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Differences in coping behaviors in parents of mentally-handicapped children and parents of nonhandicapped children.

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DIFFERENCES IN COPING BEHAVIORS IN PARENTS OF MENTALLY HANDICAPPED CHILDREN AND PARENTS OF NONHANDICAPPED CHILDREN

by

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A DISSERTATION

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ABSTRACT OF DISSERTATION
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Title Differences in Coping Behaviors in Parents of Mentally Handicapped Children and Parents of Nonhandicapped Children

The purpose of this study was to ascertain if there was a difference in perceived effectiveness of coping behaviors between mothers and fathers of a mentally handicapped child and mothers and fathers of a nonhandicapped child. The conceptual framework was derived from the work of Lazarus (1961) and Pearlin and Schooler (1978).

Utilizing a descriptive design, 64 parents (28 parents of a mentally handicapped child and 36 parents of a nonhandicapped child) were surveyed using the Family Coping Inventory (FCI). Twenty-eight parents of a mentally handicapped child completed an additional instrument, the Coping Health Inventory for Parents (CHIP).

Descriptive statistics and independent samples t-tests revealed that there was a significant difference in perceived usefulness of coping behaviors of seeking social support and self-development ($p = .004$) and being religious, thankful, and content ($p = .04$) between parents of a mentally handicapped child and parents of a nonhandicapped child. There were no significant differences in perceived usefulness of coping behaviors of maintaining family integrity and being responsible.

A significant difference between mothers in the effective use of seeking social support and self-development behaviors was found. A

significant correlation between medical support and occupation was found on the CHIP. On the patterns of the FCI, the following significant correlations were revealed: (a) parent age and seeking social support and self-development; (b) parent age and being religious, thankful, and content; (c) marital status and being responsible; (d) marital status and maintaining family integrity; (e) child status and seeking social support and self-development; and (f) child status and being religious, thankful, and content.

Recommendations include: (a) research into the reasons for the lack of availability of fathers for research and participation in early intervention programs, (b) research into the reasons why mothers of the mentally handicapped child are unemployed, (c) exploration of nursing interventions to assist parents in developing effective coping strategies, (d) investigation into the relationship between parent age and coping behaviors, (e) investigation into the coping behaviors that single parents of a mentally handicapped child identify as effective, and (f) replication of this study with an adequate sample of fathers.

Abstract Approved by: Committee Chairman Elizabeth Stullenbarger

Program Director

Date _____ Dean of Graduate School Kenneth Rogers

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CHAPTER I

The Problem

Developmental risk is an area that has received attention only over the last 2 decades. Presently, the term refers to biological conditions that carry an increased potential for cognitive, affective, social, and physical problems (Kopp & Krakow, 1983). Biological conditions refer to preterm delivery, perinatal trauma, prenatal and neonatal infections, and genetic syndromes.

In 1986, there were 3,700,000 births in the United States (March of Dimes, personal communication, April 30, 1987). Between 110,000 and 185,000 of these children are estimated to be mentally retarded.

The Association for Retarded Citizens (1987) reports that one out of every ten persons in the United States has a family member with a mental handicap. Mental ratardation is more common than rheumatic heart disease and cerebral palsy and affects more people than blindness. Thus, with the prevalence of mental retardation in young children, an increasing number of parents must adapt to being the parent of a mentally retarded child at birth or sometime during the first year as the child exhibits delays in development. The route to adaptation for the parents involves developing effective coping behaviors.

Transition to Being a Parent of a Mentally Handicapped Child

The documented period of crisis with transition to parenthood (Dyer, 1963; Hobbs & Cole, 1976; LeMasters, 1957) becomes even more of a crisis

as parents of the mentally handicapped infant must cope with not only being parents but also with being parents of a handicapped child. "Periods of upheaval, change, and vulnerability provide a time of openness, receptiveness, and readiness for help from significant others (including professionals)" (Siegel, Gardner, & Merenstein, 1985, p. 422). Because nurses are present during the initial hospital period at birth, nurses are in a unique position to provide support to the parents of the mentally handicapped child.

During the neonatal period, the parents experience unexpected stress that may influence their relationship with the infant and with the health professional. The parents face the stress of any couple becoming parents and have the additional stress of having a handicapped infant (Gallagher, Beckman, & Cross, 1983). Parents may feel socially isolated with the sense of isolation beginning at diagnosis when the parents realize that they are parents of a different infant (Slater & Winkler, 1986). Financial pressures, decisions concerning medical care, and child care responsibilities are greater challenges facing these parents than parents of nonhandicapped children. With the stress and challenge facing these parents, coping responses of each parent become important in their adaptation to the child.

Adaptation

Adaptation is defined as an acceptable compromise between triumph over and surrender to the environment by an individual (White, 1974). Adjustment and coping are the subconcepts of adaptation. Furthermore, coping is the change in behavior or the initiation of new behavior in response to change in the environment (White).

Adjustment. In adapting to the stress of being the mother or father of a mentally handicapped child, Blacher (1984) has identified the

following as stages of adjustment: (a) shock and denial, (b) emotional disorganization, and (c) emotional adjustment. These stages have been identified at birth and continue through developmental periods when the mentally handicapped child does not progress as the nonhandicapped child (Winkler, 1981).

A crisis period has been universally identified as one of the first experiences of the parents. Zamerowski (1982) has defined the crisis period as a time of intense emotion beginning when the parents are informed. The initial crisis period is self-limiting; however, as the child develops, additional crises will emerge. "Each transitional crisis has the potential to reopen old wounds and to expose again old hurts, ambivalences, and conflictual emotions experienced at the time of diagnosis" (Schild, 1982, p. 85).

An adjustment period follows the crisis in which grief is manifested (Zamerowski, 1982). Guilt, blame, and anger are common emotions that emerge as the parents deal with what is versus what might have been. Finding a cause for the problem, genetic or environmental, assists the parents in working through grief (Trout, 1983).

Coping. Coping responses have been defined as the behavioral and cognitive efforts in reaction to a stressful situation (Folkman & Lazarus, 1980; Pearlin & Schooler, 1978). The responses manage or alter the source of stress and/or regulate the stressful emotions.

Coping has been conceptualized as multidimensional (Folkman & Lazarus, 1980). A part of the multidimensionality is evidenced in the differences in the way a person copes over time. Furthermore, differences are evidenced within social roles (Pearlin & Schooler, 1978).

Coping responses have been identified as being gender related. Women use interpersonal and cognitive strategies, whereas men use

cognitive strategies (Schilling, Schinke, & Kirkham, 1985). Women develop coping resources that accommodate the needs of others. Also, women tend to seek comfort and advice from others. In contrast, men tend to keep problems to themselves and use internal coping resources.

Coping behaviors may be conscious or unconscious (Mengel, 1982). In responding to stress, coping can occur on physical, social, or psychological levels. Coping may occur on any combination of these levels or on all levels at the same time (Ziermer, 1982). Coping responses on all levels may be identified particularly during transition periods in life.

Transition periods in life are times of increased stress that require adaptation. The periods of beginning school, later school transitions, college transition, marriage transition, and the transition of parenthood have been identified as situations that require coping responses (Stewart, Sokol, Healy, Chester, & Weinstock-Savoy, 1982).

Coping in Parents of the Mentally Handicapped

The parents of a mentally handicapped child are called on not only to cope with the transition to parenthood but, also, the transition to being the parent of a handicapped child. The ability of these parents to cope depends on the resources/responses available to each parent. Some parents take one day at a time while others are able to plan for the future (Jaffe-Ruiz, 1984).

The perceived crisis resulting in the parents' response is partially due to the lack of preparation for the role of parent of a mentally handicapped child and the adaptation that is required (Price-Bonham & Addison, 1978). Some parents consciously select a strategy to deal with the stressor while other parents just respond to the stressor (Shapiro, 1983). Some parents are identified as coping well and others as less well (Byrne & Cunningham, 1985). Some parents' lack of appropriate

resources to develop realistic coping behaviors may result in complete breakdown of coping. For example, a mother shot and killed her 2 1/2-year-old son who was mentally retarded because she was "unable to cope and unable to handle the whole situation" ("Mom," 1987, p. 4E).

Literature based on a conceptual framework of coping from which it is possible to compare parents of a mentally handicapped child with parents of a nonhandicapped child has not been found. Also, within the social role of parent of a mentally handicapped child, differences in coping between mothers and fathers have received little attention (Schilling et al., 1985). Studies comparing parental gender differences in coping responses are needed (Jacobsen & Humphry, 1979; Zamerowski, 1982).

Information that is available about parents of the mentally handicapped child tends to be general and lacking in information about the multifaceted aspect of the construct of coping responses. Until comparisons between parents are made, specific information on coping behaviors as a mother or father of a mentally handicapped or nonhandicapped child cannot be shared with parents by health professionals.

Purpose

The purpose of this study was to ascertain if there was a difference in perceived effectiveness of coping behaviors between mothers and fathers of a mentally handicapped child and mothers and fathers of a nonhandicapped child.

Conceptual Framework

The conceptual framework used to guide this study is from the work of Lazarus (1961) and Pearlin and Schooler (1978). Lazarus discussed coping in the context of the situation which required a coping behavior

in response to a perceived threat or harm. Pearlin and Schooler (1978) conceptualized coping in the context of responses to the threat or harm.

Coping

Threat. Coping responses arise when a person is confronted with threatening conditions. The threat is the anticipation of harm, whereas the harm is the person's conceptualization of the consequences that the individual considers to be undesirable (Lazarus, 1961). The response of attempting to eliminate or mitigate the harm is coping. An assumption is that a person is actively responsive to the threat or harm (Pearlin & Schooler, 1978).

Coping as a process is a response to external life-strains in an attempt to prevent, avoid, or control emotional distress (Pearlin & Schooler, 1978). Thus, coping responses are an integral part of strain and stress. Strains are problems in life that have a potential for arousing a threat and are presented in the context of social roles (Pearlin & Schooler). Stress is the unpleasant feelings that are "determined by particular strainful and threatening circumstances in the environment" (Pearlin & Schooler, p. 4).

Response. Responses of coping may be identified in the resources that are available (Pearlin & Schooler, 1978). Social resources are part of the interpersonal network in which the individual exists. Family, friends, co-workers, and individuals in the community, such as church and voluntary associations, form social resources. Personality characteristics that an individual may draw upon in a threatening situation make up psychological resources. The behaviors, cognitions, and perceptions that an individual uses in response to a threat are the specific coping resources/responses.

Specific coping responses "represent some of the things that people do, their concrete efforts to deal with the life-strains they encounter in their different roles" (Pearlin & Schooler, 1978, p. 5) and take three forms. The first form is responses that change the situation to make it less strainful. The second is the responses that control the meaning of the strainful experience before the appearance of stress. The last form of responses is those that control the stress after it is experienced.

