Components of Collective Coping in Families Facing Chronic Illness

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Article Info	ABSTRACT
Article type: *Original Article* **How to cite this article:** 	**Objective:** This study aimed to explore the core components of collective coping in families managing the challenges of chronic illness, focusing on how emotional, relational, and social processes interact to sustain resilience. **Methods and Materials:** A qualitative research design was employed using semi-structured interviews with 20 family members of patients living with chronic illness in Ireland. Participants were recruited through purposive sampling to ensure variation in roles, including spouses, parents, adult children, and siblings. Interviews were conducted either face-to-face or via secure online platforms, with each lasting between 60 and 90 minutes. Data collection continued until theoretical saturation was reached. Transcripts were analyzed thematically using NVivo software version 14, following an iterative coding process of open coding, categorization, and theme development. Reflexivity and peer debriefing were used to enhance credibility and trustworthiness. **Findings:** Four overarching themes emerged, each encompassing multiple subthemes. Emotional solidarity captured shared emotional expression, empathic support, hope maintenance, anxiety management, and the protection of vulnerable members. Collaborative problem-solving included shared decision-making, role and task distribution, resource pooling, adaptive planning, and conflict resolution. Meaning-making and resilience reflected reframing illness as a shared challenge, strengthening family identity, engaging in collective spiritual practices, and narrative sharing. External support and community connection encompassed reliance on social networks, healthcare partnerships, institutional support, peer networks, and advocacy. Collectively, these themes highlighted coping as a relational and communal process rather than an individual endeavor. **Conclusion:** The findings underscore that coping with chronic illness within families is fundamentally collective, rooted in shared appraisals, collaboration, and external resource integration. Recognizing these dynamics offers valuable insights for healthcare professionals and policy makers seeking to design family-centered interventions that enhance resilience and well-being. ***Keywords:*** *Collective coping; communal coping; chronic illness; family resilience; qualitative study; Ireland*

1. Introduction

Chronic illness represents a prolonged health condition that fundamentally alters the dynamics of family life, often demanding continuous adjustment in emotional, relational, and practical domains. Families rarely experience such conditions as isolated individuals; rather, illness becomes a shared challenge that affects communication patterns, role distribution, and collective meaning-making (Helgeson et al., 2017; Rentscher, 2019). This interdependence has led scholars to develop frameworks such as communal or collective coping, which recognize that coping processes are embedded within interpersonal relationships and extend beyond individual strategies (Wolf & Fisher, 2022). The collective approach emphasizes the family's shared appraisal of stressors and coordinated efforts to address them, positioning communal coping as a central mechanism in family resilience (Vleet et al., 2018a, 2018b).

The theoretical underpinnings of communal coping are grounded in appraisal theory and stress-coping frameworks, which argue that how stressors are appraised—either individually or collectively—shapes the coping strategies employed and their eventual effectiveness (Bippus & Young, 2012; Zalewski et al., 2011). When families view chronic illness as "our problem" rather than "your problem," this shift in appraisal fosters collaboration and shared responsibility (Helgeson et al., 2016; Zajdel & Helgeson, 2020). Research has shown that shared appraisals are linked to greater relationship satisfaction, better self-care behaviors, and improved psychological outcomes (Helgeson & Vleet, 2019; Zajdel, Naqvi, et al., 2022). In contrast, when illness is treated as an individual burden, families often report role strain, emotional withdrawal, and decreased relational quality (Ben-Zur et al., 2005).

Couple and family contexts provide important lenses for understanding how collective coping unfolds. In studies of couples managing diabetes, for instance, shared illness management behaviors such as collaborative goal setting and mutual encouragement predicted higher treatment adherence and improved emotional well-being (Berg et al., 2020; Vleet et al., 2018b). Similarly, dyadic studies have highlighted the moderating role of appraisal congruence, where partners' alignment in perceiving illness stress shapes the efficacy of coping efforts (Zheng et al., 2024). These insights underscore the necessity of viewing coping not merely as an individual act but as a process co-constructed within relationships.

Beyond couples, communal coping has also been documented across diverse family structures and contexts. Research on parental coping highlights the relational reorganization required when caring for a chronically ill child, with families relying on shared strategies of hope maintenance, role flexibility, and meaning reconstruction (Albuquerque et al., 2017; Novak et al., 2020). Similarly, studies of bereavement and family adjustment reveal that joint engagement in rituals, storytelling, and support exchanges strengthens collective resilience (Scheinfeld et al., 2024). These relational responses demonstrate that coping with chronic illness is deeply social and culturally contextualized, varying across settings and populations (Guribye et al., 2011).

