

Coping with Daily Stress
Among Single and Married Mothers
of Well and Chronically Ill Preschool Children

by

Jeanette French, R.N., B.S.N.

Jennifer Gilhooly, R.N., B.S.N.

and

Deborah Welte, R.N., B.S.N.

A Thesis

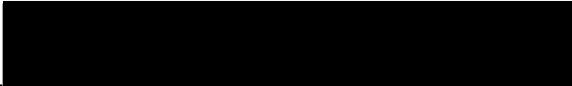
Presented to
The Oregon Health Sciences University
School of Nursing
in partial fulfillment
of the requirements for the degree of
Master of Science

June 13, 1986

APPROVED:



Sheila M. Kodadek, R.N., Ph.D., Associate Professor, Thesis
Co-Advisor



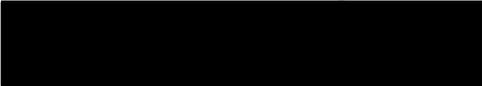
Marie Scott Brown, R.N., P.N.P., Ph.D., Professor, Thesis Co-Advisor



Shirley H. Hanson, R.N., Ph.D., Professor, Reader



Florence S. Hardesty, R.N., P.N., M.H.N.P., Ph.D., Associate Professor,
Reader



Carol A. Lindeman, R.N., Ph.D., Dean, School of Nursing

This study has been supported by traineeship grants, #2 ALL NU00250-09 and #2 All NU00250-10, and a research award from the Beta Psi Chapter of Sigma Theta Tau.

ACKNOWLEDGEMENTS

We want to acknowledge and thank the following people:

Sheila Kodadek, R.N., Ph.D. and Marie Scott Brown, R.N., Ph.D. for their constant support and instruction in the ways of research;

members of our committee, Florence Hardesty, R.N., Ph.D. and Shirley Hanson, R.N., Ph.D. for the constructive criticism and editing;

the Office of Research, especially Mary Williams, for their calm approach, constant availability, and ready suggestions during the process of analyzing our data;

Jan Freitas-Nichols, R.N., P.N.P. for her assistance in obtaining our population of mothers of chronically ill preschool children;

Pat Nehl, Linette Cowles, Mary Schutz, and Gloria Schell for the interest in our research project and the willingness to identify appropriate subjects for the study from their preschools.

Finally, we thank one another for the commitment, encouragement, laughter, sharing of ideas, and friendship that has developed over the last two years.

ACKNOWLEDGEMENTS

In every endeavor, there are those who lend us their support, their guidance, and their love. In addition to those already mentioned in our general acknowledgements, I would like to extend my special thanks to my family, especially my husband, Jon, and my daughters, Gina and Brigitte, for their unfailing support and love even during the lean times. I would also like to add a special thanks to Sherry for being my companion on this journey.

Jeanette

I wish to thank my family and friends for their support over the past two years. A very special thanks to my husband, Joe, who typed all of my papers, and to my dear children, Meaghan and Meara. The three of you were a constant source of love and laughter and always there when I needed you. To my special friend, Sheila, for your friendship, professional guidance, and assistance in making this dream come true. I love you all.

Jenny

I wish to thank my family and friends for their support and encouragement, especially my husband, John, and my children, Sarah and Peter.

Deborah Ann Welte

TABLE OF CONTENTS

CHAPTER	PAGE
I INTRODUCTION	1
REVIEW OF THE LITERATURE	2
Coping as a Process	3
Relationships: Gender, Stress, and Coping	6
Gender and Family Responsibilities	10
Coping Resources and Family Health Status.	11
CONCEPTUAL FRAMEWORK	15
Cognitive Theory of Stress	15
Coping as a Process	16
Coping Resources	16
Relationships: Cognitive Theory of Stress, Coping Process, and Coping Resources	17
HYPOTHESES	18
DEFINITION OF TERMS	18
II METHODOLOGY	21
DESIGN	21
Instruments: Jalowiec Coping Scale	21
Instruments: Daily Hassles Scale	23
Instruments: Demographic Form	24
Sample	25
Procedure	26
Analysis	28
III RESULTS	29
SAMPLE CHARACTERISTICS	29
RELIABILITY OF THE INSTRUMENTS	30
FINDINGS RELATED TO THE HYPOTHESES	33
IV DISCUSSION	39
SAMPLE IMPLICATIONS	39
SIGNIFICANCE OF HYPOTHESES	41
V CONCLUSIONS	45

SUMMARY	45
LIMITATIONS	48
IMPLICATIONS FOR NURSING PRACTICE	50
IMPLICATIONS FOR RESEARCH	52
REFERENCES	55
APPENDICES	
ABSTRACT	

LIST OF TABLES

TABLE

1	Sample Characteristics	31
2	Age of Children	32
3	Jalowiec Coping Scale: Reliability Analyses for Factors 1, 2, and 3	34
4	Daily Hassles Scale: Mean Scores of Sample Groups	35
5	Jalowiec Coping Scale: Mean Scores of Sample Groups	37

APPENDICES

APPENDIX

- A MODIFIED JALOWIEC COPING SCALE
- B JALOWIEC PERMISSION LETTER
- C MODIFIED DAILY HASSLES SCALE
- D DEMOGRAPHIC FORM
- E COVER LETTER
- F CCNSENT FORM
- G JALOWIEC COPING SCALE: COMPOSITION OF
 FIVE FACTOR SOLUTION
- H FACTOR 1 COMPOSITION: DIRECT PROBLEM-SOLVING
- I FACTOR 2 COMPOSITION: INDIRECT PROBLEM-SOLVING
- J FACTOR 3 COMPOSITION: DISTANCING COPING BEHAVIORS

The last 15 years of research in family stress and coping suggest exciting possibilities for the nurse clinician. These possibilities include interpreting and predicting family behavior in response to stress, identifying coping strategies that buffer the negative effects of stress, and facilitating adjustment, improved health status, and personal growth for family members. As clinicians and researchers, nurses are particularly interested in how families cope with both the impact of various stressors and the subsequent effects of those stressors on the mental and physical health of family members.

Research related to coping is not yet well developed and little information is currently available about family coping strategies. One area of sparse research concerns parental coping strategies. Researchers hypothesize that there is a relationship between how a parent copes with daily stressors and the health status of either the parent or the child (Belsky, 1984). Studies investigating situations in which stress is perceived as prominent (e.g., daily stressors) represent a shift from viewing family stress as dysfunctional to an interest in understanding why and how some families endure and mature in spite of adversity. As researchers, nurses may be able to further extend nursing knowledge regarding the impact of daily stress and coping on the family. As clinicians, nurses may be able to use the results of research about stress to identify families at risk for breakdown

under an accumulation of daily stressors or in the event of a severe crisis. Nurses may also use the findings from research about coping to assess characteristic family patterns of response to stress. This assessment could be useful in strengthening and expanding the family's repertoire of coping strategies.

Parental coping, specifically maternal coping, is an area of interest to the authors. The purpose of this study is to investigate three questions related to maternal coping. How do coping methods used by married mothers of chronically ill preschool children compare with coping methods used by married mothers of well preschool children? How do coping methods used by single mothers of well preschool children compare with coping methods used by married mothers of well preschool children? How do levels of daily stress perceived by single mothers of well preschool children and married mothers of chronically ill preschool children compare with levels of daily stress perceived by married mothers of well preschool children? This chapter presents the literature review, the conceptual framework, the hypotheses generated by the investigators, and a definition of terms.

Literature Review

The review of the literature has been divided into four sections. These sections will be presented in the following

order: coping as a process; relationships: gender, stress, and coping; gender and family responsibilities; and coping resources and family health status.

Coping as a Process

Research suggests that the coping process is a multidimensional response to multiple sources of stress. Moos and Tsu (1977) give an example of the multidimensions of stress by illustrating the complex array of coping strategies required to deal with the sources of stress that develop in situations of physical illness: pain, incapacitation, hospitalization, treatment procedures, maintaining emotional balance and maintaining a satisfactory self-image, and relationships with family members and friends.

Folkman and Lazarus (1980) divide the coping process into two categories of behaviors, problem-solving and affective-oriented behaviors. Problem-solving behaviors are commonly used in response to harm, loss, threat, or challenge. Individuals use these problem-solving behaviors to try to change the family-environmental relationship or the situation itself. Affective-oriented behaviors regulate or control emotional distress (i.e., crying, blaming someone else, getting angry, seeking the support of friends).

A third category of coping behaviors that has been identified in the literature is cognitive coping behaviors, methods by which the family alters its subjective perceptions of the stressor

(McCubbin, Joy, Cauble, Comeau, Patterson, & Needle, 1980).

Different combinations of the three types of coping strategies (problem-solving, affective-oriented, and cognitive) compose each family's characteristic coping style.

It is difficult for researchers to measure and describe coping because it is a dynamic process that changes as situations change (Folkman & Lazarus, 1980). Descriptions of the way an individual copes with specific situations yields situation-specific coping strategies that may not generalize to another context. In the past decade, little coping research dealt with everyday stressful situations. An exception was a study by Pearlin and Schooler (1978) which found that individuals use a broad range of coping strategies to handle stressors associated with four social roles: the role of marriage partner, household economic manager, parent, and worker. However, there are two important limitations of the Pearlin and Schooler study. The first limitation was that the respondents were asked how they usually coped with general sources of stress, rather than how they coped in a specific situation. To inquire how one usually copes may provide information about personality traits, rather than about one's response to specific stressful demands. The second limitation was that the subjects were not asked about resolved stresses and, therefore, no information was obtained about successful coping responses for resolving stressful situations.

Folkman and Lazarus (1980) assessed coping more specifically in a large middle-aged community sample with the use of interviews

and the Ways of Coping Checklist. Both of these tools were used to elicit information about the individuals' methods of coping with specific stressful situations. Findings support the assumption that coping is a complex process. In 99% of all stressful events reported, subjects used both problem-solving and affective-focused coping strategies. The researchers also found that variable, rather than consistent, coping patterns were characteristic of the subjects. This suggests that the specific stressful situation is more influential than personality traits in determining coping responses. The appraisal of an event and its context proved to be the most potent situational factors that accounted for coping variability in the Folkman and Lazarus study. The researchers found no relationship between age and coping in this study. The age range was very narrow, 45-64, which probably accounts, in part, for the results. Gender of the respondent was found to make little difference in the respondent's appraisal of events or in their affective-focused strategies. Findings did reveal that more men than women tended to use problem-solving strategies at work and in situations that could not be changed (e.g., physical illness and disabilities). The researchers were not able to account for this finding. One possible explanation is that many women in this sample held lower-level jobs that offered fewer opportunities to employ problem-solving strategies. However, to adequately investigate this explanation it would be necessary to select a sample of men and women drawn from similar job settings.

Although only a limited amount of research is available on family coping processes, the literature suggests four relationships. In general, the coping process appears to (1) diminish the effect of inherent family vulnerability factors (Boss, McCubbin & Lester, 1979; Pearlin & Schooler, 1978), (2) fortify or preserve those family resources (e.g. cohesiveness, organization, adaptability) which safeguard the family from harm or disruption (Adams, 1975), (3) decrease or eliminate family stressors and their attendant difficulties, (4) and influence the family-environmental relationship by actively changing social circumstances (McCubbin & Olson, 1980).

