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Fathers of Children with Educational Disabilities: The Role of Stress in Life Satisfaction

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FATHERS OF CHILDREN WITH EDUCATIONAL DISABILITIES: 
THE ROLE OF STRESS IN LIFE SATISFACTION.

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To my faithful wife and best friend, Kristen Palmer Strachan, thank you for standing by me through thick and thin. Your personal steadfastness and reassurance, during what seemed at times to be a never-ending and insurmountable project, permitted me the time and freedom to reach this place in my life. Thanks for teaching me many valuable lessons along the way. It is to you and you alone, I dedicate this dissertation, with much love and gratitude.
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SISU
Sisu is much more than fortitude.
It’s an old characterization
used by the Finnish people,
maybe for the last
ten thousand years.
Jean Sibelius once likened “sisu”
to a metaphysical shot in the arm
which makes a man (or a woman)
do the impossible. . .
The mystifying four letters. . .
as something
that “surpasses fearlessness. . .
an extraordinary endurance,
a kind of inner fire
or superhuman nerve force
which includes courage, tenacity,
stubborn determination,
energy, and a will (and ability)
to get things done.”
---Author Unknown

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# TABLE OF CONTENTS

LIST OF TABLES.............................................................................viii  
LIST OF FIGURES...........................................................................x  
ABSTRACT......................................................................................xi  

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. INTRODUCTION ............................................................... 1</td>
<td></td>
</tr>
<tr>
<td>Theoretical Perspectives................................................. 4</td>
<td></td>
</tr>
<tr>
<td>Family Stress Theory..................................................... 5</td>
<td></td>
</tr>
<tr>
<td>Family Resiliency Theory............................................... 18</td>
<td></td>
</tr>
<tr>
<td>Conclusion............................................................................ 21</td>
<td></td>
</tr>
<tr>
<td>Purpose of Study............................................................ 22</td>
<td></td>
</tr>
<tr>
<td>Hypothesis and Research Questions.................................. 24</td>
<td></td>
</tr>
<tr>
<td>Definitions............................................................................ 25</td>
<td></td>
</tr>
<tr>
<td>Abbreviations....................................................................... 30</td>
<td></td>
</tr>
<tr>
<td>Limitations............................................................................ 30</td>
<td></td>
</tr>
<tr>
<td>Delimitations........................................................................ 31</td>
<td></td>
</tr>
<tr>
<td>Assumptions.......................................................................... 31</td>
<td></td>
</tr>
<tr>
<td>II. REVIEW OF LITERATURE.................................................... 32</td>
<td></td>
</tr>
<tr>
<td>Historical Overview........................................................... 32</td>
<td></td>
</tr>
<tr>
<td>The Discovery of Fathers.................................................... 34</td>
<td></td>
</tr>
<tr>
<td>Fathers' Role in Society: Types &amp; Cultural Images............... 37</td>
<td></td>
</tr>
<tr>
<td>Fathers and Typically Developing Children......................... 38</td>
<td></td>
</tr>
<tr>
<td>Infants and Young Children............................................... 38</td>
<td></td>
</tr>
<tr>
<td>School-Age Children.......................................................... 42</td>
<td></td>
</tr>
<tr>
<td>Adolescents.......................................................................... 45</td>
<td></td>
</tr>
<tr>
<td>Stress and Coping.............................................................. 48</td>
<td></td>
</tr>
<tr>
<td>Parenting Stress and Fathers of Children with Disabilities..... 52</td>
<td></td>
</tr>
<tr>
<td>Parenting Stress and Life Changes......................................... 57</td>
<td></td>
</tr>
<tr>
<td>Parenting Stress and Daily Hassles....................................... 58</td>
<td></td>
</tr>
<tr>
<td>Life Satisfaction............................................................... 60</td>
<td></td>
</tr>
<tr>
<td>Conclusion.............................................................................. 61</td>
<td></td>
</tr>
<tr>
<td>III. METHODOLOGY............................................................... 63</td>
<td></td>
</tr>
<tr>
<td>Sample.................................................................................... 63</td>
<td></td>
</tr>
<tr>
<td>Instrumentation...................................................................... 65</td>
<td></td>
</tr>
<tr>
<td>Parent Data Sheet/General Information............................... 65</td>
<td></td>
</tr>
<tr>
<td>Family Inventory of Life Events and Changes....................... 65</td>
<td></td>
</tr>
<tr>
<td>Parenting Daily Hassle Scale............................................... 69</td>
<td></td>
</tr>
</tbody>
</table>
Family Crisis Oriented Personal Evaluation Scales..............71
Coping Scales for Adults/Short Form..............................73
Family Health Status Inventory........................................76
Parenting Stress Index/Short Form.................................78
Satisfaction With Life Scale...........................................80
Data Collection................................................................82
Data Analysis..................................................................83

IV. FINDINGS.....................................................................85

Introduction......................................................................85
Sample Demographics......................................................85
Description of the Variables..........................................94
Research Hypothesis.......................................................97
Research Questions.......................................................102
Related Findings..........................................................115

V. DISCUSSION AND IMPLICATIONS.................................131

Introduction....................................................................131
Summary of Research Design...........................................131
Discussion.......................................................................135
Research Methodology.................................................135
Characteristics of the Final Sample...............................137
Hypothesis and Research Questions...............................139
Implications for Research, Theory, and Practice.............150
Implications for Research..............................................150
Implications for Theory.................................................152
Implications for Professional Practice.........................155
Conclusion......................................................................157

APPENDIX A..................................................................160
APPENDIX B..................................................................162
APPENDIX C..................................................................170
APPENDIX D..................................................................172
REFERENCES................................................................179

BIOGRAPHICAL SKETCH....................................................199
LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Demographic Characteristics of the Sample</td>
<td>86</td>
</tr>
<tr>
<td>2. Specific Information on the Sample</td>
<td>91</td>
</tr>
<tr>
<td>3. Information Related to Fathers of Disabled Children</td>
<td>92</td>
</tr>
<tr>
<td>4. Comparison of Dependent and Independent Variables for Fathers with Disabled Children and Fathers with Non-Disabled Children Groups</td>
<td>99</td>
</tr>
<tr>
<td>5. Potential Ranges of Scales for Each Variable</td>
<td>100</td>
</tr>
<tr>
<td>7. Restricted Model Factor Loadings for Fathers with Disabled Children</td>
<td>107</td>
</tr>
<tr>
<td>8. Restricted Model Factor Loadings for Fathers with Non-Disabled Children</td>
<td>110</td>
</tr>
<tr>
<td>9. Direct, Indirect, and Total Effects on Life Satisfaction for the Saturated Model for Fathers with Disabled Children and Fathers with Non-Disabled Children</td>
<td>113</td>
</tr>
<tr>
<td>10. Summary of Analysis of Variance for Fathers with Disabled Children and Fathers with Non-Disabled Children for Family Stress</td>
<td>116</td>
</tr>
<tr>
<td>11. Summary of Analysis of Variance for Fathers with Disabled Children and Fathers with Non-Disabled Children for Level of Coping</td>
<td>118</td>
</tr>
<tr>
<td>12. Differences in Health Stress Symptomatology reported by Fathers with Disabled Children and Fathers with Non-Disabled Children</td>
<td>120</td>
</tr>
<tr>
<td>13. Differences in Satisfaction reported by Fathers with Disabled Children and Fathers with Non-Disabled Children</td>
<td>122</td>
</tr>
</tbody>
</table>
15. Qualitative Findings: Fathers of Disabled Children.............126
16. Summary of Hypothesis and Research Questions......................128
# LIST OF FIGURES

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>The ABCX Model.</td>
<td>6</td>
</tr>
<tr>
<td>2.</td>
<td>The Double ABCX Model.</td>
<td>15</td>
</tr>
<tr>
<td>3.</td>
<td>Path Diagram of Theoretical Model of Factors Predicting Life Satisfaction.</td>
<td>23</td>
</tr>
<tr>
<td>4.</td>
<td>Restricted Model for the Fathers with Disabled Children Group.</td>
<td>105</td>
</tr>
<tr>
<td>5.</td>
<td>Restricted Model for the Fathers with Non-Disabled Children Group.</td>
<td>108</td>
</tr>
<tr>
<td>6.</td>
<td>Saturated Model for Fathers with Disabled Children.</td>
<td>111</td>
</tr>
<tr>
<td>7.</td>
<td>Saturated Model for Fathers with Non-Disabled Children.</td>
<td>114</td>
</tr>
</tbody>
</table>
Investigating the possible complex role of paternal stress in life satisfaction is essential because of the increasing importance of the role of fathers in our society. There are many difficulties and demands that face not only fathers of typically developing children, but also disabled children in particular. That fathers of children with disabilities encounter possible unique challenges profoundly affecting levels of stress and family adaptation is a phenomenon which has warranted further study. To date little is known concerning the effects of fathers having a child with a disability since previous research has focused predominantly on mothers or siblings. Therefore, in this study, fathers with non-disabled children and fathers with disabled children were compared with regard to their stresses, coping, and life satisfaction.

In utilizing predominantly Family Stress Theory and Family Resiliency Theory, the purpose of this study was to examine the influence of family life changes (major and minor life events), level of family and individual coping, and parenting and health stress upon life satisfaction for fathers having children with educational disabilities and fathers having children without educational disabilities over the last twelve months. A survey research design was employed that utilized a total sample of 212 fathers from a county school system in Western Kentucky. Of the 212 fathers, 127 reported having a child without educational disabilities and 85 reported having a child with educational disabilities. Research instruments included the Family Inventory of Life Events and Changes, Parenting Daily Hassles scale, Family Crisis Oriented Personal Evaluation Scales, Coping Scales for Adults, Parenting Stress Index, Family Health Status Inventory, and Satisfaction With Life Scale.

Various statistical analyses were utilized to examine the data. Analysis of variance was conducted to test differences between the two father groups. In addition, a confirmatory factor analysis was utilized to determine if the proposed indicators in the study were valid measures of the latent constructs. A path analysis was also employed to examine the relationships among the variables.

The findings indicated that there were differences between the two
 groups. Fathers of disabled children experienced greater levels of family stress, more occurrences of parenting daily hassles, greater degree of difficulty related to parenting daily hassles, less variety and number of family resources, less individual sharing of problems, more emotional and physical health symptoms, greater parenting stress, and less overall satisfaction with life. There were no differences found between the two groups of fathers on level of individual coping pertaining to dealing with problems, non-productive coping, and optimism.

Results of the confirmatory factor analysis determined that the variables parenting stress, non-productive coping, and sharing did not adequately measure the latent constructs in the restricted model for both father groups and were therefore subsequently removed. For the saturated model, the variable family events had the greatest total effects for the fathers with disabled children group whereas level of stress had the greatest total effects in the fathers with non-disabled children group. Moreover, saturated path analysis indicated that for fathers with non-disabled children, level of stress and level of coping were predictive of life satisfaction. However, for the fathers with disabled children, level of stress alone was predictive of life satisfaction. The percentage of variance explained in the model for fathers with disabled children was higher (74%) than in the fathers with non-disabled children (52%).

The findings confirmed the appropriateness of using Family Stress Theory when examining stress and coping dimensions in fathers with disabled school-age children. Implications for theory, future research, and professional practice were discussed based on the results of this study. Continued research should focus on developing programs specifically designed to assist fathers with the unique challenges of parenting children with disabilities. Community professionals and educators should be aware of how different cultures and value systems may influence coping for fathers of school-age children. For fathers of disabled children, the findings highlighted the notion of chronic loss and sorrow, as well as grief-related reactions pertaining to their children. Another contribution that surfaced from this study was the idea of emotional turmoil experienced by fathers in the rearing of their disabled children.
CHAPTER 1: INTRODUCTION

In the past . . . little attention was directed to the father’s role in the life of the child with a disability or to effects on fathers (Keller & Honig, 2004, p. 337).

Fathers have been long neglected in the area of research, especially in families with children with developmental disabilities (Russell & Matson, 1998, p. 30).

Only a few investigators have examined the family experience of fathers . . . of school-age children with disabilities (Dyson, 1997, p. 268).

Research on the effects on families of having a child with a disability has focused mainly on mothers or siblings with little attention being paid to fathers (Hornby, 1992, p. 363).

Background of the Problem

In the past decade and a half, a proliferation of scholarly writing, public debate, and policy interest have brought heightened awareness and much noticeable attention to the topic of fatherhood (Goodnough & Lee, 1996; Lamb, 1995; 1997; 2004; Marsiglio, 1993; Ricci & Hodapp, 2003; White, 1994). Some of the interest in this subject matter stems from timely discussion about egalitarian parental and gender roles, as well as the need to recognize and investigate the diverse, complex, and changing nature of fatherhood dimensions in our society (Russell & Radojevic, 1992). Simultaneously, a re-examination of paternal roles and the significance of fathering is evolving due to a rapid increase in the number of working wives and mothers, increasing marital disruption, divorce and custody arrangements, and the increasing pressure for fathers to bear more responsibility in child-rearing practices (Amato, 1994; Crouther, Bumpus, Head, & McHale, 2001; Dickstein, Stein, Pleck, Myers, Lewis, Duncan, & Brod, 1991; Greif & Bailey, 1990; Jain,
Belsky, & Crnic, 1996). Although there has been a tremendous upsurge of interest in father-child relationships and fathers’ involvement in primary care giving, there remains an absence of information on paternal involvement of children with educational disabilities. Moreover, there has been increasing recognition of the importance of investigating the possible complex role of stress on fathers having a disabled child.

Over the last 25 years or so, the area of interest in this country has progressed from the notion of fathers as predominantly involved in the financial management of the family and discipline of children to fathers assuming a greater responsibility in caretaking of their children with varying ages and diverse needs (Anderson, Kohler, & Letiecq, 2002; Bozett & Hanson, 1991; Hewlett, 1992; Hosley & Montemayor, 1997; Lamb, 1987; 1997; 2004; Parke, 1996; Pleck, 1997; Riposo, 1999; Roopnarine & Carter, 1992). The interest in fatherhood has also been facilitated by recent changes in the profile of the traditional nuclear family which, in part, contains aspects related to diverse family forms and division of parental household labor (Bardill, 1998; Bumpass, 1990; Marsiglio, 1993). Previous focus and inquiry surrounding academic dialogue pertaining to fatherhood issues have explored areas such as parent-child relationships, absentee fathers, and family functioning (Berry & Rao, 1997; Carpenter, 2002).

