Development and Pilot Testing of a Coping Kit for Parents of Hospitalized Children

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ABSTRACT

OBJECTIVE: Serious pediatric illness places great stress on families. Parents who learn coping skills may better manage these stressors. This study sought to develop and refine a stress coping intervention for parents of hospitalized children, assess the intervention acceptability among these parents, and gather preliminary data on stress, negative and positive affect, anxiety, depression, and self-efficacy.

METHODS: We conducted an observational study in 2 phases, enrolling parents of children who were inpatients with serious illness, 10 in Phase 1 and 40 in Phase 2. All parents completed at baseline measures of stress and psychological well-being and were introduced to the *Coping Kit for Parents*. Follow-up interviews were conducted at 1 week (all parents) and 1 month (Phase 2 parents only) regarding the acceptability of the intervention.

RESULTS: At baseline, parents reported that stressful situations were frequent (mean = 30.6, standard deviation [SD] = 6.8) and difficult (mean = 26.2, SD = 7.1) and revealed elevated levels of negative affect (mean = 27.3, SD = 7.7), depression (mean = 8.5, SD = 3.7), and anxiety (mean = 11.3, SD = 3.1) and moderate levels of self-efficacy related to their child's illness (mean = 3.3, SD = 0.5). The majority of parents used the kit regularly and on a scale of 1 to 7 agreed that the kit was helpful (mean = 6.0, SD = 0.9), interesting (mean = 5.7, SD = 1.3), practical (mean = 5.7, SD = 1.4), enjoyable (mean = 6.0, SD = 1.3), and they would recommend it to other parents (mean = 6.4, SD = 0.9).

CONCLUSIONS: The *Coping Kit for Parents* is an acceptable stress management intervention that could be made available to parents of children with serious illness at pediatric hospitals with minimal staff training or time commitment.

KEYWORDS: children with serious illness; coping skills; hospitalization; parents; stress

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WHAT'S NEW

The *Coping Kit for Parents* is a brief, flexible stress management intervention that could be made available to parents of children with serious illness at pediatric hospitals with minimal staff training or time commitment.

SERIOUS PEDIATRIC ILLNESS places great stress on families. Parents of children with serious chronic conditions report high levels of stress, anxiety, and depression.[1] Some researchers have suggested that a combination of stress, psychosocial difficulties, low quality of life, and physical health problems may interfere with parents' ability to care for their child and may lead to poorer outcomes for both parent and child.[2]

Parents caring for a child with serious illness may benefit from using a variety of coping strategies, including managing negative emotions, seeking social support, meaning making, and reframing.[3,4] A recent meta-analysis of coping interventions for parents of hospitalized children found that many of these approaches have been effective in reducing anxiety and stress among parents.[5] These interventions often are problem-focused, giving parents information and strategies for managing their child's specific health issues. Some studies have addressed a broader population of parents hospitalized for any serious illness or have taught parents skills for increasing overall resilience.[6,7]

One drawback, however, of the aforementioned programs is that they require parents and health staff to commit to multiple sessions for weeks or months. The large number of patients at pediatric hospitals and limited staff time present challenges to conducting longer, time-intensive activities such as individual therapy, support groups, or workshops. Researchers report difficulties in recruiting sick children for these studies.[7,8] Some parents are reluctant to leave their child's bedside while the child is in the hospital, and they may be too busy caring for the child at home after discharge to participate in individual or group sessions. As a consequence, many (if not most) parents of hospitalized children do not benefit from these interventions.

A potential approach to address these challenges is suggested by a variety of brief interventions shown to promote well-being and relaxation among adults in general[9] and among adult patients.[10,11] Although some studies of interventions for parents of hospitalized children have shown benefits for brief, minimal coping interventions, such as an hour of yoga or a single scrapbooking session,[12,13] these specific activities may not appeal to all parents and require that the parent leave the child's bedside. To our knowledge, no coping interventions exist that are broad enough to support parents of hospitalized children regardless of the child's specific medical condition and flexible enough to allow parents to learn coping strategies at a time of their choosing. Such an intervention is potentially more accessible to stressed parents and feasible with minimal additional staff burden.