Relationships: Gender, Stress and Coping

Gender roles have traditionally been conceptualized as dichotomous roles, male and female, at opposite ends of a continuum. This conceptualization suggests that there may be differences between the coping strategies used by mothers and fathers. A recent study by McCubbin, McCubbin, Patterson, Cauble, Wilson and Warwick (1983) used the Coping Health Inventory for Parents (CHIP) to measure parental coping. McCubbin et al. selected parents with children diagnosed with cystic fibrosis for their subjects. Factor analysis of the study items revealed three coping styles or patterns: (a) maintaining family integration, co-operation and optimistic definition of the problem; (b) maintaining social support, self-esteem, and psychological stability; and (c) understanding the medical situation through

communication with other parents and with the medical staff. The findings revealed some definite gender differences. Mothers' coping tended to focus on the interpersonal dimensions of family life, family cohesiveness and family expressiveness. These results reflect the traditional feminine affective role for this sample in which 49% of the women were full-time homemakers. However, the investigators did not determine whether or not these women were homemakers by choice or by the circumstances related to having a chronically ill child at home and the unavailability of child care. Fathers' coping patterns tended to be broader in range than the mothers' coping patterns and were associated primarily with the system maintenance dimensions of family life, cohesiveness, organization, and control.

Until recently, our culture appears to have supported different socialization patterns for men and women. Men have been socialized to repress emotional responses as inappropriate and have been encouraged to use more problem-solving behaviors. Women have been encouraged to rely more on the use of affective behaviors of coping and use fewer problem-solving behaviors. Ventura and Boss (1983) looked at the possibility that men and women use different coping behaviors in the same situation. These investigators studied parental coping behaviors in a sample of mother and fathers with 2-3 month old infants. Coping behaviors were operationally defined through specific items on the Family Coping Inventory. Three factors, or coping patterns, explained 74% of the variance: seeking social support and self-development,

maintaining family integrity, and being religious, thankful and content. Of the 28 individual coping behaviors, mothers found 17 of them more useful than did fathers. Open-ended questions were used to determine what coping behaviors fathers used that were not included on the Family Coping Inventory. Results indicated that a number of the fathers' coping behaviors were not incorporated into the Family Coping Inventory: accepting financial responsibility, developing occupational skills, getting away to hike, fish, or hunt, setting standards for childrearing, and strengthening relationships with older children. These findings suggest that it may be necessary to examine the coping methods of mothers and fathers separately.

Recently an androgenous gender role has been conceptualized. Spence, Helmrich and Stapp (1974, 1975) defined an androgynous person as one who scored high on both masculinity and femininity attribute measures. These researchers found that androgynous persons also scored higher on self-esteem and social competence measures, than those who scored primarily masculine or feminine in orientation or scored low on both gender attribute measures. Other studies have linked the maintenance of traditional, rigid, gender-specific role standards with measures of high anxiety, low self-esteem, and low self-acceptance (Consentino & Heilbrun, 1964; Gall, 1969; Harford, Willis, & Deabler, 1967). Androgyny may be an important psychological resource and a key to role adaptability that may contribute to the successful reduction of stress.

The relationship between gender roles and specific coping

behaviors was also examined by Patterson and McCubbin (1984) in a sample of 82 wives of Navy personnel who were assigned to an eight month deployment aboard a Navy carrier. This study postulated that there would be a positive association between having an androgynous gender-role orientation and wives' use of helpful coping patterns to manage the separation. Androgyny was operationally defined as wives who scored high on both masculine and feminine traits or instrumental and expressive traits respectively. Factor analysis revealed five coping patterns similar to previously described studies: maintaining family integrity, developing interpersonal relationships and social support, managing psychological tension and strain, believing in lifestyle and optimism (focusing on the perceived benefits of the spouse's profession and faith in God and the future), and developing self-reliance and self-esteem. Results indicated that androgynous gender-role orientation was significantly associated with all of the coping patterns except developing self-reliance and self-esteem. The researchers suggested that this coping pattern appears to be related more to masculinity than to androgeny, which was defined as high scores on both masculine and feminine traits. Further findings show a significant relationship between androgynous gender-role orientation and the use of a broad, balanced coping repertoire. In addition, these data also demonstrated a highly significant inverse relationship between androgyny and distress. Androgyny appears to be an important psychological resource in the development of a extensive coping

repertoire and is intimately linked to decreased stress in this sample. Further studies are needed to clarify the influence of gender-role orientation in stress reduction under different conditions.

Gender and Family Responsibilities

Traditionally mothers have had primary responsibility for child care. In a study of 1,154 randomly selected married couples, Araji (1977) examined husbands' and wives' role attitudes and behavior congruence. Seven family roles, including housekeeper, child-care, and provider were considered. The results indicated 75% of the respondents felt that wives should perform the majority of child care tasks.

As more women are employed outside the home and fathers become more involved with child care, one might not expect women to assume primary responsibility for child care. However, research suggests that this is not true. Beckman and Houser (1979) explored the relationship between the wife's employment, sex-role traditionalism, and the division of household labor. The data indicated that tasks are divided in a traditional sex-role manner, regardless of the wife's employment status. (Women tended to be responsible for the child care, meal preparation, housework, etc.) Nyquist, Slivken, Spence, and Helmreich (1985) studied 164 middle class parents and found little evidence that changes in attitudes about role sharing within the home (particularly with respect to traditional women's tasks) have been accompanied by

changes in actual practice. They also note that those tasks traditionally assigned to women (e.g., child care, housekeeping) are also more time consuming than the home maintenance tasks (e.g., lawn mowing) traditionally assigned to men.

It is not surprising that women also assume the major responsibility for the care of ill children, as well as for the accompanying tasks of escorting ill children to and from physician's offices and clinics and managing home therapy routines (Breslau, 1983; Carpenter, 1980; Sabbeth, 1984). For the mother of a chronically ill child, the responsibilities multiply. Breslau (1983) and Breslau, Weitzman and Messenger (1980) concluded that the mothers of disabled children spend more time in household work, than do fathers of disabled children or parents of well children. This finding suggests that the care of the disabled child is not at the total expense of other household responsibilities, although it may be at the expense of the mothers' leisure time activities (e.g., adult education, cultural pursuits, recreation, socializing and the use of mass media). Although studies in this area lack control groups and reliable measures, much of the data suggests an increase in depression among mothers of chronically ill children (Allen, Townley, & Phelan, 1974; Lawler, Nakielny, & Wright, 1966; McCrae, Cull, & Burton, 1973; Walker, Thomas and Russell, 1971).

Coping Resources and Family Health Status

A number of authors have suggested that maladaptive coping

can enhance the probability of and/or maintain illness in family members, although outcomes are generally complex and not linearly predictable (Hoebel, 1977; Holmes & Masada, 1973; Palazzoli, 1974; Peck, 1974). Lask and Matthew (1979) evaluated the effectiveness of family psychotherapy as an adjunct to conventional medical treatment in severe childhood asthma. The purpose of the family therapy intervention was to assist the family in the development of coping skills that would effectively alleviate some of the stresses which, in interaction with other physical factors, contribute to the recurrence of asthmatic attacks. Random assignment determined subject placement in either the control group or the experimental group. Both groups received standard medical treatment for asthma. The experimental group scored significantly better in day-wheeze and thoracic gas volume measures than the control group. The implications are that learning effective coping skills ameliorates stress and contributes to an improved physical health status.

Social support has been found to have a positive effect on coping strategies and to act as a buffer of stressful events (Ventura & Boss, 1983). Cobb (1976) described social support as a buffer or moderator of life stress and gave empirical evidence for this position. He reported on social support buffering the psychological reactions of hospitalized children, stresses associated with the complications in pregnancy, and adjustments to job stress or job loss.

Health surveys indicate that single mothers and their

children experience higher levels of psychological distress and use mental health facilities more than members of two-parent households (Guttentag, Salasin, & Belle 1980). Despite the increased interest in the female-headed family and its effect on women and children, very little is known about the social experiences of this family form and how it differs from the nuclear family. It is also unclear whether the observed differences of female-headed families and other family structures are temporary responses to recent marital disruption or a characteristic of the single-parent status (McLanahan, 1983).

Single-parent families have been described in the literature as disorganized, disruptive, non-compliant and depressed (Perdue & Horowitz, 1977; Tankson, 1979). Hetherington, Cox and Cox (1978) investigated the aftermath of divorce in a longitudinal study involving both divorced and intact families. Areas which caused problems in coping for divorced persons were those associated with emotional distress and changes in self-concept and identity; those related to the practical problems of living; and those related to the interpersonal problems of maintaining a social life, developing intimate relationships, and interacting with the ex-spouse and child. In all of these areas, the difficulties with coping peaked at one year post-divorce and markedly decreased by two years post-divorce. One important factor that was determined to alleviate some of these stressors and proved to be an important coping resource was the existence of a support system for the divorced woman. Colleta's (1979) study demonstrated a positive

relationship between the availability of family support systems and maternal role performance. Norbeck and Sheiner (1982) found that the absence of a close friend and the lack of available persons to call upon for practical help were related to parenting problems for single mothers. Evaluation of the preschool children in this study revealed an association between emotional and behavioral problems in the child and the mother's lack of a close relationship with a family member.

A longitudinal comparison study by McLanahan (1983) of two-parent and female-headed families examined the relationship between family structure and stress. Results indicated that female-headed families experienced a greater number of major life events and had more chronic life strains (low income, poor education) than two-parent families. In addition, non-married persons have been found to be more isolated and have fewer psychological resources than their married counterparts (Brown & Harris, 1978).

Other studies have linked an accumulation of family life stressors with changes in mother-infant attachment, from secure to anxious (Vaughn, Egeland, Sroufe & Waters, 1979). Research has also indicated that a relationship exists between stress and family violence, in particular, child abuse. In a review of the literature on child abuse and neglect, Belsky (1984) describes three areas that influence parental functioning: personality and psychological well-being of the parent, characteristics of the child, and contextual sources of stress and support. Belsky also

suggests that because parental functioning is multiply determined, coping strategies that buffer stress within the parenting system can protect against breakdown.

An accumulation of family stressors and a corresponding inadequate coping response have also been linked to depression (Keith & Schaffer, 1980), marital difficulties (Maynard, Maynard, McCubbin & Shao, 1980), non-compliance with medical regimens (Sabbeth, 1984) and negative changes in pulmonary function in children with cystic fibrosis (Patterson & McCubbin, 1980). Nurses, as both clinicians and researchers, need to know more about coping, which appears to have critical dual roles in buffering the negative impact of stress in families and facilitating family adjustment, health, and personal growth.

Conceptual Framework

The conceptual framework for this research project is based upon the relationships among the cognitive theory of stress, coping as a process, and two coping resources (social support and androgeny).

Cognitive Theory of Stress

The cognitive theory of stress defines stress as a "relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and as endangering his or her well-being" (Folkman, 1984, p. 840). Two processes crucial to the cognitive theory of

stress are cognitive appraisal and coping. Cognitive appraisal is the initial process of appraising a situation as benign, threatening, or harmful. If a situation is not perceived as benign, the secondary process of coping occurs (Lazarus & Launier, 1978).

Coping as a Process

Coping is defined as "...efforts, both action-oriented and intrapsychic, to manage (i.e. master, tolerate, reduce, minimize) environmental and internal demands, and conflicts among them, which tax or exceed a person's resources" (Lazarus & Launier, 1978, p. 311). These efforts are either directed toward solving the problem or toward regulating the emotions accompanying the problem (Lazarus & Launier, 1978).

Coping Resources

Social support is defined as the availability of friends and family to call upon for emotional and practical help. Social support has been found to buffer the effects of stress. Androgyny, another coping resource, is defined as a gender role orientation characterized by both traditionally masculine, instrumental attributes and traditionally feminine, expressive attributes. Androgyny has been linked with role adaptability and positive coping behaviors.