Despite limited attention in the past, fatherhood itself has become a topic that has evoked much interest, not only in academic discourse and research studies, but also in the media and support organizations (Lamb, 1981; 1997; 2004). In more recent years there has been a growing body of knowledge on a combination of interrelated topics, which examine, quite pointedly, issues such as father-child relationships, fatherhood education and support groups, father involvement, and most specifically paternal stress.

Parenting stress, in general, has been frequently examined in research studies on parent-child interactions (Pelchat, Bisson, Bois, & Saucier, 2003). Family care giving, according to Grant and Whittell (2000), has long been informed by an understanding of stress as a central part of the parenting experience. Almost all children produce an element of stress for mothers and fathers; however, the stress of parenting children with disabilities is often exacerbated (Rousey, Best, & Blacher, 1992). In the past there has been dialogue among family scholars regarding several forms of parenting and family stress, which are a result of various normative and non-normative life events (Lavee, Sharlin, & Katz, 1996). According to Cameron,
Dobson, and Day (1991), parenting children can at times be experienced as stressful.

Since primary focus of concern in research studies has usually been with the mother, little exploration and effort so far has been directed toward examining fathers having a child with a disability (Hornby, 1992; Keller, 1999; Riposo, 1999; Walker, 2000). Carpenter (2002) eloquently points out that “in families of children with disabilities . . . the father often goes unrecognized . . .” (p. 198). In the arena of family needs, very little is known about the way in which fathers manage parenting stress and utilize coping strategies in dealing with disabled children. Of the sparse research that has been conducted with fathers of children with special needs, three important points have been suggested: (1) fathers and mothers react differently to disabled children, (2) fathers may experience less stress and may use different coping strategies in dealing with a special needs child, and (3) fathers’ attitudes toward the child with a disability significantly influence the family’s ability to adapt to this situation (Cooper & Allred, 1992). Rousey et al., (1992) also point out that family reactions related to having a child with a disability may be experienced differently by fathers and mothers, usually more so when the child is school-age.

In nearly all of the available research related to family functioning, parenting attitudes, and parenting behaviors, stress has been conceptualized within a context of major life events (Crnic & Booth, 1991). While these major life events are well established as stressors, the study of minor stresses or “daily hassles” has suggested that this area may be a more meaningful and relevant context by which stress may be conceptualized (Crnic & Booth, 1991; Crnic & Greenberg, 1990). The notion of daily hassles (those irritating, frustrating, distressing demands and annoyances) would seem to be especially applicable to parents, including fathers, since children can present various situations over the course of a day that may be perceived as annoying and irritating and may add to the overall stress of a parent (Crnic & Greenberg, 1990; Crnic & Booth, 1991; Kanner, Coyne, Schaefer, & Lazarus, 1981). Since parenting is a challenging process and evidence exists to support the notion that stress is a significant determinant of parenting, both ongoing stresses and strains of daily living, as well as major life events ought to be evaluated as they relate to fathers with disabled and non-disabled children. Klohnmen (1996) proposes that although every individual has “to deal with minor hassles and major stressors, negotiate life transitions, and adapt to life changes, some individuals are much more
competent than others in effectively coping with difficult times” (p. 1067).

Over the years, research on paternal stress related to children with disabilities was noticeably lacking from the existing knowledge base (Riposo, 1999). Prior research investigating fathers of children with disabilities often based their findings on ratings of parent attitudes, interviews with mothers regarding fathers’ perceptions and experiences, and observational impressions (Hornby, 1987; Riposo, 1999). Other studies, in a similar fashion, have based findings and results of paternal contentment and life satisfaction on the overreliance of information associated with mothers (Blacher, 1984; Riposo, 1999; Wolfensberger, 1967). Since available research is rather limited regarding paternal coping skills, adaptation to disabled children, and fathers’ resiliency in the face of adversity and stress, this present study focuses on a crucial link in understanding such pertinent dynamics. Just like mothers and the family unit as a whole, fathers also experience life and parenting dimensions in the midst of major events and transitions, minor daily hassles, multiple stressors, and potential coping skills. Therefore, research ought to investigate these items more thoroughly. Furthermore, it must be emphasized that since most studies in the past have focused on mothers’ subjective well-being and life satisfaction with special needs children, it is important in this study to include these specific variables in an examination of fathers’ stress and coping strategies with their disabled and non-disabled children.

**Theoretical Perspectives**

Theorizing is the process whereby one develops and organizes various concepts in a systematic manner so that a particular phenomenon may be understood more clearly (Doherty, Boss, LaRossa, Schumm, & Steinmetz, 1993). More specifically, a theory is the set of interconnected elements that transpire from this actual process. According to Klein and White (1996) theories are, “abstract and general ideas that are subject to rules of organization” (p. 1). While theories may help one comprehend notions of fatherhood research more adequately, they may also constrain one by examining and focusing on some issues over others with equal significance. In the past, various theoretical frameworks have had the tendency to ignore fathers since they identified with the traditional concept of a remote and uninvolved father figure (Parke, 1996). However, in more recent times, several complex theories have been employed in conceptualizing fatherhood.
The conceptual frameworks for this particular study are derived from two rather significant, overlapping theories: Family Stress Theory and Family Resiliency Theory. Reuben Hill’s ABCX family crisis perspective has continued to be regarded as one of the most influential models in research and theory building efforts related to family stress investigations. Hill’s (1949) model is recognized as an organizing framework for a study of crucial and integral issues surrounding the area of families under stress (Walker, 1985). Family Resiliency Theory has emerged predominantly from research studies of children, who not only faced much adversity, but also continued to function quite competently and with little psychopathology (Patterson, 2002).

According to Hawley (2000), resilience is not a new or original concept. Though the study of individual resilience is familiar to the field of developmental psychopathology and mental health, it has only recently become a significant theoretical framework in family science literature. Patterson (2002) claims that, “although, in many ways, the concepts that underlie it [family resilience], are already contained in family stress theory, a focus on resilience draws greater attention to family success and competence” (p. 358). Cowan, Cowan, and Schulz (1996) point out that the sociological tradition of Family Stress Theory advanced by Hill (1949, 1958) paves the way for recent emphasis and interest in risk, vulnerability, and resilience. Both Family Stress Theory and Family Resiliency Theory will be discussed in the following section as a foundation for this study.

Family Stress Theory

When Reuben Hill (1958) devised the ABCX model (see Figure 1), he provided a meaningful and valuable foundation for the scientific inquiry of family stress (Burr, 1973; Boss, 1988). Hobfoll and Spielberger (1992) claim that, “Hill’s legacy in the area of family stress has been unusually long-standing in comparison to most scientific contributions” (p. 101). Although much of the research on family stress and crisis since 1970 has utilized Hill’s (1949) ABCX model, it is interesting to note the theoretical relevance for families with disabled children has only been observed in recent years (Minnes, 1988). Family Stress Theory provides a useful format for assessing and helping families by explaining and analyzing adjustment to critical life stressors, including, but not limited to, disabled family members (Hill, 1949; 1958). The ABCX family crisis model was originally developed by Hill (1949) to identify the variables that could explain differences among
\[
A + B + C \rightarrow X
\]

A = Stressor Event  
B = Family Resources  
C = Definition of Stressor Event  
X = Crisis (level of disorganization) 

Figure 1: The ABCX Model (Hill, 1949)
families in their adaptation to stressful events and situations (Crosbie-Burnett, 1989).

Figley (1983) claims that family stress research has been concerned primarily with external, mostly unpredictable, catastrophic events. A sudden, unpredictable event within a particular family unit may disrupt the lifestyle and typical routine of a survivor and cause a sense of destruction and loss along with a permanent detailed memory of the event (Figley, 1983; Sauers, 1993). Examples of unexpected, non-normative and traumatic life events, which may be recalled by individuals and/or family members either voluntarily or involuntarily, encompass chronic, crippling childhood illness, drug abuse, rape, unemployment, natural disasters, war, and abandonment (Figley, 1983; Sauers, 1993).

Family Stress Theory considers the family system to be a unit, which is constantly changing to internal and external environmental cues. Boss (2001) believes the family external context is made up of five dimensions: historical, economic, developmental, hereditary, and cultural. Boss (1988) also claims that, "the external context is made up of components over which the family has no control" (p. 27). However, the internal context is comprised of components that a family can change and control. A family’s internal context consists of three dimensions: the structural, the psychological, and the philosophical (Boss, 1988). Families do not live in isolation, but rather as a part of a larger context, which includes many different and oftentimes debilitating stressors (Boss, 1988). Although family stress has typically been viewed and defined in a negative and detrimental manner, it is not necessarily harmful nor does it always end in trouble for all family units (Boss, 1988).

In order to comprehend the varying abilities of families to adjust to specific life stressors such as illness, losses, or even death, Hill (1949; 1958) promoted the ABCX family crisis model as a conceptual framework in understanding adaptation and adjustment to normative and non-normative demands placed on individuals and families throughout the natural life course (Hobfoll & Spielberger, 1992). Hill (1958) proposed that when studying family crisis, four familiar elements must be considered:

A - (the stressor event) interacting with,
B - (the family resources) interacting with,
C - (the definition/perception of the event) producing,
X - (the crisis) (Cowan, Cowan, & Schulz, 1996; Dollahite, 1991).

These three basic variables continue to be the foundation of stress theory
and have remained virtually unchanged throughout the years (Saloviita, Italinna, & Leinonen, 2003).

Hill (1949) defines a stressor (A factor) as a life event or transition impacting upon the family unit, which creates, or has the potential of creating, change in the family system (McCubbin & Patterson, 1983, p. 8). This change may occur in any aspect of family life such as its goals, interactional patterns, specific roles, values, rules, or boundaries (McCubbin & Patterson, 1983). It should be noted that “a stressor event is not synonymous with stress” (Boss, 1988, p. 36), but rather marks a potential beginning point for the process of change and possible ensuing stress in a family system (Boss, 1987; 1988; Burr, 1973; Sauers, 1993). Golan (1978) labels the stressor event as a precarious event which, “is the starting point that marks a change in the ecological balance” of a system (p. 64). Burr (1973) is in agreement with Golan’s (1978) notion that a stressor event itself becomes the beginning place which marks a shift or change in the equilibrium of the family system. Thus, a stressor event has been described by Boss (1987) as “an event that is capable of causing change and stress but that does not necessarily do so every time” (p. 698).

It is vitally important to recognize stressor events, which can be varied and multiple, so that professionals and/or family members make safe, reasonable, and valid assessments pertaining to strategic family management. Hill (1949; 1958) claims that stressor events can be categorized in three ways: (a) by source, (b) by type of event, and (c) by effects upon a particular family system. Over the years, stressor events have been discussed and analyzed by many prominent family scholars in order to prepare the family unit for life course events. Several ideas related to the source of stressor events have been put forth. An examination of the concept of source views stressor events as ongoing and/or unique occurrences in the family system. For example, mental illness may be passed down through family generations, whereas the birth of a handicapped child may be absolutely unique to a family unit. External family events can be generated from outside the family system and can result in varying degrees of stress. External events may include one of the following: floods, tornadoes, hurricanes, earthquakes, or war. Such events are viewed as environmental stressors and have certain, distinct effects on a family. Interestingly, Boss (1988) pointed out that it is possible for families to perceive the same stressor event in a totally different way. Secondly, a stressor event may be categorized based upon the type of event impacting the family. The type of
event can "be highly correlated with the family’s ability or inability to manage stress or recover from crisis" (Boss, 1988, p. 39). Families can suddenly change through the effect of a stressor event, which typically takes place through dismemberment (loss of a family member), accession (addition of an unprepared family member), and demoralization (loss of family morale and family unity) (Sauers, 1993). Hill (1958) classified stressors in terms of their impact on the family unit. The following categories were identified:

1. **Dismemberment:**
   - Death of a child, spouse, or parent
   - Hospitalization of spouse
   - War separation

2. **Accession:**
   - Unwanted pregnancy
   - Additions to the family
   - Aging family members

3. **Demoralization:**
   - Alcoholism
   - Drug addiction
   - Delinquency and events bringing disgrace to the family

Boss (1987) purports that stressors can be further classified as: maturational versus situational, normative versus non-normative, developmental versus environmental, predictable versus unexpected, and volitional versus non-volitional. In more recent research, Boss (1988) contends that stressor events which are a part of everyday life and of the routine human developmental process, can be classified as follows:

1. **Internal:** Events which begin from someone inside the family, such as getting drunk, suicide, or running for election.

2. **Normative:** Events that are expected over the family life cycle, such as birth, launching an adolescent, marriage, aging, death.

3. **Ambiguous:** You cannot get the facts surrounding the event. It is so unclear that you are not even sure that it is happening to you or your family.

4. **Volitional:** Events that are wanted and sought out, such as a freely chosen job change, a college entrance, or a wanted pregnancy.

5. **Chronic:** A situation that has long duration, such as diabetes, chemical addiction, or racial discrimination.
(6). **Cumulative:** Events that pile up, one right after the other, so that there is no resolution before the next one occurs. A dangerous situation in most cases.

Boss (1988) also cites several stressor events that are not typically predictive. These stressor events are usually unexpected and non-normative:

(1). **External:** Events that begin with someone or something outside the family, such as earthquakes, terrorism, the inflation rate, or cultural attitudes toward women and minorities.

(2). **Non-Normative:** Events that are unexpected, such as winning a lottery, getting a divorce, dying young, war, or being taken hostage. These events are often but not always disastrous.

(3). **Non-Ambiguous:** Clear facts that are available about the event: what is happening, when, how, how long, and to whom.

(4). **Non-Volitional:** Events that are not sought out but just happen, such as being laid off or the sudden loss of someone loved.