The overall objective of the current study was to develop and pilot test a brief and flexible stress management intervention called the *Coping Kit for Parents* that could be made available to all parents of children hospitalized with a serious illness. Our specific goals were to 1) develop and refine intervention materials for the *Coping Kit*, 2) assess the acceptability of the intervention, and 3) gather preliminary data on stress, negative and positive affect, anxiety, depression, and self-efficacy among parents of hospitalized children.

METHODS

This study was approved by The Children's Hospital of Philadelphia (CHOP) Institutional Review Board, and all participants provided informed consent.

PARTICIPANTS

Parents at CHOP were recruited based on the following inclusion criteria: their child had been recently admitted to the neonatal intensive care unit, pediatric intensive care unit, cardiac intensive care unit, or the integrated care service (a team that coordinates care for inpatients who are medically complex and fall under multiple specialty areas) for a medical illness that was unlikely to resolve quickly, or their child had been referred for pediatric palliative care; the parent had decision-making responsibilities for the child (ie, the patient was <18 years old or cognitively impaired such that their parental adults made all medical decisions on their behalf); and a psychologist, social worker, nurse leader, or physician leader in the unit thought the parent would be willing to participate in the study (ie, the patient was not so sick that asking the parent about a research study would be inappropriate). Exclusion criteria included the following: the child was admitted for a traumatic injury or minor surgery, the parent was younger than 18 years old, the parent did not speak English, the parent was not able to read and understand the study materials, and the parent was not able to participate in follow-up contacts for the study in person, by phone, or internet. Parents received $20 cash for completing each study visit.

DEVELOPMENT OF INTERVENTION MATERIALS

We reviewed the literature to find examples of specific brief coping and positive psychology interventions that could be introduced to parents. Our goal was to offer a set of activities that parents could choose from and then do on their own time when it was convenient for them. We also wanted activities that would build on each other and target behaviors, cognitions, and emotions. First, we reviewed the literature to find examples of specific brief coping and positive psychology interventions that could be introduced to parents. Next, a team with extensive experience conducting research with parents of children with serious illness, including a psychologist from the neonatal intensive care unit (C.P.), a psychologist from the pediatric oncology unit (L.B.), a physician (C.F.), social psychologist (D.H.), and research coordinator (K.C.), met to discuss possible activities and how to implement them. In some cases, we based activities on exercises that members of this group had used successfully with parents in their own practice.

We developed a *Coping Kit* containing 10 activities (Table 1, Figs. 1 and 2).[9,14-24] Our goal was to offer a variety of brief, empirically based activities that parents could choose from and could do on their own with minimal instruction. In particular, we wanted to offer activities that the parent could do for 5 to 10 minutes, either at the child's hospital bedside or at home. Parents were encouraged to do one activity a day for 5 minutes and told they could do more than that if they wished.

The 3 levels of activities were based both on the perceived difficulty of each activity and on what skills we thought would be most immediately useful and what skills we thought parents should build up to. For example, breathing is a Level 1 activity that is relatively simple for parents to learn and can be used to calm down and relax in many situations. Level 2 and 3 activities build on skills learned through Level 1 activities; they may be more difficult for parents in the short term but beneficial with practice over time. An example of a level 2 activity is connections, where parents are asked to asked to write names of people who are helping them in some way or could help them in the future. An example of a level 3 activity is positive experiences, in which parents are asked to try to think of positive things (no matter how small) that have happened to them as a result of their child's illness. Parents were explicitly told that higher level activities may be upsetting, in which case they were encouraged to use level 1 activities to help manage any feelings of distress triggered by higher level activities.