Social Roles. Life-strains arise from social roles (Pearlin & Schooler, 1978). The response of coping may be shared by individuals in the same social role. Also, life-strains arise from the multiple roles an individual occupies in the social structure. The social roles of husband, wife, parent, and worker are oriented to structured social experiences.

Gender Differences. Within the responses of coping, differences arise within a social role (Pearlin & Schooler, 1978). Gender differences are such an example. Based on the sociliazation process of the different sexes, men and women respond differently to a stressful situation.

Application of the framework presented may be made to the situation of being a parent. The threatening situation and life-strains that may produce harm are raising a child, mentally handicapped or nonhandicapped. Coping is the response of the individual parent, male or female, occupying that social role. The parent relies on social, psychological, and specific coping resources to cope with the role of parent. Because the parent cannot change the situation or prevent the stress and remain an active parent, responses that control the stress emerge as significant.

Metaparadigm

In identifying the metaparagidm of nursing, the process of coping may be placed within the discipline of nursing. A metaparadigm has been defined as a world view within a discipline (Hardy, 1978). General parameters of the discipline and a broad orientation are provided for the basis of research.

Agreement on the central concepts of nursing now exists (Flaskerud & Holloran, 1980). Person, environment, health, and nursing have been identified as the metaparadigm of nursing. Within the framework of coping, these four phenomena exist. Person is the individual responding to the threat or harm while environment is the space in which the individual interacts. Health is the condition, emotional and physical, of the individual. Nursing is the act of assisting in identifying coping resources and responses.

The person is any individual facing demands that are highly relevant to personal welfare (Lazarus, Averill, & Opton, 1974). This person uses coping resources and responses to meet these demands. For the purpose of the present study, a parent is the person.

Mechanic (1974) identified three qualities that the person must possess to cope successfully with the demands. The person must possess coping capabilities such as skills to meet the social and environmental demands. Motivation to meet the demands must be present. Finally, capabilities to maintain a state of psychological equilibrium must be present to direct energies and skills to meet the demands.

Health is viewed as more than the absence of illness. Health is a fluid state that responds to the stress experiences of the person (Mengel, 1982). Health is thus influenced by the coping resources/ responses of the person.

Stress has been defined as the relationship between the person and the environment that is appraised by the person as endangering personal well-being with coping being the efforts to manage the relationship (Folkman, 1984). Coping further refers to the efforts to meet the demands of the internal and external environment.

"Nursing is the diagnosis and treatment of human responses to actual or potential health problems" (American Nurses' Association, 1980, p. 9). The nurse is concerned with human responses of which coping is one. Nursing interventions include assisting the person to identify resources and to choose responses.

Interrelationships of the Concepts. The person-environment fit is important through the person's attempts to meet the demands of the environment (French, Rodgers, & Cobb, 1974; Mechanic, 1974). This relationship is based on how the person perceives the self in relation to the environment. White (1974) stated that to be successful in coping with the demands of the environment the person must (a) secure adequate information about the environment, (b) possess an internal environment that can process information, and (c) maintain freedom of movement and freedom to use resources/responses.

The person does possess responsibility for health (Mengel, 1982). When environmental life-strains produce stresses, the internal environment of the person may be changed which influences health. The person can rely on support from professional nursing (Mechanic, 1974). Thus, to be effective, nursing must look at the dynamic relationships among the person, health, and environment.

In providing nursing for the parents of a mentally handicapped child, a nurse could diagnose each parent's coping resources. Treatment then would involve identifying coping responses for each parent based on the appropriate social role.

Statement of the Problem

The problem statement for this study was as follows: Is there a difference in perceived effectiveness of coping behaviors between mothers and fathers of a mentally handicapped child and mothers and fathers of a nonhandicapped child?

Research Questions

The following were the research questions formulated for this study:

1. Are there differences in perceived effectiveness of coping behaviors between mothers and fathers?

2. Are there differences in perceived effectiveness of coping behaviors between mothers and fathers of mentally handicapped children?

3. Are there differences in perceived effectiveness of coping behaviors between mothers and fathers of mentally handicapped children and mothers and fathers of nonhandicapped children?

Definition of Terms

For the purpose of this study the following definitions applied:

Coping is the "behavior that protects people from being psychologically harmed by problematic social experience" (Pearlin & Schooler, 1978, p. 2). Coping is made operational through the Family Coping Inventory as adapted by Ventura (1986).

Mother is the female primary caretaker for the child and lives with the child.

Father is the male primary caretaker for the child and lives with the child.

Mentally handicapped child is a child aged 6 months to 18 months who is diagnosed as mentally retarded and has no known physical defects.

Mental ratardation is any intellectual inadequacy which originates in the developmental period and which may impair social adjustment at maturity.

Nonhandicapped child is a child aged 6 months to 18 months who has no known mental or physical defects.

Assumptions

For the purpose of this study, the following assumptions were made:

1. Coping is a universal phenomenon and can be measured (Pearlin & Schooler, 1978).

2. Individuals actively respond to stressors (Pearlin & Schooler, 1978).

3. Coping responses are elicited in parents as each child passes through developmental stages.

Delimitations

The delimitations of this study were as follows:

1. No attempt was made to assess the quality of the parents' relationship.

2. No attempt was made to assess the quality of the parent-child relationship.

Limitations

For the purpose of this study, the following limitations were identified:

1. A restricted view of responses to a stressful situation is presented as coping was measured only at one point in time (Panzarine, 1985).

2. The sample was a sample of convenience and does not represent all parents.

3. The ages of the children varied and, therefore, the parents experienced a varying amount of time to develop coping behaviors.

Significance of the Problem

Nursing is defined as "the diagnosis and treatment of human responses to actual or potential health problems" (American Nurses' Association, 1980, p. 9). Parents use coping behaviors in response to being a parent. Research on coping behaviors in parents is relevant to nursing service, research, and education.

A major emphasis in clinical nursing has been to assist clients in developing coping responses to physiological and psychological stressors. With an emphasis on prevention, anticipatory guidance in identifying coping responses before a stressful event occurs will become increasingly important (Panzarine, 1985). With prenatal screening tests for genetic defects becoming routine practice, the diagnosis of possible mental retardation in the baby is now being made before delivery. Parents are beginning to seek prenatally information that used to be sought after the birth (Association for Retarded Citizens, Inc. of Jefferson County, personal communication, August 20, 1987). Presently, information and services for the developmentally delayed child tend to be incomplete and disjointed (Waisbren, 1980).

Societal issues of health care cost and the emphasis on health have focused the need for nursing education on maintenance of health and prevention of illness. With information in hand, nursing students can be prepared to provide anticipatory guidance to the parents of a mentally handicapped child in developing strategies of coping that will be of benefit to each parent.

Nursing research has focused on situation-specific assessments of coping behaviors. Research into categorization of coping strategies is the next phase (Panzarine, 1985). Furthermore, research into the effectiveness of coping behaviors should yield a sound basis for the development of programs to share these behaviors with parents.

CHAPTER II

Review of Related Literature

The purpose of the review of research literature is to present the findings of research relevant to the variables of interest in this study. Research related to coping in parents of the nonhandicapped child and parents of the mentally handicapped child is presented.

Parents of the Nonhandicapped Child

In the present study, coping is the concept of interest in relationship to being a mother or father. The present review of research is placed within the conceptual framework. Social role is combined with threat to mean being a parent.

Response

In a sample of 60 mothers and 60 fathers, first-time parents reported stresses at 3 to 5 months postpartum (Ventura, 1987). In analyzing the data from the Ways of Coping Questionnaire, eight coping processes emerged: (a) confrontive coping, (b) distancing, (c) self-control, (d) social support, (e) accepting responsibility, (f) escape-avoidance, (g) problem-solving, and (h) positive reappraisal. There was no difference between mothers' and fathers' use of these coping processes.

Concerns of new families during the first year were identified from a structured interview (McKim, 1987). Additional analysis of the responses of the 184 mothers yielded coping resources as being doctors, friends, and the mother's parents.

Using role theory as a framework, Myers-Walls (1984) measured the effect of the use of coping strategies on the ease of transition to parenthood. Forty-two mothers of 2-month-old children evaluated the use of favorable definition of the situation, establishment of a salient role, compartmentalization, and compromise of standards as coping strategies. A positive correlation between the use of coping strategies and the ease of transition to parenthood was established.

One hundred mothers and 100 fathers of 2- to 3-month-old infants were the subjects for a study assessing parental coping behaviors through the use of the Family Coping Inventory (Ventura & Boss, 1983). Through factor analysis, the coping patterns that emerged were seeking social support and self-development, maintaining family integrity, and being religious, thankful, and content.

In relating parent functioning and infant temperament to parent coping in 200 mothers and fathers, Ventura (1982) found that parents who were depressed used social support responses in coping. Furthermore, parents who were depressed identified their infants as less soothable. Parents who were not depressed found the behaviors for maintaining family integrity to be more effective as coping responses. Additionally, parents who identified maintaining family integrity as the most useful coping responses saw their infants as using more smiling and laughing behaviors.

Stress during the transition to parenthood was measured in a longitudinal study (Miller & Sollie, 1980). The responses were recorded at midpregnancy, 5 to 6 weeks postpartum, and 6 to 8 months on 109 couples. From open-ended questions eliciting responses to negative and positive aspects of becoming parents, the coping strategies that emerged were: (a) adaptability in changing from an orderly, predictable life to a

relative disorderly and unpredictable one, (b) having patience, (c) becoming more organized, (d) becoming flexible, (e) utilizing social support, and (f) looking to the future.

Summary. Coping responses in parents of the nonhandicapped child have been identified as processes (Ventura, 1987), strategies (Miller & Sollie, 1980; Myers-Walls, 1984), and behaviors (Ventura & Boss, 1983). A relationship between the emotional status of the parents and coping was demonstrated along with a relationship between coping patterns and infant temperament (Ventura & Boss). The coping resource of social support has been validated (McKim, 1987; Miller & Sollie; Ventura, 1987; Ventura & Boss).

Social Role

LeMasters (1957) investigated the addition of a first child to a family as a crisis. Forty-six couples were interviewed during one period of the child's first 5 years. Eight-three percent of the couples reported an extensive or severe crisis. Mothers reported loss of sleep, extensive confinement in the home, guilt over not being the perfect mother, and worry over appearance. Fathers identified crisis as financial worries, disenchantment with the parental role, and a decrease in the wife's sexual response. The author concluded that preparation for parenthood would significantly alter the crisis.

Dyer (1963) sought to validate LeMasters' (1957) findings. Thirty-two couples answered questionnaires separately but were not interviewed as in LeMasters' study. In 53% of the couples, crisis was identified as either extensive or severe. Crisis was manifested in the mothers as (a) tiredness, (b) loss of sleep, (c) feelings of neglecting the husband, (d) feelings of inadequacy as a mother, (e) being tied down, and (f) a decrease in social activities. The fathers identified crisis

as (a) loss of sleep, (b) adjusting to new routines, (c) financial worries, and (d) increased amount of time required by the baby. The author concluded that the findings supported LeMasters' findings.