(5). **Acute:** An event that lasts a short time but is severe, such as breaking a limb, losing a job, or flunking a test.

(6). **Isolated:** An event that occurs alone, at least with no other events apparent at that time. It can be pinpointed easily.

Since stressor events can be varied and multiple, Boss (1988) emphasizes that they seldom impact a family system individually or one at a time. In other words, events, transitions, and family life changes, whether stressful or not, are constant and ongoing. The term “stress pile-up” is used to denote an, “accumulation of stressor events . . . in which several stressor events or situations occur at the same time or in quick sequence, thus compounding the degree of pressure on the family” (Boss, 1998, p. 45).

McCubbin and Patterson (1983) also agree with the notion of “stressor pile-up” since crises typically develop over a period of time and rarely deal with a single stressor, but rather, accumulated stressful events and transitions. According to Crosbie-Burnett (1989), pile-up refers to the demands on the family that are related to “the initial stressor, prior strains, normative developmental changes, consequences of the family’s attempt to cope with the initial stressor, and/or ambiguity about the family situation” (p. 329). Therefore, the concept of “stressor pile-up” is crucial to the understanding of a family’s level of stress, its resulting vulnerability to crisis, or its proficiency to maintain and/or restore balance from a particular crisis (Boss, 1988). “The accumulation of stressor events may explain family crisis better than any one isolated event” (Boss,
The B factor, pertains to the family’s resources/capabilities for handling the demands of stressors and life difficulties, and has been referred to as the family’s ability to prevent an event, episode, or incident in the family from generating crisis, disruption, or disturbance (Burr, 1973; Sauers, 1993). Resources, according to McCubbin and Patterson (1983), become a central component of the family’s capabilities for managing change. Hobfoll and Spielberger (1992) define resources as, “the strengths of individuals, families, or larger systems that are valued or that act as a vehicle for obtaining that which is valued” (p. 102). McCubbin (1979) describes resources as the combination of individual family members’ strengths and assets, along with the family’s capabilities of resistance in the presence of a stressor event. Examples of resources may include the following: intelligence, health, education, job skills, social skills, money, possessions, relationship skills, networks, social supports, and a spirit of cooperation (Boss, 1987).

According to McCubbin and McCubbin (1987), there are three potential categories of resources which have emerged in the family stress literature and are viewed as the most prominent for meeting the demands placed on a family system. These notable resources are: (a) personal resources, which consist of intelligence, knowledge and skills, personality traits, physical and emotional health, a sense of control, and self-esteem; (b) family system resources, which promote notions of cohesion, adaptability, family organization, and communication skills; and, (c) community resources and support, which are comprised of groups and institutions families can call upon to assist during times of hardship or crisis, such as medical and healthcare services, churches, schools, employers, and governmental organizations. Interestingly, Crosbie-Burnett (1989) suggests that a measure of the family’s ability to cope with a specific stressor event can be determined by the utilization of existing and available familial resources.

Hill (1949) describes the C factor in his ABCX model as “the definition the family makes of the event; that is, whether family members treat the event as if it were or were not a threat to their status, goals, and objectives” (p. 9). Boss (1988) continued in this area of research by identifying the C factor as, “. . . a powerful, if not the most powerful, variable in explaining how the family defines and reacts to a stressful event” (p. 36). The subjective perception and meaning that a family makes of a stressor event(s) and its associated distress is a reflection of the
family’s values, histories, culture(s), religion(s), economics, and developmental stages (Crosbie-Burnett, 1989). The family’s own perception of the stressfulness of an event and the resources it has to cope with the event are very important (Hobfoll & Spielberger, 1992). Whether or not a stressor event leads to a crisis, disintegration, or breakdown in a family will depend upon the meanings used by the family to comprehend why it occurred and what can be done to relieve and lessen the stressful situation (Boss, 1987; 1988). On one hand, if a family views a stressor event as one it can manage, a crisis may be minimized and ultimately avoided. In contrast, if a family views a stressor event as one it cannot manage, a crisis will transpire or be more critical (Walker, 1985). The subjective meaning of a stressor event not only mirrors the family’s values, but also its experience in dealing with change and confronting previous crises (Boss, 1988; Sauers, 1993).

Both the overall family meaning of a stressor event and the individual member’s understanding in conjunction with influences of other family members are important. These unique and distinct individual meanings may allow family members to work in unison toward crisis resolution or they may hamper resolution from being achieved (Boss, 1987; 1988; Lazarus, 1966; Walker, 1985). Therefore, the meaning a family attaches to a stressor event along with each individual’s perspective serves a notable role in stress management (Minnes, 1988). Essentially, the C factor in the ABCX model is “the definition the family makes of the seriousness of the experienced stressor” (McCubbin & Patterson, 1983, p. 9).

Stressor events, life changes, and crisis-provoking situations are all a part of the life course that need to be managed effectively. Stress is generated when tension is not resolved in a functional and healthy way. Boss (1988) describes family stress as an upset in the steady state or equilibrium of a particular family (Boss, 1987; Boss, 1988). Again, it is important to point out that a family’s perception may vary in how they perceive life difficulties. Boss (1988) believes this is, “. . . critical in determining the degree of stress felt by the family and the outcome, that is, crisis or coping” (p. 46). Moreover, what may seem stressful to one family may not be particularly stressful for another (Boss, 1988).

McCubbin and Patterson (1983) describe family stress as “a state which arises from an actual or perceived imbalance between demand (e.g., challenge, threat) and capability (e.g., resources, coping) in the family’s functioning” (p. 10). Throughout the family science literature, stress has held an important position in the family’s definition of the stressor event.
Families and individuals attach a unique meaning to impinging stressors, which allow them to move toward crisis or resolution (Walker, 1985). According to McCubbin and Patterson (1983), stress transpires when tension is not resolved and managed effectively. It varies in degree, "depending upon the nature of the situation, the characteristics of the family unit, and the psychological and physical well-being of its members" (McCubbin & Patterson, 1983, p. 9). Distress in the family is often referred to as being in an unpleasant or disorganized state (Sauers, 1993). Within the ABCX model, stress changes to distress when it is subjectively defined as uncomfortable or undesirable by a family system or individual (McCubbin & Patterson, 1983). Therefore, the family’s own subjective perception of the stressfulness of a particular event determines, to a large extent, how it will be experienced. The "subjective definition" appears to be extremely relevant in determining the level of family crisis-proneness (Hill, 1958).

Crisis (the X factor) has been defined as a continuous variable referring to the amount of damaging distress, disorganization, or disablement in the family social system (Burr, 1973). In the stress model, crisis is distinguished by the family’s inability to restore stability and maintain equilibrium and can ultimately result in a debilitated system (Boss, 1987; Sauers, 1993). Boss (1988) describes family crisis as a disturbance in the family balance that is so overwhelming, a pressure that is so stringent, or a change that is so acute that the family system becomes stuck and immobilized. At this stage, family members are unable to continue functioning at an appropriate level due to the overwhelming amount(s) of perceived stress (Lund, 1997).

Many family systems and individuals go through typical life course events with elevated levels of stress, some thriving on it, and yet they never reach a crisis point (Boss, 1988). However, the families and individuals who do realize a crisis point are not destined to be definitively incapacitated. "Stress and crisis are not, however, one in the same" (Hobfoll & Spielberger, 1992, p. 107). Boss (1988) claims that crisis is preceded by stress although stress does not always end in crisis. According to Lipman-Blumen (1975), "crisis is a sufficient, but not necessary, condition for . . . change" (p. 890). Therefore, if the family is able to use available resources and define the stressor event in such a way as to prevent a breakdown, the stress may never reach a crisis point (Lund, 1997). Cavan and Ranck (1938) claim that once a crisis has passed over, families can re-establish themselves along with their resources. Families can take steps
toward recovery from a crisis and reconstruct their reality by changing the rules through which their system functions and maintains a steady state (Reiss, 1981; Sauers, 1993). Crisis does not have to destroy or debilitate the family structure. In fact, a family can use the recovery process to lead its members to a new, and possibly, elevated level of functioning (Sauers, 1993).

Hill’s (1949) original ABCX model of stress concentrates predominantly on pre-crisis variables that explain variations in family ability to deal with the impact of a stressor event. The original ABCX model also assesses the degree to which a particular outcome is perceived as a crisis for the family (Sauers, 1993). However, since the evolution of Hill’s (1949) classic family stress model, other expanded and more dynamic models have been developed such as McCubbin and Patterson’s Double ABCX Model of Adjustment and Adaptation (Deardorff, 1992; McCubbin, Needle, & Wilson, 1985; McCubbin & Patterson, 1982, 1983). The Double ABCX model, which emerged from studies of war-induced family crises (McCubbin, Boss, Wilson, & Lester, 1980; McCubbin & Patterson, 1981, 1982, 1983), has extended and redefined Hill’s (1949) model to include coping strategies, family efforts to acquire new resources, changes in family definitions of the situation, pile-up of stressors and strains, and outcomes from the coping attempts (Sauers, 1993). The Double ABCX model highlights family events over a period of time, so that aA denotes the pile-up of stressors; bB, the resources families accumulate and employ to manage a situation; cC, how they perceive events during their period of adjustment; and xX, the outcome for the family defined in terms of bonadaptation or maladaptation (Orr, Cameron, & Day, 1991).

McCubbin and Patterson’s Double ABCX Model of Adjustment and Adaptation (see Figure 2) asserts that “family outcomes following the impact of a stressor event or crisis are the by-products of multiple factors in interaction with each other” (Farhood, 1999, p. 195). The Double ABCX model recognizes the weakness of the ABCX model of stress (that only a single event is stressful) and links Hill’s pre-crisis variables with specific post-crisis variables (Sauers, 1993). In addition, the Double ABCX model includes the amount, type, and cumulative nature of stressors facing the family system, as well as the family’s resistance resources and an appraisal of the stressor adaptation over time (Saunders, 1999). The accumulation or pile-up of stressors impacts the way the family’s resources can be expected to resist or alleviate crises (Hill, 1949; McCubbin & Patterson, 1983).

According to McCubbin and Patterson (1983), the Double ABCX model
**Figure 2:** The Double ABCX Model (McCubbin & Patterson, 1983)
extends Hill’s model by further delineating the pre-crisis variables and adding post-crisis variables in an effort to describe:

(a). the additional life stressors and strains which shape the course of family adaptation,

(b). the critical psychological, intra-familial, and social resources families acquire and employ over time in managing crisis situations,

(c). the changes in definition and meaning families develop in an effort to make sense of their predicament,

(d). the coping strategies families employ; and,

(e). the outcome of family efforts (p. 11).

Within the Double ABCX model, emphasis is placed upon two major factors: family demands and family adaptive resources. Moreover, the model is viewed as, “a framework that can reduce the possibility of intrusiveness during the identification of the family’s strengths and needs” (Deardorff, 1992, p. 76). Deardorff (1992) claims that this model is a particularly useful framework in examining family dynamics since it takes into account the ongoing time-related process of adaptation.

Demands or needs of individuals, families, and society at large are not static, but rather change over time (Boss, 1988; McCubbin & Patterson, 1983). Typical life-cycle transitions and events can be viewed as opportunities that place demands on the family unit since they require change. For example, normal growth and development of family members, as well as ongoing societal changes, are all additional life stressors put upon the family system (Sauers, 1993). Since family crises develop and are settled over a period of time, families are rarely managing an individual stressor event, but rather a pile-up of demands (McCubbin & Patterson, 1983; Sauers, 1993). This pile-up or accumulation of demands is identified as the “aA factor” in the Double ABCX model and signifies the accrual of stressors, strains, and demands that the family experiences (Deardorff, 1992). The demands or strains on the family unit transpire from: (a). individual family members, (b). the family system, and/or (c). the community in which the family and its members reside (McCubbin & Patterson, 1983). Other stressors or strains on the family may include: financial hardship, intrafamily strains such as marital discord, and work-family strains (Deardorff, 1992). In addition, daily tasks and caretaking responsibilities associated with a disabled family member can be viewed as a chronic stressor, which creates additional hardships on routine
life demands.

McCubbin and Patterson (1983) have acknowledged that there are five types of stressors and strains which involve a pile-up in the family during a crisis situation: (a) the initial stressor and its hardships; (b) normative transitions; (c) prior strains; (d) the consequences of family efforts to cope; and (e) intrafamilial and social ambiguity. These stressors and strains have been written about extensively in the family science literature.

The “bB factor” in the Double ABCX model represents the family adaptive resources, which are a part of the family’s capabilities for meeting demands and needs which emerge in the context of a crisis (McCubbin & Patterson, 1983). Three resources which affect a family’s adaptation to crises are: (a) family members’ personal resources, such as financial/economic, education, health, and psychological resources; (b) the family system’s internal resources, such as family cohesion and adaptability; and (c) social support, such as emotional support, esteem support, and network support (McCubbin & Patterson, 1983). Deardorff (1992) described the “bB factor” as, “the existing family strengths and supports and new resources available to meet identified needs” (p. 77). Family strengths may involve: family accord, qualitative parental communication, shared orientation to childrearing, satisfaction with family life, and problem-solving skills (Deardorff, 1992). Family supports may include: assistance from extended family members and friends along with community-based support from schools, churches, and medical services (Deardorff, 1992).

The “cC factor” in this model is the family definition and meaning. In the midst of crises and demands for changes, the family unit oftentimes struggles to give new meaning to a particular situation (McCubbin & Patterson, 1983). The “cC” factor involves not only the initial stressor event, but also the accumulated stressor events. When families are able to redefine a situation and give it new meaning and perspective, they are typically: (a) clarifying the hardships and issues so as to render them more manageable and less problematic; (b) decreasing the intensity of the emotional burdens connected to the crisis situation; and (c) encouraging the family unit to continue with its basic tasks of promoting members’ social and emotional development (McCubbin & Patterson, 1983). Additionally, if the family can view and redefine a crisis situation as a challenge or an opportunity for growth, family coping and adaptation are facilitated more easily. McCubbin and Patterson (1983) refer to the “cC factor” as “the meaning the family gives to the total crisis situation . . . and estimates of
what needs to be done to bring the family back into balance” (p. 15). Incorporated within this definition, are the stressors believed to have caused the crisis, as well as additional stressors and strains, and resources both old and new (McCubbin & Patterson, 1983). According to Deardorff (1992), the “cC” factor includes the family’s subjective definition of the stressor, the accompanying pile-up, and the effect on the family.