We worked with a graphic designer to develop a set of 48 6" × 4" double-sided cards held together with a ring and designed to have the appearance of a thoughtful gift. The cards were divided into 10 sections (one for each activity), with slightly larger (6.5" × 4") tabbed dividers in between each section. The cards were laminated to

Table 1. Empirical Basis for *Coping Kit for Parents* Activities and Parent Reactions

Activity	Description	Evidence	Parent Reaction
Level 1			
1. Breathing	Breathing relaxation exercise. Six cards for each breath in and out.	Level 1 activities drew from mindfulness-based meditation and relaxation interventions.[14,15]	“The relax and breathe activities were very helpful in times when I was feeling stressed or tense. I found myself doing them (even after I was done with the kit) during times of quiet or silence.”
2. Relax	Progressive muscle relaxation. Thirteen cards describing different body parts to tense and relax.		
3. Guided imagery	Two cards describing settings often used in guided imagery: a beach and a forest.		Uses it in a spiritual sense—was a mountain climber previously and imagines being on a spiritual mountain known in her religion. She says that this activity helped her go there because it is something she really misses.
Level 2			
4. Connections	Parents asked to write down relatives, friends, and other people in the community who are helping them in some way as well as other people the parents could contact to get additional help.	Based on studies showing the benefits of identifying sources of social support.[16,17]	Gave her positive ways to think about things, how to ask other people for help, and helped her learn how to maximize what they need right now.
5. Strengths	There are 21 cards with different character strengths. Parents are asked to think about which strengths they have shown recently and how they applied this strength to taking care of their child.	From a positive psychology intervention.[9]	By doing this activity, it was the first time that she realized how proud she was of her ability to advocate for her baby to the hospital staff. And it was because the cards outlined these different strengths that she recognized different traits that she has as character strengths.
6. Feel	There are 20 cards with different positive and negative emotions. Parents are asked which emotions they have experienced recently and what made them feel that way.	Expressive writing interventions[18] and empathetic listening interventions.[19]	“Instead of suppressing the feelings, I could let them go.”
Level 3			
7. Positive experiences	Parents are asked to try to think of positive things (no matter how small) that have happened to them, their child, or their family as a result of everything their child has been through.	Benefit finding research.[21,22]	“I loved how the kit asked to think ahead and about positive experiences. I feel like a lot of people can only see the negative side of being admitted to a hospital, but I have realized that there is beauty, strength, knowledge, and love all around us.”
8. Hopes	Parents are asked to think of hopes or goals they have for their child and whether there is anything they can do to make progress toward this hope. After a few days or weeks, they are asked to review their hopes to see if they have made progress or if the situation has changed.	Hope research.[23,24]	Hopes fostered a conversation with dad about things they each are hoping for. “Hopes had me focus on the positives and goal setting”

(*continued on next page*)

Table 1 (*Continued*)

Activity	Description	Evidence	Parent Reaction
9. Envision	Parents are asked to envision a positive but realistic event they can envision happening in their child's future.	Hope research[24] and our clinical experience helping parents envision realistic, positive futures for children with serious illness	"Forcing myself to think about the future was kind of hard at first, but it reminded me how things were before my daughter was sick and gave me hope that she would get back to that point soon."
10. Journey	Parents are asked to write down (or record in some other way) about their positive and negative experiences taking care of their child, how they felt during this experience, how this experience changed them, and what they have learned.	Benefits of writing about and attempting to find meaning in negative experiences.[18,24]	She never tried journaling before, and started doing it the week after giving the coping kit and explaining the journey activity. Said that she really was surprised how helpful this was for her, and that she really enjoyed journaling.

make the *Coping Kit* sturdier and more durable. The cards in each section were different colors to distinguish the sections. The colors and overall design were chosen to be calming based on the graphic designer's experience. The *Coping Kit* was designed to be portable (eg, to fit in a purse or backpack) so that parents could take the *Coping Kit* with them to the child's hospital room or home. The *Coping Kit for Parents* can be viewed at https://feudtnerlab.research.chop.edu/copingkit.php.