In the literature, transition to parenthood usually is referred to as the period of acquisition of the first child. Hobbs and Cole (1976) looked at the difficulty of adjustment to the roles of mother and father in 65 couples and concluded that mothers expressed having more difficulty than fathers. Further analyses revealed no predictor variable for the amount of difficulty for either mother or father. Out of 14 variables such as baby's age, parents' income, and method of feeding, none correlated significantly with the difficulty level.

During the transition period to parenthood, 22 husbands and wives prenatally identified projected postpartal concerns (Broom, 1984). After delivery, the same couples identified their present concerns. In comparing the two periods, the couples were able to prenatally identify postpartal concerns and issues regarding the marital relationship.

Summary. In adapting to the social role of parent, mothers and fathers have described crisis periods (Dyer, 1963; LeMasters, 1957). However, beginning in the decade of 1970, researchers established that the crisis period was a period of transition (Broom, 1984; Hobbs & Cole, 1976). During the transitional period, mothers exhibited more difficulty in adapting than fathers (Hobbs & Cole).

Gender Differences

Impact of pregnancy and parenthood on mothers and fathers was assessed by investigating mood, social change rating, satisfaction, anticipation, and experience of parenthood (Feldman & Nash, 1984). A sample of 31 mothers and 31 fathers was selected from Lamaze classes and was assessed before birth and at 6 months after birth. Mothers had

significantly higher scores on mood scale. Fathers tended to be more satisfied with autonomy/competence but mothers expressed significantly more satisfaction with their relationship with the baby. Mothers expressed more positive and negative social changes than did fathers. Furthermore, mothers underestimated the extent to which their lives would be arranged around the baby more than did fathers.

The impact of childbearing on the marital relationship and the influence of sex role attitudes, marital equity, father involvement, and infant temperament on marital adjustment was investigated in new parents (Tomlinson, 1987). Six questionnaires were given to 96 mothers and fathers. No difference was found between mothers and fathers in marital satisfaction. Only pre-birth marital satisfaction influenced post-birth adjustment in both groups.

Humenick and Bugen (1987) compared mothers' and fathers' expectations versus reality about the interactions with their infant. A pre- and post-test design was used with 33 mothers and 37 fathers from Lamaze classes. Mothers expected to spend more time with the infant than did fathers. Mothers reported significantly more time with the infant at 3 weeks than anticipated. Fathers reported spending less time with the infant at 3 weeks than expected.

Using the Family Coping Inventory, Ventura and Boss (1983) examined the differences in coping responses between mothers and fathers. Mothers identified seeking social support and self-development and being religious, thankful, and content as more helpful in coping than fathers. Both parents identified maintaining family integrity as useful coping responses.

Differences in coping behaviors between mothers and fathers were identified by Ventura (1986). Forty-seven mothers and 47 fathers of

2- to 3-month-old infants were assessed by using an adapted version of the Family Coping Inventory. Mothers found social support and self-development to be more helpful in coping than did fathers. No further differences were established. No correlations were found between socio-economic status and coping.

Summary. Regarding marital satisfaction, no difference was found between mothers and fathers (Tomlinson, 1987). Ventura and Boss (1983) found that mothers and fathers used different coping responses with mothers favoring social support resources.

Summary

Coping behaviors, patterns, and strategies of parents have been identified. Social support has emerged as a common coping response in parents and a resource particularly for mothers.

Differences between mothers and fathers regarding coping responses have been identified. However, in all of the studies reviewed, the mother and father were a couple. Ventura (1986) concluded that coping behaviors and patterns are "similar for each parent because the parents live in the same family system" (p. 80). Thus, the need for research using mothers and fathers who are not a couple has been established.

Parents of the Mentally Handicapped Child

The present review of research focuses on the concepts from the conceptual framework. Research on responses, social role, and gender difficulties are presented with threat being subsumed in the social role, parent of a mentally handicapped child.

Response

Concerns of parents of developmentally delayed children were identified in 16 families (Strauss & Munton, 1985). Through interviews

parents identified coping through seeking support from parent groups, developmental program staff, ministers, and a religious faith.

Strengths in parents of developmentally disabled children were identified as the feeling of being strong and the desire to be encouraged to be strong in a sample of 27 (Winkler, Wasow, & Hatfield, 1983). When comparing parents' responses to social workers, 43 workers in a social service agency did not identify that parents wanted the encouragement to be strong. Both parents and social workers identified chronic sorrow in the parents.

Abbott and Meredith (1986) compared marital and family strengths of parents with retarded children and parents of nonhandicapped children. An additional purpose of the study was to assess the use of coping strategies in parents of the retarded child. Sixty parents of school-age children in each group completed five questionnaires. Coping was addressed through the use of open-ended questions. No difference in family and marital strengths was found between the parent groups. The researchers identified successful coping as parents defining their situation in a positive way. Coping resources were identified as religious belief, assistance from a church, and parent support groups.

Stressors related to the presence of a handicapped child in the family and the relationship of resources on the stressors were investigated (Petersen, 1984). Mothers of children aged 1 to 19 years with physical, mental, or multiple handicaps were interviewed. The Social Readjustment Scale, Scale of Locke and Wallace, Hopkins System Checklist, and two investigator-constructed questionnaires were completed by 105 mothers. Analysis revealed that the greater the number of stressors, the greater the effect on maternal health and marital adjustment. Fewer stressors were identified if there were a greater number of resources

(physical and emotional support, division of labor with the child, love and affection from significant other, and satisfaction with community services).

The impact of a child with Down Syndrome upon the parents was measured by assessing the parents' mental and physical health and marriage in a prospective study (Gath, 1977). Thirty families with a child with Down Syndrome and 30 families with a healthy child were assessed periodically from birth until the child reached 2 years of age. Mothers or fathers completed the Eysenck Personality Inventory and Malaise Inventory. No differences were found between parents in mental and physical health. Negative measures of marital relationships were higher in the Down's group with one divorce and one permanent separation occurring. No separations were experienced by parents of healthy children.

Coping strategies of 40 families with a mentally retarded child in special education classes were assessed by using the Beavers System Model of family assessment (Beavers, Hampson, Hulgus, & Beavers, 1986). Coping strategies in capable families were found to be (a) focusing on small gains, (b) being a family, and (c) using more than one approach to manage the child. In capable families, the child did not dominate the family and a shared family responsibility was evident.

Fairfield (1983) explained the manner in which parents cope with a child with a genetic disorder. Within an Adlerain framework, the use of recall was explored. Adlerain theory stated that "the early memories of an individual reveal . . . the person's view or attitudes about life, the 'life style'" (Fairfield, p. 411). One-hundred-thirteen mothers or fathers of a child with 1 of 35 different genetic disorders were interviewed. Twenty percent of parents reported early positive memories of a situation with a handicap person while 79% reported early negative

memories. A significant chi square revealed a congruence between early positive memories and positive current feeling towards the child. The authors concluded that use of early recall was appropriate to validate whether or not a parent's positive presentation of coping is real.

Summary. Parents of the mentally handicapped child used the coping responses of participating in parent support groups and relying on religious faith (Abbott & Meredith, 1986; Strauss & Munton, 1985). Stress was reduced if coping resources of physical and emotional support from a significant other were present (Petersen, 1984). However, Gath (1977) reported marital separation and divorce in these parents.

Social Role

Kornblatt and Heinrich (1985) defined coping as reflecting "the family's capacity to successfully adapt to particular types of health problems" (p. 14). The abilities of families to cope with the needs of children with developmental handicaps were assessed through the use of an instrument developed by the investigators that combined the Extra-Hospital Nursing Needs and Family Coping Inventory questionnaires. Sixty-six percent of the 24 families scored a decreased level of coping. Families in the city demonstrated a high level of needs and a low coping score, while families in the county demonstrated the same level of needs but a higher coping score. School-age families exhibited a higher coping score than pre-school families. The conclusions made were that needs and coping must be assessed independently and that geographic location of the parents influenced coping with the needs of the child.

Stress in 30 parents of mentally retarded children was identified particularly during developmental and transitional periods in the child's development (Winkler, 1981). Ten periods, from diagnosis to the 21st birthday, were identified as parents compared "what is" to "what might

have been:" (a) diagnosis, (b) time for walking, (c) time for talking, (d) occasions when siblings surpass the child, (e) alternative placement decisions, (f) entry into school, (g) crisis in behavior management, (h) onset of puberty, (i) 21st birthday, and (j) guardianship decisions.

Increased psychological distress was documented in mothers of disabled children (Breslau, Staruch, & Mortimer, 1982). A group of 369 mothers of physically and mentally disabled children were measured against a group of 456 mothers of nonhandicapped children. Mothers of disabled children exhibited higher distress scores than the control group. However, no relationship between the type of disability of the child and distress scores was found. The authors suggested that the higher level of distress in mothers of disabled children will affect their adjustment and adaptation.

Stress and variables that mediate stress were assessed in parents of handicapped children and parents of nonhandicapped children (Friedrich & Friedrich, 1981). Five questionnaires were distributed to 34 mothers of handicapped children and 34 mothers of a control group. Mothers of the handicapped children demonstrated more stress than the control and demonstrated less evidence of the mediator variables of marital satisfaction, psychological well-being, social support, and religiosity. The authors concluded that more services that offer social support should be available for these mothers.

The impact on relationships within and outside the family of a developmentally disabled child and the types of support available were researched (Waisbren, 1980). Because the governmental services for the developmentally disabled are more organized and on a greater level in Denmark than in the United States, the study was conducted in both countries with a control group in both countries. Sixty mothers and

fathers of children less than 18 months in each country were administered a questionnaire adapted from six others. Parents of both groups and in both countries expressed similar responses on most dimensions related to coping. Social activities, physical health, activities with the baby, and plans for the future were not significantly different.

Waisbren (1980) investigated further the dimensions of coping. Using canonical correlation, a relationship between support of the father's parents and coping was established. If the fraternal grandparents were perceived as being supportive, the mother and father had more positive feelings towards the baby and were willing to make plans for the future. This relationship only held true for parents of the developmentally disabled child. However, parents who demonstrated positive feelings toward the child, evidenced greater physical symptoms of stress and more negative feelings toward the marriage. The author concluded that with more support, the parents would demonstrate positive feelings towards the child while internalizing the strain.

Patterns of living were explored in a study of 47 families of developmentally delayed children and 31 families of nonhandicapped children (Wishart, Bidder, & Gray, 1981). No difference was found between the two groups. The researchers concluded that the presence of a developmentally delayed child did not appear to change the pattern of family living.

Friedrich (1979) researched the usefulness of predicting coping behaviors from demographic and psychological variables. The sample consisted of 98 mothers of a handicapped child aged 2 to 19 years. A multiple regression equation yielded the most significant contributing variables as being marital satisfaction, child's residence, and child's sex. Marital satisfaction alone accounted for 79% of the variance in

coping. The author concluded that the more secure the mother felt in her marital relationship the more capable she felt in coping with her child's handicap.