The most central concept of the Double ABCX model is the “xX factor,” used to describe the outcome of family efforts to achieve a new level of balance after a crisis situation, and is represented as family adaptation (Burr, 1973; McCubbin & Patterson, 1983). Deardorff (1992) defines adaptation as, “the outcome of family efforts to achieve a new balance and fit at both the individual-to-family level and the family-to-community levels of functioning” (p. 77). According to McCubbin and Patterson (1983), the concept of family adaptation involves a continuum between bonadaptation (the positive end of the continuum) and maladaptation (the negative end of the continuum).

McCubbin and Patterson (1983) continue by characterizing bonadaptation as a balance at both levels of functioning which results in: (a) the maintenance or strengthening of family integrity; (b) the continued promotion of both member development and family unit development; and, (c) the maintenance of family independence and its sense of control over the environmental influences. Maladaptation, at the negative side of the continuum, is characterized by a continued imbalance at the level of family functioning and involves: (a) deterioration in family integrity; (b) a reduction or deterioration in the personal health and development of a member or the well-being of the family unit; or (c) a loss or decline in family independence and autonomy (McCubbin & Patterson, 1983; McCubbin & McCubbin, 1996). Adaptation is viewed as a useful concept to describe the outcome of family post-crisis adjustment. There are three important factors that need to be discussed: (a). the individual family member, (b). the family system; and (c). the community of which family members and the family system are a part (McCubbin & Patterson, 1983).

**Family Resiliency Theory**

Family Resiliency Theory, a counterpart framework of Family Stress Theory, is a relatively new perspective that emphasizes the complex, but meaningful role which family dimensions, behaviors, and capabilities play in
shielding the impact of stressful life events and in facilitating the family’s recovery in the face of family adversity (McCubbin, Thompson, & McCubbin, 1996). The Family Resiliency framework is viewed as an outgrowth of the evolution in Family Stress Theory and has been somewhat unacknowledged until recent years. According to McCubbin, Thompson, and McCubbin (1996), the Resiliency Model is grounded in the classic work of Reuben Hill (1949, 1958) and, (a) highlights the major domains of family functioning critical to family recovery; (b) introduces the important family processes and goals of harmony and balance in the face of adversity; (c) emphasizes the importance of family appraisal, inclusive of culture and ethnicity, involved in family change and recovery; and, (d) focuses on the centrality of the family’s relational processes of adjustment and adaptation.

The concept of resilience has emerged predominantly from studies of children who have functioned quite well despite exposure to adversity when psychopathology was expected (Patterson, 2002). Not only have longitudinal research studies examined resiliency in children at risk to adverse developmental outcomes, but they have also investigated children’s competence as a protective factor in the face of risk situations (McCubbin, McCubbin, Thompson, Han, & Allen, 1997). Although family resilience has typically been described in the developmental psychopathology literature as noted above, in recent years it has become an increasingly visible concept in the family science field (Hawley, 2000).

According to Walsh (2002), the resiliency framework is viewed as a valuable conceptual map which guides prevention and intervention efforts in supporting and strengthening families in crisis. This perspective basically shifts the deficit-based lens, related to family vulnerabilities and risk situations, to a strength-based lens composed of capabilities to withstand and rebound from adversity and crises (Walsh, 1996; 2003). The resiliency framework alters previously held ideas and beliefs regarding vulnerabilities and crises in the family unit from “damaged” families and individuals to “challenged” families and individuals. According to Walsh (1996), utilizing this framework and ideology affirms families and/or individuals reparative potential (Hawley, 2000; Patterson, 2002; Walsh, 1996; 1998; 2002; 2003).

Family Resiliency framework assumptions include the following: (a) families experience stress and hardship as a predictable aspect of family life over the life cycle; (b) families also possess strengths and develop competencies to protect and assist in the recovery from both expected and unexpected non-normative stressors and strains and to foster the family’s
recovery following a family crisis; (c) families benefit from and contribute to a network of relationships in the community, particularly during periods of family stress and crisis; (d) families will search for and establish a view that will give the family meaning, purpose, and shared perspective so the family can move forward as a group; and (e) families faced with major stressors, and crises seek to restore order, balance, and harmony even in the midst of great upheaval (McCubbin, Thompson & McCubbin, 1996). Thus, the process of adjustment and adaptation involves changes within family relationships, as well as relationships with the larger community to reestablish individual and family well-being (McCubbin & McCubbin, 1996).

Resiliency, according to McCubbin, Thompson, and McCubbin (1996), can be defined as:

The positive behavioral patterns and functional competencies individuals and the family unit demonstrate under stressful or adverse circumstances, which determine the family’s ability to recover by maintaining its integrity as a unit while insuring, and where necessary restoring, the well-being of family members and the family unit as a whole (p. 5).

Another useful definition of resilience is the ability to overcome adversity and be successful in spite of exposure to high risk (Fraser, Richman, & Galinsky, 1999). Other frequently cited definitions include the ability to sustain competence under pressure and the capacity to recover from trauma (Masten, 1994).

Throughout the family literature, resilience has been variously defined and conceptualized. Multiple descriptions of family resilience exist in the family science domain (Hawley, 2000). Within the existing definitions, several common threads are evident. In the first place, resilience is viewed as surfacing in the face of hardship. Secondly, resilience carries a property of buoyancy. And thirdly, resilience tends to be viewed in terms of wellness rather than pathology (Hawley, 2000; Hawley & DeHaan, 1996).

According to Hawley (2000), resilience is often discussed in terms of risk factors (items that increase the likelihood of barriers to effective functioning) and protective factors (resources that aid in buffering the effects of adversity). Typically, resilience is found when risk factors are minimized and protective factors are available (Hawley, 2000). Wolin and Wolin (1993) have identified seven protective characteristics which include: insight, independence, relationships, initiative, humor, creativity, and morality (Hawley, 2000).
The Resiliency Model, as proposed by McCubbin, Thompson, and McCubbin (1996), is based on the work of Reuben Hill, the Double ABCX Model, and the Typology Model of Family Adjustment and Adaptation. These theoretical frameworks have focused on a stressor, the family’s effort to use resistance resources, the family’s appraisal of the situation, and the family’s coping patterns and problem-solving abilities to maintain functioning while dealing with a stressor. In the Resiliency Model of Family Stress, capability is defined as the potential the family has for meeting all of the demands it faces. Two sets of capabilities are emphasized: (a) resources and strengths [what the family has] and, (b) coping behaviors and strategies [what the family does].

Walsh (1998) believes that families undergoing the same stressors can ultimately lead to different outcomes, depending on how the family meets its challenges. Walsh (1998) concludes that the keys to family resilience are contained within three crucial areas:

(a) **Family belief system**: involves making meaning of adversity, having a positive outlook, and utilizing spirituality and transcendence.

(b) **Organizational patterns**: involves flexibility, connectedness, and social and economic resources.

(c) **Communication processes**: involves clarity, open emotional expression, and collaborative problem-solving.

**Conclusion**

Integration of Family Stress Theory and Family Resiliency Theory is applicable to the study of fathers with disabled and non-disabled children since these frameworks identify significant stressful life changes/events and key processes that enable families/individuals to withstand and rebound from disruptive challenges. In recent years, family scholars and researchers have emphasized the linkages between family stress theory and the family resiliency perspective (Patterson, 2002). In many ways, the concepts that underlie the family resiliency framework are already contained within family stress theory. Additionally, the focus on resilience accentuates the notion of family success and competence along with the capability of rising above and managing stress in an effective manner (Hawley, 2000; Patterson, 2002; Walsh, 1996; 1998; 2002; 2003).

Stress theory and the resiliency framework begin with an initiating
event and end with an outcome, hopefully a positive and favorable one that demonstrates resilience. It is only through stressful events and life challenges, perhaps major and minor, that resilience can be established. Life challenges provoke family members and individuals to confront new stressors and to grow and learn from the experience. This is the essence of resilience (Hawley, 2000; Patterson, 2002; Walsh, 1996; 1998; 2002; 2003).

Children, both disabled and non-disabled, can present unique challenges and stresses throughout the parenting years. During these years, fathers may experience the pile-up of stressors. Family resources are part of the capabilities for meeting these demands and difficulties, which typically surface during a state of crisis (McCubbin & Patterson, 1983; Sauers, 1993). Internal and/or external resources may be called upon to buffer the impact of pile-up or influence the definition of the situation and aid in promoting available solutions (McCubbin & Patterson, 1983; Sauers, 1993). So that fathers can cope with such demands, they must define the stressors as potential challenges or explore a new meaning for the crisis (McCubbin & Patterson, 1983; Sauers, 1993). Though some families crumble and deteriorate during a state of crisis, others have the ability to remain strong and reorganize so as to restore some functional stability (McCubbin & Patterson, 1983; Sauers, 1993). Therefore, the integration of stress theory and the resiliency model allows one to conceptualize how fathers may experience stress and manage crisis (such as disabled children) and adapt successfully over time to such difficult demands.

Purpose of the Study

Investigating the possible complex role of stress in life satisfaction is essential because of the increasing importance of the role of fathers and the unique difficulties of dealing with a disabled child. To date little is known concerning the effects on fathers having a child with a disability since previous research has focused predominantly on mothers or siblings. This study will compare fathers with and without disabled children in terms of their perceived level of stress regarding family life changes in the last year, parenting daily hassles, levels of individual and family coping, parenting and health stress, and life satisfaction. In addition, using the Double ABCX Model (see Figure 3) and Family Resiliency framework, this study will integrate family life changes, parenting daily hassles, levels of individual and family coping, as well as health and parenting stress to
Figure 3: Path Diagram of Theoretical Model of Factors Predicting Life Satisfaction.
determine if these variables can predict life satisfaction of fathers with and without disabled children.

The Double ABCX Model is a popular framework for analyzing parental stress and can be used to conceptualize the process of adaptation among fathers with disabled children. The Resiliency Framework, which is basically contained within the family stress model, will aid in conceptualizing more meaningfully the notion that families and/or individuals who endure stressful events can cope well under apparent adversity and can rebound from challenging situations.

In this study, the "A" factor, stressor event, consists of the pile-up of stressors and strains. In this proposed model, these (A) stressors, will be comprised of two components: (1). family life changes, which will measure the stresses and strains experienced by the father and (2). parenting daily hassles, which will measure the father's perceptions of frequency and personal distress caused by typical, but potentially irritating tasks and behaviors of their children. The "B" factor, family resources, will be made up of two components: (1). individual coping, which will measure the coping strategies that fathers may utilize in the face of hardships and (2). family coping, which will measure the problem-solving attitudes and behaviors fathers develop to respond to problems or difficulties. The "C" factor, definition of the event, will be comprised of three components: (1). parenting stress, which will measure stress in the parent-child system, (2). physical health, which will measure indicators of physical health or lack of physical health and, (3). psychological health, which will measure indicators of emotional health or lack of emotional health. The "X" factor, crisis and/or outcome, will be comprised of life satisfaction which will measure global cognitive judgments of the father's life.

Hypothesis and Research Questions

The purpose of this study will be to determine if differences exist between the two groups: (a). fathers with disabled children, and (b). fathers with non-disabled children/typically developing children. In this study, one null hypothesis and two research questions will be examined as reported:

Hypothesis: There will be no difference between the two groups of fathers (those with disabled children and those with non-disabled children) regarding:
(a) family life changes in their lives as measured by the Family Inventory of Life Events and Changes (FILE).
(b) daily parenting hassles as measured by the Parenting Daily Hassles scale (PDH).
(c) family coping as measured by the Family Crisis Oriented Personal Evaluation Scales (F-COPES)
(d) individual coping as measured by the Coping Scale for Adults (CSA).
(e) health (physical and psychological) stress in their lives as measured by the Family Health Status Inventory (FHSI)
(f) parenting stress as measured by the Parenting Stress Index (PSI).
(g) life satisfaction as measured by the Satisfaction With Life Scale (SWLS).

**Research Question 1:** Can family life changes/events and parenting daily hassles in conjunction with family and individual coping, health and parenting stress be integrated to predict life satisfaction of fathers with disabled children as measured by the Family Inventory of Life Events and Changes (FILE), Parenting Daily Hassles scale (PDH), Family Crisis Oriented Personal Evaluation Scales (F-COPES) and Coping Scale for Adults (CSA), Family Health Status Inventory (FHSI) and Parenting Stress Index (PSI), and Satisfaction With Life Scale (SWLS).

**Research Question 2:** Can family life changes/events and parenting daily hassles in conjunction with family and individual coping, health and parenting stress be integrated to predict life satisfaction of fathers with non-disabled children as measured by the Family Inventory of Life Events and Changes (FILE), Parenting Daily Hassles scale (PDH), Family Crisis Oriented Personal Evaluation Scales (F-COPES) and Coping Scale for Adults (CSA), Family Health Status Inventory (FHSI) and Parenting Stress Index (PSI), and Satisfaction With Life Scale (SWLS).

**Definitions**

The definitions listed below are presented to clarify the terminology utilized in this study:

1). **Stress:** is “the state manifested by a specific syndrome which consists of all the nonspecifically-induced changes within a biologic system” (Selye, 1978, p. 64). It can be also defined as the pressure or tension in the system which can result in change in equilibrium (Boss, 1988).
2). **Stressor Event**: an occurrence that is of significant magnitude to provoke change in the family system (Boss, 1988). It has also been defined as an event that has the potential to cause change in the family because it disturbs the status quo (Boss, 1988).