BASELINE MEASURES

At the baseline session, parents were asked to report demographic information for themselves (financial situation, health insurance, and spiritual community) and their child (age and primary diagnosis). To assess parental stress, parents completed the Pediatric Inventory for Parents Role Function, a 10-item measure of stress related to role conflicts for parents of ill children.[25,26] Parents reported how often different experiences happened and how difficult each experience was. Anxiety and depression were measured with the Hospital Anxiety and Depression Scale.[27,28] We measured parent affect with the Positive and Negative Affect Scale.[22,30] We used a modified version of the Confidence about Doing Things measure, to assess parent self-efficacy related to managing their child's condition.[31,32]

PHASE 1: RAPID CYCLE TESTING

We conducted an initial round of rapid cycle testing with 10 parents to get initial reactions to the materials and suggestions for changes. A research team member (K.C. or K.S.) introduced each parent to the *Coping Kit* for an average of 15 minutes (with a range of 10−130 minutes), practicing the breathing activity with the parent, giving a brief overview of the other activities, and answering any questions the parent had pertaining to any activity. At the end of the session, parents were given the *Coping Kit* and a printed instruction sheet outlining the overall kit and the 10 activities.

K.C. has more than 12 years of experience interviewing parents of children with serious illness and conducting research in this setting. Training a research team member (K.S.) in how to introduce the *Coping Kit* to parents took approximately 3 hours, including a half hour of reviewing the *Coping Kit*, K.S. shadowing 2 sessions in which K.C. introduced the kit to parents, and K.C. observing K.S. until she delivered the intervention following the same criteria that K.C. did.

At 1 week after introduction of the *Kit*, if the child was still in the hospital, the parent was asked complete a survey in person on paper. If the child had been discharged, the parent was contacted by phone and offered the option of completing the survey online using a link or completing the survey over the phone. The survey questions asked how many days they used the *Coping Kit*, how long they used it each day, what activities they used, which activities were helpful, what was helpful about the activities,

BREATHING

Close your eyes and take deep breaths.

Try to breathe in slowly through your nose, fill your lungs completely, and then slowly let the air out through your mouth.

As you let your breath out, go to the next card.

Repeat this for six breaths.