Relationships: Cognitive Theory of Stress, Coping Process, and Coping Resources

The relationships among the cognitive theory of stress, coping as a process, and the coping resources (social support and androgyny) form the conceptual framework of this paper. Coping is the response to the cognitive appraisal of a situation perceived as threatening or harmful. This response is an effort to master or minimize the threat. Social support enhances a positive coping response by buffering or moderating the stressful situation. The coping response is also enhanced by an androgynous gender-role orientation. An androgynous orientation which expands the coping repertoire to include both masculine and feminine responses, results in increased versatility and adaptability in a stressful situation with the potential for a better outcome.

Parental coping, specifically maternal parental coping, is the area of interest of the authors. Based on this conceptual framework, the investigators speculate that a single mother is likely to have less social support than a married mother and, therefore, will experience higher levels of stress in the course of daily life. This increased level of stress will be reflected a greater number of hassles reported on the Daily Hassles Scale (Hassles Scale) by single mothers than by married mothers. Further, since single mothers frequently assume both the role of mother and father in the family, they are likely to behave more androgenously than mothers in families where the father is also present. The investigators expect that the single mothers in the

study do have a more androgynous orientation than married mothers and it will be reflected in the reporting of more problem-solving coping behaviors on the Jalowiec Coping Scale (JCS).

Parenting children with chronic illness is assumed to be more stressful than parenting healthy children. Based on this assumption, the investigators expect that the parents of chronically ill children will report more hassles on the Hassles Scale than will the parents of well children.

Hypotheses

1. Single mothers of well preschool children will experience a higher level of stress, as measured by the Hassles Scale, than will married mothers of well preschool children.

2. Married mothers of chronically ill preschool children will experience a higher level of stress, as measured by the Hassles Scale, than will married mothers of well preschool children.

3. Single mothers of well preschool children will exhibit a greater number of problem-solving coping behaviors, as measured by the JCS, than will married mothers of well preschool children.

Definition of Terms

Stress: "A relationship between a person and the environment that is appraised by the person as taxing or exceeding his or her

resources and as endangering his or her well-being" (Folkman, 1984, p. 840).

Coping: "...efforts, both action-oriented and intrapsychic, to manage (i.e. master, tolerate, reduce, minimize) environmental and internal demands, and conflicts among them, which tax or exceed a person's resources" (Lazarus & Launier, 1978, p. 311).

Social Support: The availability of friends and family to call upon for emotional and practical help.

Androgyny: A gender role orientation characterized by both traditionally masculine, instrumental attributes and traditionally feminine, expressive attributes.

Single mother: Any woman who is the sole caretaker of at least one preschool child due to divorce, widowhood, or having never been married.

Married mother: Any woman who is currently married and has at least one preschool child.

Preschool child: A child who is 3 to 5 years of age.

Well preschool child: A child who is 3 to 5 years of age and has no known chronic illness.

Chronic illness: "A disorder of prolonged duration which can be progressive, fatal, or associated with a relatively normal lifespan despite impaired physical or mental functioning" (McKeever, 1981).

Operational definition of a chronically ill preschool child:

A child (age 3 to 5 years) who has a congenital cardiac defect that currently requires Digoxin therapy, is at least one year post cardiac surgery, and is not anticipating cardiac surgery within the next 6 months.

Chapter 2

Methodology

Chapter 2 presents a description of the methods used in this study. The presentation will include: the study design, instruments, sample, settings, procedures, and analysis.

Design

A comparative descriptive design was used for this research project. The purpose of this study was to provide more information about the level of daily stresses experienced by the mothers of preschool children and the nature of the coping behaviors used by these mothers. This approach was selected because of the paucity of knowledge available in this area. In addition, the nature of the variables involved did not permit the manipulation of variables required by an experimental design.

Extraneous variables may influence the outcome of any research study. The extraneous variables considered most important to control in this study were socioeconomic status, age of the mothers, age of the children, and the type of childhood chronic illness. These variables were controlled by building them into the design.

Instruments: Jalowiec Coping Scale

A modified JCS (see Appendix A), which assesses the individual, was chosen as the most appropriate tool for this

study. Permission to use the JCS and modify the instructions were obtained from the author (see Appendix B). This scale consists of forty coping strategies, 25 of which are problem-oriented and 15 of which are affective-oriented. The coping strategies are rated on a one to five graded response scale to indicate the degree of use by the respondent (1=never, 5=almost always). The instructions for the scale were modified slightly by adding the phrase "this past week". This modification was done in an effort to gather more explicit information about the number of times coping methods were used in the past week and to facilitate comparison with the Hassles Scale. The modified instructions read as follows: "Please estimate how often you used the following ways to cope with stress this past week by picking one number for each item". In addition, the following statement was made at the end of the JCS: "Do you use any coping methods that were not mentioned on this scale? If so, please list them." The JCS can be completed in 10 minutes or less. In addition to the JCS, a copy of the Hassles Scale, a cover letter, a demographic form, a consent form and a stamped, preaddressed envelope made up the packet that was given to each participant.

Reliability is supported for the JCS. Stability for the JCS was evaluated using a test-retest with a two week interval (N=28). Spearman's rank ordering of the data yielded significant ($p < .001$) reliability coefficients of .86 for affective-oriented and .85 for problem-oriented scores (Jalowiec, Murphy & Powers, 1984). Internal consistency was supported by two additional studies

yielding overall alpha coefficients of .86 (N=141) and .85 (N=150) (Jalowiec, Murphy, & Powers, 1984).

Content validity is supported by the process by which the instrument was developed. A systematic, comprehensive literature review to identify many diverse coping strategies was done and from it were drawn the specific items used in the scale. Construct validity for the JCS was investigated through factor analysis. The problem-oriented classification of coping strategies was supported by factor analysis. The affective-oriented classification was considered sufficient, but suggested a multidimensional aspect of coping behavior. Further testing is required to determine if a multidimensional structure of coping behavior would be more appropriate than a two dimensional structure (i.e., problem-solving and affective-oriented) (Jalowiec, Murphy & Powers, 1984).

Instruments: Daily Hassles Scale

A modified Hassles Scale (see Appendix C) was chosen as the second instrument for this study to measure the degree of daily stress experienced by the mothers in this study. The Hassles Scale consists of 117 items relating to work, health, family, friends, environment, practical considerations and chance occurrences. Each item is rated on a 1 to 3 graded response scale to indicate the severity of the hassle to the respondent (1 = somewhat severe, 2 = moderately severe, 3 = extremely severe). The respondent was asked to grade only those items she considers

to be a hassle. The instructions for the scale were modified slightly. The original tool asked respondents to assess hassles that had occurred in the past month. For the purposes of this research project, the respondents were asked to rate hassles that had occurred in the past week. This facilitated comparison with the JCS coping scores.

Test-retest reliability was determined by the original researchers over a 9 month period of time. Monthly administrations of the Hassles Scale with 100 subjects resulted in an average reliability of .79 for frequency of hassles reported. The average month to month correlation for intensity of hassles was .48 (Kanner, Coyne, Schaefer, & Lazarus, 1981).

Content validity for the Hassles Scale appears adequate. The scale items were generated by a research staff using peer consultation. Sources of daily hassles included work settings, health, friends, and the environment. In addition, subjects of a study using an earlier version of the scale were asked to add hassles that were not included in the original scale and these were incorporated in the later version of the Hassles Scale (Kanner et al., 1981).

Instruments: Demographic Form

A demographic form (see Appendix D) was developed by the investigators for the purpose of this study. Data collected included: age of the mother, marital status, education, total

yearly income, occupation, number of hours worked outside the home, number of children living at home, ages of children living at home, and number of other adults living in the home assisting with childcare.

Sample

This study used a convenience sample and was originally designed to have three convenience groups: 30 married mothers of well preschool children (group 1, control group); 30 married mothers of chronically ill preschool children (group 2); and 30 single mothers of well preschool children (group 3). During data collection, less than 30 married mothers of chronically ill preschool children who met the study criteria were obtained. Therefore, single mothers of chronically ill preschool children were also accepted into the study, resulting in four groups. The four groups included: 49 married mothers of well preschool children (group 1); 17 married mothers of chronically ill preschool children (group 2); 16 single mothers of well preschool children (group 3); and 7 single mothers of chronically ill preschool children (group 4). The entire sample of 89 was used for the analysis and interpretation. A major disadvantage of using a convenience sample is that generalizability of the findings is limited.

The sites from which the sample populations were obtained were the Crippled Children's Division (CCD) at the Oregon Health Sciences University (OHSU), Medford, and Eugene cardiac clinics

and four daycare centers in Beaverton and Hillsboro, Oregon. The married and single mothers of chronically ill preschool children who met the study criteria were contacted at the respective cardiac clinics and all agreed to participate in the study. The married and single mothers of well preschool children were contacted by mail. The rate of questionnaire return was 48.6% for married mothers of well preschool children and 37.2% for single mothers of well preschool children. Approval for proceeding with this research project was obtained from the Human Subjects Committee and the directors of each facility.

Procedure

The data were collected in the fall of 1985. A list of mothers and permission to contact them by mail was obtained from the directors of four Children's World day care centers, Beaverton and Hillsboro, Oregon. The initial mailing occurred during the third week of October, 1985. Questionnaires were accepted through 15 December, 1985. The investigators obtained 65 subjects from these settings, 16 single mothers of well preschool children and 49 married mothers of well preschool children. A packet was mailed to each mother consisting of a cover letter explaining the purpose of the study (see Appendix E), a consent form (see Appendix F), a demographic sheet, a copy of the modified JCS, a copy of the modified Hassles Scale and a stamped, preaddressed envelope. Confidentiality was assured. One month subsequent to the initial mailing, the investigators began making follow-up

telephone calls to single mothers who had not responded to the mailing to encourage the return of the study materials and to answer any questions concerning the study. Although many of the single mothers contacted promised to complete the questionnaires, none of them actually did so. Follow-up telephone calls were not made to the married mothers in this sample because the initial response was adequate for the purposes of this study.

The director of the pediatric outpatient cardiology clinics at OHSU, Portland, Oregon, granted permission for this study. The investigators obtained 24 subjects from these settings, specifically, mothers of preschool children who currently require digoxin therapy because of a congenital cardiac defect. Because the patients came to these clinics from all over the Pacific Northwest, the investigators believed that personally approaching these mothers at the time of their child's clinic visit would expedite data collection. One of the investigators or the pediatric cardiology nurse practitioner gave a verbal explanation of the study to each potential subject, who had been prescreened by chart review according to study criteria. Subjects who indicated a willingness to participate were given the research packet to complete in the waiting room or in the clinic room. Patients and their families typically had a waiting time of two to three hours per clinic visit. Based on actual observation, the time required for the mothers to fill out the research packet questionnaires was 15 minutes, rather than the 40 minutes originally predicted. Completed packets were returned to the

investigator, the nurse practitioner, or to the clinic receptionist.

Analysis

The data from the JCS were analyzed by first obtaining three scores for each respondent. These scores were the total coping score (the sum of all the items), the problem-oriented score (the sum of the problem-oriented items), and the affective-oriented score (the sum of the affective-oriented items). Using ANOVA, a comparison of the scores between groups was done.

The data from the Hassles Scale generate three summary scores for analysis: (1) frequency, a simple count of the number of items checked; (2) accumulated severity, the sum of the 3 point severity ratings; and (3) intensity, the cumulated severity divided by the frequency. The intensity score is indicative of the intensity of the average hassle, regardless of the sum of the hassles checked. Using ANOVA, a comparison of the scores between the groups was done.