3). **Coping**: is “the management of a stressful event or situation by the family as a unit with no detrimental effects on any individual in that family” (Boss, 1988, p. 69). It can also be defined as a cognitive activity incorporating: (a) an assessment of impending harm (primary appraisal) and, (b) an assessment of the consequences of any coping action (secondary appraisal) (Lazarus, 1966; 1976). It refers to the degree of problem-solving and coping strategies used to manage stressors or crisis (McCubbin, Larsen, & Olson, 1991).

4). **Crisis**: a situation which creates a sense of sharpened insecurity or which block the usual patterns of action and call for new ones (Hill, 1958).

5). **Resilience**: “a process, capacity or outcome of successful adaptation despite challenges or threatening circumstances . . . good outcomes despite high risk status, sustained competence under threat and recovery from trauma” (Masten, Best, & Garmezy, 1990, p. 426). It has also been defined as the way adults cope with unexpected or challenging life events and involves the interactions of risks and assets that result in good outcomes.

6). **Life Satisfaction**: is a “global assessment of a person’s quality of life according to his chosen criteria” (Shin & Johnson, 1978, p. 478). It refers to a cognitive, judgmental process (Diener, Emmons, Larsen, & Griffin, 1985) as well as the degree, severity, or magnitude of generalized contentment.

7). **Children with Educational Disabilities**: refers to children between the ages of 5 and 12 years old who have an active Individualized Education Plan (I.E.P.) and have been diagnosed as having physical, mental, or social/emotional deficits that require special assistance in performing daily activities. The diagnosed disability should be experienced by the child as having an adverse effect on his or her educational performance.

8). **Daily Hassles**: refers to the irritating, frustrating, annoying, and distressing demands that to some degree characterize everyday transactions with the environment.
9). Subjective Well-being: refers to a field of psychology that attempts to understand people’s evaluations of their lives. Frequent positive affect, infrequent negative affect, and a global sense of satisfaction with life define high subjective well-being.

10). New Father: refers to the man who is both highly nurturing towards his children and increasingly involved in their care and the housework.

11). Fathering: long-term and intensive activities fathers are expected to perform.

12). Fatherhood: distinct status attained by a male having a child.

13). Autism: a developmental disability significantly affecting verbal and nonverbal communication and social interaction, generally evident before age three that adversely affects a child’s educational performance. Other characteristics often associated with autism are engagement in repetitive activities and stereotyped movements, resistance to environmental change or change in daily routines, and unusual responses to sensory experiences (Kentucky Administrative Regulations, 2000, p. 2).

14). Deaf/Blind: a concomitant hearing and visual impairment that has an adverse affect on the child’s educational performance, the combination of which causes severe communication and other developmental and educational needs that cannot be accommodated in special education programs solely for children with deafness or children with blindness, unless supplementary assistance is provided to address educational needs resulting from the two disabilities (Kentucky Administrative Regulations, 2000, p. 3).

15). Developmental Delay: a child within the ages of three through eight who has not acquired skills, or achieved commensurate with recognized performance expectations for his or her age in one or more of the following developmental areas: cognition, communication, motor development, social-emotional development, or self-help/adaptive behavior. Developmental delay includes a child who demonstrates a measurable, verifiable discrepancy between expected performance for the child’s chronological age and current level of performance (Kentucky Administrative Regulations, 2000, p. 3).

16). Emotional-Behavior Disability: a child, when provided with interventions to meet instructional and social-emotional needs, continues to exhibit one or more of the following, when compared to
the child’s peer and cultural reference groups, across settings, over a long period of time and to a marked degree: (a) severe deficits in social competence or appropriate behavior, (b) severe deficits in academic performance, (c) a general pervasive mood of unhappiness or depression, and (d) a tendency to develop physical symptoms or fears associated with personal or school problems (Kentucky Administrative Regulations, 2000, p. 3).

17). **Functional Mental Disability**: a child who has low cognitive functioning (at least three or more standard deviations below the mean), adaptive behavior deficits, and severe deficits that exist in overall academic performance including acquisition, retention, and application of knowledge and is typically manifested during the developmental period (Kentucky Administrative Regulations, 2000, p. 5).

18). **Hearing Impaired**: a child who has a hearing loss that has an adverse affect on the child’s educational performance, whether permanent or fluctuating, ranging from mild to profound, and of a degree that the child is impaired in the processing of linguistic information through hearing, with or without amplification (Kentucky Administrative Regulations, 2000, p. 4).

19). **Mild Mental Disability**: a child who has low cognitive functioning (at least two, but no more than three, standard deviations below the mean), adaptive behavior deficits, and severe deficits that exist in overall academic performance including acquisition, retention, and application of knowledge and is typically manifested during the developmental period (Kentucky Administrative Regulations, 2000, p. 5).

20). **Multiple Disabilities**: a concomitant impairment that has an adverse affect on the child’s educational performance (e.g., mental disability-blindness, mental disability-orthopedic impairment, etc.), the combination of which causes severe educational needs that cannot be accommodated in special education programs solely for one of the impairments. Multiple disability does not mean deaf-blindness (Kentucky Administrative Regulations, 2000, p. 5).

21). **Orthopedic Impairment**: a severe orthopedic impairment that adversely affects a child’s educational performance. The term includes an impairment caused by a congenital anomaly (e.g., clubfoot, absence of some member, etc.), an impairment caused by
22). Other Health Impairment: having limited strength, vitality, or alertness, including a heightened alertness to environmental stimuli, that results in limited alertness with respect to the educational environment that (a) is due to a chronic or acute health problem (e.g., as acquired immune deficiency syndrome, asthma, attention deficit disorder or attention deficit hyperactivity disorder, diabetes, epilepsy, a heart condition, hemophilia, lead poisoning, leukemia, nephritis, rheumatic fever, sickle cell anemia, or tuberculosis) and (b) adversely affects a child’s educational performance (Kentucky Administrative Regulations, 2000, p. 6).

23). Specific Learning Disability: a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken, or written, that may manifest itself in diminished ability to think, speak, read, write, spell, or to do mathematical calculations, including conditions like perceptual disabilities, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia. Specific learning disability does not include learning problems that are primarily the result of visual, hearing, or motor disabilities, of mental disability, of emotional disturbance, or of environmental, cultural, or economic disadvantage (Kentucky Administrative Regulations, 2000, p. 8).

24). Speech/Language Disability: a communication disorder, including stuttering, impaired articulation, a language impairment, a voice impairment, delayed acquisition of language, or an absence of language, that adversely affects a child’s educational performance (Kentucky Administrative Regulations, 2000, p. 8).

25). Traumatic Brain Injury: an acquired injury to the brain caused by an external physical force, resulting in total or partial functional disability or psychosocial impairment, or both, that adversely affects a child’s educational performance. Traumatic brain injury does not mean brain injuries that are congenital or degenerative, or brain injuries induced by birth trauma. Traumatic brain injury means open or closed head injuries resulting in impairments (Kentucky Administrative Regulations, 2000, p. 9).
Visual Impairment: a child who has vision loss, even with correction, and has an adverse affect on the child’s educational performance (Kentucky Administrative Regulations, 2000, p. 10).

**Abbreviations**

FILE: Family Inventory of Life Events and Changes (McCubbin et al., 1983)
CSA: Coping Scale for Adults (Frydenberg & Lewis, 1997).
PSI/SF: Parenting Stress Index/Short Form (Abidin, 1995).
FHSI: Family Health Status Inventory (Norem, Malia, & Garrison, 1988)
SWLS: Satisfaction with Life Scale (Diener et al., 1985)
ADD: Attention Deficit Disorder
ADHD: Attention Deficit Hyperactivity Disorder.
SWB: Subjective Well-being.
IEP: Individualized Educational Plan.
KAR: Kentucky Administrative Regulations

**Limitations**

The study will be limited by the following:

1. Participation by the fathers/respondents will be totally voluntary.
2. The results of this study may not be generalized extensively to other locations due to the sample being from the same school district, town, and overall geographic area.
3. Participants interpretations of the questionnaire items may influence how they respond.
4. This research study will involve the measurement of personal perception. Therefore, the measures of family changes/events (both major and minor), level of coping (both individual and family), level of stress (both health and parenting), and life satisfaction will be associated with fathers’ perceptions of their influence.
Delimitations

The study will be delimited by the researcher to the following:

1. The sample will be delimited geographically to the McCracken County School District, Western Kentucky. One should use caution when generalizing results from this study to other geographic locations.

2. The sample will include only fathers (biological, step, and adoptive) who reside with typically developing children or children with educational disabilities between the ages of 5 to 12 years old (elementary/school-age children).

3. Participants’ data/information will be based on self-report. Thus, results may be impacted by societal and environmental expectations.

Assumptions

The following assumptions will be set forth in this study:

1. Participants will answer the questionnaire in a honest fashion. The responses on the questionnaire will be representative of their sincere thoughts and feelings pertaining to the subject matter.

2. Participants involved in this research study will self-disclose openly and freely.

3. Participants will be cognitively capable of accurately and carefully completing the questionnaire.

4. School system personnel will facilitate the distribution of the questionnaire as described in an informal meeting.
CHAPTER 2: LITERATURE REVIEW

Introduction

This chapter provides a review of the current literature with respect to fathers having children with and without disabilities. It will commence with a detailed historical review of fatherhood as a significant topic of research, and then will report on the discovery of fathers and their role in society. Information on fathers and typically developing children will be presented next. Stress and coping dimensions along with parenting stress of fathers having children with disabilities will be addressed in the following section. Key variables such as family life changes and daily hassles will be discussed. And lastly, a review of life satisfaction will be provided.

Historical Overview

After serious investigation, Demos (1982) concluded that, “the historical study of fatherhood is waiting to be born” (p. 425). Although fatherhood has a long history, it was not until recent years that historians and scholars attempted to view this topic as having much relevance or importance (Eggebeen & Knoester, 2001; Marsiglio, Amato, Day, & Lamb, 2000; Lamb, 2004; Nickels, 1997). Traditionally, historians tended to choose other topical possibilities for academic discussion and research, since fatherhood was not conceived to be a legitimate area of study (Demos, 1982). In the past, social scientists viewed the place of fathers in the family to be a domain which did not merit recognition since the maternal bond created by pregnancy and childbearing was of greater value and substance (Furstenberg & Harris, 1992).

It is only in the last 20 years or so that historians and scholars began for the first time to vigorously and actively examine the role of men within a family context (Lamb, 2004; Nickels, 1997). In particular, family scholars examined the issue of just how the modern family was changing and the related implications associated with family life (Perry-Jenkins & Crouter, 1990). Another major area of research examined the changing nature
of fatherhood images, as well as perceptions of father-role identities (Marsiglio, 1993). Before the 1970’s, when research regarding father dimensions was rather sparse, fatherhood was often referred to as “hypothetical history” (Demos, 1982). While reviewing the literature on fatherhood dimensions, paternal roles, and father-child interactions throughout the years, it was evident that minimal importance had been historically ascribed to fathers (Lamb, 1976; 1981; 1986; 1993; 2004).

In order to understand more clearly the notable concern and confusion with fatherhood, Lamb (1997) pointed out that it was helpful to examine the historical changes that had materialized with regard to the conceptualization of paternal roles. It was very apparent that the perception and role of fatherhood has changed dramatically during the last century (Carpenter, 2002). Although data were limited when it came to examining historical records, documents, and literature, four distinct periods or phases over the last two centuries of American social history were identified. (Lamb, 1986; Pleck, 1987; Lamb, 2000; Nickels, 1997). These four phases were distinguished by the emergence of a predominant emphasis concerning a “suitable” fathering role during a specific period of time (Lamb, 1986; 1997; 2000; 2004).

The first phase extended from Puritan times through the Colonial period into early Republican times. During this lengthy period, the father’s role was predominantly perceived as that of moral educator. Fathers were responsible for ensuring that their children were reared with appropriate values based on religious study and knowledge of the Bible. Although education was an important part of this value system, it was stressed only to the extent that it promoted reading of the Scriptures. Therefore, education was secondary to the prevailing notion of moral guardianship. During this era, good fathers were viewed as men who provided a model of good Christian living and who trained their children in the Scriptures (Lamb, 1986; 1997; 2000; 2004; Pleck, 1984).

The second historical stage was affiliated with the time of industrialization. During this time, a shift in the dominant conceptualization of the father’s role was observed (Pleck, 1984). While the promotion of Christian values and the emphasis of Biblical scholarship remained important in father-child relationships, the father role changed from that of moral guardian to breadwinner. This conceptualization of the father continued throughout the mid-nineteenth century through the Great Depression (Pleck, 1976). Therefore, fathers were judged good if they
characterized the term of breadwinning (Lamb, 1986; 1997; 2000; 2004).

The third phase which came about as a result of the Great Depression and the disruption of World War Two highlighted a new conceptualization of the father as a gender-role model. During this period of time professional literature focused on the need for fathers to be strong sex-role models. Although books and articles provided information on the sex-role ideology, there appeared to be little emphasis placed on an adequate masculine role model directed at fathers and their sons (Lamb, 1986; 2000; 2004; Pleck, 1984).

Lastly, a fourth phase was reached in the 1970’s through which another conceptualization of the father as an active, nurturing, and caretaking parent was realized. In the popular media, various movies such as “Kramer versus Kramer” and “The World According to Garp” exemplified the nurturing, caretaking notion of fatherhood. “Active parenting was defined as the central component of fatherhood and was implicitly (sometimes even explicitly) portrayed as the yardstick by which good fathers might be assessed” (Lamb, 2000, p. 27). Though this conceptualization of fathering was unmistakably evident in private realms, later it became an area of emphasis for professional study (Lamb, 1986; 1997; 2000; 2004; Pleck, 1984).