breath 1

breath 2

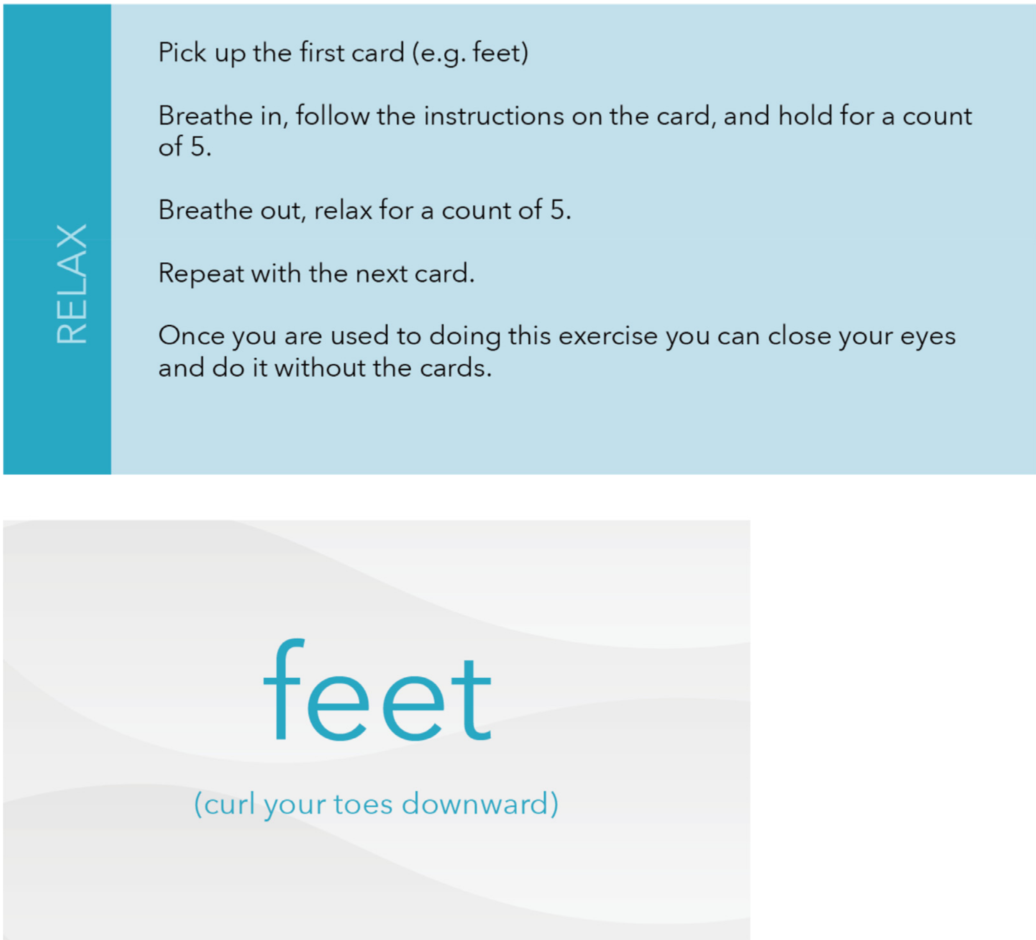
Figure 1. *Breathing exercise cards.*

whether they liked the design of the kit, and what changes they would make to improve the kit.

Phase 2: Intervention Assessment Group

The 40 parents in the intervention assessment group went through the same procedures and completed the same measures as the rapid cycle testing parents at baseline and 1 week. Because some parents in Phase 1 had trouble recalling exactly how long they had used the *Kit* each day and what activities they had done, parents in the intervention assessment group were asked to keep a paper log in which they answered 2 questions daily: how long they had used the *Coping Kit* that day and what activities they had done (from a checklist). In Phase 2, parents who consented to receiving text message reminders were sent up to three reminders about using the *Coping Kit.*

Parents completed the 1-month survey in person if the child was still in the hospital or had a choice of completing the survey by phone or online if the child had been discharged. At 1 month, parents in Phase 2 responded to Likert scale items asking how much they agreed with statements such as “The Coping Kit was helpful” on a scale of 1 (strongly disagree) to 7 (strongly agree). Items included whether they agreed that the *Coping Kit* was helpful, interesting, practical, and enjoyable and that they



RELAX

Pick up the first card (e.g. feet)

Breathe in, follow the instructions on the card, and hold for a count of 5.

Breathe out, relax for a count of 5.

Repeat with the next card.

Once you are used to doing this exercise you can close your eyes and do it without the cards.

feet

(curl your toes downward)

Figure 2. *Relax exercise cards.*

would recommend it to other parents. Parents also were asked how many days each week they had used the *Coping Kit*, how long they usually used the *Coping Kit* on those days, which activities were most helpful, and what was helpful about these activities.

STATISTICAL APPROACH

We calculated descriptive statistics (eg, means, standard deviations [SDs], percentages) for demographics, baseline measures, and *Coping Kit* use for all Phase 1 and Phase 2 parents who completed the baseline and 1-week interview. In addition, we calculated descriptive statistics for *Coping Kit* use and acceptability measures for the Phase 2 parents who completed the 1-month interview. The primary objectives of this analysis were to establish the acceptability of implementing the *Coping Kit* among the target population of parents and to assess whether such an intervention would be warranted in this population.

RESULTS

PHASE 1: RAPID CYCLE TESTING (N = 10)

Phase 1 was conducted from November 2016 to February 2017. Seventy parents were screened for Phase 1 (Fig. 3), and 9 mothers and 1 father were enrolled (Table 2). Two parents of 1 patient participated for a total of 9 separate patients. We made minor changes to the *Coping Kit* materials after Phase 1 based on the feedback from these parents, including changing the way the cards were held together (eg, switching from a binding of 1 ring to 2 rings in response to a parent complaint, "It kind of falls apart with only one ring"), adding summary cards for some activities (eg, after the 13 cards with body parts for the relax exercise, we added a summary card listing all 13 body parts on one card), and mentioning additional resources at CHOP.

PHASE 2: INTERVENTION ASSESSMENT (N = 40)

Phase 2 was conducted from March to September 2017. Ninety-two parents were screened for Phase 2 (Fig. 3), and 30 mothers and 10 fathers were enrolled (Table 2). Both parents participated for 8 patients for a total of 32 separate patients. Three children of 5 participating Phase 2 parents died while the parents were enrolled, and these parents were excluded from subsequent follow-up visits.