Chapter 3

Results

The results of the investigation are presented in this chapter in the following order: sample characteristics, findings related to the hypotheses, a comparison of the four sample groups, and reliability analyses.

Sample Characteristics

This study was originally designed with three groups of subjects. Because of the limited availability of married mothers of chronically ill preschool children, single mothers of chronically ill children were also accepted into the study. This resulted in four distinct groups: married mothers with well preschool children (group 1); married mothers with chronically ill preschool children (group 2); single mothers with well preschool children (group 3); and single mothers with chronically ill preschool children (group 4). All mothers were between 22 and 41 years of age. Married mothers of well preschool children (group 1) had the highest level of income (\$35,000-39,999), while single mothers of chronically ill preschool children (group 4) had the lowest (\$5,000-9,999). Single mothers of chronically ill preschool children (group 4) worked the greatest number of hours outside the home, while married mothers of chronically ill preschool children (group 2) worked the least. Married mothers of

well preschool children (group 1) had the highest level of education; single mothers of chronically ill preschool children (group 4) had the lowest level of education. Mothers of chronically ill preschool children (groups 2 and 4) had more children than mothers of well preschool children (groups 1 and 3). However, all mothers (married and single) reported having only one to three children. More married mothers (groups 1 and 2) reported another adult living at home assisting with childcare than single mothers (groups 3 and 4). Table 1 presents demographic frequency data for age, income, number of hours worked outside the home, education, number of children, and number of other adults living at home assisting with childcare; table 2 describes the age ranges of the children in groups 1, 2, 3, and 4.

Reliability of the Instruments

The investigators found coping behavior to be more multidimensional than dichotomous, which is similar to the findings of Jalowiec, Murphy, and Powers (1984). When alternate factor solutions using the present data were examined, a three factor solution was determined to be most meaningful conceptually (see Appendix G). Factor 1 was labeled direct problem-solving (see Appendix H); factor 2 was labeled indirect problem-solving (see Appendix I) Factor 3, labeled distancing coping behaviors, consisted of a collection of coping responses that appeared to be unrelated to either direct or indirect problem-solving (see Appendix J). The items in Factor 3 also appeared to be only

TABLE 1

SAMPLE CHARACTERISTICS

	<u>GROUP 1</u>	<u>GROUP 2</u>	<u>GROUP 3</u>	<u>GROUP 4</u>
<u>AGE OF MOTHER</u>				
Mean	31.93	27.18	31.67	27.33
SD	3.99	3.21	4.59	2.50
Range (years)	24-35	22-34	25-41	25-32
<u>INCOME</u>				
Mean	7.13	5.82	4.69	2.00
SD	2.55	2.77	1.85	1.41
Range	\$35-39,000	\$25-29,999	\$25-29,999	\$5-9,999
<u>HOURS WORKED OUTSIDE HOME</u>				
Mean	31.86	22.65	37.13	39.00
SD	14.98	25.26	10.9	30.10
<u>HIGHEST LEVEL OF EDUCATION</u>				
High School %	18.4	58.8	25.0	83.3
n	(9)	(10)	(4)	(5)
College %	57.1	29.4	62.5	16.7
n	(28)	(5)	(10)	(1)
Grad. School %	24.5	11.8	12.5	0.0
n	(12)	(2)	(2)	(0)
<u>NUMBER OF CHILDREN</u>				
One child %	49.0	11.8	87.5	28.6
n	(24)	(2)	(14)	(2)
Two children %	49.0	64.7	6.3	42.9
n	(24)	(11)	(1)	(3)
Three children%	2.0	23.5	6.3	42.9
n	(1)	(4)	(1)	(2)
<u>NUMBER OF OTHER ADULTS IN HOME ASSISTING WITH CHILDCARE</u>				
None %	20.4	25.0	93.8	33.3
n	(10)	(4)	(15)	(2)
One adult %	75.5	75.0	6.3	50.0
n	(37)	(12)	(1)	(2)
Two adults %	4.1	0.0	0.0	16.7
n	(2)	(0)	(0)	(1)

Group 1 (Married mothers with well preschool children)
 Group 2 (Married mothers with chronically ill preschool children)
 Group 3 (Single mothers with well preschool children)
 Group 4 (Single mothers with chronically ill preschool children)

TABLE 2

AGE OF CHILDREN

	<u>GROUP 1</u>	<u>GROUP 2</u>	<u>GROUP 3</u>	<u>GROUP 4</u>
<u>AGE OF FIRST CHILD</u>				
Mean	3.35	3.80	3.78	5.35
SD	1.41	2.24	1.74	2.24
Range (years)	1-9	.5-9	1-8	3-9
<u>AGE OF SECOND CHILD</u>				
Mean	3.96	3.6	4.50	5.36
SD	2.38	1.87	2.12	2.70
Range (years)	.5-4.5	.5-6	3-6	.83-8
<u>AGE OF THIRD CHILD</u>				
Mean	4.00	3.68	3.00	2.25
SD	0	3.65	0	3.53
Range Years)	4.0	.75-9	3.0	2-2.5

Group 1 (Married mothers with well preschool children)
 Group 2 (Married mothers with chronically ill preschool children)
 Group 3 (Single mothers with well preschool children)
 Group 4 (Single mothers with chronically ill preschool children)

weakly related to each other conceptually. Table 3 portrays a comparison of the reliability analyses of each of the three factors of the JCS. Factor 1 and factor 2 had alpha coefficients of 0.88 and 0.70, respectively. As anticipated, the relationship between the items in Factor 3 was not statistically significant ($\alpha = 0.06$).

Reliability was supported for the Hassles Scale in this study ($\alpha = 0.94$). This reliability is acceptable. An alpha of .70 is recommended for basic research (Nunnally, 1978).

Findings Related to the Hypotheses

The findings supported the first hypothesis that single mothers of well preschool children would experience higher levels of stress, as measured by the Hassles Scale, than married mothers of well preschool children. The findings did not support the second hypothesis that married mothers of chronically ill preschool children would experience higher levels of stress, as measured by the Hassles Scale, than would married mothers of well preschool children. Table 4 compares the frequency and intensity scores on the Hassles Scale for all groups. Single mothers of well preschool children (group 3) reported the second highest scores for frequency and intensity of hassles, while single mothers with chronically ill preschool children (group 4) reported the highest scores. Married mothers of chronically ill preschool children (group 2) scored the lowest in frequency and intensity of

TABLE 3

JALOWIEC COPING SCALE:
RELIABILITY ANALYSES FOR FACTORS 1, 2, AND 3

	<u>ITEM</u> <u>MEANS</u>	<u>ITEM</u> <u>VARIANCES</u>	<u>INTER-ITEM</u> <u>CORRELATIONS</u>	<u>ALPHA</u>
<u>FACTORS</u>				
1	3.27	1.10	0.38	0.88
2	2.17	0.77	0.16	0.70
3	2.61	0.90	0.01	0.06

Factor 1 (Direct problem-solving coping behaviors)

Factor 2 (Indirect coping behaviors)

Factor 3 (Distancing coping behaviors)

TABLE 4

DAILY HASSLES SCALE:
MEAN SCORES OF SAMPLE GROUPS

	GROUP 1	GROUP 2	GROUP 3	GROUP 4
<u>FREQUENCY OF HASSLES</u>				
Mean	22.49	17.94	26.56	39.86
SD	10.41	9.84	16.28	34.13
Range	6-47	0-39	8-72	23-117
<u>INTENSITY OF HASSLES</u>				
Mean	1.54	1.43	1.73	1.96
SD	.41	.48	.43	.56
Range	1-2.4	0-2.2	1.1-2.5	1.3-2.9

Group 1 (Married mothers with well preschool children)
 Group 2 (Married mothers with chronically ill preschool children)
 Group 3 (Single mothers with well preschool children)
 Group 4 (Single mothers with chronically ill preschool children)

hassles. These scores were significant for the frequency of hassles (ANOVA, $F=4.15$, $df = 3$, $p < 0.05$) and the intensity of hassles (ANOVA, $F = 3.20$, $df = 3$, $p < 0.05$).

The overall comparison between the four groups on the frequency subscale (Hassles Scale) was significant ($p < 0.05$). A post hoc Scheffe' test was used to determine where the significant differences lay. The results indicated that single mothers with chronically ill preschool children (group 4) were significantly different from married mothers with well and chronically ill preschool children (groups 1 and 2). Single mothers with chronically ill preschool children (group 4) were not significantly different from single mothers with well preschool children (group 3).

The findings also did not support the third hypothesis that single mothers of well preschool children would experience a greater number of problem-solving coping behaviors, as measured by the JCS, than would married mothers of well preschool children. Table 5 presents a comparison of the mean scores of groups 1, 2, 3, and 4 on each factor of the JCS. Married mothers with well preschool children (group 1) scored the highest on Factor 1, direct problem-solving. Single mothers with chronically ill preschool children (group 4) scored the highest on Factors 2 and 3, indirect problem-solving and distancing coping behavior. All groups used distancing coping behaviors more than direct or indirect problem-solving. Despite these results, the ANOVA

TABLE 5
JALOWIEC COPING SCALE:
MEAN SCORES OF SAMPLE GROUPS

	GROUP 1	GROUP 2	GROUP 3	GROUP 4
<u>DIRECT PROBLEM-SOLVING</u>				
Mean	39.59	34.88	33.38	38.86
SD	10.38	6.52	8.13	16.16
Range	18-75	19-43	21-47	27-65
<u>INDIRECT PROBLEM-SOLVING</u>				
Mean	30.63	28.65	28.00	34.00
SD	11.19	5.36	5.66	9.26
Range	19-77	21-40	20-42	26-54
<u>DISTANCING BEHAVIORS</u>				
Mean	46.08	42.47	45.00	48.57
SD	15.29	4.76	7.92	15.69
Range	34-119	34-52	38-70	38-83

Group 1 (Married mothers with well preschool children)
 Group 2 (Married mothers with chronically ill preschool children)
 Group 3 (Single mothers with well preschool children)
 Group 4 (Single mothers with chronically ill preschool children)

revealed no significant differences between the four groups on any of the three factors of the JCS.

Chapter 4

Discussion

Chapter 4 presents a discussion of the results of the investigation. Sample implications, significance of the hypotheses, and instrument effectiveness are included.

Sample Implications

The investigators had little difficulty obtaining an adequate response rate from a sample of married mothers of well preschool children for this study. The first questionnaires were returned within a week of the initial mailing. Of the 105 questionnaires mailed to married mothers of well preschool children, 51 were returned (48.6%). Two of the returned questionnaire packets were not accepted for the study because one of the consent forms was unsigned and the other set of questionnaires was completed incorrectly.

It was more difficult to obtain an adequate response rate from a sample of single mothers of well preschool children. Forty-three single mothers received the mailed questionnaires; 16 of these single mothers returned the completed questionnaires over a 6 week period. Although the questionnaire return rate for this population was 37.2%, the actual number of single mothers available in the daycare settings was fewer than anticipated. It

appears that single mothers with lower incomes are less likely to be able to afford daycare in these settings. Follow-up telephone calls made by the investigators to answer questions and increase the questionnaire rate of return were ineffective. All of the single mothers contacted by telephone reported feeling overwhelmed and unable to find the fifteen minutes needed to fill out the questionnaires. These single mothers told the investigators about a number of circumstances that they felt contributed to the stressfulness of their lives: huge workloads (usually the combination of work outside the home and inside the home), little/no leisure time, fatigue, and the additional work, time, and financial constraints associated with the coming holidays. Data were collected during October, November, and December, 1985. Perhaps, conducting the study during a different time of the year (e.g., late winter or early spring) would have resulted in a somewhat improved rate of questionnaire return. However, because of time constraints inherent in the role of single mother, approaching this group by mail may continue to be difficult. Lack of telephone service for many single mothers combined with the difficulty of actually contacting those who do have a telephone, seems to rule out this method as a viable alternative for data collection. Perhaps contacting single mothers at their place of employment and/or offering reimbursement for participation in a study would improve the response rate.