Communal coping theory has been extended and refined over the years to account for both explicit and implicit forms of coping. Explicit communal coping involves overt acknowledgment of shared stressors and joint problem-solving, while implicit forms may include unspoken coordination and silent emotional alignment (Helgeson et al., 2016; Helgeson et al., 2021). These nuanced distinctions highlight that not all communal coping is verbally expressed; instead, it may manifest in subtle acts of care, shared routines, or nonverbal emotional exchanges (Horner & Helgeson, 2022). For instance, studies have shown that small daily acts, such as preparing meals together or attending medical appointments as a family, reinforce the sense of togetherness essential for sustaining resilience (Zajdel, Helgeson, et al., 2022).

A growing body of literature has tested the theoretical dimensions of communal coping through experimental and longitudinal approaches. Experimental work has demonstrated that communal framing of stress improves relational satisfaction and reduces physiological stress responses (Zajdel & Helgeson, 2021). Longitudinal investigations further suggest that communal coping predicts sustained relationship quality and better chronic illness outcomes over time (Helgeson et al., 2019; Kelley & Helgeson, 2025). These findings illustrate that communal coping is not merely a short-term adaptation but a process with long-term implications for relational and health trajectories.

The mechanisms through which communal coping exerts its effects have been a subject of increasing scholarly interest. Shared appraisal acts as a foundational mechanism, orienting family members toward a collective mindset (Basinger, 2017). Collaboration in problem-solving, coordination of caregiving roles, and mutual emotional

support function as downstream processes that operationalize this mindset (Basinger et al., 2021; Zajdel & Helgeson, 2024). Positive emotionality, trust, and relational closeness emerge as mediators linking communal coping to both relational and health-related outcomes (Horner & Helgeson, 2022; Yi et al., 2024). At the same time, scholars caution that communal coping may not always yield positive results; in some cases, it can create dependency, blur individual boundaries, or exacerbate relational conflicts (Helgeson et al., 2017; Rentscher, 2019).

The broader literature on stress and coping also informs the conceptualization of communal coping. Appraisal-based models emphasize the interaction between perceived efficacy, threat, and available resources (Jordan & Vogt, 2017; Wolf & Fisher, 2022). Research in fields as diverse as disaster response and public health communication illustrates that communal coping strategies are often more effective when families or communities perceive collective efficacy and adopt proactive approaches (Bubeck et al., 2017; Ort & Fahr, 2018). These insights resonate with findings from chronic illness contexts, where families' belief in their shared capacity to manage illness predicts better adjustment outcomes (Thompson et al., 2015; Thompson et al., 2014).

Emotional processes are equally central to communal coping. Studies highlight that managing collective emotions—fear, anxiety, hope—forms a core dimension of family adjustment to illness (Cho et al., 2020; Dunkley et al., 2014). For example, dyadic studies of couples with diabetes reveal that shared emotional expression helps regulate stress and fosters intimacy (Berg et al., 2009). Similarly, intergenerational family narratives often serve as vehicles for reframing illness in more hopeful or meaningful terms, thereby reinforcing resilience (Novak et al., 2020). Such findings suggest that communal coping is as much an emotional process as it is a behavioral or cognitive one.

At the same time, communal coping is shaped by sociocultural and contextual factors. Research on refugees demonstrates that collective coping is embedded within community ties and cultural practices (Guribye et al., 2011). In collectivist cultures, communal coping often emerges more naturally as illness is readily defined as a shared concern (Yi et al., 2024), while in more individualistic contexts, it may require intentional effort to reframe illness as a collective issue (Ben-Zur et al., 2005). This cultural sensitivity underscores the need to situate communal coping research within specific contexts, including the Irish families explored in this study.

Despite extensive empirical and theoretical advances, important gaps remain. Much of the research has focused on couples, particularly those managing diabetes, leaving less attention to broader family systems or other chronic illnesses (Helgeson & Vleet, 2019; Zajdel & Helgeson, 2024). Additionally, while quantitative models have provided strong evidence of communal coping's effects, qualitative studies remain limited, particularly those capturing the lived experiences and narratives of families navigating chronic illness in everyday life (Scheinfeld et al., 2024). Furthermore, while communal coping is often framed as a uniformly positive process, few studies critically examine its limitations, such as potential over-involvement, conflict, or disparities in caregiving burdens (Rentscher, 2019; Zajdel, Naqvi, et al., 2022).