BASELINE MEASURES (PHASE 1 AND 2)

The 50 parents who completed the baseline session were experiencing moderately elevated levels of

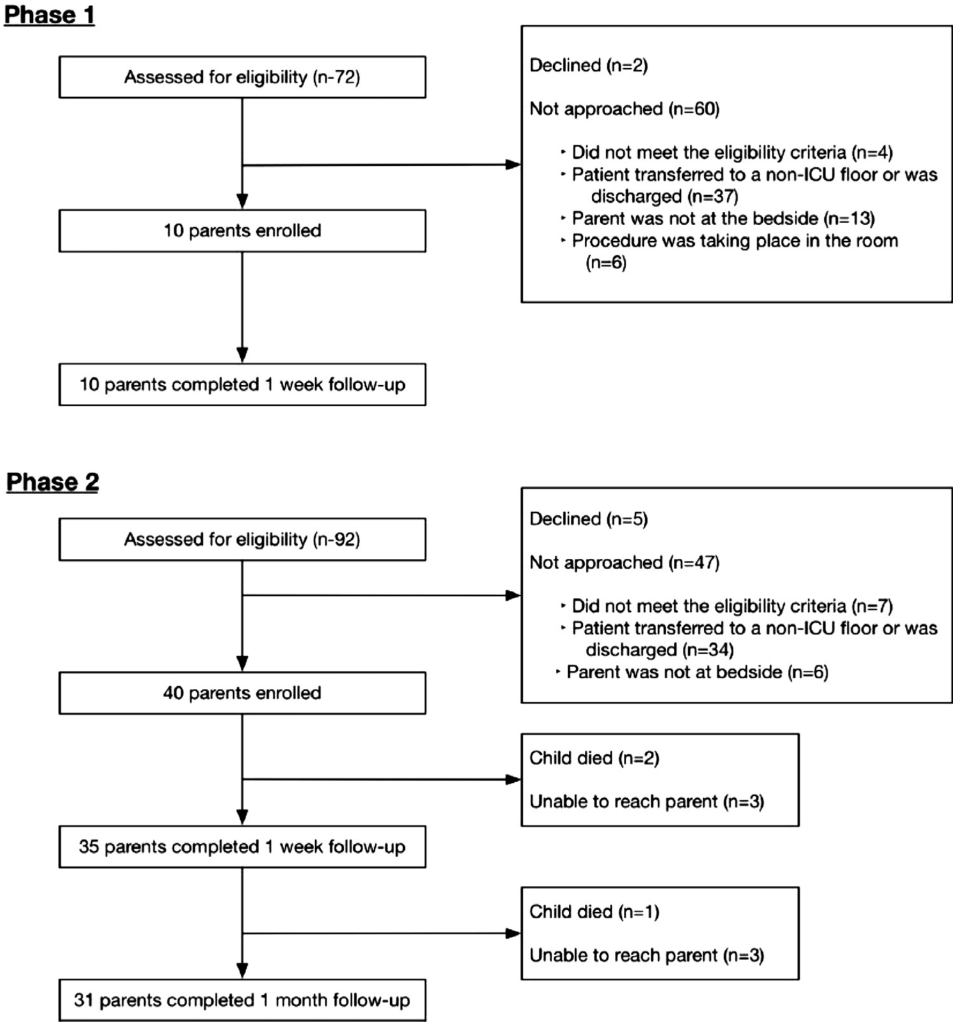


Figure 3. *Enrollment. ICU indicates intensive care unit.*

depression and anxiety, high levels of negative affect, and moderate levels of positive affect (Table 3). The parents reported that stressful situations related to their child's illness (eg, being unable to go to work) were somewhat frequent and difficult (Table 3). These parents had moderate levels of self-efficacy related to their child's illness (Table 3).