The selection of married mothers of chronically ill preschool

children was limited by the study criteria and the relatively short time for data collection. The specificity of the chronic illness, the age of the child, and the criteria that the child be at least one year post cardiac surgery and not anticipating cardiac surgery within the next 6 months, limited the number of available respondents. Because of the limited availability of married mothers of chronically ill preschool children and the time constraints around data collection, single mothers of chronically ill preschool children were also accepted into this study. The investigators and the pediatric cardiology nurse practitioner found that all of the mothers who were asked to participate and met the study criteria agreed to do so. Extension of the time for data collection would facilitate obtaining a larger sample population from these settings (CCD cardiac clinics) in the future.

Significance of Hypotheses

The findings supported the first hypothesis that single mothers of well preschool children experience a higher level of stress, as measured by the Hassles Scale, than married mothers of well preschool children. This was expected, since the literature indicates that single mothers are likely to have less social support than married mothers; are more likely to work longer hours and earn less than married mothers; and are less likely to have assistance with childcare in the home. These factors contribute

to higher levels of stress in the course of daily life. In addition, the findings indicated that of the four groups, single mothers of chronically ill preschool children exhibited the highest levels of stress, as measured by the Hassles Scale. This follows logically as these mothers are not only single, but are also parenting a chronically ill preschool child, presumably a more difficult and stressful task than parenting a well preschool child. According to the present data, these mothers also had the lowest level of education, worked the longest hours and had the lowest income of the four groups.

The findings did not support the second hypothesis that married mothers of chronically ill preschool children experience a higher level of stress, as measured by the Hassles Scale, than married mothers of well preschool children. Social support may operate as a buffer, decreasing the effect of inherent family vulnerability to stress. Surprisingly, married mothers of chronically ill preschool children (group 2) exhibited the lowest levels of all four groups in both frequency and intensity of hassles. This could be attributed to the fact that the majority of these mothers in group 2 appear to have adequate social support, as well as actual physical help with childcare in the home (75% reporting the presence of another adult in the home assisting with childcare). In addition, the particular cardiac clinics from which the subjects were drawn provide a source of comprehensive interdisciplinary support (emotional, financial, and

social services) for families. Social support may also provide a foundation for the development of more sophisticated coping strategies (e.g., cognitive coping behaviors, methods by which the family alters its subjective perceptions of the stressor). The data indicate that married mothers of chronically ill preschool children report lower levels of frequency and intensity of hassles than single mothers of well and chronically ill preschool children.

Although their income was second only to the married mothers with well preschool children (group 1), married mothers of chronically ill preschool children (group 2) worked the least number of hours outside the home. Whether by choice or by circumstance, working the fewest number of hours outside the home appears to be related to a lower level of frequency and intensity of hassles as measured by the Hassles Scale.

The findings did not support the third hypothesis that single mothers of well preschool children exhibit a greater number of problem-solving coping behaviors, as measured by the JCS, than married mothers of well preschool children. The results indicated that married mothers of well preschool children and single mothers of chronically ill preschool children (groups 1 and 4) actually exhibited greater numbers of problem-solving behaviors, although even this finding was not significant. Due to the small number of single mothers with chronically ill preschool children, caution should be used in interpreting these results.

The investigators hypothesized that although single mothers were likely to experience higher levels of daily stress and likely to have less social support, the assumption of the dual parenting role (mother and father) would be reflected in a more androgynous orientation toward coping. However, an androgynous coping response (using both masculine, problem-solving and feminine, affective coping strategies) does not appear to be adopted automatically with the assumption of multiple roles. Perhaps androgyny is learned, stimulated when a person chooses to assume additional roles. Choice is clearly nonexistent for many single mothers. In addition, the influence of transgenerational family beliefs regarding gender-specific roles combined with situational increased anxiety and low self-esteem, also has been linked with traditional gender role preservation (Consentino & Heilbrun, 1964; Gall, 1969; Harford, Willis, & Deabler, 1967).

Chapter 5

Conclusions

Conclusions drawn from this study are presented in this chapter. A summary of the research, limitations of this study, implications for nursing practice, and recommendations for further research conclude this section.

Summary

Coping with the impact of various stressors and the subsequent effect of those stressors on the mental and physical health of family members is a frequent context of nursing practice. Attention has shifted from viewing family stress as dysfunctional, to an interest in understanding why and how some families endure and mature despite adversity. As clinicians, nurses are in a position to identify families at risk for breakdown under an accumulation of daily stressors or in the event of a severe crisis. Nurses may be able to use the findings from research about coping to provide direct intervention and support.

The literature indicates that coping is a complex multidimensional response. Coping behaviors have been divided into two categories in the literature, problem-solving and affective-oriented (Folkman & Lazarus, 1980). McCubbin, et. al (1980) have also identified a third category, cognitive coping

behavior. Although simplistic, difficult to measure statistically, and not always conceptually useful, coping data suggests four relationships. The coping process appears to (1) reduce inherent family vulnerability to stressors, (2) strengthen intrinsic family resources, (3) reduce the effect of actual stressors, and (4) actively change social circumstances. Empirical evidence suggests that social support has an important positive effect on the coping response and is a buffer of stressful events (Ventura & Boss, 1983). Other researchers have discovered a connection between the lack of such a support system and problems in parenting, problems in children's emotional development, and problems with children's behavior (Norbeck & Sheiner, 1982).

Researchers have also investigated the relationship between gender and coping behavior. Different socialization patterns for men and women, now diminishing in importance in America, appear to have heavily influenced the acceptability of different coping behaviors for each gender. Studies suggest that an androgynous gender role orientation and an extensive, balanced coping repertoire are closely related, although little is known about the development of the androgynous gender role.

This nonexperimental descriptive study was designed to provide information about the level of daily stress experienced by mothers of preschool children and the nature of the coping behaviors used by these mothers. The findings supported the

hypothesis that single mothers would experience higher levels of stress than married mothers. Single mothers of chronically ill preschool children (group 4), reported the highest levels of stress (Hassles Scale), the lowest level of education, the greatest number of hours worked, and the lowest income of the four groups. The findings did not support a second hypothesis that suggested that married mothers of chronically ill preschool children (group 2) would experience higher levels of stress than married mothers of well preschool children (group 1). The majority of the married mothers of chronically ill preschool children in group 2 (75%) reported another adult living in the home assisting with childcare. It may be that social support operates to buffer inherent family vulnerability (i.e., chronic illness) and may provide a foundation for the development of more sophisticated coping strategies. In addition, the cardiac clinics from which the sample was selected provide an interdisciplinary comprehensive support system (emotional, financial, social services) for these families.

A third hypothesis suggesting that single mothers would report a greater number of problem-solving behaviors than married mothers was not supported. The literature indicates that a link exists between increased problem-solving behavior, androgyny, and a versatile, balanced coping response. Single mothers in this study reported fewer problem-solving behaviors suggesting that the role of single parent does not necessarily promote androgyny. The

investigators suggest that the development of an androgynous gender role orientation is more a function of socialization and choice rather than an instinctive situational response and may also be related to education and middle-class cultural orientation.

Limitations

A number of limitations hamper generalizability of the findings to other populations of mothers with preschool children. These include the use of a convenience sample and the small sample size of the comparison groups (groups 2, 3, and 4). Obtaining subjects from the single mother population proved to be difficult. Follow-up phone calls to increase the questionnaire return rate were nonproductive. Many of the single mothers did not have a telephone and when a telephone was available, the single mothers were often working or unavailable. Often, when a telephone contact was made, these mothers cited many reasons for not completing the questionnaires including: overwhelming responsibilities, little leisure time, lack of interest, fatigue, and financial constraints related to the upcoming holidays (Thanksgiving and Christmas). Although some subjects promised to complete the fifteen minute questionnaires, none of the single mothers who were contacted returned the forms.

Several limitations related to the instruments hampered this study. The Hassles Scale did not include problems associated with

childcare/daycare, which were consistently mentioned by the subjects. Other hassles written in at the end of the questionnaires by the respondents included: imminent birth of another child, an older child no longer napping, all family members ill with upper respiratory infection, and fear of being alone. These additions suggest that the Hassles Scale may need to be updated.

A number of limitations relate to the use of the JCS. The lack of clarity in the instructions to the respondents was a serious limitation. For this study, the authors modified the instructions to request more explicit information about the number of times particular coping methods were used in the past week. This was done to obtain information about the stressfulness of the situation, rather than an assessment of a personal style of coping. In addition, not all of the coping strategies described in the tool appeared to be applicable to the population studied (e.g., using drugs) or were not specific to parenting. It is difficult to determine whether reported usage or nonusage of particular coping strategies reflected a social desirability response set or actual behavior. Finally, the difficulty in developing categories of coping strategies, other than direct problem solving, that are clinically useful, conceptually meaningful, and statistically significant, limited the reliability of the tool.

Implications for Nursing Practice

This descriptive study adds to the body of knowledge concerning the manner in which mothers of preschool children cope with daily stress. The results focus attention on single mothers with well and chronically ill preschool children. The findings of this research are similar to those reported in the literature. That is, single mothers have financial problems, chronic stress, and fewer resources than married mothers (Horowitz & Perdue, 1977; McLanahan, 1983; Tankson, 1979). The proportion of female-headed families has increased over 100% in the last 20 years. Recent Census figures report over 20% of childrearing families are headed by single mothers (McLanahan, 1983). It is projected by the year 1990 that nearly 50% of all children under the age of 18 will have lived in a single-parent family, most headed by women (Schoor & Moen, 1979).

Nursing implications can be drawn from this study. Nurses caring for childrearing families are likely to encounter a large proportion of single mothers in any setting. Sensitivity to the problems prevalent in this family structure will facilitate development of realistic care plans and interventions (e.g., linking financial resources and single mothers to offset treatment costs) and thus increase compliance.

Many of the single mother respondents in this study wrote additional comments at the end of both the JCS and the Hassles

Scale. Examples include the following: "Thank-you for asking", "It was nice to share my feelings", "This was helpful", "I don't have anyone to share these feelings with." These comments suggest an emotional need unfulfilled in single mothers. An awareness of and sensitivity to their emotional needs can enhance the nurse-client relationship, provide support for the mother, and increase compliance with the plan of care. In addition, provision of social support within the single parent family has been linked with a decrease in stress and protection against family breakdown (Belsky, 1984).

All mothers in this study experienced a variety of stressors related to being the parent of preschool children. The literature reports that the combination of low income, poor education, and the presence of young children is negatively related to mental health and well being (Leim & Leim, 1978). These findings suggest a nursing assessment that includes the context of daily life is appropriate for all mothers, but is essentially imperative for single mothers.

Single mothers, in particular single mothers of chronically ill children, appear to be the most vulnerable to daily stress. Interventions that strengthen and diversify the coping responses of single mothers should become a standard part of the nurses' repertoire. Although the development of nursing plans and interventions for the vulnerable single mother population is critical, this study also suggests that these nursing implications

are important for all mothers of preschool children.