**The Discovery of Fathers**

There has been a virtual explosion of interest on the topic of fatherhood (Lamb, 1981; 1986; 1997; 2004). Findings indicated that fathers were highly influential contributors to their children’s development (Lamb, 1981). Specifically, social scientists discovered that fathers were significant contributors in many aspects of family functioning pertinent to children’s welfare (Lamb, 1976; 1979; 1981; 1997; 2004; Lamb & Oppenheim, 1989; Shapiro et al, 1995). In the past, theoretical and empirical attention was given almost exclusively to mothers (Biller, 1993; Lamb, 1981; 1993; 1997; 2004). During the 1990’s, more extensive and eclectic social science research surfaced on numerous aspects of fathering (Marsiglio, Amato, Day & Lamb, 2000). Up until the 1970’s, the primary focus of child development and parenting research in the United States was on one group: mothers in middle-class families (Lamb, 1976; 1981; 1986; 2004; Werner, 1984). In more recent times, contemporary research has taken a more comprehensive and balanced view of parenting whereby both the father and the mother were studied in relation to family functioning (Entwisle & Doering, 1988; Lamb, 1986; 1993; 1997;
Moreover, researchers seem to have turned more and more of their attention to the father-infant relationship (Lamb, 1981). Lamb (1979) calls this the “era of paternal discovery.”

During the past three decades, a plethora of social, political, and economic issues combined to reveal a “new” father. It appeared that four important social conditions established the marked interest in uncovering the “new” father: (a) the women’s movement, (b) the fathers’ presence in the birthplace, (c) the increased understanding of the effects of father absence, and (d) the changing economic conditions (Lamb, 1986; 1993; 2004; Shapiro, Diamond & Greenberg, 1995). The women’s movement empowered mothers to leave the home and seek equality in the workforce. Growing out of this time period, the women’s familiar role as housewife and mother was also strongly challenged (Lamb, 1979; 1986, 1993; Shapiro et al., 1995). With the loss of a full-time homemaker and the need for children to have active-parenting, additional opportunities opened up for fathers (Shapiro et al, 1995). Many men responded to this challenge by increasing the amount of time spent with their children (Lamb, 1986; 1993; 2004; Shapiro et al., 1995).

During the mid-1960’s only fifteen percent of fathers in intact families planned to be present during childbirth. In 1985 eighty-five percent of North American fathers planned to attend the birth of their child (Lamb, 1981; 1986; 1993; 2004; Shapiro et al., 1995). The discovery of early father bonding and connection during childbirth was received with great excitement (Shapiro et al., 1995). In the 1970’s the term “engrossment” was created through which the father’s reaction to childbirth and the early bonding experience was described as having long-term implications (Lamb, 1981; 1986; 1993; 2004; Morris, 1974; Shapiro et al., 1995). According to Shapiro (1993), fathers who involved themselves in the pregnancy and childbirth experience desired a more active role in parenting.

A review of the literature over the past ten years or so indicated that absent fathers had a negative impact on children (Arendell, 1992; Boss, 1986; Crockett, Eggebeen, & Hawkins, 1993; Lamb, 1993; 2004; Mott, 1990; Pruett, 1993). There were many studies that suggested that various forms of paternal absence were affiliated with later developmental problems in children, adolescents, and adults (Lamb, 1986; 1993; 2004; Shapiro et al., 1995). On the other hand, there was an extensive literature base that indicated the powerful role that positively involved fathers could play in developing their children’s healthy long-term psychological adjustment (Biller & Solomon, 1986; Lamb, 1976; 1981; 1986; 1993; 2004; Shapiro et al., 1995).
Shifting family economics and maintenance of living standards have made dual incomes somewhat of a necessity. It appeared throughout the literature review that there was no longer the traditional, single role of breadwinner (Shapiro et al., 1995). With both partners in the workforce, the father’s role took on increased importance. Household duties and parenting fell more heavily on both the mother and the father (Lamb, 1986; 1993; 2004; Shapiro et al., 1995). Men were permitted to parent in their own unique way. In this kind of setting, children were exposed to different and contrasting parenting experiences (Lamb, 1981; 1986; 1993; 2004; Shapiro et al., 1995).

During the 1970’s and the 1980’s, dramatic shifts were taking place regarding the changing roles of fathers in society. An important milestone during this period of time was the designation of Father’s Day as a national holiday. In 1972, Father’s Day was finally recognized. This significant development occurred almost fifty-eight years after Mother’s Day was introduced in 1914 (LaRossa, 1997; Nickels, 1997). Several researchers and family theorists surmised that increased attention from this new paternal holiday may have added to a greater interest in fatherhood issues (Lamb, 2004; Nickels, 1997). That fathers could contribute to the nuclear family and possibly influence the development of their children was now more accepted in the professional arena (Marsiglio, 1993). Throughout this time frame, interest in fatherhood intensified. The number of fatherhood researchers increased, as well as the number of research studies, which targeted paternal social policy (Marsiglio, Amato, Day & Lamb, 2000). In academic settings research began to examine the topic of fatherhood more closely, although the data continued to be obtained almost entirely from mothers (Lamb, 1981). Up until the 1970’s, sociologists still viewed the father on the periphery of the family system and parenting was conceptualized in terms of mothers’ influence on children (Boss, 1986; Entwisle & Doering, 1988; Lamb, 2000; 2004). In other areas, national conferences acknowledged the discovery of the “new” father in speeches and group discussions across the nation (Lewis, 1986; Nickels, 1997). In the United States, the first national conference was held in 1975. It promoted fatherhood issues throughout the country by addressing men’s changing roles over the years (Nickels, 1997). However, it was almost seven years later (in 1982) that the subject matter of men finally became a predominant theme at the conference level (Lewis, 1986; Nickels, 1997).
Fathers’ Role in Society: Types and Cultural Images

Cultural images, both stereotypical and ideal, provided a frame of reference for scholarly examination of the literature pertaining to fatherhood (LaRossa, 1988). Existing norms, values, and beliefs were used by various professionals and even politicians to explain the meaning of fatherhood during particular times. LaRossa (1988) described the “culture of fatherhood” as the shared norms, values, and beliefs surrounding men’s parenting and the “conduct of fatherhood” in terms of paternal behaviors. In order to understand the cultural meanings of fatherhood, one must investigate how particular meanings were shaped by societal influences (Marsiglio, 1993; Tiedje & Darling-Fisher, 1996).

Within the context of fathering, mainstream ideal images associated with the “good father” were not always consistent with fathers’ actual behaviors (Marsiglio, 1993). Similarly, cultural images were discussed in light of what fathers actually did versus what the perceived norms suggested in terms of the “participant father” and the “absent father” (LaRossa, 1988; Tiedje & Darling-Fisher, 1996). The process of interpreting norms was not always straightforward since men heard both the societal depiction of fatherhood “messages” and “metamessages” (Jurich, White, White, & Moody, 1991). Oftentimes there was confusion and contradicting views of fathering. The media often featured idealized images of the “new, involved father.” On the other hand, there was the portrayal of a “deadbeat” dad who showed little if any interest in his children (Deinhart, 1998; Lamb, 2000; 2004). Although negative images of fathers were not necessarily new to the cultural arena, they appeared more pronounced due to media exposure. There was no reliable data to document the extent to which the American population attached weight to these negative (or positive) images (LaRossa, 1988).

As a result of the impact of various socioeconomic and cultural factors, men developed their own unique fathering style. Research showed that there were central elements within these diverse father styles (Yablonsky, 1982). Through a particular “father type,” men acted out multiple roles in the family context. In other words, different types of fathers were defined in terms of the different roles they played. Yablonsky (1982) studied and wrote extensively on the following five basic father styles:

(a) the “compassionate” father was viewed as an emotionally healthy man who usually placed his children’s needs over his own,
(b) the "peer-type" father was perceived as one who loved his children but did not assume the proper status of a father,
(c) the "macho" father was defined as one who exaggerated the meaning of masculinity,
(d) the "psychopathic" father was described as untrustworthy, impulsive and improvident, and
(e) the "egocentric" father was viewed as uncompassionate and manipulative.

In a study conducted by Jain, Belsky, and Crnic (1996), four types of fathers were identified: (1). caretakers, (2). playmates-teachers, (3). disciplinarians and, (4). disengaged fathers.

Closer scrutiny of the cultural images and prevailing father styles suggested that there were multiple and often conflicting messages rather than a single, coherent ideal (Lamb, 2004; LaRossa, 1988; Marsiglio, 1993; Shapiro et al., 1995). Cultural ideals, then, may have presented a mixed message. Recent inquiry about the conventional cultural image of the father led researchers to ignore a wider range of father types and styles (Parke, 1996). Therefore, fathering should perhaps be understood in light of both cultural dimensions and prominent father styles as they function together (Lamb, 2004; LaRossa, 1988; Marsiglio, 1993; Shapiro et al., 1995).

Fathers and Typically Developing Children

Infants and Young Children

Although there was considerable research on the development of father-infant relationships since the 1970’s, infant research studies revealed a tendency to emphasize the interactions of mothers with their young children (Lamb, 1986; 1997; 2004; Nickels, 1997; Starrels, 1994). In general, prior research viewed paternal roles relative to maternal performance and standards, rather than investigating the uniqueness of fatherhood itself (Fitzgerald, Mann & Barratt, 1999). Historically, fathers were examined in research studies in connection with their effects on the mother-infant relationship (LaRossa, 1991; Nickels, 1997) and long before the 1970’s most studies on the parent-child relationship assumed the mother was the dominant influence on children’s development (Zaslow, Rabinovich, & Suwalsky, 1991). Throughout the literature review, knowledge of fathers’ impact on child development and interactional qualities was scant. When research on the father-infant relationship began in earnest, researchers sought to determine
whether infants actually established a relationship with their father. At this period of time, it was not yet formally recognized if fathers were proficient or qualified in attending to their children’s needs (Lamb, 1997; 2004; Nickels, 1997). In addition, it was not clearly understood if infants and young children acknowledged their fathers’ parental actions and behaviors (Lamb, 1997; Nickels, 1997). The literature review consistently promoted the notion that little attention was given to fathers in the context of their parenting practices with infants and young children.

Over the years, several studies revealed that infants and young children do not innately and instinctively relate only to mothers, but to both parents (Kotelchuck, 1976; Lamb, 1976; 1995; 1997; 2004). Other studies consistently showed that infants become attached to their fathers at about the same time they developed an attachment to their mothers, and to the same degree (Lamb, 1977; 1978). In a study conducted by Lamb (1997), it was found that secure parent-infant attachments were fostered when adults were consistent in appropriate and prompt responses. In several lengthy home observations, Lamb (1988) found that infants aged 7, 8, 12, and 13 months showed no preference for either parent over the other. During the second year of life, however, boys showed a different preference for father attachment, whereas girls showed no significant preference for either parent (Lamb, 1997).

In a qualitative study, using a convenience sample of 14 first-time fathers ages 28 to 44, it was found that fathers developed a close attachment with their infants by rocking, playing, singing, or holding them (Anderson, 1996). Findings suggested that fathers become more closely connected with their infants as they become more responsive and psychologically involved. Young children’s responses to mothers and fathers also showed differentiation of relationships. Under stressful conditions in a laboratory setting, 18 to 24 month old children displayed a preference for mothers over fathers in their attachment behaviors (Lamb, 1976), whereas in the less constrained context of the home, infants and toddlers preferred fathers as partners in social play interactions (Belsky, 1979).

Throughout the review of literature, various studies have focused on the competencies and parenting abilities of both mothers and fathers. In a study conducted by Burbach, Fox and Nicholson (2004) using a sample of 136 fathers, research revealed that fathers and mothers responded similarly to challenging childhood behaviors. In Nickel’s (1997) review of the literature, it was found that both parental figures were proficient in their
care-taking behaviors and in several parenting areas/styles they were rather alike (Cowan & Bronstein, 1988). However, in a detailed article written by Pruett (1993), evidence existed to suggest that fathers and mothers tended to be dissimilar in some aspects of parenting. Pruett (1993) stated that, “fathers have an essential nurturing function that is distinctly their own” (p. 46).

In another study using a sample of 23 families, it was found that men’s psychological characteristics, particularly their autonomy and job satisfaction, predicted their play time and the quality of their interactions with their young children (Grossman, Pollack & Golding, 1988). Overall, research indicated that fathers, like mothers, tended to be just as proficient and competent in the care giving of their infants and young children (Lamb, 1997; 2004, Nickels, 1997; Parke, 1996; Pruett, 1993; Yablonsky, 1982) and that fathers also interacted with their young infants both alone and in the presence of others (Parke & Tinsley, 1981). According to Nickels (1997), these findings pertained to both fathers who were middle class, as well as fathers who had low socioeconomic standing. Various studies found that even with newborn infants, fathers established a bond similar to mothers, regardless of attendance in prenatal educational classes (Jones, 1985; Lamb, 1997; Nickels, 1997). The literature review indicated that fathers who spend more time taking care of their young children may develop stronger attachments to them, and their children may benefit from these enhanced connections (Grossman, Pollack & Golding, 1988). Moreover, involved and interactive fathers tended to have children who were better able to adapt to life stresses (Pruett, 1993).

One of the most outstanding findings of the father-infant research suggested that mothers and fathers were uniquely distinct in their interactions with babies, infants and young children (Lamb, 1997; 2004; Nickels, 1997). Anderson (1996) noted that fathers developed a close relationship with their infants through unique “holding” behaviors, which promoted independence and individual existence. From Anderson’s (1996) study, it was shown that fathers participated in a variety of unique caretaking, play, and comfort activities. Several observational studies, within and without the home environment, indicated that fathers played with their infants much differently using less play equipment, whereas mothers responded to their infant’s curiosity and exploratory activities (Lamb, 1997; Nickels, 1997; Parke, 1990; Pruett, 1993). In a study to better understand fathers’ contribution to their parenting role, it was discovered that
fathers’ play was more idiosyncratic, and unpredictable (Lamb, 1975). Other findings consistently showed fathers as more involved in physically stimulating and playful interactions (Lamb, 1981, 1985; Parke, 1981). Research supported the idea that fathers proved more likely to establish a heightened, arousing and playful relationship with their infants (Clarke-Stewart, 1980; Krampe & Fairweather, 1993).

In a comparison study using a representative sample of 100 father-mother dyads, findings indicated that fathers spent a significantly greater proportion of interaction time with their infants in play activities, whereas mothers spent a significantly greater proportion of their interaction time in other functional activities (McBride & Mills, 1993). Research suggested that fathers also interacted with their infants in a more tactile and aggressive manner, whereas mothers were more likely to interact with verbal repetition and imitation of baby sounds (Parke, 1996).