Coping outcomes were measured in 140 parents of mildly retarded children by using the Questionnaire on Resources and Stress-Friedrich (Friedrich, Wilturner, & Cohen, 1985). Only the factor on parent and family problems was used. Through the use of multiple regression analyses, a relationship was established among marital adjustment, locus of control, family support, and depression. Parents who were not depressed, demonstrated the following: (a) an internal locus of control, (b) a happy marriage, (c) felt support from the family, and (d) a lower score on the coping outcome of parent and family problems.

Summary. In adapting to the social role of parent of a mentally handicapped child, mothers and fathers exhibited stress (Friedrich & Friedrich, 1981; Winkler, 1981) and distress (Breslau et al., 1982). A mediator variable of stress has been found to be social support (Friedrich & Friedrich; Friedrich et al., 1985), particularly if the father's parents were perceived as being supportive (Waisbren, 1980).

Gender Differences

Through retrospective interviews, mothers' feelings were identified after the birth of a mentally retarded child (Childs, 1985). When the child was 1 year old, 50 mothers were interviewed. The feelings of guilt, denial, inferiority, questioning of religious beliefs, shame, confusion, death wish, anger, need to blame others, loneliness, unloved, infanticide (letting child die), and helplessness were expressed. The authors stated that further research was needed to determine the adjustment of the mother.

In assessing 42 mothers of infants at risk for developmental and physiological problems, repetitive and intrusive thoughts concerning the infants declined after discharge (Affleck, Tennen, & Gershman, 1985). A conclusion of the study was that those thoughts were cognitive adaptations to the high-risk infant.

Using seven questionnaires, Cummings, Bayley, and Rie (1966) identified stress in mothers of mentally retarded, chronically ill, and neurotic children. In a sample of 240 mothers of children age 4 to 13 years, mothers of the mentally retarded children demonstrated more stress than the other groups.

In a 1976 article, Cummings reported the data on fathers from the 1966 study. The conclusions were the same in that fathers of mentally retarded children seem to experience more stress than fathers of chronically ill children or neurotic children.

Tallman (1965) investigated the coping responses in 80 mothers and 69 fathers of severely mentally retarded children between the age of 6 to 12 years. Fathers were found to be less skillful in coping than mothers. Furthermore, fathers were more vulnerable to the social stigma and extrafamilial influences than were mothers. Finally, fathers reacted more strongly by totally withdrawing or becoming greatly involved with a son but maintained a limited routine involvement with a daughter.

The family-child relationship was studied in 30 families of children from 1 to 17 years (Molsa & Ikonen-Molsa, 1984). Reactions of denial, aggressive behavior, depression, guilt, shame, rejection, isolation, and adaptation were identified in mothers, fathers, siblings, and grandparents. Three stages of reactions were defined as initial, intermediate, and final. In the final stage, 83% of the mothers, 86% of siblings, 67% of fathers, and 75% of grandparents adapted to the

situation. Rejection of the child occurred in 13% of mothers and 20% of the fathers. Additionally, the mother-handicapped child relationship was strengthened, while the mother-siblings relationships were weakened. The father-siblings relationships were strengthened, while the father-handicapped child relationship was weakened.

Summary. Fathers have been found to be less skillful in coping than mothers (Tallman, 1965). Furthermore, fathers were more influenced by outside forces than mothers. The relationship between the mother and child was stronger than the father-child relationship (Molsa & Ikonen-Molsa, 1984).

Summary

Various coping responses of parents of a mentally handicapped child have been identified with the theme of social support emerging as a most useful response. Stress and distress have been established in these parents with moderator variables being social support and family relationship.

Mothers and fathers of the mentally handicapped child have been studied separately and together. However, in all of the studies reviewed, mothers and fathers were a couple. Furthermore, none of the studies researched the family with only one child. None of the studies used coping as the framework or investigated the difference in coping responses between mothers and fathers.

CHAPTER III

Methodology

Introduction

The purpose of this study was to ascertain if there was a difference in perceived effectiveness of coping behaviors between mothers and fathers of a mentally handicapped child and mothers and fathers of a nonhandicapped child. The purpose was accomplished by examining differences in perceived effectiveness of coping behaviors between the parents. Chapter III provides a description of the research methods used in this study.

Design of Study

The methodology of this study was implemented utilizing a descriptive design. The variables of interest were mothers and fathers of mentally handicapped children, mothers and fathers of nonhandicapped children, demographic variables, and coping behaviors.

Sample

The target population of the study was adults at least 20 years old who were parents of a mentally handicapped child or parents of a nonhandicapped child. The sample was derived from parents whose child attended an early intervention program for developmentally delayed children, pediatricians' offices, and child care centers. The sample size of 80 (20 in each group) was calculated for the purpose of obtaining a statistical power of .80 (Cohen, 1977). The criteria for sample selection were as follows:

1. Mothers and fathers aged 20 years and older. Adolescent parents were excluded because of differences reported between adolescent parents and adult parents (Jarrett, 1982; Mercer, 1980).

2. Mothers and fathers of a mentally handicapped child aged 6 months to 18 months. To ensure independence of responses, the mothers and fathers were not parents of the same child.

3. Mothers and fathers of a nonhandicapped child aged 6 months to 18 months. To ensure independence of responses, the mothers and fathers were not parents of the same child.

4. Parents with only one child.

Instrumentation

Demographic Profile

A demographic instrument was developed to determine demographic characteristics of the sample. The characteristics of the nonhandicapped child were age and sex (see Appendix A). The characteristics of the mentally handicapped child were age, sex, developmental problem, and physical problem (see Appendix B). The characteristics of the parents were sex, age, marital status, education, and occupation.

Family Coping Inventory (FCI)

Coping behaviors were assessed in parents of mentally handicapped children and nonhandicapped children by using the FCI as adapted by Ventura (1986) (see Appendix C). The FCI determines the usefulness to parents of coping behaviors. Ventura (1986) adapted the FCI to include items helpful to fathers. Construct validity has been reported with external validity established (Ventura, 1982).

As defined in the FCI, coping is "individual or group behavior used to manage the hardships and relieve the discomfort associated with life changes or difficult life events" (McCubbin, Boss, Wilson, & Dahl, 1981,

p. 1). This definition is consistent with that of Lazarus (1961) by placing coping in the context of a threatening situation and Pearlin and Schooler (1978) by defining coping as behavior or a response to the threatening situation.

The FCI as adapted by Ventura (1986) is a 34-item instrument. Parents select coping behaviors on a 4-point scale from no help to very helpful. Through factor analysis, the items were divided into four patterns (see Appendix D). Internal consistency (Cronbach alpha) reliabilities for the four patterns were reported as: (a) .62 for seeking social support and self-development; (b) .66 for maintaining family integrity; (c) .62 for being religious, thankful, and content, and; (d) .68 for being responsible (Ventura, 1986). In the most recent study, reliabilities were reported as: (a) social support .64 for mothers and .66 for fathers, (b) family integrity .60 for mothers and .80 for fathers, (c) positive attitude .48 for mothers and .57 for fathers, and (d) responsibility .43 for mothers and .65 for fathers (J. N. Ventura, personal communication, March 3, 1987).

The FCI was scored by placing the initials of the appropriate pattern and the parent's score to the right of each item. The scores for each pattern were totaled and those pattern scores became the reported scores.

Coping Health Inventory for Parents (CHIP)

Coping behaviors were further assessed in parents of the mentally handicapped child by using the CHIP (see Appendix E). This instrument was developed to "assess parents' perceptions of their response to the management of family life when they have a child member who is seriously

and/or chronically ill" (McCubbin, 1987, p. 175). The development of CHIP was partially guided by theories of the individual psychology of coping as written by Pearlin and Schooler (1978).

The CHIP has been used in studies of parents of children with physical impairment, mental/behavioral conditions (autism, mental retardation, and youth affective disorder), and multiple handicaps/disabilities (McCubbin, 1987). Furthermore, the CHIP has been used in studies that compared the parents of handicapped children to parents of well children.

The CHIP is a 45-item checklist listing specific coping behaviors. Three patterns have been established by factor analysis: (a) family integration, cooperation, and an optimistic definition of the situation; (b) maintaining social support, self-esteem, and psychological stability; and (c) understanding the health care situation through communication with other parents and consultation with the health care team (McCubbin, 1987). Parents mark how helpful each behavior is on a scale of 0 to 3 from not helpful to extremely helpful. Additionally, a parent may indicate that a behavior is not helpful because a choice is made not to use it or the behavior is not possible (McCubbin, McCubbin, Nevin, & Cauble, 1983).

The CHIP was scored by placing the parent's score for each item in the circle to the right of each item (see Appendix E). The circle represents the appropriate pattern for each item. Items marked under the "chose not to" and "not possible" columns are scored as 0. The scores for each pattern were totaled and those pattern scores became the reported scores.

Cronbach's alphas for internal consistency reliability have been computed for each of the following coping patterns of the CHIP:

(a) maintaining family integration (.70), (b) maintaining social support and psychological stability (.79), and (c) understanding the medical situation (.71). Construct validity was determined through factor analysis and discriminant function analysis (McCubbin, 1987).

Protection of Human Rights

Application was made to the Institutional Review Board (IRB) of the University of Alabama at Birmingham. Approval for the study was granted on August 6, 1987, by the IRB on an exempt status (see Appendix F). Verbal permission was granted from all agencies and pediatricians.

Procedure for Data Collection

Due to privacy considerations, all agencies and organizations requested that parents be contacted by office staff. Therefore, all materials were distributed to parents by the staff.

Parents of Nonhandicapped Children

Parents were solicited through pediatricians' offices and child care centers. Each pediatrician (see Appendix G) and child care director was sent a letter (see Appendix H) describing the study, the sample, time required, and confidentiality. A one-page abstract of the proposal (see Appendix I) was constructed to address issues not covered in the letter. A telephone call was made to the pediatrician and director 1 week after the letters were mailed to answer questions. If the pediatrician and director agreed to participate, packets for each parent containing a letter of invitation for participation (see Appendix J), Demographic Profile, FCI, stamped self-addressed envelope, and pen were delivered to the office or mailed. Out of 14 contacts, 5 pediatricians and 3 child care centers agreed to participate. A total of 100 packets were distributed in three states.

Parents of Mentally Handicapped Children

Initially, the Association for Retarded Citizens, Inc., of Jefferson County agreed to participate in the study. However, out of 100 preschool children, only one parent met the criteria of an only child aged 6 months to 18 months. Two additional early intervention programs in Birmingham were identified and agreed to participate with a total of six families. Due to the small number of eligible parents in each program, all parents who agreed to participate in each program consisted of the sample. Furthermore, the decision was made to expand the geographic area for data collection. The procedure was, then, changed as follows.