Implications for Research

The results of this study result in the formulation of several research questions. The first question suggested by the data is: To what degree does the marital status of a mother influence the frequency and intensity of hassles, as measured by the Hassles Scale? The results of this study indicate that single mothers report a greater frequency and intensity of hassles than do married mothers. Future descriptive research directed towards separating the factors that influence the frequency and intensity of hassles (e.g., marital status, low income, limited education, and social support network) is important. This would determine the degree to which marital status contributes to the experience of daily stress and to the ability to cope with daily hassles.

The results also indicate that married mothers of chronically ill preschool children reported the lowest scores in the frequency and intensity of daily hassles, while single mothers of chronically ill preschool children reported the highest scores. This raises a second question: Why do married mothers of chronically ill preschool children report less frequent and less intense daily hassles than single mothers of chronically ill preschool children? Researchable factors that could influence daily stress include low income, limited education, social support from marital system, family, or friends, and ability to obtain

support from the health care system. Other related factors concern the diagnosis of the preschool child. Chronicity versus acuity of illness, duration of the illness, previous experience with the illness, morbidity of illness, and the degree of disability the preschool child experiences also may influence daily stress.

A third question resulting from this study concerns the identification and clarification of the group of coping behaviors categorized as "distancing behaviors". Although statistically insignificant as a factor, these coping behaviors were used more frequently by the mothers in this study than either direct or indirect problem-solving coping behaviors. Future research is needed to identify interrelationships among the particular coping behaviors in this category and between the other two categories of coping behaviors. Additional research could be directed toward determining the reason for the apparent preference for the use of distancing coping behaviors by mothers of preschool children.

Replication of this study is important because of the implications for both nursing research and practice. Random sampling from a variety of communities, larger sample sizes, and the collection of data from mothers of toddler, school-age, and adolescent children would greatly enhance generalizability. It is also crucial to develop instruments which reliably identify and measure a wide variety of coping responses. To fully describe the multidimensional nature of coping behavior, it may be necessary to

use a variety of different research methodologies (e.g. questionnaires, interviews, ethnographic observations). Reliable, valid, and generalizable data would improve clinicians' ability to buffer the negative impact of stress in families and facilitate family adjustment, health, and personal growth.

Reference List

- Adams, B. (1975). The family: A sociological interpretation (2nd ed.). Chicago: Rand McNally.
- Allen, J., Townley, R., & Phelan, P. (1974). Family response to cystic fibrosis. Australia Pediatrics, 10, 136-146.
- Araji, S. (1977). Husbands' and wives' attitude-behavior congruence on family roles. Journal of Marriage and the Family, 39, 309-320.
- Beckman, L., & Houser, B. (1979). The more you have, the more you do: the relationship between wife's employment, sex-role attitudes, and household behavior. Psychology of Women Quarterly, 4, 160-174.
- Belsky, J. (1984). The determinants of parenting: A process model. Child Development, 55, 83-96.
- Boss, P., McCubbin, H., & Lester, G. (1979). The corporate executive wife's coping patterns in response to routine husband-father absence. Family Process, 18, 79-86.
- Breslau, N. (1983). Care of disabled children and women's time use. Medical Care, 21, 620-629.
- Breslau, N., Weitzman, M., & Messenger, K. (1980). Psychologic functioning of siblings of disabled children. Pediatrics, 67, 344-353.
- Brown, G. & Harris, T. (1978). Social origins of depression: A study of psychiatric disorder in women. New York: Free Press.

- Carpenter, E. (1980). Children's health care and the changing role of women. Medical Care, 18, 1208.
- Cobb, S. (1976). Social support as a moderator of life stress. Psychosomatic Medicine, 38, 300-314.
- Colleta, N. (1979). Support systems after divorce: incidence and impact. Journal of Marriage and the Family, 41, 837-846.
- Consentina, F., & Heilbrun, A. (1964). Anxiety correlates of sex-role identity in college students. Psychological Reports, 14, 729-730.
- Folkman, S. (1984). Personal control and stress and coping processes: A theoretical analysis. Journal of Personality and Social Psychology, 46, 839-852.
- Folkman, S., & Lazarus, R. (1980). An analysis of coping in a middle-aged community sample. Journal of Health and Social Behavior, 21, 219-239.
- Gall, M. (1969). The relationship between masculinity-femininity and manifest anxiety. Journal of Clinical Psychology, 25, 294-295.
- Guttentag, M., Salasin, S., & Belle, D. (1980). The mental health of women. New York: Academic Press.
- Harford, T., Willis, C., & Deabler, H. (1967). Personality correlates of masculinity-femininity. Psychological Reports, 21, 881-884.

- Hetherington, E., Cox, M., & Cox, R. (1978). The aftermath of divorce. In J. Stevens & M. Matthews (Eds.), Mother-child, father-child relations (pp. 120-138). Washington D.C.: National Association for the Education of Young Children.
- Hoebel, F. (1977). Coronary artery disease and family interaction: a study of risk factor modification. In P. Watzlawick & J. Weakland (Eds.), The interactional view (pp. 363-374). New York: Norton.
- Holmes, T., & Masuda, M. (1973). Life changes and illness susceptibility. In J. Scott & E. Senay (Eds.), Separation and depression (pp. 161-186). Washington D.C.: American Association for the Advancement of Science.
- Jalowiec, A., Murphy, S., & Powers, M. (1984). Psychometric assessment of the Jalowiec coping scale. Nursing Research, 33, 157-161.
- Kanner, A., Coyne, J., Schaefer, C., & Lazarus, R. (1981). Comparison of two modes of stress measurement: Daily hassles and uplifts versus major life events. Journal of Behavioral Medicine, 4 (1), 1-23.
- Keith, P., & Schafer, R. (1980). Role strain and depression in two-job families. Family Relations, 29, 483-488.
- Lask, B., & Matthew, D. (1979). Childhood asthma. A controlled trial of family psychotherapy. Archives of Disease in Childhood, 54, 116-119.

- Lawler, R., Nakielny, W., & Wright, N. (1966). Psychologic implications of cystic fibrosis. Canadian Medical Association Journal, 94, 1043-1046.
- Leim, R., & Leim, J. (1978). Social class and mental illness reconsidered: The role of economic stress and social support. Journal of Health and Social Behavior, 19, 139-156.
- Lazarus, R., & Lanier, R. (1978). Stress-related transactions between person and environment. In L.A. Pervin & M. Lewis (Eds.), Perspectives in Interactional Psychology (pp. 287-327). New York: Plenum.
- Maynard, P., Maynard, N., McCubbin, H., & Shao, D. (1980). Family life and the police profession: Coping patterns wives employ in managing job stress and the family environment. Family Relations, 29, 495-501.
- McCrae, W., Cull, A., & Burton, L. (1973). Cystic fibrosis: Parents' response to the genetic basis of the disease. Lancet, 2, 141-143.
- McCubbin, H., Joy, C., Cauble, A., Comeau, J., Patterson, J., & Needle, R. (1980). Family stress and coping: A decade review. Journal of Marriage and the Family, 11, 855-871.
- McCubbin, H., McCubbin, M., Patterson, J., Cauble, A., Wilson, L., & Warwick, W. (1983). CHIP-coping health inventory for parents: An assessment of parental coping patterns in the care of the chronically ill child. Journal of Marriage and the Family, 5, 359-369.

- McCubbin, H., & Olson, D. (1980). Beyond family crisis: Family adaptation. Paper presented at the Families in Disaster Conference, Uppsala, Sweden (June).
- McKeever, P. (1981). Fathering the chronically ill child. The American Journal of Maternal/Child Nursing, 6, 124-128.
- McLanahan, S. (1983). Family structure and stress: A longitudinal comparison of two parent and female headed families. Journal of Marriage and the Family, 45, 347-357.
- Moos, R., & Tsu, V. (1977). The crisis of physical illness: An overview. In R. Moos (Ed.), Coping with physical illness (pp. 1-22). New York: Plenum.
- Norbeck, J., & Sheiner, M. (1982). Forces of social support related to single-parent functioning. Research in Nursing and Health, 5, 3-12.
- Nunnally, J. (1978). Psychometric theory (2nd ed.). New York: McGraw-Hill.
- Nyquist, L., Slivken, K., Spence, J., & Helmreich, R. (1985). Household responsibilities in middle-class couples: The contribution of demographic and personality variables. Sex Roles, 12, 15-35.
- Palazzoli, S. (1974). Self-starvation: From individual to family therapy in the treatment of anorexia nervosa. New York: Jason Aronson.
- Patterson, J., & McCubbin, H. (1984). Gender roles and coping. Journal of Marriage and the Family, 2, 95-104.

- Pearlin, L., & Schooler, C. (1978). The structure of coping. Journal of Health and Social Behavior, 19, 2-21.
- Peck, B. (1974). Physical medicine and family dynamics: The dialectics of rehabilitation. Family Process, 13, 469-479.
- Perdue, B., & Horowitz, J. (1977). Single parent families. Nursing Clinics of North America, 12, 503-511.
- Sabbeth, B. (1984). Understanding the impact of chronic childhood illness on families. Pediatric Clinics of North America, 31, 47-56.
- Schorr, A., & Moen, P. (1979). The single parent and public policy. Social Policy, 9, 15-21.
- Spence, J., Helmrich, R., & Stapp, J. (1974). The personality attributes questionnaire: A measure of sex role stereotypes and masculinity-femininity. Journal Supplement Abstract Service Catalog of Selected Documents in Psychology, 4, 43.
- Tankson, E. (1979). The single parent. In S. Johnson (Ed.), High Risk Parenting: Nursing Assessment and Strategies for the Families at Risk (pp. 213-226). New York: Lippincott.
- Vaughn, B., Egeland, B., Sroufe, A., & Waters, E. (1979). Individual differences in infant-mother attachment at twelve and eighteen months: Stability and changes in families under stress. Child Development, 50, 971-975.
- Ventura, J., & Boss, P. (1983). The family coping inventory applied to parents with new babies. Journal of Marriage and the Family, 11, 867-875.

Walker, J., Thomas, M., & Russell, I. (1971). Spina bifida and the parents. Developmental Medicine and Child Neurology, 13, 462-476.

APPENDICES

APPENDIX A
MODIFIED JALOWIEC COPING SCALE

COPING SCALE

People react in many ways to stress and tension. Some people use one way to handle stress, while others use many coping methods. We are interested in finding out what things people do when faced with stressful situations. Please estimate how often you used the following ways to cope with stress this past week by circling one number for each item.