Addressing these gaps requires research that illuminates the nuanced, context-dependent, and lived dimensions of communal coping within families. Qualitative approaches, with their emphasis on capturing subjective experience and meaning, are particularly well-suited for this task. By focusing on families facing chronic illness in Ireland, this study aims to contribute to the literature by identifying the components of collective coping as expressed through family members' own voices. Through thematic analysis of semi-structured interviews, the study seeks to extend existing frameworks while capturing the cultural, emotional, and relational dimensions that shape coping in practice. The ultimate goal is to deepen our understanding of how families transform individual suffering into collective resilience, thereby enriching both theoretical models and practical interventions for supporting families navigating chronic illness.

2. Methods

2.1. Study Design and Participants

This study employed a qualitative research design to explore the components of collective coping among families dealing with chronic illness. A purposive sampling strategy was used to recruit participants who could provide rich, relevant, and diverse perspectives on the phenomenon under investigation. The study included 20 participants, all residing in Ireland, who were members of families currently experiencing or having recently experienced chronic illness in one or more family members. The sample was composed of parents, spouses, and adult children to ensure variation in viewpoints within family structures. Recruitment continued

until theoretical saturation was reached, meaning no new themes or insights emerged from additional interviews.

2.2. Measures

Data were collected through semi-structured interviews, which allowed participants to freely describe their lived experiences while ensuring that the interviews covered core topics of interest, such as coping strategies, family communication, shared meaning-making, and emotional support. An interview guide was developed with open-ended questions to encourage elaboration while maintaining flexibility to follow emerging lines of inquiry. Interviews were conducted face-to-face or via secure online platforms, depending on participants' availability and preferences. Each interview lasted between 60 and 90 minutes and was audio-recorded with participants' consent. All recordings were transcribed verbatim, and participants' identities were anonymized through the assignment of pseudonyms.

2.3. Data Analysis

The data were analyzed using thematic analysis, facilitated by NVivo software version 14. Analysis followed an iterative, inductive process. Initially, transcripts were read multiple times to ensure immersion in the data. Open coding was applied to identify meaningful units of text, which were then grouped into categories and subcategories reflecting recurring patterns and emerging concepts. Through constant comparison, these categories were refined and clustered into broader themes that captured the core components of collective coping. The coding process continued until theoretical saturation was reached. To enhance the trustworthiness of the findings, peer debriefing and member checking were conducted. Additionally, reflexive journaling was maintained throughout the study to ensure awareness of researcher bias and positionality.

3. Findings and Results

The study sample consisted of 20 participants from various regions of Ireland, representing diverse family roles and demographic backgrounds. Of the participants, 12 were female and 8 were male. Age ranged from 28 to 67 years, with the largest group falling between 40 and 55 years (n = 9). In terms of family role, 7 participants were spouses of the patient, 6 were adult children, 5 were parents of an ill child, and 2 were siblings. Regarding education, 9 participants had completed higher education, 7 held secondary-level qualifications, and 4 reported vocational training as their highest level of education. The majority were employed either full-time or part-time (n = 11), while 6 were homemakers and 3 were retired. Duration of illness within the family context varied: 8 participants reported living with chronic illness for more than 10 years, 7 for between 5 and 10 years, and 5 for less than 5 years. This demographic distribution reflects a heterogeneous group, providing a range of perspectives on the collective coping processes explored in this study.

Table 1

Themes, Subthemes, and Concepts of Collective Coping in Families Facing Chronic Illness

Category (Main Theme)	Subcategory	Concepts (Open Codes)
1. Emotional Solidarity	Shared Emotional Expression	"Crying together," "Expressing frustration," "Open acknowledgment of fear," "Collective laughter as relief"
	Empathic Support	"Listening without judgment," "Validation of feelings," "Recognizing unspoken emotions," "Emotional reassurance"
	Hope Maintenance	"Holding onto optimism," "Encouraging words," "Spiritual or religious hope," "Future-oriented thinking," "Symbolic rituals for hope"
	Managing Anxiety	"Breathing together," "Collective calming strategies," "Limiting exposure to distressing information"
	Protecting Vulnerable Members	"Shielding children from distress," "Minimizing emotional burden," "Selective disclosure"
2. Collaborative Problem-Solving	Shared Decision-Making	"Family meetings," "Consensus on treatment choices," "Delegation of responsibilities," "Joint negotiation with healthcare providers"
	Task Distribution	"Dividing caregiving roles," "Scheduling household tasks," "Role flexibility," "Involving extended family"
	Resource Pooling	"Combining financial resources," "Time-sharing," "Pooling knowledge about illness," "Collective information-seeking"
	Adaptive Planning	"Adjusting family routines," "Contingency planning," "Balancing work and care," "Rearranging priorities"
	Conflict Resolution	"Avoiding blame," "Compromise strategies," "Third-party mediation," "Forgiveness after disputes," "Using humor to defuse tension"