Some research focused on fathers’ parenting styles and attitudes with regard to their infants (Woodworth, Belsky, & Crnic, 1996). Cowan and Cowan (1987) found that fathers with more child-centered attitudes reported greater levels of involvement with their 18 month old children. Observing infants from 8 to 24 months of age, Lamb (1988) found that fathers’ parenting styles compared to mothers’ styles involved more physical games such as swinging, tumbling, and bouncing. It was not clear, though, whether the role of father as playmate persisted as children age. It was reported that infants responded in a more positive way to fathers’ play rather than to mothers’ (Lamb, 1976, 1977). Although fathers and mothers possibly interacted in different ways, both were viewed as important for the infant’s later social development (Lamb, 1976; 1977; 1981; 1993; 1997; 2004).

In a study conducted by Clarke-Stewart (1980), using natural observations in the home, it was found that the mother was the predominant partner in terms of time spent with the infant. This was due to easier availability of the mother during the important early years of an infant’s life (Parke, 1981). Infants appeared to prefer mothers over fathers although these preferences probably developed because mothers were primary caretakers. If fathers were to become primary caretakers or to share more in caretaking responsibilities, these preferences might well be reversed (Lamb, 1997). It appeared that within a traditional nuclear family, fathers spent less time with their infants than mothers did (Yogman, Cooley, & Kindlon, 1988). Jones (1985) pointed out that fathers formed competent paternal-infant attachments regardless of the amount of time spent together. In a multi-methodological
study consisting of 39 volunteer father-son dyads, it was found that 
affectionate touch was one important element in a quality father-child 
relationship (Salt, 1991). Numerous studies suggested that both quality and 
quantity of paternal interactions with young children should be examined more 
closely (Lamb, 1981; 1993; 2004; McBride & Mills, 1993; Nickels, 1997; 
Shulman & Klein, 1993).

In conclusion, the research studies on early childhood revealed that 
fathers were very much interested in their infants and young children (Lamb, 
1987; 1997; 2004; Nickels, 1997). Not only were fathers interested in their 
youngsters, but they also connected with them through unique play and 
stimulating interactions. In addition, it was found that fathers, like 
mothers, were just as proficient, competent and attentive in caring for their 
infants and young children (Nickels, 1997). It was evident that infants were 
capable of forming an attachment with both parental figures at about the same 
point during the first twelve months of life (Lamb, 1997; 2004; Nickels, 
1997). There was little evidence of innate differences between fathers and 
mothers in their potential for interaction with infants. While mothers and 
fathers were similar in some parenting approaches, in others, they interacted 
very differently (Nickels, 1997; Pruett, 1993). It could be the case that 
fathers in less technologically developed cultures may have more time for 
routine care giving of infants and young children, compared to fathers in 
technologically advanced societies (Fitzgerald, Mann & Barratt, 1999).

School-Age Children

Little empirical research existed on the impact of fathers on 
elementary age children, since the focus of father-child and mother-child 
interaction has typically been with infants (Cowan & Bronstein, 1998; Hanson 
& Bozett, 1987; Montemayor, McKenry, & Julian, 1993; Nickels, 1997; Starrels, 
1994). Fatherhood, as an emerging area of scientific inquiry, has generally 
not resulted in any significant attention to the feelings, attitudes, and 
behaviors of fathers of elementary age children (Bradley, 1985). In 
addition, few studies addressed life satisfaction in middle childhood, as 
well as differences found in mother-child and father-child relationships 
during normative developmental tasks in older children (Collins & Russell, 
1991; Young, Miller, Norton, & Hill, 1995).

Available research with school-age children suggested that paternal 
influence was extremely important. Although there were limited studies 
pertaining to fathers and school-age children, several ideas regarding the 
role of fathers in families with young children were briefly mentioned
Greater participation in fathering elementary age children was consistently related to improved child development with regard to academic achievement, personal identity, and social adjustment (Lamb, 1981). School-age children who had active, nurturing, and committed fathers were generally much more successful in their academic, athletic, and social pursuits. Similarly, older children with involved fathers had higher self-esteem than those who were paternally deprived (Biller, 1993; Lamb, 1981; 1993; 2004).

Research on parent-child interaction with elementary children revealed consistent differences in parental involvement. For example, studies showed that fathers spent less time with elementary age children (Biller, 1993; Shulman & Klein, 1993). In comparison, a greater proportion of time was spent with older children, mostly in leisure or play. Several research studies also indicated that fathers’ tactile and energetic style of interaction with infants and young children carried forward with older children and adolescents (MacDonald & Parke, 1986; Nickels, 1997). The literature review suggested that fathers interacted with their children by encouraging curiosity in the solution of intellectual and physical challenges (Pruett, 1993). In a study conducted by Montemayor and Brownlee (1987), it was found that fathers appeared to initiate an assertive role for their school-age children over a polite one, through hands-on activity and physical interaction.

Throughout the years, several research studies have emphasized paternal play and de-emphasized routine care giving behaviors associated with school-age children. In a study based on intensive qualitative interviews, it was found that fathers believed in spending play time with their young children; however, they felt regret over having to also make time for work commitments (Daly, 1996). Although fathers’ interacted playfully with their school-age children, there is some research that suggested that fathers tended to direct more attention, control, and responsive behavior towards young children (Volling, 1997). According to Nickels (1997), older school-age children appeared to learn assertive behavior through active, high-spirited, and energetic play. Interestingly, young children did not learn negative behaviors, such as aggression, through stimulating and lively play with their fathers (Nickels, 1997). Several studies reported that more research in the area of playful paternal interaction with young children was required in order to find specific determinants that promote positive child development. It could be that through engaging in physical play with fathers, a young
child learns the value of positive communication and healthy expression (Boyum & Parke, 1995).

In a multi-method study conducted by Salt (1991) using the TOKS (Touch OK Scale) and 39 father-and-son dyads, young school-age children reported that their “fathers do more affectionate and nurturing types of touch than they do playful types of touch” (p. 553). This study supported the idea that both fathers and sons were more accepting of fathers touching sons prior to preadolescence. Moreover, a father’s “touching interaction” may play a critical role in understanding levels of increased social and cognitive development in children. This study suggested that the preadolescent stage is a turning point for boys as they mature into adult men. However, it should be noted that Salt’s (1991) research was based on the perception of the preadolescent son. Findings suggested that the subject of touch between fathers and their sons was in need of further research (Salt, 1991).

Research on fathering and school-age children suggested that fathers often feel inadequate in carrying out their paternal role appropriately due to occupational demands, which limited time spent with their children (Hanson & Bozett, 1987). It appeared that fathers of elementary age children were tied more to sons than daughters and assumed an instrumental role rather than an expressive one. Relationships with daughters during this age period were often less close, ostensibly because of the difficulty men had identifying with the special needs of young females (Hanson, & Bozett, 1987). In an older, but important study conducted by Radin (1981), research revealed that paternal closeness and connection was highly related to children’s overall achievement-orientation. This study also highlighted the importance of positive father-child relationships in terms of increased child competence. Within the fatherhood literature, paternal emotional expressiveness has been linked to children’s social competence. In an observational study conducted by Boyum and Parke (1995), findings suggested that expressiveness and observed paternal affect were both meaningful predictors of children’s sociometric ratings. Overall, research emphasized the important connection between fathers and their children’s social, academic, and emotional development (Nickels, 1997; Phares & Compas, 1992).

Although available research on fathers and school-age children (5 to 12 years) was rather limited and insufficient, existing studies suggested that fathers played a significant role in the family (Lamb, 1993; 2004). Fathers who interacted positively (with playful interaction) and promoted healthy expressions of affect tended to have children who were more stable. A
considerable amount of research posited that fathers continued to play a crucial role in their child’s development throughout the early years of life. The review of literature supported the idea that self-esteem and emotional development increased in positive ways for school-age children who spent quality time with their fathers. In addition, these fathers appeared to assist in building positive social and cognitive development, as well as overall academic achievement (Lamb, 1993; 2004; Nickels, 1997). Fathers’ unique style of playful and active interaction was an important factor in terms of productive child-rearing practices.

**Adolescents**

Research on fathers’ impact on infants and young children far exceeded an understanding of fathers’ role with adolescents. Since the mid-1980’s most of the studies assessing characteristics of the father-adolescent relationship were atheoretical and descriptive (Hosley & Montemayor, 1997). While fathering roles and fathers’ interactions with infants and young children were thoroughly investigated, there was a paucity of attention to the area of father-adolescent research (Hosley & Montemayor, 1997; Lamb, 1981; 1986; 1993; 1997; 2004).

Available research suggested that both fathers and mothers played unique roles in adolescent development. Fathers tended to concentrate on separateness and differentiation, whereas mothers tended to focus on connectedness and closeness (Parke, 1996). Fathers helped adolescents to develop a sense of identity and autonomy. An Israeli study conducted by Shulman and Klein (1993) using a sample of nearly 80 adolescent girls ranging in age from 12 to 16 years, found that fathers were perceived by their teens as providing more support for autonomy than mothers. Various studies suggested that fathers and adolescents interacted in playful, outdoor activities (Shulman & Klein, 1993). Father-adolescent relationships were often referred to as “peer-like” which promoted more equal and egalitarian exchanges (Parke, 1996). Adolescents spent less time with both of their parents than did younger children (Hosley & Montemayor, 1997). The decrease in time spent with parents may be due to adolescents becoming more involved with peer oriented activities. Fathers were more selective in discussions with adolescents, preferring problem-solving discussions about their children’s academic performance and occupational goals (Noller & Bagi, 1985).

Hosley and Montemayor (1997) proposed that there were differences between father-child and father-adolescent relationships. For example, available research indicated continuity through time in fathers’
relationships with their children while other research indicated that the father-child relationship underwent constant, gradual change. Since adolescence was often conceptualized as a stormy and stressful period that led to conflict in parent-child relationships, some posited that there were dramatic changes in the father-child relationship during this time (Hosley & Montemayor, 1997; Lamb, 1981; 1986; 1993; 1997; 2004).

In the review of literature pertaining to fathers and adolescents, several studies suggested that serious conflict/tension between fathers and their adolescent children was not typical (Collins & Russell, 1991; Nickels, 1997). On the other hand, there was a body of research that revealed increased adolescent-father conflict when fathers perceived their work to be pressured or stressful (Crouter, Bumpus, Head & McHale, 2001). Research has partially supported the idea that a father’s lack of involvement in his adolescent’s life produces lower levels of self-esteem for the child (Clark & Barber, 1995). The overwhelming majority of father-child research studies proposed that as adolescents moved towards adulthood, fathers maintained a very important role in the family system (Lamb, 1997; Nickels, 1997). For example, fathers with adolescents were more likely to exhibit behavior that fosters autonomy and interpersonal competence (Collins & Russell, 1991). It is possible that adolescent-father relationships appeared more disengaged due to potentially long work hours for the father. This may be related to adolescents having a closer relationship with their mother (Crouter, Bumpus, Head & McHale, 2001). The review of literature suggested higher levels of adolescent criminal behavior when the father is on the periphery of the family, or not present at all. Prevention of problems and potential risk-taking behaviors in adolescents were curbed by the healthy interactions and behaviors of fathers. These interactions were similar to the ones utilized by fathers in building self-esteem in their school-age children.

In an older study conducted by Fry (1982), it was found that there were less runaway adolescent children when fathers showed positive traits and consistent parenting roles. The literature review suggested that when fathers maintained a close relationship with their adolescents, there tended to be a sharp decrease in acting-out behaviors. In a study conducted by Brownfield (1987), using questionnaire data from a sample of students in 11 junior and senior high schools, it was found that boys were “less likely to fight” with other boys, if they self-disclosed personal thoughts and feelings, as well as future goals with their fathers. In addition, this study promoted the notion that the quality of the father-adolescent
relationship may be more important than the mere absence or presence of a father figure. “Boys who felt understood by their fathers perceived time spent with fathers as pleasurable, with shared common interests” (Hosley & Montemayor, 1997, p. 166).

The literature review consistently indicated less positive father-adolescent relationships, for both sons and daughters, when fathers spent long hours at work or chose to be disconnected from the family (Crouter, Bumpus, Head & McHale, 2001). In another study with a sample size of 443 California youths, ages 9 through 17, it was found that those least likely to drink alcohol and use other drugs had an emotionally close relationship with their father (Coombs & Landsverk, 1988). These older children were expected to have age-appropriate behaviors and comply with expected conduct rules. Coombs and Landsverk (1988) stated that, “regardless of age, parenting style appears to influence the extent to which youngsters use substances” (p. 480).

In a study conducted by Crouter, Bumpus, Head and McHale (2001) using 190 dual-earner families, it was found that role overload, as well as poor involvement in the family, impacted father-adolescent relationships negatively. In contrast, from a sample of 640 adolescents aged 12 to 16 years old, it was found that life satisfaction for adolescents was positively correlated with fathers who were supportive, appreciative and encouraging (Young, Miller, Norton & Hill, 1995). It was also found in this study that fathers who promoted closeness and developed trust tended to increase life satisfaction for their adolescent children. An examination of the individual items revealed that, “... adolescents’ perception of how their parents feel about them ... is the most important factor associated with their satisfaction with themselves and their lives” (Young, Miller, Norton & Hill, 1995, p. 821). Interestingly, materialistic items were not viewed as having an appreciable effect on these adolescents’ overall life satisfaction. In fact, it seemed that adolescents may prefer a concerned and involved father rather than one who engages them with frivolous or trivial actions and behaviors. The review of literature suggested that fathers who emphasized recreational activities and promoted the “Disneyland Dad” ideology, did not always have adolescents who had strong feelings of connection and/or closeness (Larson, 1993). Eggebeen and Knoester (2001) eloquently pointed out that, “fatherhood tightens intergenerational family ties” (p. 389). In the review of literature, this idea specifically applied to the father-adolescent relationship.