Coping Method	Never	Occasionally	About half the time	Often	Almost Always
1. Worry (A)	1	2	3	4	5
2. Cry (A)	1	2	3	4	5
3. Work off tension with physical activity or exercise (A)	1	2	3	4	5
4. "Hope that things will get better" (A)	1	2	3	4	5
5. Laugh it off, figuring that "things could be worse" (A)	1	2	3	4	5
6. Think through different ways to solve the problem or handle the situation (P)	1	2	3	4	5
7. Eat; smoke; chew gum (A)	1	2	3	4	5
8. Drink alcoholic beverages (A)	1	2	3	4	5
9. Take drugs (A)	1	2	3	4	5
10. Try to put the problem out of your mind and think of something (A)	1	2	3	4	5
11. Let someone else solve the problem or handle the situation for you (P)	1	2	3	4	5

Coping Method	Never	Occasionally	About half the time	Often	Almost Always
12. Daydream; fantasize (A)	1	2	3	4	5
13. Do anything just to do something, even if you're not sure it will work (P)	1	2	3	4	5
14. Talk the problem over with someone who has been in the same type of situation (P)	1	2	3	4	5
15. Get prepared to "expect the worst" (A)	1	2	3	4	5
16. Get mad; curse; swear (A)	1	2	3	4	5
17. Accept the situation as it is (P)	1	2	3	4	5
18. Try to look at the problem objectively and see all sides (P)	1	2	3	4	5
19. Try to maintain some control over the situation (P)	1	2	3	4	5
20. Try to find purpose or meaning in the situation (P)	1	2	3	4	5
21. Pray; "put your trust in God" (A)	1	2	3	4	5
22. Get nervous (A)	1	2	3	4	5
23. Withdraw from the situation (A)	1	2	3	4	5
24. Blame someone else for your problems or the situation you're in	1	2	3	4	5
25. Actively try to change the situation (P)	1	2	3	4	5

Coping Method	Never	Occasionally	About half the time	Often	Almost Always
26. Take out tensions on someone or something else (A)	1	2	3	4	5
27. Take off by yourself; "want to be alone" (A)	1	2	3	4	5
28. Resign yourself to the situation because things look hopeless (A)	1	2	3	4	5
29. Do nothing in the hope that the situation will improve or the problem "will take care of itself" (A)	1	2	3	4	5
30. Seek comfort or help from family or friends (A)	1	2	3	4	5
31. Meditate, use yoga, biofeedback, "mind over matter" (A)	1	2	3	4	5
32. Try to find out more about the situation so you can handle it better (P)	1	2	3	4	5
33. Try out different ways of solving the problem to see which works best (P)	1	2	3	4	5
34. Resign yourself to the situation because it's "your fate", so there is no sense trying to do anything about it (A)	1	2	3	4	5
35. Try to draw on past experience to help you handle the situation (P)	1	2	3	4	5
36. Try to break the problem down into "smaller pieces" so you can handle it better (P)	1	2	3	4	5
37. Go to sleep, figuring "things will look better in the morning" (A)	1	2	3	4	5

Coping Method	Never	Occasionally	About half the time	Often	Almost Always
38. Set specific goals to help you solve the problem (P)	1	2	3	4	5
39. "Don't worry about it, everything will probably work out fine" (A)	1	2	3	4	5
40. Settled for the next best thing to what you really wanted (P)	1	2	3	4	5

DO YOU USE ANY COPING METHODS THAT WERE NOT MENTIONED ON THIS SCALE? IF SO, PLEASE LIST THEM.

A = affective-oriented coping method
P = problem-oriented coping method

APPENDIX B
JALOWIEC PERMISSION LETTER

College of Nursing
Room 727
University of Illinois
845 South Damen
Chicago, IL 60612
312-996-2559
January 30, 1985

Jeanette French, RN, BSN
1220 NE Cochran Dr.
Gresham, Oregon 97030

Dear Ms. French:

Thank you for the interest you expressed in the Jalowiec Coping Scale. I have enclosed a copy of the instrument.

Permission is granted to use the coping scale for your joint research project on child-rearing. As you are already aware, I do ask investigators to share their raw coping and demographic data with me for psychometric and normative analysis of the tool. I have enclosed a list that notes the information I request from investigators.

You will have to make your own copies of the scale as needed, since I do not have enough copies for large-scale distribution. Instructions to the subject for completion of the instrument are at the top of the form. If you want to look at situation-specific coping, the wording in the instructions would need to be slightly altered to reflect the situation being studied. Scores can be derived for problem-oriented and affective-oriented coping styles by summing the items separately for each subscale. The tool notes which items belong to which subscale.

Regarding other studies that have used the coping scale, three are cited in the '84 article enclosed (Baldree, Murphy, Swanson). Currently, the number of investigators using the scale totals more than 100; however, many of these studies are still in progress; therefore, reports are not yet available. There also may be reports in the literature that I am not yet aware of. Many of the studies using the scale have been masters theses and doctoral dissertations and therefore would be available through interlibrary loan from the specific universities. Literature search would uncover some of these sources. In addition, I am enclosing a list of several investigators with similar research interests who you can contact for further information on their studies.

Sincerely,


Anne Jalowiec, RN, PhD Cand.

APPENDIX C
MODIFIED DAILY HASSLES SCALE

The Hassles Scale

Directions: Hassles are irritants that can range from minor annoyances to fairly major pressures, problems, or difficulties. They can occur few or many times. Listed on the following pages are a number of ways in which a person can feel hassled. First, circle the hassles that have happened to you in the past week. Then look at the numbers on the right of the items you circled. Indicate by circling a 1, 2, or 3 how SEVERE each of the circled hassles has been for you in the past week. If a hassle did not occur in the last week, do NOT circle it.

HASSLES	SEVERITY		
	1. Somewhat severe	2. Moderately severe	3. Extremely severe
_1. Misplacing or losing things.....	1	2	3
_2. Troublesome neighbors.....	1	2	3
_3. Social obligations.....	1	2	3
_4. Inconsiderate smokers.....	1	2	3
_5. Troubling thoughts about your future.....	1	2	3
_6. Thoughts about death.....	1	2	3
_7. Health of a family member.....	1	2	3
_8. Not enough money for clothing.....	1	2	3
_9. Not enough money for housing.....	1	2	3
_10. Concerns about owing money.....	1	2	3
_11. Concerns about getting credit.....	1	2	3
_12. Concerns about money for emergencies.....	1	2	3
_13. Someone owes you money.....	1	2	3
_14. Financial responsibility for someone who doesn't live with you.....	1	2	3
_15. Cutting down on electricity, water, etc..	1	2	3

_16.	Smoking too much.....	1	2	3
_17.	Use of alcohol.....	1	2	3
_18.	Personal use of drugs.....	1	2	3
_19.	Too many responsibilities.....	1	2	3
_20.	Decisions about having children.....	1	2	3
_21.	Non-family members living in your house..	1	2	3
_22.	Care for pet.....	1	2	3
_23.	Planning meals.....	1	2	3
_24.	Concerned about the meaning of life.....	1	2	3
_25.	Trouble relaxing.....	1	2	3
_26.	Trouble making decisions.....	1	2	3
_27.	Problems getting along with fellow workers.....	1	2	3
_28.	Customers or clients give you a hard time.....	1	2	3
_29.	Home maintenance (inside).....	1	2	3
_30.	Concerns about job security.....	1	2	3
_31.	Concerns about retirement.....	1	2	3
_32.	Laid-off or out of work.....	1	2	3
_33.	Don't like current work duties.....	1	2	3
_34.	Don't like fellow workers.....	1	2	3
_35.	Not enough money for basic necessities...	1	2	3
_36.	Not enough money for food.....	1	2	3
_37.	Too many interruptions.....	1	2	3
_38.	Unexpected company.....	1	2	3
_39.	Too much time on hands.....	1	2	3

_40.	Having to wait.....	1	2	3
_41.	Concerns about accidents.....	1	2	3
_42.	Being lonely.....	1	2	3
_43.	Not enough money for health care.....	1	2	3
_44.	Fear of confrontation.....	1	2	3
_45.	Financial security.....	1	2	3
_46.	Silly mistakes.....	1	2	3
_47.	Inability to express yourself.....	1	2	3
_48.	Physical illness.....	1	2	3
_49.	Side effects of medication.....	1	2	3
_50.	Concerns about medical treatment.....	1	2	3
_51.	Physical appearance.....	1	2	3
_52.	Fear of rejection.....	1	2	3
_53.	Difficulties with getting pregnant.....	1	2	3
_54.	Sexual problems that result from physical problems.....	1	2	3
_55.	Sexual problems other than those resulting from physical problems.....	1	2	3
_56.	Concerns about health in general.....	1	2	3
_57.	Not seeing enough people.....	1	2	3
_58.	Friends or relatives too far away.....	1	2	3
_59.	Preparing meals.....	1	2	3
_60.	Wasting time.....	1	2	3
_61.	Auto maintenance.....	1	2	3
_62.	Filling out forms.....	1	2	3

_63.	Neighborhood deterioration.....	1	2	3
_64.	Financing children's education.....	1	2	3
_65.	Problems with employees.....	1	2	3
_66.	Problems on the job due to being a woman.....	1		
_67.	Declining physical abilities.....	1	2	3
_68.	Being exploited.....	1	2	3
_69.	Concerns about bodily functions.....	1	2	3
_70.	Rising prices of common goods.....	1	2	3
_71.	Not getting enough rest.....	1	2	3
_72.	Not getting enough sleep.....	1	2	3
_73.	Problems with aging parents.....	1	2	3
_74.	Problems with your children.....	1	2	3
_75.	Problems with persons younger than yourself.....	1	2	3
_76.	Problems with your lover.....	1	2	3
_77.	Difficulties seeing or hearing.....	1	2	3
_78.	Overloaded with family responsibilities..	1	2	3
_79.	Too many things to do.....	1	2	3
_80.	Unchallenging work.....	1	2	3
_81.	Concerns about meeting high standards....	1	2	3
_82.	Financial dealings with friends or acquaintances.....	1	2	3
_83.	Job dissatisfactions.....	1	2	3
_84.	Worries about decisions to change jobs...	1	2	3
_85.	Trouble with reading, writing, or spelling abilities.....	1	2	3

_86.	Too many meetings.....	1	2	3
_87.	Problems with divorce or separation.....	1	2	3
_88.	Trouble with arithmetic skills.....	1	2	3
_89.	Gossip.....	1	2	3
_90.	Legal problems.....	1	2	3
_91.	Concerns about weight.....	1	2	3
_92.	Not enough time to do the things you need to do.....	1	2	3
_93.	Television.....	1	2	3
_94.	Not enough personal energy.....	1	2	3
_95.	Concerns about inner conflicts.....	1	2	3
_96.	Feel conflicted over what to do.....	1	2	3
_97.	Regrets over past decisions.....	1	2	3
_98.	Menstrual (period) problems.....	1	2	3
_99.	The weather.....	1	2	3
_100.	Nightmares.....	1	2	3
_101.	Concerns about getting ahead.....	1	2	3
_102.	Hassles from boss or supervisor.....	1	2	3
_103.	Difficulties with friends.....	1	2	3
_104.	Not enough time for family.....	1	2	3
_105.	Transportation problems.....	1	2	3
_106.	Not enough money for transportation.....	1	2	3
_107.	Not enough money for entertainment and recreation.....	1	2	3
_108.	Shopping.....	1	2	3

_109.	Prejudice and discrimination from others.....	1	2	3
_110.	Property, investments, or taxes.....	1	2	3
_111.	Not enough time for entertainment and recreation.....	1	2	3
_112.	Yardwork or outside home maintenance....	1	2	3
_113.	Concerns about news events.....	1	2	3
_114.	Noise.....	1	2	3
_115.	Crime.....	1	2	3
_116.	Traffic.....	1	2	3
_117.	Pollution.....	1	2	3

HAVE WE MISSED ANY OF YOUR HASSLES? IF SO, WRITE THEM IN BELOW:

ONE MORE THING: HAS THERE BEEN A CHANGE IN YOUR LIFE THAT
AFFECTED HOW YOU ANSWERED THIS SCALE? IF SO, TELL US WHAT IT WAS:

APPENDIX D
DEMOGRAPHIC FORM

Demographic Data

- _1. Your age _ _
- _2. Circle your marital status.
_ A. Single, not living with partner.
_ B. Single, living with significant other.
_ C. Married, living with husband.
_ D. Divorced, less than 1 year.
_ E. Divorced, 1 to 3 years.
_ F. Divorced, 3 or more years.
_ G. Widowed, less than 1 year.
_ H. Widowed, 1 to 3 years.
_ I. Widowed, 3 or more years.
- _3. Education. Circle highest level completed.
_ A. Elementary: 1, 2, 3, 4, 5, 6
_ B. Junior High: 7, 8
_ C. High School: 9, 10, 11, 12
_ D. College: 13, 14, 15, 16
_ E. Graduate School: 17, 18, 19, 20, 21, 22
- _4. Circle your total yearly income.
_ A. Less than \$4,999
_ B. \$5,000 to \$9,999
_ C. \$10,000 to 14,999
_ D. \$15,000 to \$19,999
_ E. \$20,000 to \$24,999
_ F. \$25,000 to \$29,999
_ G. \$30,000 to \$34,999
_ H. \$35,000 to \$39,999
_ I. \$40,000 to \$44,999
_ J. Greater than \$45,000
- _5. Occupation _____
- _6. Number of hours per week worked outside the home _ _
- _7. Number of children living at home _ _
- _8. Ages of children living at home _____
- _9. Number of other adults living with you who provide a lot of help with child and home care _ _

APPENDIX E
COVER LETTER

THE OREGON HEALTH SCIENCES UNIVERSITY

School of Nursing
Department of
Family Nursing

3181 S.W. Sam Jackson Park Road Portland, Oregon 97201 (503) 225-8382

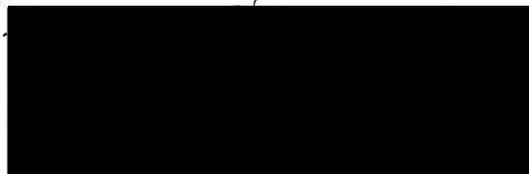
Dear Parent,

We are inviting you to participate in a study entitled "A Comparison of Maternal Coping Methods". This study is being done as part of the requirements for a Master's degree at Oregon Health Sciences University by Jeanette French, R.N., Jennifer Gilhooly, R.N., and Deborah Welte, R.N. under the direction of Sheila Kodadek, R.N., PhD. and Marie Scott-Brown, R.N., PhD. The purpose of the study is to compare how mothers of preschoolers cope with the stresses of daily life. The directors of Children's World, Pat Nehl and Linette Cowles, and the Human Subjects Research Committee at Oregon Health Sciences University have approved the project.

If you agree to participate in the study, you will be asked to fill out the enclosed questionnaires, including background information about yourself, stresses you encounter in daily life with preschool children, and how you cope with these stresses. It should take you about 40 minutes to complete the questionnaires. All information will remain confidential. When the project is completed, the results of the project will be made available to you through Pat Nehl and Linette Cowles at Children's World.

If you agree to participate, please sign the enclosed consent form, fill out the questionnaires, and return both in the enclosed self-addressed envelope. Thank you for your time and contribution to this research project.

Sincerely,



APPENDIX F
CONSENT FORM

Oregon Health Sciences University

Consent Form

You are being asked to participate in a study entitled "A Comparison of Maternal Coping Methods". This study is being done in partial fulfillment of the requirements for a Master's degree in Nursing for the principal investigators, Jeanette French, R.N., Jennifer Gilhooly, R.N., and Deborah Welte, R.N. They are working under the direction of Sheila Kodadek, R.N., PhD. and Marie Scott-Brown, R.N., PhD. The purpose of this study is to provide knowledge for health professionals on the coping behaviors of mothers with pre-school children. It is also to provide a basis from which future studies could investigate the effectiveness of these coping methods.

You will be asked to fill out three forms: an information sheet describing your background, a coping questionnaire, and a stress questionnaire. There should be no risks or benefits to you personally. All information you provide will remain confidential. If we have not received your questionnaires within 14 days, a follow-up telephone call will be made to answer any of your questions. In addition, 3 to 5 individuals will be randomly selected for an interview at the conclusion of the study. If you have any additional questions, you may contact the investigators through the Family Nursing Department, Oregon Health Sciences School of Nursing at (503) 225-8382.

It is not the policy of the Department of Health and Human

Services, or any other agency funding the research project in which you are participating to compensate or provide medical treatment for human subjects in the event the research results in physical injury. The Oregon Health Sciences University, as an agency of the State, is covered by the State Liability Fund. If you suffer any injury from the research project, compensation would be available to you only if you establish that the injury occurred through the fault of the University, its officers or employees. If you have further questions please call Dr. Michael Baird, M.D., at (503) 225-8014.

I understand I may refuse to participate, or withdraw from this study at any time without affecting my relationship with, or treatment at, the Oregon Health Sciences University.

I have read the foregoing and agree to participate in this study.

signature

date

APPENDIX G
JALOWIEC COPING SCALE:
COMPOSITION OF FIVE FACTOR SOLUTION

APPENDIX G

JALOWIEC COPING SCALE: COMPOSITION OF FIVE FACTOR SOLUTION

<u>COPING STRATEGY</u>	<u>FACTOR LOADINGS</u>				
	I	II	III	IV	V
1. Worry (A)	-.42	.47	.37	-.14	.01
2. Cry (A)	-.21	.34	.37	-.13	.22
3. Activity/exercise (A)	.24	.19	.35	.26	-.11
4. Optimism (A)	-.16	.37	-.02	-.51	-.05
5. Humor (A)	.16	.01	-.23	-.12	.43
6. Consider diff. soln. (P)	.71	.10	.24	.17	.08
7. Eat/smoke (A)	-.25	.08	.51	-.07	.17
8. Drink (A)	-.15	.21	.46	.16	.45
9. Drugs (A)	-.30	-.00	.06	-.08	-.49
10. Put problem aside (A)	.04	.26	-.43	.10	.26
11. Others solve prob. (P)	.07	.32	-.50	.29	.09
12. Daydream (A)	-.31	.05	.24	.10	.17
13. Try anything (P)	-.12	.38	-.11	.06	.04
14. Discuss problem (P)	.30	.45	-.29	.18	-.03
15. Pessimism (A)	.07	.50	.32	-.06	.14
16. Get mad/curse (A)	-.17	.45	.33	.32	.27
17. Acceptance (P)	.19	.25	-.13	-.28	-.06
18. View prob. objectively (P)	.65	.03	.17	.01	.17
19. Maintain control (P)	.49	-.02	.41	.08	.01
20. Seek purpose/meaning (P)	.48	.02	.52	-.21	.20
21. Pray/trust God (A)	-.02	.14	.08	-.28	.28
22. Get nervous (A)	-.41	.57	.22	-.24	.14
23. Situational withdrawl (A)	-.16	.30	-.11	.41	.07
24. Blame others (A)	-.17	.47	-.09	.26	.01
25. Try to change sit. (P)	.67	.20	.23	.23	-.19
26. Tension onto others (A)	-.11	.36	.28	-.05	-.30
27. Isolation (A)	.20	.17	-.05	.44	-.03
28. Resignation/hopeless (A)	-.28	.51	-.16	.14	-.23
29. Let prob. solve itself (A)	-.15	.37	-.28	.06	.21
30. Comfort from others (A)	.07	.36	-.42	-.23	.01
31. Meditation (A)	.22	-.28	-.06	.54	.28
32. Informtion-seeking (P)	.64	-.05	-.01	-.15	-.12
33. Try diff. solutions (P)	.51	.14	-.02	-.00	.22
34. Resignation/fate (A)	-.14	.29	-.36	.03	-.02
35. Use past experience (P)	.73	.23	-.03	-.0	-.18
36. Handle prob. in parts (P)	.75	.31	-.09	-.16	-.03
37. Sleep (A)	.21	.16	-.29	.39	.25
38. Set goals (P)	.57	.22	.14	.28	.03
39. Don't worry (A)	.21	-.06	-.45	-.31	.47
40. Settle for next best (A)	.14	.39	-.32	.14	-.22

APPENDIX H

FACTOR 1 COMPOSITION:

DIRECT PROBLEM-SOLVING

APPENDIX H

JALOWIEC COPING SCALE:

FACTOR 1 COMPOSITION: DIRECT PROBLEM-SOLVING

- 6. Consider different solutions (P)
- 12. Daydream (A)
- 18. View problem objectively (P)
- 19. Maintain control (P)
- 20. Seek purpose/meaning (P)
- 25. Try to change situation (P)
- 32. Information-seeking (P)
- 33. Try different solutions (P)
- 35. Use past experience (P)
- 36. Handle problem in parts (P)
- 38. Set goals (P)

APPENDIX I
FACTOR 2 COMPOSITION:
INDIRECT PROBLEM-SOLVING

APPENDIX I

JALOWIEC COPING SCALE:

FACTOR 2 COMPOSITION: INDIRECT PROBLEM-SOLVING

1. Worry (A)
11. Let others solve the problem (P)
13. Try anything (P)
14. Discuss problem (P)
15. Pessimism (A)
16. Get mad/curse/swear (A)
22. Get nervous (A)
24. Blame others (A)
26. Release tension on others (A)
28. Resignation/it's hopeless (A)
29. Let problem solve itself (A)
30. Get comfort/help from others (A)
40. Settle for the next best thing (A)

APPENDIX J
FACTOR 3 COMPOSITION:
DISTANCING COPING BEHAVIORS

APPENDIX J

JALOWIEC COPING SCALE:

FACTOR 3 COMPOSITION: DISTANCING COPING BEHAVIORS

2. Cry (A)
3. Activity/exercise (A)
4. Optimism (A)
5. Humor (A)
7. Eat/smoke (A)
8. Drink (A)
9. Drugs (A)
10. Put problem aside (A)
17. Acceptance (P)
21. Pray/trust God (A)
23. Situational withdrawal (A)
27. Isolation (A)
31. Meditation/mind over matter (A)
34. Resignation/it's fate (A)
37. Sleep (A)
39. Don't worry, everything will work out (A)

ABSTRACT

As clinicians and researchers, nurses are particularly interested in how families cope with both the impact of various stressors and the subsequent effects of those stressors on the mental and physical health of family members. At present, little research has been done concerning daily family stressors and parental coping strategies, although parenting preschool children is portrayed in the literature as stressful. Single parenting and parenting children with chronic illnesses are logically assumed to be more stressful than parenting well children. Based upon these assumptions, the purpose of this comparative descriptive study was two fold: (a) to investigate the daily stresses perceived by mothers of well and chronically ill preschool children (b) to investigate the types of coping strategies used by these mothers.

A modified Daily Hassles Scale (Hassles Scale) was used to measure the frequency, severity, and intensity of daily hassles. A modified Jalowiec Coping Scale (JCS) was used to measure the number and types of coping strategies employed by the mothers in the study. The data from a total convenience sample of 89 mothers (49 married mothers of well preschool children, 17 married mothers of chronically ill preschool children, 16 single mothers of well preschool children, and 7 single mothers of chronically ill preschool children) were analyzed. ANOVAs were used to make between group comparisons of the scores obtained on the Hassles Scale and the JCS.

The results of the study indicated: (a) single mothers of well preschool children experienced higher levels of daily stress than married mothers of well preschool children, (b) married mothers of chronically ill preschool children experienced the least amount of stress of the four groups studied, and (c) single mothers of chronically ill preschool children and married mothers of well preschool children used problem-solving coping behaviors more than single mothers of well preschool children or married mothers of chronically ill preschool children.

This descriptive study has some general implications for nursing practice. The results are similar to findings reported in the literature that single mothers have financial problems, chronic stress, and fewer resources than married mothers. Sensitivity to the problems prevalent in this family structure will encourage a more comprehensive assessment of these families, provision of emotional support, realistic care plans, and increased compliance.

Research questions generated from this study indicate a need for replication with random sampling, larger sample sizes, and data collection from mothers of toddler, school-age, and adolescent children to increase generalizability. It may also be necessary for future researchers to use a variety of research methodologies in order to better describe the multidimensional nature of coping strategies.