The researcher attempted to obtain lists of early intervention programs in each of six states (Alabama, Mississippi, Louisiana, Georgia, Tennessee, and Ohio). Telephone calls were made to the Department of Education in each state as a starting point. After an average of three calls to different state departments, the appropriate agency was located. Only in one state was there such a list and the researcher was told that the list was outdated and was not being distributed. No state possessed a list of private programs. Two states had state-supported programs and the researcher was referred to individual counties in the largest cities.

Another attempt to locate state-wide programs was made by contacting the Association for Retarded Citizens of the United States for a list of state associations and contact persons. Four of the six state associations were contacted with three agreeing to send a list of early intervention programs and the directors. Only one state actually sent a list. Follow-up contact yielded no further results. Attempts at

locating private programs were made by contacting a national parent support group and professionals. The procedure for contacting each of the contacts was as follows.

Letters (see Appendix K) and proposal abstracts (see Appendix L) were mailed requesting information on early intervention programs. A telephone call to the appropriate person 1 week later was made to answer questions and either receive the information on the telephone or be assured of a list of programs by mail. If the person was not available, at least three follow-up telephone calls were made over 2 weeks. If no response was obtained from the agency, then no further contact was made. Out of 20 contacts, 1 did not respond, 5 responded but did not follow through with information, and 14 responded with information requested. The procedure for contacting each early intervention program was as follows.

Letters (see Appendix M) and proposal abstracts (see Appendix L) were sent to the director of each early intervention program. One week later a telephone call was made. If the person was not available, at least three follow-up telephone calls were made. If no response by the agency followed, no further contact was made. Four agencies required additional information for an internal committee to review and approve. Upon agreement to participate, packets containing a letter of invitation to participate (see Appendix N), FCI, CHIP, Demographic Profile, stamped self-addressed envelope, and pen were mailed or delivered to each program. Emphasis on soliciting participation by fathers was made.

Each program director was asked for additional sources of programs until no new programs emerged. Out of 41 programs, 7 did not respond, 4 responded but did not follow through, 5 had no families with an only child, 4 had no children under 18 months, and 20 agreed to participate.

One program was eliminated by the researcher because of an internal approval process that required rewriting the proposal and an approximate time of 5 months. A total of 144 packets were distributed.

Contacts were made from August 10, 1987, until January 15, 1988. February 15, 1988, was the date for analysis of data to be in. Therefore, the total data collection time was 6 months.

Analysis of Data

The data were analyzed using descriptive and inferential statistics. Descriptive statistics were used to describe the sample. Inferential and descriptive statistics were used to address the research questions.

Analysis of the data was performed by using the SPSS statistical computing package, Version 2 (1987). The research questions were addressed by using the t-distribution and descriptive statistics with the data from the FCI. The data from the CHIP were analyzed using descriptive statistics.

The level of significance was set at .05. Because literature on coping as a mother or father of a mentally handicapped child was found to be scarce, any differences in the effectiveness of coping behaviors between parents should be demonstrated by setting a less conservative level of significance. With the differences in choices of coping behaviors by mothers and fathers, the health professional can assist parents in choosing coping behaviors that will be of benefit to the parent, thus eliminating the common approach of trial and error. Therefore, the researcher was willing to risk a Type I error.

Summary

The focus of this chapter was on the methodology developed for this study. The design of the study and identification of the variables were followed by a description of the criteria for sample selection. A

discussion of the instruments used in data collection included the validity and reliability estimates for each of the instruments. Permission to conduct this study was stated along with a detailed presentation of the data collection procedure. The chapter concluded with a description of the data analysis techniques.

CHAPTER IV

Findings

Introduction

The purpose of this study was to ascertain if there was a difference in perceived effectiveness of coping behaviors between mothers and fathers of a mentally handicapped child and mothers and fathers of a nonhandicapped child. The findings are presented in three sections: (a) descriptive information about the subjects and variables, (b) analyses of data that addressed the research questions, and (c) supplemental analyses. The chapter concludes with a summary of the findings.

Descriptive statistics were performed on the demographic variables to describe the subjects. Descriptive statistics, also, yielded information on the variables of the study: sex of the parent, child status (handicapped or nonhandicapped), and coping (patterns of the FCI).

Subjects

Total Sample

The total sample consisted of 64 parents, 55 mothers and 9 fathers. The mean age of the sample was 29.6 years with 29.7 years representing the mean age of mothers and 29.1 years representing the mean age of fathers.

Description of Parents

Analyses of the demographic data revealed that the sample consisted of 28 parents of a mentally handicapped child with a mean age of 28.1 years. Thirty-six subjects were parents of a nonhandicapped child with

a mean age of 30.7 years. The ages ranged from 20 years to 42 years. Descriptive statistics for sex and age of each group of parents are presented in Table 1.

Table 1

Descriptive Statistics for Sex and Age of Parents by Child Status

			Parent Age		
Parent	f	%	Mean	Median	SD
Handicapped Child					
Mother	26	92.9	28.42	28	5.04
Father	2	7.1	24.00	24	4.24
Nonhandicapped Child					
Mother	29	80.6	30.82	31	4.69
Father	7	19.4	30.57	31	4.65

Additional demographic variables of the parents were assessed. Frequencies and percentages are presented in Table 2 for marital status, education, occupation, and residence.

Several independent chi-square analyses were performed to determine whether or not the demographic data differed between the parents of a mentally handicapped child and parents of a nonhandicapped child. Because over 50% of the cells for occupation and education contain less than five subjects, the cells were collapsed into two groups for both variables. The groups for education became high school only and college. Occupation was divided into employed and unemployed groups. There were no differences found in five of the six demographic data as demonstrated in

Table 2

Frequencies and Percentages for Marital Status, Education, Occupation, and Residence of Parents by Child Status

	Handicapped		Nonhandicapped	
Demographic Variable	f	%	f	%
Marital Status				
Married	22	78.6	33	91.7
Single	3	10.7	1	2.8
Separated	1	3.6	1	2.8
Divorced	2	7.1	1	2.8
Education				
11th Grade	2	7.1	0	0.0
12th Grade	3	10.7	3	8.3
Some College	13	46.4	7	19.4
Associate's Degree	3	10.7	5	13.9
Bachelor's Degree	6	21.4	9	25.0
Graduate Degree	1	3.6	12	33.3
Occupation				
Unemployed	15	53.6	6	16.7
Professional	4	14.3	21	58.3
Technical	9	32.1	9	25.0
Residence				
Ohio	5	17.9	10	27.8
South	23	82.1	26	72.2

Table 3. The difference in occupation revealed that 20 mothers of the handicapped child were unemployed while only six of the mothers of a nonhandicapped child were unemployed.

The variables of child status (handicapped or nonhandicapped) and sex of the parent were analyzed to determine if significant differences in distribution were present. Chi-square analyses demonstrated no significant difference in distribution between child status [χ^2 (1, N = 65 = 1.0, p = .317]. However, analyses revealed a significant difference in

Table 3

Chi-Square Analyses of Demographic Variables by Child Status

Demographic Variable	Chi-Square	df	p
Parent Age	20.94	19	0.339
Parent Sex	1.08	1	0.297
Marital Status	2.57	3	0.462
Education	.58	5	0.446
Occupation	8.12	2	0.004*
Residence	3.99	1	0.527

*p = .004

distribution of sex of the parent [χ^2 (1, N = 64) = 33.06, $p < .0001$]. Therefore, differences between mothers and fathers were only analyzed using descriptive statistics.

Description of Children

Although the parents were the sample, a description of their children yielded further demographic information of the parents. The age of the children ranged from 6 months to 18 months with a mean age of 12.7 months. There were 38 males and 26 females. Table 4 demonstrates additional descriptive statistics of the children.

Variables

The variable of coping was assessed through the patterns of the Family Coping Inventory. The variables which determined the groups of parents were child status and sex of the parent. The descriptive statistics for these variables are presented in Table 5.

Table 4

Descriptive Statistics of the Children

			Child Age		
Child	f	%	Mean	Median	SD
Handicapped					
Females	15	46.4	12.4	12.0	3.46
Males	13	53.6	12.0	11.0	4.26
Nonhandicapped					
Females	11	30.6	13.6	16.0	5.06
Males	25	69.4	12.8	14.0	4.74

Table 5

Descriptive Statistics of Social Support, Family Integrity, Religiousness, and Responsibility

	Child Status		Sex of Parent	
Variable	Handicapped	Nonhandicapped	Female	Male
Social Support				
Mean	45.7	39.4	42.2	41.7
SD	8.6	7.9	9.2	5.8
Family Integrity				
Mean	18.8	18.9	18.8	19.4
SD	3.4	3.2	3.7	3.0
Religiousness				
Mean	15.0	13.3	14.0	14.0
SD	2.9	3.4	3.2	3.8
Responsibility				
Mean	14.6	15.5	15.1	15.4
SD	4.8	4.5	4.7	4.9

Research Questions

Data obtained from the 64 subjects were used to address the research questions. Because the mothers and fathers were not parents of the same child, independent samples *t*-tests were utilized for data analysis. The assumption of equal variances was tested and the variances were found to be homogeneous. For each of the four patterns of the FCI and the three patterns of the CHIP, skewness was assessed. No pattern was skewed. Additionally, the patterns were analyzed for normality and outliers. A normal distribution was present with no outliers.

Reserach Question 1

Are there differences in perceived effectiveness of coping behaviors between mothers and fathers? Data from the FCI from the 64 subjects were used to address this question. Because only nine fathers returned questionnaires, descriptive statistics were selected to analyze the data.

In addressing the means for each of the patterns, some differences were found. Mothers demonstrated higher means than fathers on the seeking social support and self-development pattern while fathers demonstrated higher means on the maintaining family integrity and being responsible patterns. The means for mothers and fathers on the being religious, thankful, and content pattern were equal. The descriptive statistics are presented in Table 6.

Research Question 2

Are there differences in perceived effectiveness of coping behaviors between mothers and fathers of mentally handicapped children? Data from the FCI and the CHIP from the 28 subjects were used to address this question. Because only two fathers returned questionnaires, descriptive statistics were selected to analyze the data.

Table 6

Descriptive Statistics of the FCI for Mothers and Fathers

FCI	Mothers	Fathers
Seeking Social Support		
Mean	42.29	41.77
Median	43.0	42.0
Mode	45.0	43.0
Standard Deviation	9.22	5.89
Maintaining Family Integrity		
Mean	18.81	19.44
Median	19.0	20.0
Mode	19.0	20.0
Standard Deviation	3.37	3.04
Being Religious, Thankful, and Content		
Mean	14.09	14.0
Median	14.0	15.0
Mode	16.0	18.0
Standard Deviation	3.27	3.80
Being Responsible		
Mean	15.10	15.44
Median	15.0	15.0
Mode	12.0	15.0
Standard Deviation	4.70	4.92

In assessing the means for each of the patterns in the FCI, differences were found. On the seeking social support pattern, mothers had a higher mean than fathers. On the maintaining family integrity, being religious, thankful, and content, and being responsible patterns fathers demonstrated higher means than mothers. The descriptive statistics are presented in Table 7.