3. Meaning-Making and Resilience	Reframing Illness	"Seeing illness as a test," "Viewing adversity as growth," "Spiritual interpretation," "Illness as strengthening bonds"
	Strengthening Identity	"Pride in resilience," "Family identity as fighters," "Defining illness as 'our challenge,'" "Intergenerational storytelling"
	Collective Spiritual Practices	"Family prayers," "Attending religious rituals together," "Faith-based support groups"
	Narrative Sharing	"Telling illness stories," "Remembering milestones," "Celebrating small victories," "Documenting experiences"
4. External Support and Community Connection	Seeking Social Support	"Relying on neighbors," "Friendship networks," "Community solidarity," "Support from extended relatives"
	Healthcare Partnership	"Trusting medical staff," "Regular communication with doctors," "Joint hospital visits," "Collaborative care planning"
	Institutional Resources	"Charity support," "Government health programs," "Accessing NGOs," "Financial aid applications," "Educational workshops"
	Peer Support Networks	"Connecting with other families," "Online support groups," "Exchanging coping tips," "Sharing emotional burdens"
	Public Expression of Struggle	"Advocacy efforts," "Raising awareness," "Public storytelling," "Engaging in fundraising events"

Emotional Solidarity

Families emphasized the centrality of shared emotional expression. Many participants described how "crying together became a form of release," while others highlighted moments when "we laughed together, even during the worst times—it was our way of surviving." This collective articulation of emotions fostered a sense of unity. Empathic support emerged as another essential subtheme; participants stressed that "being listened to without judgment" or "just knowing someone understood without words" created comfort and reduced isolation. Maintaining hope was also widely practiced, with families drawing strength from "holding onto optimism," or, as one participant put it, "lighting a candle every night gave us something to believe in." Anxiety management was commonly handled through collective techniques such as "breathing together" or "deciding not to talk about the scariest possibilities at night." Protecting vulnerable members was deliberate; one mother explained, "We never told the younger children how serious the illness was—we wanted them to feel safe."

Collaborative Problem-Solving

Shared decision-making was a defining feature of how families coped with illness. Several participants noted that "we held family meetings after each doctor's appointment to decide together what to do next." Task distribution allowed families to share responsibilities, with one spouse reflecting, "My husband managed the hospital runs, and I focused on keeping the house stable." Resource pooling was common, especially financially: "We all pitched in from our savings, no matter how small," reported one adult child. Families engaged in adaptive planning by altering routines, such as "rearranging work hours so someone could always be home." Conflict resolution was equally important; humor often played a role, as expressed by a participant who said,

"Sometimes we joked about the hospital food just to avoid fighting about bigger things."

Meaning-Making and Resilience

Families often reframed illness in ways that allowed them to endure. One participant shared, "We told ourselves this illness was a test, not a punishment," while another viewed it as "a chance for us to become closer and stronger." Strengthening identity was another process; families embraced a collective identity as resilient fighters, with statements like, "We started calling ourselves 'the warriors.'" Collective spiritual practices were pivotal, including family prayers and faith rituals, which participants said "helped us feel guided and supported." Narrative sharing also built resilience. Families told and retold illness stories—"We still remember the day Dad walked again after surgery; we celebrate it every year." Such practices cultivated meaning and fostered continuity amid uncertainty.

External Support and Community Connection

Families did not cope in isolation. Seeking social support was fundamental, with one participant recalling, "Our neighbors cooked for us for weeks—it was like the whole street was part of our family." Healthcare partnerships also shaped coping; families built trust with medical teams, noting, "We always went together to see the consultant, so everyone understood." Institutional resources were utilized when available, from charities to government programs: "Without the NGO's help, we could not have afforded the treatment," admitted one participant. Peer support networks, particularly online groups, were critical: "Talking with another mother going through the same thing saved my sanity." Public expression of struggle through advocacy or fundraising was another channel; as one father stated, "By speaking out, we felt our pain had purpose beyond our home."