ONE-WEEK FOLLOW-UP (PHASE 1 AND 2)

In total, 44 parents completed the 1-week follow-up interview; 42 (95%) of these parents reported using the *Coping Kit* at least once. Of the 39 parents who provided data on the number of days they used the kit, 35 (90%) used it regularly (3 times or more) over the week for an average of 5 days per week. Forty-four parents reported how long they used the *Coping Kit* each day, with most saying they used the *Kit* for 5 to 10 minutes each day and they used it for an average of 38 minutes total for the week. Parents reported they used the breathing, relax, and guided imagery activities most often, and that these 3 activities were the most helpful. Sample responses to the question "What was most helpful about these activities" are included in Table 1.

Most parents reported liking the size, portability, and colors of the *Coping Kit*, although a few parents would have preferred that the *Kit* be a little smaller or presented as notebook or app. One parent said, "I think this *Kit* is a great idea. It really makes you feel like CHOP not only cares about your child, but also cares about you too."

ONE-MONTH FOLLOW-UP (PHASE 2)

Of the 31 Phase 2 parents who completed the 1-month follow-up interview, 11 were conducted at the beside because the child was still an inpatient. The remaining 20 parents were at home, with 17 completing the surveys online and 3 doing the surveys by phone. All parents reported using the *Coping Kit* at least once, and 22 parents (71%) used the *Coping Kit* regularly (3 days or more per week) for an average of 3.8 days per week and for an average of 12 minutes on each day that they used it. Parents reported that the activities they used the most and that were most helpful were breathing, relax, positive

Table 2. Demographic and Clinical Characteristics of 50 Parents and 41 Patients

Type	n (%)
Parents	
Mother	39 (78)
Age, y	
18–34	29 (58)
35–38	8 (16)
39–55	13 (26)
Race	
White	36 (72)
African American	7 (14)
Asian American/other	7 (14)
Ethnicity	
Hispanic	8 (16)
Marital status	
Married/partnered	34 (68)
Education	
High school or less	6 (12)
College	28 (56)
Graduate school	16 (32)
Full-time employment	23 (46)
Annual family income	
$20,000 or less	9 (18)
$20,001 to $40,000	6 (12)
$40,001 to $100,000	19 (38)
More than $100,000	6 (12)
Did not answer	1 (2)
Insurance	
Private	25 (50)
Government	13 (26)
Private and government	12 (24)
Financial hardship	27 (54)
Faith-based community	35 (70)
Children	
Age, y	
≤1	24 (56)
1–4	7 (14)
5–9	5 (10)
10–17	3 (6)
18–20	2 (4)
Diagnostic categories*	
Metabolic	0 (0)
Neurologic	2 (4)
Malignancy	2 (4)
Congenital	8 (16)
Respiratory	7 (14)
Cardiovascular	15 (30)
Gastrointestinal	2 (4)
Renal/urologic	1 (2)
Prematurity	2 (4)

*Diagnostic categories are not mutually exclusive, as a child can have multiple conditions. Therefore, the sum of the percentages adds up to more than 100%.

experiences, and hopes. Parents reported that the *Coping Kit* was helpful (mean = 6.0, SD = 0.9), interesting (mean = 5.7, SD = 1.3), practical (mean = 5.7, SD = 1.4), enjoyable (mean = 6.0, SD = 1.3), and they would recommend it to other parents (mean = 6.4, SD = 0.9). When asked what they would change about the *Coping Kit,* parents suggested including audio recordings, especially for the relaxation exercises, turning the *Coping Kit* into an app that they could conveniently access on a phone or tablet, adding coloring activities, adding physical activities such as walking, and adding more cards to write on.

Table 3. Measures of Anxiety, Depression, Stress, and Efficacy for 50 Parents

	Mean (SD) (Range)
Hospital Anxiety and Depression Scale	
Depression (n = 50)	8.5 (3.7) (2–18)
Anxiety (n = 50)	11.3 (3.1) (6–18)
Positive and Negative Affect Scale	
Negative Affect (n = 49)	27.3 (7.7) (12–39)
Positive Affect (n = 50)	33.5 (7.4) (13–50)
Pediatric Inventory for Parents: Role Function	
Frequency of Stressful Situations Related to Illness (n = 47)	30.6 (6.8) (17–44)
Difficulty of Stressful Situations Related to Illness (n = 45)	26.2 (7.1) (14–43)
Confidence about Doing Things: Parenting Self-Efficacy (n = 50)	3.3 (0.5) (2.2–4.0)

