

Communication barriers occur, sometimes between the patient and the rest of the family and sometimes among caregiving family members due to factors such as a burden associated with caregiving roles. With the quality time they spend, the introduction of effective communication (smooth and frequent communication about every aspect of the family, such as medication, patient's situation, care needs, and any other changes) among caregiving families results in a strong sense of unity, we-ness, or understanding within the family. Similarly, studies show that families can mitigate the effects of chronic illness by communicating effectively within the family (Deist, 2013; Walsh, 2003) as essential to easing the burden that each family member would bear when caring for a family member with chronic illness. A strong sense of unity or we-ness enables family strengths and a sense of pleasure in being together (Öhman and Söderberg, 2004). According to the Family Resilience Framework, in order to optimize family functioning even in situations where chronic illness can cause dysfunction, the family must develop a strong sense of unity and understanding among caregiving family members in order to cope with the challenges and changes brought on by the chronic illness.

5. Conclusions and Recommendations

The findings revealed that the caregiver families of chronically ill family members utilize various relational coping resources. Conferring to the Family Resilience Framework, caregiving families have to manage to obtain the relational social resources through their inside-out affiliations. Inside the home, the caregiving family members of the patient build a strong sense of unity or we-nesses through their familial relationships to strengthen the family’s coping capacity. Similarly, in their outside affiliations through their religious belief and spiritual practices, and friendship circle, the caregiving families become able to enhance their coping capability to mitigate the effects of a family member’s diagnosis with chronic illness. The findings indicated that knowledge about chronic diseases in general, and family therapy or family counseling services, in particular, are lacking in the health system. The study revealed that families’ interpersonal factors or relational resources, like religious affiliations and friendships with people who had the same chronic health situation, produced opportunities to enhance and accrue relational coping resources. This study argues that in the absence of formal supports, such as family counseling, informal relational coping resources play a pivotal role for families in mitigating the impacts of living with chronic illness. Despite its debilitating effect, the family experiences living with a member diagnosed with the chronic disease received lacking attention at the hospital level. Therefore, to enhance coping capacities, the study recommends that hospital services need to have mechanisms and support the families living with chronic illness, which could improve their awareness of the chronic disease, so it could help the caregiving families in mitigating the challenges and its overall complications.

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7. Conflict of Interest

The author has stated that he has no conflicts of interest.

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