4. Discussion and Conclusion

The findings of this study identified four interrelated themes that define how families collectively cope with chronic illness: emotional solidarity, collaborative problem-solving, meaning-making and resilience, and external support and community connection. Each theme comprised multiple subdimensions, ranging from shared emotional expression and empathic support to joint decision-making, reframing illness, and engagement with healthcare or peer networks. Together, these themes illustrate that coping with chronic illness is not merely an individual task but a complex, dynamic, and shared process situated within the family system. The results add to the growing body of evidence on communal coping and provide nuanced insights into how families transform individual suffering into collective resilience.

Emotional Solidarity emerged as a central category, underscoring the importance of families creating shared spaces for emotional expression, empathy, and protection of vulnerable members. Participants described crying together, laughing as a form of relief, and offering reassurance to one another. These findings align with prior work that highlights the role of emotional synchronization and mutual validation in communal coping (Helgeson et al., 2019; Horner & Helgeson, 2022). In particular, research on daily manifestations of communal coping suggests that subtle emotional cues, such as empathic listening or protective silence, strengthen relational bonds and buffer psychological distress (Helgeson et al., 2016; Helgeson et al., 2021). Our participants' emphasis on shielding children from distress also resonates with studies documenting selective disclosure and protective communication strategies within family coping (Novak et al., 2020). Furthermore, the maintenance of hope observed in this study parallels evidence that collective optimism functions as a powerful resource for sustaining engagement with long-term treatment regimens (Vleet et al., 2018a; Yi et al., 2024). By sharing emotional burdens, families not only regulated distress but also cultivated a sense of solidarity that reinforced their ability to confront illness together.

The second theme, Collaborative Problem-Solving, captured how families distributed tasks, engaged in shared decision-making, pooled resources, and negotiated conflicts. Participants described practical coordination such as scheduling medical visits, pooling finances, or balancing caregiving and employment responsibilities. These behaviors are consistent with dyadic research demonstrating that collaborative planning and joint responsibility predict improved illness management and relational satisfaction (Berg et al., 2020; Zajdel & Helgeson, 2020). Importantly, our findings highlight the role of family meetings and consensus-building, echoing results from studies showing that aligned appraisals and shared decision-making enhance both relational and health outcomes (Zajdel, Helgeson, et al., 2022; Zheng et al., 2024). The presence of conflict resolution strategies, often facilitated by humor or compromise, reflects evidence that communal coping does not eliminate conflict but reshapes it into manageable and constructive forms (Ben-Zur et al., 2005; Helgeson et al., 2017). These results reinforce the argument that communal coping involves both emotional and instrumental collaboration, with problem-solving serving as a practical mechanism through which collective appraisal is enacted.

Meaning-Making and Resilience formed another core component of collective coping. Families reframed illness as a shared test or opportunity for growth, strengthened their collective identity as resilient units, and engaged in spiritual practices and narrative sharing. These findings are consistent with theoretical models emphasizing appraisal as a critical dimension of communal coping (Basinger, 2017). The process of reframing illness echoes research showing that positive reinterpretation predicts both improved psychological adjustment and relational stability (Helgeson et al., 2017; Rentscher, 2019). Likewise, the emphasis on family identity resonates with evidence that communal coping strengthens perceptions of "we-ness" and shared resilience (Kelley & Helgeson, 2025; Vleet et al., 2018b). The role of spirituality observed here is supported by studies noting that faith-based rituals and practices provide families with meaning frameworks that transcend individual suffering (Albuquerque et al., 2017; Scheinfeld et al., 2024). Narrative sharing, where families tell and retell stories of illness and survival, mirrors findings from studies showing that illness narratives function as vehicles for coherence, continuity, and collective resilience (Jordan & Vogt, 2017; Zajdel & Helgeson, 2021). Taken together, these results illustrate that meaning-making is not a passive process but an active, socially embedded mechanism that sustains resilience over time.