The data obtained from the 28 subjects from the CHIP were used also to address this question. Fathers demonstrated higher means than mothers on the patterns of maintaining social support and medical support and

Table 7

Descriptive Statistics on the FCI for Mothers and Fathers of a Mentally Handicapped Child

FCI	Mothers	Fathers
Seeking Social Support		
Mean	46.0	42.50
Median	45.0	42.50
Mode	45.0	42.0
Standard Deviation	8.97	0.70
Maintaining Family Integrity		
Mean	17.76	19.50
Median	19.0	19.50
Mode	19.0	19.0
Standard Deviation	3.60	0.70
Being Religious, Thankful, and Content		
Mean	14.96	15.50
Median	16.0	15.5
Mode	16.0	15.0
Standard Deviation	3.06	0.70
Being Responsible		
Mean	14.15	20.50
Median	12.50	20.5
Mode	11.0	19.0
Standard Deviation	4.72	2.12

communication with other parents. On the family pattern, mothers and fathers were found to have an almost equal mean. Descriptive statistics are presented in Table 8.

Because the effectiveness of social support was measured on both instruments, Pearson Product Moment correlations between the patterns were performed. A significant positive correlation between social support on the FCI and CHIP was found for mothers (r = .533, p = .005) while a perfect negative correlation was demonstrated for fathers (r = -1.00, $p < .0001$).

Table 8

Descriptive Statistics on the CHIP for Mothers and Fathers of a Mentally Handicapped Child

CHIP	Mothers	Fathers
Social Support		
Mean	40.53	49.5
Median	42.0	49.5
Mode	42.0	48.0
Standard Deviation	8.51	2.12
Family Integrity		
Mean	29.03	29.0
Median	27.0	29.0
Mode	25.0	28.0
Standard Deviation	8.05	1.41
Medical Support		
Mean	18.61	21.0
Median	20.0	21.0
Mode	21.0	18.0
Standard Deviation	4.02	4.24

Research Question 3

Are there differences in perceived effectiveness of coping behaviors between mothers and fathers of mentally handicapped children and mothers and fathers of nonhandicapped children? Data from the FCI for the 64 subjects were used to address this question.

Because parents from one midwestern state and five southern states answered questionnaires, an independent samples t-test was performed on the scores for each pattern to determine if differences in responses existed between the two regions. As demonstrated in the following data, no significant difference was found: (a) seeking social support and self-development ($t = -.95$, $p = .347$), (b) maintaining family integrity

(t = -.06, p = .951), (c) being religious, thankful, and content (t = -1.31, p = .204), and (d) being responsible (t = -1.8, p = .085).

Because no difference was found between the two regions, parents were grouped only by child status. An independent samples t-test was performed on the score for each pattern and revealed a significant difference in the seeking social support pattern and the being religious, thankful, and content pattern. No significant differences were found in the maintaining family integrity pattern and the being responsible patterns (see Tables 9 through 12).

Table 9

Responses of Mothers and Fathers by Child Status on the Seeking Social Support Pattern

Parents	n	Mean	SD
Handicapped child	28	45.75	8.62
Nonhandicapped Child	36	39.47	7.97
t = 2.97*			

*p = 0.004

Table 10

Responses of Mothers and Fathers by Child Status on the Maintaining Family Integrity Pattern

Parents	n	Mean	SD
Handicapped child	28	18.82	3.47
Nonhandicapped child	36	18.97	3.22
t = -.18*			

*p = .86 (NS)

Table 11

Responses of Mothers and Fathers by Child Status on the Being Religious, Thankful, and Content Pattern

Parents	n	Mean	SD
Handicapped child	28	15.00	2.95
Nonhandicapped child	36	13.36	3.44
t = 2.04*			

*p = .04

Table 12

Responses of Mothers and Fathers by Child Status on the Being Responsible Pattern

Parents	n	Mean	SD
Handicapped child	28	14.60	4.85
Nonhandicapped child	36	15.58	4.59
t = -.8*			

*p = .417 (NS)

Supplemental Analyses

Supplemental analyses were performed on the data from the patterns of the FCI, CHIP, and demographic variables. Differences between mothers were analyzed by conducting independent samples t-test. Correlations were performed between demographic variables and the patterns of both instruments.

Mothers

The responses of the 55 mothers were further analyzed by assessing differences between mothers on the patterns of the FCI. Before analyses were performed, differences in mothers' responses between the two geographical regions were assessed. No significant differences were found on the patterns: (a) seeking social support and self-development (t = -1.09, p = .28), (b) maintaining family integrity (t = .14, p = .89), (c) being religious, thankful, and content (t = -1.82, p = .086), and (d) being responsible (t = -1.07, p = .29).

Because no difference was found between the mothers of the two regions, mothers were grouped only by child status. No significant difference was found between mothers on the maintaining family integrity pattern (t = =.10, p = .92); the being religious, thankful, and content pattern (t = 1.92, p = .06); and the being responsible pattern (t = -.144, p = .15). A significant difference was found in the seeking social support and self-development pattern as demonstrated in Table 13.

Table 13

Responses of Mothers on the Seeking Social Support Pattern of the FCI

Mother	n	Mean	SD
Handicapped child	26	46.0	8.97
Nonhandicapped child	29	38.96	8.25
t = 3.01*			

*p = .004

Demographic Variables

The data obtained from the 64 subjects from the FCI and the 28 subjects from the CHIP were assessed for correlation between the patterns and the demographic variables. A negative correlation was found between occupation and medical support pattern (r = -.40, p = .04) on the CHIP. The significant correlations on the patterns of the FCI are as follows: (a) parent age and seeking social support and self development (r = -.27, p = .03); (b) marital status and maintaining family integrity (r = -.44, $p < .001$); (c) parent age and being religious, thankful, and content (r = -.31, p = .01); (d) marital status and being responsible (r = -.31, p = .01); (e) child status and seeking social support (r = -.35, p = .004); and (f) child status and being religious, thankful, and content (r = -.24, p = .04).

Summary of the Findings

A total of 64 parents participated in a study to ascertain differences in the perceived effectiveness of coping behaviors between parents of a mentally handicapped child and parents of a nonhandicapped child. With the exception of occupation, the parents did not differ with respect to the demographic variables.

Significant differences were found between the two groups of parents in the effective use of seeking social support and self-development behaviors and the effective use of being religious, thankful, and content behaviors. Additional analyses demonstrated significant differences between mothers in the effective use of seeking social support and self-development behaviors. A significant correlation between medical support and occupation was found on the CHIP. On the patterns of the FCI, the following significant ocrrelations were found: (a) parent age and seeking social support and self-development; (b) parent age and being

religious, thankful, and content; (c) marital status and maintaining family integrity; (d) marital status and being responsible; (e) child status and seeking social support and self-development; and (f) child status and being religious, thankful, and content.

CHAPTER V

The Outcomes

The purpose of this study was to ascertain if there was a difference in perceived effectiveness of coping behaviors between mothers and fathers of a mentally handicapped child and mothers and fathers of a nonhandicapped child. The methodology of this study was implemented utilizing a descriptive design. Statistically significant differences in the perceived effectiveness of coping behaviors of seeking social support and self-development and being religious, thankful, and content between the two groups of parents were established. No statistically significant differences in the perceived effectiveness of coping behaviors of maintaining family integrity and being responsible were established between the two groups.

Discussion

This section contains a discussion of the methodological issues related to the sample, the research questions, and the conceptual framework. A discussion of the relevant literature is presented in relation to the research questions.

Methodological Issues

A sample of convenience was the initial method utilized to obtain subjects for this study. For the parents of a nonhandicapped child, a sample of pediatricians and day care centers was selected. However, due to the lack of parents with an only child aged 6 to 18 months, the population in each group became the sample. Furthermore, due to the small

number of parents with an only child aged 6 to 18 months with a mental handicap, the population of early intervention programs and the parents in each program constituted that group.

Originally, a sample size of 80 parents was planned so that data could be analyzed from four equal cell sizes of 20. Within the first 2 weeks of data collection, the researcher realized that obtaining that size would be very difficult. The number of parents in each early intervention that met the criteria for this study averaged four. Therefore, the geographical area was expanded to five southern states and one midwestern state. Because of financial constraints, contacts with the program directors were limited to the telephone for three states. In the other three states, the researcher made initial contact by telephone followed by personal contact with a limited number of directors. The response rate of parents facilitated through personal contact of the director was 25% to 80% while the response rate by telephone was 25% to 60%.

The lack of updated lists of early intervention programs proved to be a major problem. Persistence of the researcher through telephone calls to numerous state agencies in each state yielded information in only two states which had statewide programs. No state could provide a list of private early intervention programs. Lists of early intervention programs from statewide private programs such as the Association for Retarded Citizens could only be obtained if the state association approved releasing the list.

Privacy considerations for the parents by the programs prevented the researcher from having any contact with the parents. However, during

follow-up telephone contacts with the directors, the researcher was assured that all of the questionnaires had been distributed to the parents.

The lack of response by fathers proved to be a major concern of this study. The directors of all of the early intervention programs stated that the staff of the programs had little contact with fathers. The mother was the parent that brought the child to the center and received the questionnaire. One early intervention program director stated the program staff tried to start a father's group. However, the project was abandoned because no fathers would participate (S. Tauber, personal communication, February 4, 1988).

The two sample criteria that presented the most problems were the criteria of an only child and the independence of parents. In the non-handicapped sample, two pediatricians' offices contacted had no parents who met the criteria. One child care center with an enrollment of 80 children under 5 years of age only had two parents eligible for the study. In the handicapped sample, the range of parents for each program was one to ten. In a county-wide program with a population of over one million people, only two parents met the criteria. Concerning independence of parents, speculation can only be made that fathers might have participated more if parents of the same child could participate so that parents in each family could have participated.

Research Questions

Research Question 1. Are there differences in perceived effectiveness of coping behaviors between mothers and fathers? Analysis of the means of the data from this study revealed that mothers perceived the coping behaviors of seeking social support and self-development to be

more effective than fathers. Fathers perceived that the behaviors of maintaining family integrity and being responsible were more effective.

Ventura (1986) found that mothers identified seeking social support and self-development as more helpful in coping than did fathers. No further differences were established. However, in a 1983 study, Ventura and Boss found that mothers also perceived that being religious, thankful, and content behaviors were more helpful than fathers. Both parents identified maintaining family integrity as useful coping responses.

Coping strategies which were useful to parents of 6- to 8-month-old children were identified as follows: (a) adaptability in changing from an orderly, predictable life to a relative disorderly and unpredictable one, (b) having patience, (c) becoming more organized, (d) becoming flexible, (e) utilizing social support, and (f) looking to the future (Miller & Sollie, 1980). However, differences between mothers and fathers were not assessed by the authors.