DISCUSSION

We found that the *Coping Kit for Parents* was used enthusiastically by the majority of parents 3 or more times a week. The need for a stress intervention in this population was evident, as parents were experiencing moderate depression and anxiety, high levels of negative affect, elevated stress, and lower self-efficacy related to their child's illness.[15,30,32,33]

Some parents reported wishing they had received the *Coping Kit* in the past when they were in more stressful situations related to their child's illness. Most parents focused on the breathing and relax activities, but each activity was used by some parents. Although parents consistently rated the breathing and relax activities as most helpful at 1 week and 1 month, some of the more advanced activities (ie, positive experiences and hopes) also were rated among the most helpful activities at the 1-month assessment. This finding suggests that, as we intended when we designed the activities, over time parents become more comfortable with and experience more benefits from engaging in Level 2 and Level 3 activities.

Parents of children with serious illness experience social isolation, disrupted sleep, lower quality of life, and low levels of support from others.[34] These parents report struggling to balance taking care of their sick child on top of their usual responsibilities, leaving little time for them to take care of themselves.[35] Research studies have found that high levels of stress over time can have negative effects on physical and mental health for parents of medically fragile children.[1]

Many pediatric clinicians recognize that providing support to parents can improve the health outcomes of their pediatric patients.[2,32] Staff availability, however, is limited and varies across hospital units. Staff must triage and focus on helping parents in crisis and may not have time for more general stress management among parents with less urgent needs. Previously developed interventions are limited to specific medical conditions, ask parents to attend multiple sessions, require specific staff skills and materials, or offer activities that may only appeal to a subset of parents. The *Coping Kit for Parents* is a simple intervention requiring minimal staff training and time commitment from staff and parents that can be used by parents of children with different medical conditions, gives parents the ability to choose the activities that most appeal to them, and offers parents flexibility in terms of when and where to do the activities. The *Coping Kit* is not intended to replace more intensive therapy that parents in crisis may need. Instead, the *Coping Kit* can serve as primary level intervention distributed broadly to parents who are not in crisis.

The findings from our pilot study need to be interpreted with the following limitations kept in mind. First, we did not collect data on larger family dynamics, including other family members, or on specific strengths that families might have to help them cope with their situation. Second, we did not assess whether clinicians or hospital staff could feasibly implement the intervention. Third, our sample was from one institution, and the intervention may not be received as well at other institutions. Fourth, although our sample was representative of the state of Pennsylvania in terms of racial and ethnic diversity, our results cannot be generalized to parents of other races and ethnicities. Finally, we did not collect psychological measures over time so our pilot study does not address whether parents who used the *Coping Kit* experienced better outcomes than parents who did not.

Potential next steps for the *Coping Kit* include conducting a follow-up study to assess the feasibility of having hospital staff (eg, social workers, psychologists, or nurses) implement the *Coping Kit* in specific units of the hospital. Future studies also could include measures of the overall family dynamic (eg, the Family Environment Scale), measures of perceived social support (Social Provisions Scale), and could collect data from other family members to examine whether the *Coping Kit* provides indirect benefits for siblings, spouses, and other family members. The manual (Supplementary Data online) provides suggestions of how all activities could be introduced to parents in future projects. Future projects also could offer additional guidance and support to parents on how to use the higher-level activities (including online video and audio recordings) or developing an app based on the *Coping Kit*, and adding additional activities suggested by parents such as coloring or going for walks. A controlled evaluation is necessary to determine whether the *Coping Kit* has a measurable impact in improving parent psychosocial state, stress, and parenting self-efficacy.

CONCLUSIONS

Parents of seriously ill children experience stress, negative affect, anxiety, and depression, which combined may affect their own well-being as well as their ability to care for their children. The *Coping Kit for Parents* is a brief and flexible stress management intervention that could be made available to all parents of children with serious illness who are hospitalized at a pediatric hospital with minimal staff training.

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SUPPLEMENTARY DATA

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