The final theme, External Support and Community Connection, demonstrated that families extend coping beyond the household by seeking social, institutional, and peer resources. Participants described reliance on neighbors, engagement with healthcare providers, and participation in online support groups. This aligns with findings that

communal coping is strengthened through connections with external networks that provide material, informational, and emotional resources (Helgeson & Vleet, 2019; Yi et al., 2024). Trust in healthcare professionals and collaborative relationships with providers also reflect earlier evidence that positive patient–provider interactions facilitate adherence and foster communal responsibility (Berg et al., 2009; Horner & Helgeson, 2022). The reliance on institutional resources such as NGOs and government programs echoes research emphasizing the role of structural supports in enabling families to sustain coping efforts (Bubeck et al., 2017; Ort & Fahr, 2018). Finally, engagement in advocacy and public expression parallels studies suggesting that transforming private struggles into public action enhances families' sense of agency and provides broader social meaning to their experiences (Cho et al., 2020; Thompson et al., 2015). Our findings thus confirm that communal coping does not occur in isolation but is embedded within broader community and institutional contexts.

Overall, this study provides empirical support for the communal coping framework and illustrates its applicability beyond couples to encompass family systems. The identification of emotional solidarity, collaborative problem-solving, meaning-making, and external support highlights the multi-dimensional nature of collective coping. These results align with prior conceptualizations of communal coping as involving both shared appraisal and joint action (Wolf & Fisher, 2022; Zajdel, Naqvi, et al., 2022). At the same time, our findings contribute new insights by showing how these processes manifest in everyday family practices such as storytelling, humor, and protective silence. They also reveal the dual role of external connections—both as sources of support and as avenues for extending coping beyond the private sphere.

Nevertheless, it is important to note that communal coping is not uniformly beneficial. As some studies caution, over-involvement or blurred boundaries can create tension, dependency, or inequities in caregiving roles (Helgeson et al., 2017; Rentscher, 2019). While our participants generally emphasized positive experiences, the challenges of conflict management and resource strain suggest that communal coping also entails vulnerabilities. This finding resonates with the broader stress and coping literature, which emphasizes the importance of balance between shared and individual strategies (Dunkley et al., 2014; Zajdel & Helgeson, 2020). Future interventions should therefore acknowledge both the strengths and potential pitfalls of

communal coping, ensuring that support structures help families navigate these complexities.

5. Suggestions and Limitations

This study, while offering valuable insights, has several limitations. First, the qualitative design and sample size of 20 participants limit the generalizability of the findings. Although theoretical saturation was achieved, the experiences of Irish families may not fully represent those of families in other cultural or social contexts. Second, the reliance on self-reported narratives may introduce recall bias or social desirability effects, particularly in discussing sensitive topics such as conflict or emotional distress. Third, the cross-sectional nature of the data limits the ability to capture how communal coping evolves over time, particularly across different stages of illness trajectory. Fourth, the study primarily included family members who were willing to participate in interviews, which may exclude perspectives from individuals less engaged in communal processes. Finally, although NVivo 14 facilitated systematic coding, the interpretive nature of thematic analysis means that findings are shaped by researcher subjectivity, despite efforts at reflexivity and peer debriefing.

Future research should build on these findings by incorporating longitudinal designs to explore how communal coping changes across illness progression, from diagnosis to long-term management. Comparative studies across cultures and health conditions would provide valuable insights into how sociocultural factors shape communal coping processes. Additionally, integrating mixed-method approaches, combining qualitative narratives with quantitative measures of health and relational outcomes, could strengthen causal inferences and provide a more holistic picture. Future studies should also consider the perspectives of marginalized family members, such as children or elderly relatives, whose voices may be less represented in current research. Finally, intervention studies testing the effectiveness of communal coping training or family-based therapeutic programs could provide evidence for practical applications that strengthen resilience in families managing chronic illness.

For practice, these findings suggest the importance of supporting families not only at the individual level but also as collective units. Healthcare providers should be trained to recognize and reinforce communal coping behaviors, such as shared decision-making and collaborative problem-solving. Family-centered interventions can be designed to

facilitate emotional solidarity, encourage meaning-making activities such as storytelling, and strengthen connections to community and institutional resources. Support groups should be structured to include whole families rather than individuals, ensuring that coping strategies are aligned and mutually reinforcing. Finally, policy frameworks should acknowledge the family as a critical site of coping, investing in resources and services that enable families to transform the burden of chronic illness into a shared pathway of resilience and growth.

Authors' Contributions

All authors have contributed significantly to the research process and the development of the manuscript.

Declaration

In order to correct and improve the academic writing of our paper, we have used the language model ChatGPT.

Transparency Statement

Data are available for research purposes upon reasonable request to the corresponding author.

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Declaration of Interest

The authors report no conflict of interest.

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Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants.

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