Research Question 2. Are there differences in perceived effectiveness of coping behaviors between mothers and fathers of mentally handicapped children? From an analysis of the means of the scores between mothers and fathers, mothers were found to perceive seeking social support and self-development as more effective than fathers. Fathers identified the behaviors of maintaining family integrity, being religious, thankful, and content, and being responsible as more effective than mothers.

Parents of retarded children identified coping resources as religious belief, assistance from a church, and parent support groups (Abbott & Meredith, 1986). While no differences between parents were assessed, the use of social support and religious belief resources is consistent with the present study.

Maintaining the family by being a family was a coping strategy identified as used in capable families (Beavers et al., 1986). Other strategies used were focusing on small gains and using more than one approach to manage the child. Again, no differences between parents were assessed by the researchers.

Research Question 3. Are there differences in perceived effectiveness of coping behaviors between mothers and fathers of mentally handicapped children and mothers and fathers of nonhandicapped children? Statistically significant differences were found between parents of the two groups. Parents of a mentally handicapped child perceived the coping behaviors of seeking social support and self-development and being religious, thankful, and content as more effective than did parents of a nonhandicapped child.

The findings of the present study differ from the findings of the study by Waisbren (1980). No differences in coping were evidenced by parents of a developmentally delayed child and parents of a control group. All parents found social activities, physical health, activities with the baby, and plans for the future useful coping strategies.

Supplemental Analyses

Mothers. A statistically significant difference between the perceived usefulness of coping behaviors by mothers was identified. Mothers of a mentally handicapped child identified seeking social support and self-development coping behaviors as more useful than did mothers of a nonhandicapped child.

The findings of this study are consistent with a study by Friedrich and Friedrich (1981). Mothers of a handicapped child demonstrated more

stress when less evidence of psychological well-being, social support, religiosity, and marital satisfaction was present. Social support was the common thread between the studies.

Demographic Variables. In the present study, significant statistical relationships between marital status and maintaining family integrity and marital status and being responsible were found. This finding suggests that parents who were married used the coping behaviors of maintaining family integrity and being responsible while parents who were single, separated, or divorced did not perceive these behaviors as effective in coping as a parent.

Several studies identified marital satisfaction as relating to the use of coping strategies. Pre-birth marital satisfaction influenced post-birth adjustment (Tomlinson, 1987). Negative measures of marital relationships were found in a group of parents with a child having Down's Syndrome (Gath, 1977). Friedrich and Friedrich (1981) found that marital satisfaction was a mediator variable for stress. Marital satisfaction was revealed as the most significant contributing variable for predicting coping behaviors (Friedrich, 1979). However, no studies were found that investigated the relationship of marital status with coping.

Significant statistical relationships between child status and seeking social support and self-development and child status and being religious, thankful, and content were established. The findings of the present study suggest that parents of a mentally handicapped child perceived the coping behaviors of seeking social support and self-development and being religious, thankful, and content as effective in coping as a parent.

The importance of social support, positive attitudes, and religious beliefs was documented in the literature for parents of a handicapped

child. Parents identified coping through seeking support from parent groups and ministers (Gath, 1977; Strauss & Munton, 1985). Social support and religiosity were found to be mediator variables of stress (Friedrich & Friedrich, 1981).

Additional findings in the current study established a significant statistical relationship between the age of the parent and seeking social support and self-development and being religious, thankful, and content. The younger parent perceived the use of seeking social support and self-development and being religious, thankful, and content coping behaviors as more effective than did the older parent. No literature was found that investigated the relationship between the age of the parent and coping.

A significant statistical relationship between employment and the use of medical support was established in the present study. Parents who were unemployed perceived the support of medical personnel and services and communication with other parents as effective coping behaviors. The majority of unemployed parents in the present study were mothers of a handicapped child. No literature was found that specifically investigated employment of parents of a handicapped child. However, one study did reveal that parents identified coping through seeking support from developmental program staff (Strauss & Munton, 1985).

Conceptual Framework

The conceptual framework used to guide this study was from the work of Lazarus (1961) and Pearlin and Schooler (1978). Lazarus discussed coping in the context of the situation which required a coping behavior in response to a perceived threat or harm. Pearlin and Schooler conceptualized coping in the context of responses to the threat or harm.

Things people do to manage the strains and stresses in their role are the specific coping responses. One of the social roles people fill is that of parent. Furthermore, within each social role, differences arise, some of which are gender related.

In the present study, differences within a social role were evidenced. Parents of a mentally handicapped child perceived the use of coping responses of seeking social support and self-development and being religious, thankful, and content as more useful than did parents of a nonhandicapped child. Gender differences also were established between mothers and fathers in the use of seeking social support and self-development, maintaining family integrity, and being responsible.

Conclusions

Based on the findings of this study, the following conclusions were made:

1. Mothers identify the effective use of seeking social support and self-development coping behaviors.

2. Maintaining family integrity and being responsible are coping behaviors perceived as effective by fathers.

3. Fathers of a mentally handicapped child perceive maintaining family integrity, being religious, thankful, and content, and being responsible as effective coping behaviors.

4. Mothers of a mentally handicapped child perceive seeking social support and self-development as effective coping behaviors.

5. Parents who are married perceive maintaining family integrity and being responsible as effective coping behaviors.

6. Parents of a mentally handicapped child perceive the coping behaviors of seeking social support and self-development and being religious, thankful, and content as effective coping behaviors.

7. Younger parents perceive seeking social support and self-development and being religious, thankful, and content as effective coping behaviors.

8. Parents who are unemployed perceive the support of medical personnel and services and communication with other parents as effective coping behaviors.

9. Lists of early intervention programs for developmentally delayed children are difficult to obtain.

10. Fathers are not available for research or participation in early intervention programs.

Implications

Because of the lack of generalizability of the findings of the present study, the implications apply only to the sample. The implications are presented for consideration in nursing practice and education.

The findings of this study suggest that mothers and fathers of a mentally handicapped child do perceive different coping behaviors as being effective. Therefore, nurses in a practice setting can suggest the appropriate coping behaviors to the parents. Nurses should assess the types of personal and professional support available to parents. Interventions then can be developed to encourage the parents to use the supports. Guidance could be provided for the parents at periodic intervals through home visits.

Efforts should be made to include fathers in the early intervention program's plans for his child. Fathers could be approached individually, in father groups, or in parent groups. Perhaps home visits by the program staff could facilitate a father's participation.

Professionals involved with the early intervention programs need to assure that lists of both public and private programs in each state and

community are made readily available to both professionals and more importantly to parents. A central agency responsible for maintaining the lists would be most beneficial.

The knowledge on coping as a parent should be available to undergraduate nursing students. The opportunity to use the knowledge in guiding new parents in developing coping strategies to cope with being a parent can be made available through clinical practice. Graduate nursing students should have the opportunity then to assist parents of a mentally handicapped child in developing appropriate coping strategies.

Recommendations

Recommendations for further research are derived from the findings of the present study. The recommendations are as follows:

1. Questions regarding the availability of fathers need to be addressed such as:

   A. What are the reasons both for the lack of father participation in early intervention programs and the lack of availability of fathers for research?

   B. What are the strategies that may be developed to increase father participation?

2. Questions regarding the employment status of parents of mentally handicapped children need to be addressed such as:

   A. What are the reasons for the unemployment of mothers of a mentally handicapped child?

   B. Why do parents of the mentally handicapped child perceive the support of medical personnel as effective?

3. Additional studies should be developed that would explore nursing interventions to assist parents in developing effective coping strategies.

4. Studies should be developed to investigate the relationship between parent age and coping behaviors.

5. A study should investigate the coping behaviors that single parents identify as effective.

6. Replication of this study with an adequate sample of fathers should be conducted.

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Appendix A

Demographic Profile (Nonhandicapped)

Demographic Profile

PARENT

1. Age _____ (years)

2. Sex
   A. Female _____
   B. Male _____

3. Marital Status
   A. Single _____
   B. Married _____
   C. Separated _____
   D. Divorced _____
   E. Widowed _____

4. Education (check one)
   A. Below 7th grade _____
   B. 7th grade _____
   C. 8th grade _____
   D. 9th grade _____
   E. 10th grade _____
   F. 11th grade _____
   G. 12th grade _____
   H. Some college _____
   I. Associate's degree _____
   J. Bachelor's degree _____
   K. Graduate degree _____

5. Occupation
   A. Unemployed _____
   B. Professional _____ (Specify) _____

   _____

   C. Technical _____ (Specify) _____

   _____

   D. Other (Specify) _____

   _____

CHILD

1. Age _____ (months)

2. Sex
   A. Female _____
   B. Male _____

Appendix B

Demographic Profile (Handicapped)

Demographic Profile

PARENT

1. Age _____ (years)

2. Sex
   A. Female _____
   B. Male _____

3. Marital Status

   A. Single _____
   B. Married _____
   C. Separated _____
   D. Divorced _____
   E. Widowed _____

4. Education (check one)
   A. Below 7th grade _____
   B. 7th grade _____
   C. 8th grade _____
   D. 9th grade _____
   E. 10th grade _____
   F. 11th grade _____
   G. 12th grade _____
   H. Some college _____
   I. Associate's degree _____
   J. Bachelor's degree _____
   K. Graduate degree _____

5. Occupation
   A. Unemployed _____
   B. Professional _____ (Specify) _____

   _____

   C. Technical _____ (Specify) _____

   _____

   D. Other (Specify) _____

   _____

CHILD

1. Age _____ (months)

2. Sex
   A. Female _____
   B. Male _____

3. Describe your child's developmental problem _____

   _____

   _____

4. Describe any physical problems of your child _____

   _____

   _____

Appendix C

Family Coping Inventory

Appendix D

Family Coping Inventory (Patterns)

Family Coping Inventory (Patterns)

Seeking Social Support and Self-Development
Learning new skills
Developing myself as a person
Becoming more independent
Building close relationships with people
Crying
Talking to some one about how I feel
Showing that I'm strong
Involvement in social activities
Planning my future
Keeping my self in shape and well groomed
Watching television
Making sure I take advantage of all the state and local economic benefits
Going shopping with friends
Engaging in relationships and friendships which are satisfying to me
Seeking out friends who understand how difficult it is for me at times
Participation in gatherings and events with relatives

Maintaining Family Integrity
Doing things with my child
Trying to be a parent to the child
Believing that the institutions I and my spouse work for has my family's best interest in mind
Trying to maintain family stability
Investing myself in my child
Trusting my partner to support me and my child

Being Religious, Thankful, and Content
Reliving the past; reflecting on memorable moments
Believing that things will work out
Believing in God
Wishing my child were not here and things were different
Telling myself that I have many things to be thankful for
Believing that life with my family would not be any better if the child was not here

Being Responsible
Accepting financial responsibilities
Developing occupational skills
Getting away outdoors
Planning to have this child
Setting standards for childrearing
Talking to my spouse

Appendix E

Coping Health Inventory for Parents

Appendix F

Institutional Review Board Approval Form

The University of Alabama in Birmingham
Institutional Review Board for Human Use
205/934-3789

FORM 4: IDENTIFICATION AND CERTIFICATION OF RESEARCH PROJECTS INVOLVING HUMAN SUBJECTS

The Institutional Review Board (IRB) must complete this form for all applications for research and training grants, program project and center grants, demonstration grants, fellowships, traineeships, awards, and other proposals which might involve the use of human research subjects independent of source of funding.

This form does not apply to applications for grants limited to the support of construction, alterations and renovations, or research resources.

PRINCIPAL INVESTIGATOR Cynthia Chatham

PROJECT TITLE Differences in Copig Behaviors in Mothers and Fathers of Mentally Handicapped Children and Mothers and Fathers of Non Handicapped Children

_____ 1. This is a training grant. Each research project involving human subjects proposed by trainees must be reviewed separately by the Institutional Review Board (IRB).

_____ 2. This application includes research involving human subjects. The IRB has reviewed and approved this application on _____, in accordance with UAB's assurance approved by the United States Public Health Service. The project will be subject to annual continuing review as provided in that assurance.

_____ This project received expedited review.

_____ This project received full board review.

_____ 3. This application may include research involving human subjects. Review is pending by the IRB as provided by UAB's assurance. Completion of review will be certified by issuance of another FORM 4 as soon as possible.

__X__ 4. Exemption is approved based on number(s) __3a__.

8-4-87
Date

Russell Cunningham, M.D.
Interim Chairman of the
Institutional Review Board

Appendix G

Letter to Pediatricians

1700 B Valley Avenue
Birmingham, Alabama 35209
August 10, 1987

Dr.

Dear Dr.

I have reached the point in my graduate program where my dissertation is all that remains. My topic is the study of the difference in coping between mothers and fathers of the mentally-handicapped child and parents of the nonhandicapped child. Based on the findings of my study, I would like to develop a program that will provide parents with proven strategies for coping.

Currently I am identifying groups of parents with an only child aged 6 months to 18 months that might be interested in participating. I am asking permission to contact mothers and fathers (not of the same child) in your practice. Permission to conduct this study has been granted by my graduate committee and the University of Alabama at Birmingham Institutional Review Board.

Each parent will be given a demographic sheet and a questionnaire to return by mail with a self-addressed stamped envelope. The time required will be 10 to 15 minutes. Confidentiality will be maintained and no individual responses will be reported, only group responses.

I will be in Gulfport after August 26, 1987, and will contact you to answer questions. Questionnaires and university permission forms will be available.

Thank you for your consideration in helping me complete my dissertation.

Sincerely,

Cynthia A. Chatham, RN

Appendix H

Letter to Child Care Directors

1700 B Valley Avenue
Birmingham, Alabama 35209
January 4, 1988

Director
Child Care Center

Dear Director:

I am a doctoral student in the School of Nursing at the University of Alabama at Birmingham. My dissertation topic is the study of the differences in coping between parents.

Currently I am identifying groups of parents with an only child aged 6 months to 18 months that might be interested in participating. I am asking your permission to distribute questionnaires through your program to mothers and fathers (not of the same child). Permission to conduct this study has been granted by my graduate committee and the University of Alabama at Birmingham Institutional Review Board. (Enclosed find an abstract of the proposal and all material given to parents.)

Each parent will be given a demographic sheet and one questionnaire to return by mail with a self-addressed stamped envelope. The time required will be approximately 10 minutes. Confidentiality will be maintained and no individual responses will be reported, only group responses.

Thank you for your consideration in helping me complete my dissertation. I will call your office on Monday morning, January 11, 1987, to answer questions. If this time is not convenient, please call me at 933-6964.

Sincerely,

Cynthia A. Chatham, RN
Doctoral Candidate

Enclosures

Appendix I

Abstract of Proposal (Nonhandicapped)

Abstract of Dissertation Proposal

Title: Differences in Coping Behaviors in Mothers and Fathers of Mentally Handicapped Children and Mothers and Fathers of Nonhandicapped Children

Purpose: To ascertain if there is a difference in coping between mothers and fathers of a mentally handicapped child and mothers and fathers of a nonhandicapped child. Based upon the findings of this study, a program will be developed to inform parents during pregnancy and immediately after of proven strategies for coping.

Definition of Term: Nonhandicapped child: A child who has no known mental nor physical defects.

Permission for Study: Graduate Committee, July 10, 1987, and the Institutional Review Board of the University of Alabama at Birmingham, August 6, 1987.

Confidentiality: Maintained by not identifying parents and by not reporting individual responses, only group responses.

Procedure: Give parents a letter, a demographic sheet, and Family Coping Inventory with a stamped self-addressed envelope. Total time for parents: approximately 10 minutes. (Procedure may be altered depending on agency or group requests.)

Sample Criteria: Parent: Mothers and fathers (not of the same child), aged 20 years or older, with only one child. Child: Aged 6 months to 18 months.

Appendix J

Letter to Parents (Nonhandicapped)

1700 B Valley Avenue
Birmingham, Alabama 35209
August 20, 1987

Dear Parent:

I am a part-time nurse in the Nursery at Memorial Hospital at Gulfport, MS during quarter breaks and a doctoral student in the School of Nursing at the University of Alabama at Birmingham. My dissertation topic is the study of the difference in coping between mothers and fathers. Based on the findings of my study, I would like to develop a program that will provide new parents with proven strategies for coping.

Currently I am identifying groups of parents that might be interested in participating. Confidentiality will be maintained by not identifying parents and no individual responses will be reported, only group responses. The time involved is approximately 10 to 15 minutes.

Enclosed find a Demographic Profile, Family Coping Inventory, a pen, and a stamped self-addressed envelope. If you wish to participate, please return the Profile and FCI by . Completion of the questionnaires serves as consent to participate. Please accept the pen as a token of my appreciation. If you have any questions, please call me collect at (205)-933-6964.

Thank you for your consideration in helping me complete my dissertation.

Sincerely,

Cynthia A Chatham, RN

Enclosures

Appendix K

Letter to Agencies

1700 B Valley Avenue
Birmingham, Alabama 35209
September 10, 1987

Dear :

I am a doctoral student in the School of Nursing at the University of Alabama at Birmingham. My dissertation topic is the study of the differences in coping between mothers and fathers of the mentally handicapped child and parents of the nonhandicapped child. Based on the findings of my study, I would like to develop a program that will provide parents with proven strategies for coping that would be available during pregnancy and after the birth.

Currently I am identifying groups of parents with an only child aged 6 months to 18 months that might be interested in participating. Due to the small number of families in Birmingham, I am seeking families in other states. I am asking for a list of early intervention programs and permission to distribute questionnaires through your association to mothers and fathers. Permission to conduct this study has been granted by my graduate committee and the University of Alabama at Birmingham Institutional Review Board. (Enclosed find an abstract of the proposal.)

Each parent will be given a demographic sheet and two questionnaires to return by mail with a self-addressed stamped envelope. The time required will be approximately 20 mintues. Confidentiality will be maintained and no individual responses will be reported, only group responses.

Thank you for your consideration in helping me complete my dissertation. I will call your office on morning, 1987, to answer questions. If this time is inconvenient, please call me collect at (205)-939-6964.

Sincerely,

Cynthia A. Chatham, RN
Doctoral Candidate

Enclosure

Appendix L

Abstract of Proposal (Handicapped)

Abstract of Dissertation Proposal

Title: Differences in Coping Behaviors in Mothers and Fathers of Mentally Handicapped Children and Mothers and Fathers of Nonhandicapped Children

Purpose: To ascertain if there is a difference in coping between mothers and fathers of a mentally handicapped child and mothers and fathers of a nonhandicapped child. Based upon the findings of this study, a program will be developed to inform parents during pregnancy and immediately after of proven strategies for coping.

Definition of Term: Mentally handicapped child: Any intellectual inadequacy which originates in the developmental period and which may impair social adjustment at maturity.

Permission for Study: Graduate Committee, July 10, 1987, and the Institutional Review Board of the University of Alabama at Birmimgham, August 6, 1987.

Confidentiality: Maintained by not identifying parents and by not reporting individual responses, only group responses.

Procedure: Give parents a letter, a demographic sheet, Family Coping Inventory and the Coping Health Inventory for Parents with a stamped self-addressed envelope. Total time for parents: approximately 20 minutes. (Procedure may be altered depending on agency or group requests.)

Sample Criteria: Parent: Mothers and fathers (not of the same child), aged 20 years or older, with only one child. Child: Aged 6 months to 18 months.

Appendix M

Letter to Early Intervention Progarm

1700 B Valley Avenue
Birmingham, Alabama 35209
September 10, 1987

Dear :

I am a doctoral student in the School of Nursing at the University of Alabama at Birmingham. My dissertation topic is the study of the differences in coping between mothers and fathers of the mentally handicapped child and parents of the nonhandicapped child. Based on the findings of my study, I would like to develop a program that will provide parents with proven strategies for coping that would be available during pregnancy and after the birth.

Currently I am identifying groups of parents with an only child aged 6 months to 18 months that might be interested in participating. Due to the small number of families in Birmingham, I am seeking families in other states. I am asking for permission to distribute questionnaires through your early intervention program to mothers and fathers. Permission to conduct this study has been granted by my graduate committee and the University of Alabama at Birmingham Institutional Review Board. (Enclosed find an abstract of the proposal.)

Each parent will be given a demographic sheet and two questionnaires to return by mail with a self-addressed stamped envelope. The time required will be approximately 20 mintues. Confidentiality will be maintained and no individual responses will be reported, only group responses.

Thank you for your consideration in helping me complete my dissertation. I will call your office on morning, , 1987, to answer questions. If this time is inconvenient, please call me collect at (205)-933-6964.

Sincerely,

Cynthia A. Chatham, RN
Doctoral Candidate

Enclosures

Appendix N

Letter to Parents (Handicapped)

1700 B. Valley Avenue
Birmingham, Alabama 35209
September 30, 1987

Dear Parent:

I am a part-time nurse in the Nursery at Memorial Hospital at Gulfport, MS during quarter breaks and a doctoral student in the School of Nursing at the University of Alabama at Birmingham. My dissertation topic is the study of the difference in coping between mothers and fathers of a mentally handicapped child. Based on the findings of my study, I would like to develop a program that will provide new parents with proven strategies for coping.

Currently I am identifying groups of parents that might be interested in participating. Confidentiality will be maintained by not identifying parents and no individual responses will be reported, only group responses. The time involved in approximatley 10 to 15 minutes.

Enclosed find a Demographic Profile, Family Coping Inventory, Coping Health Inventory for Parents, a pen, and a stamped self-addressed envelope. If you wish to participate, please return the Profile, CHIP, and FCI by . Completion of the questionnaires serves as consent to participate. Please accept the pen as a token of my appreciation. If you have any questions, please call me collect at (205)-933-6964.

Thank you for your consideration in helping me complete my dissertation.

Sincerely,

Cynthia A. Chatham, RN

Enclosures