In conclusion, it appeared that fathers who were emotionally and
physically connected to the family, tended to have more meaningful relationships with their adolescents. Long work hours and increased role overload led to a rise in negative adolescent behavior. The literature indicated that fathers play a critical role in the lives of their adolescent children. Such roles included: nurturer, confidant, friend, and supporter. The literature review also suggested that regardless of the activity that father and adolescent shared, time shared together was time well spent (Cooksey & Fondell, 1996). It was evident that fathers who did not exhibit nurturing behaviors/interactions had adolescents who may be more vulnerable to life demands and pressures. Additionally, these adolescents may be in jeopardy due to their high-risk and dangerous lifestyles, possibly brought on by limited paternal interaction and negative parenting. The impact of fathers’ interactions on their adolescents carried forward into early adulthood and beyond (Amato, 1996).

**Stress and Coping**

Although the concept of stress has been around for centuries, it was only during the last five decades or so that it was systematically conceptualized as an area of research (Lazarus & Folkman, 1984; Selye, 1956). One of the earliest and most prolific pieces of writing on the subject matter of individual stress was the classic work of Hans Selye’s (1956) who was the first to define stress adaptations in the human body (Boss, 1988). Selye’s (1956) stress model has been used by many disciplines throughout the years as a useful frame of reference when examining nonspecifically-induced changes within a system (Selye, 1978). His stress model initially included four stages:

1). Stressors consisted of a wide variety of events and conditions that represented threat or insult to the organism.

2). Conditioning factors that altered the impact of the stressor on the organism, as in coping resources in the Psychosocial Model.

3). The general adaptation syndrome (G.A.S.) as an intervening state of stress as indicated by a physiological state of the organism.


For Hans Selye (1956), the heart of the matter of stress was the general adaptation syndrome (G.A.S.) in and of itself which consisted of a three stage response: the alarm reaction, the stage of resistance, and the stage of
exhaustion (Lazarus & Folkman, 1984). Through his research, to identify and
describe a biologically based and generalized response syndrome to
threatening agents, Selye (1956) acknowledged that stress ultimately could be
defined as the “state of wear and tear of the body” (p. 55).

Lazarus and Folkman (1984) wrote extensively about the concept of
stress and defined psychological stress as, “a particular relationship
between the person and the environment that was appraised by the person as
taxing or exceeding his or her resources and endangering his or her well-
being” (p. 19). In attempting to explain this relationship, they postulated
that the environment affected the person and the person affected the
environment in a circular, recursive, and mutually reciprocal manner (Lazarus
& Folkman, 1984; Selye, 1956). Moreover, cognitive appraisal and coping were
two critical processes through which the person-environment relationship was
mediated (Lazarus & Folkman, 1984; Selye, 1956). The stressfulness of an
event experienced by an individual was influenced by one’s cognitive
appraisal (subjective interpretation of a transaction or event) and the
utilization of positive coping resources (Boss; 1988; Lazarus & Folkman,
that individual characteristics and environmental factors were areas that
influenced the cognitive appraisal of the person-environment relationship.
Although their stress model was inclusive of pertinent notions related to
subjective appraisal, meaning, and coping strategies, it tended to promote a
more individualistic approach that pertained to stress dimensions (Boss,
1988; Lazarus & Folkman, 1984; Selye, 1956).

It was not until the mid-1970’s that family researchers became more
interested in family successes rather than family failures (Boss, 1988).
This major shift in the family stress research resulted in the inclusion of
the concept of coping. While coping research has apparently evolved from
stress research, it has moved from a deficit model of adaptation to exploring
people’s capacity to deal with life’s circumstances (Frydenberg, 2002).
Coping has been defined as the collection of overt and covert strategies that
individuals and/or families use during confrontation with a challenge
(Hetherington & Blechman, 1996). According to Wills, Blechman, and McNamara
(1996) coping methods or strategies included the following: (a) individual
and/or collective problem-solving responses (i.e. getting information,
considering alternatives, and making decisions about a course of action), (b)
observable communication behaviors (i.e. discussing situations and
cooperating with other people), and (c) unobservable cognitive operations
(i.e. minimizing stress, focusing on positive aspects of a situation). Research studies revealed that family coping strategies were not created in solitary happenings, but rather developed and were progressively modified over time (McCubbin, Thompson, & McCubbin, 1996).

Within Hill’s (1949) ABC-X model, coping has seemingly operationalized the B-factor (family resources); however, Boss (1988) cautioned that family coping is more than family resources and should not be perceived as the same construct. In fact, Boss (1988) went further and claimed that coping was a new dimension not found in Reuben Hill’s original ABC-X model. In a detailed and exhaustive account of her coping theory and research, Boss (1987) postulated that the family’s coping resources were “... its individual and collective strengths at the time the stressor event occurs” (p. 702). Boss (1987) continued with her discussion by defining family resources as the sociological, economic, psychological, emotional, and physical assets through which individuals and/or the family as a whole can utilize in response to a single stressor event or a pile-up of stressful events. While family resources might be available, Boss (1987) pointed out that it does not necessarily imply that the family will use them. “Family coping (as opposed to being in crisis), is a process and outcome variable; it refers to what the family does with its resources” (Boss, 1987, p. 702).

Using a cognitive and phenomenological approach, Lazarus (1966; 1967) further explained the process of individual coping as a cognitive activity involving the following: (a) an assessment of impending harm (primary appraisal) and (b) an assessment of the consequences of any coping action (secondary appraisal) (Boss, 1988). From this perspective, Lazarus (1977) identified the coping process as the cognitive use of primary and secondary appraisals of what was taking place whereas coping strategies were “the actual responses to a perceived threat” (Boss, 1988). According to Lazarus (1966), coping behaviors are identified as: (a) “direct action behaviors” (an attack or escape from threat) which might be utilized in order to change a stressful relationship with a physical or social environment, and (b) “intrapsychic forms of coping” which are defense mechanisms (detachment or denial) used to reduce the amount of emotional reaction rather than to change particular circumstances (Boss, 1988). Although Lazarus’s (1966) theoretical work was directed toward a more individualistic approach, Boss (1988) claimed that his work on coping was relevant to Family Stress Theory because he gave attention to values, beliefs, expectations, and motivations which were all significant within the family stress context. Therefore, Boss’s (1988)
definition of family coping is described as the, "cognitive, affective, and behavioral process by which individuals and their family system as a whole manage rather than eradicate stressful events or situations" (p. 60).

The coping resources and strategies mentioned above reflect the notion of functional coping; however, Boss (1988) acknowledged that it was possible and probable for dysfunctional coping to exist in certain families. Due to learned behavior, fixed family rules, and most specifically strong family denial systems, coping strategies in dysfunctional families tended to be impulsive and unconscious with little to no cognitive planning (Boss, 1988). A family can move toward insightful, beneficial strategies and cognitive restructuring only after its denial system is infiltrated (Boss, 1988). This can be a difficult task if the dysfunctional patterns of coping have persisted for several generations (Boss, 1988).

Vulnerability is frequently conceptualized in terms of coping resources (Boss, 1988). A vulnerable individual and/or family is regarded as one whose coping resources are deficient (Boss, 1988). Thus, coping resources or strategies may enhance vulnerability if the adaptations ultimately consist of “harmful side effects” (Boss, 1988). Coping, as with stress, may involve positive or negative consequences for individuals and families alike (Boss, 1988). “Sometimes, therefore, a radical change in family behavior is preferable to coping and adaptation” (Boss, 1988, p. 66).

When examining the concepts of stress and coping, Boss (1988) suggested that one keep the following points in mind:

(1). Coping is the management of a stressful event or circumstance by the family unit with no destructive effects on any individual in the family.

(2). Stressor events are certain in family life; thus the ability to cope is important in determining which families are invulnerable to crisis. Coping does not necessarily mean health for the family. In other words, sometimes going into a crisis is better than continually adapting.

(3). Stressor events, although seemingly harmless, may promote the production of family stress levels which must be contained in order to avert crisis.

(4). Since coping involves individuals, as well as the family unit, researchers and clinicians must assess both responses in ascertaining valid information.
(5). In the coping process related to internal context, a family may choose to use denial as a coping mechanism.

(6). Family resources and family strategies are not the same thing.

(7). The family’s managing stress may be a more transparent goal than is coping.

(8). The concept of active coping is not always desirable.

**Parenting Stress and Fathers of Children with Disabilities**

There is a growing body of literature supporting the idea that stress impacts the process of parenting (Boss, 2001; Creasey & Jarvis, 1994; Feldman, 1987; Noppe, Noppe, & Hughes, 1990; Pelchat, Bisson, Bois, & Saucier, 2001; Rodriguez & Murphy, 1997; Walker, 2000). The large majority of research studies demonstrated that parenting stress was frequently a problematic area as it relates to parenting practices (Pelchat et al., 2001; Webster-Stratton, 1990). This has been shown with both samples of families in the general population (McKay, Pickens, & Stewart, 1996), as well as samples of parents of disabled children of various ages (Darke & Goldberg, 1994; Girolametto & Tannock, 1994; Onufak, Saylor, Taylor, Eyberg, & Boyce, 1995; Pelchat et al., 2001). Research showed contextual sources of stress as a significant determinant of parenting along with parents’ individual psychological resources (Belsky, 1984; Crnic & Greenberg, 1990; Riposo, 1999). In addition, various researchers have found that stress decreased the ability of parents to be “sensitive, responsive, and nurturing” toward their children (Crnic, Friedrich, & Greenberg, 1983; Crnic & Greenberg, 1990; Riposo, 1999). Moreover, research demonstrated that parenting stress had negative effects on children’s developmental functioning, parent-child interactions, marital quality, and parental child abuse (Belsky, 1980; Creasey & Jarvis, 1994; Keller, 1999; Lavee, Sharlin, & Katz, 1996; Lawson & Hays, 1989; Lillie, 1991; Mash, Johnston, & Kovitz, 1983; Noppe, et al., 1990; Rodriguez & Murphy, 1997; Riposo, 1999; Walker, 2000). Various researchers found that families who had children with educational disabilities typically experienced increased stress, especially with child-rearing responsibilities (Fuller & Rankin, 1994; Honig & Winger, 1997; Keller, 1999; Keller & Honig, 2004; Lillie, 1991; Riposo, 1999; Walker, 2000).

A considerable amount of research was conducted on the role of the father in typically developing children (Riposo, 1999). Unfortunately, this
was not the case regarding fathers of children with disabilities (Riposo, 1999). Throughout the review of literature, there were limited research studies that concentrated entirely on fathers’ perceptions of parenting and the stress that oftentimes transpired from various parental responsibilities (Walker, 2000). In an analysis and review conducted by Hornby (1992) using eight published accounts of fathers having children with disabilities, several poignant themes pertaining to paternal stress reactions emerged. Hornby (1992) discovered through these personal accounts that fathers had a range of intense reactions and responses. The following seven prevalent themes were observed: high intense reactions to the disability, paternal inner-conflict and adaptation, negative feelings toward professionals and members of the public, stress-related feelings, concern about appropriate care for a disabled child, intense ambivalence between positive and negative feelings related to the disabled child, and finally acknowledgment of paternal personal growth.

Fathering stress reactions, in the caring for a disabled child, appeared to parallel previous research conducted with mothers whereby family members experienced potential negative effects (Featherstone, 1981; Fewell & Vadasy, 1986; Hornby, 1992; Phillip & Duckworth, 1982). Various researchers suggested that stress experienced by fathers was associated with the age, sex, and severity of the child’s disability (Hornby, 1992; 1994; Keller & Honig, 2004; Riposo, 1999). Interestingly, paternal reactions were viewed as somewhat complex since many personal and family variables were involved in determining how fathers experienced overall stressful events with a disabled child (Hornby, 1992). Although the findings of Hornby’s (1992) study provided various guidelines for future research, he cautioned that the sample may not be truly representative of fathers since the majority of participants were professionals, mostly with graduate degrees.

A noticeable and emerging consensus of assertions regarding the stress effects on fathers of parenting children with disabilities was reported in Hornby’s (1994) analysis of nine existing reviews of literature. The following eight assertions are summarized below:

1). Fathers’ adaptation to sons with disabilities was not as good when compared to daughters with disabilities.

2). Fathers’ adaptation was related to the severity of their children’s disabilities.

3). The stress experienced by fathers was related to the age of their children.
4). The adaptation of fathers was related to their level social support.

5). The adaptation of fathers was related to their personality characteristics.

6). Social class, educational level and income were inversely related to the stress experienced by fathers.

7). Many fathers of children with disabilities experienced depression and/or personality difficulties.

8). Fathers of children with disabilities experienced considerable marital distress and deserted the family more frequently than the average.

It was interesting to find that while assertion three indicated stress experienced by fathers was related to age of a disabled child, other research suggested this was not the case (Bailey, Blasco & Simeonsson, 1992; Beckman 1991). Additional research literature pertaining to paternal stress, as it related to ages of disabled children, was extremely limited.

Hornby (1994) pointed out that more empirical studies were required “. . . in order to ensure that the most comprehensive perspectives of fathers’ experiences are obtained” (p. 182). Due to the methodological shortcomings of these nine literature reviews, Hornby (1994) suggested that future research studies practice sound methodology especially as it relates to representative sampling of fathers and the utilization of a large variety of measures. Moreover, future research should focus on the comparison of fathers with non-disabled children so that it can be determined which findings are specific to fathers with children with disabilities (Hornby, 1994).

Available research evidence indicated that previously held assertions regarding fathers of children with disabilities may not be totally accurate (Hornby, 1995). In a follow-up study conducted by Hornby (1995) using 87 fathers of children with Downs Syndrome, it was found that the existing literature provided a somewhat erroneous perspective of the experience of fathers having disabled children. In this study, Hornby (1995) initially sought to provide research evidence to promote his original assertions (Hornby, 1994) regarding stress effects on fathers with disabled children by further investigating father responses on measures of adaptation, stress, personality, social support, and marital functioning. Results provided quite a different view of the effects on fathers of children with disabilities than has typically emerged in the literature. For example, stress experienced by
fathers was not related to the ages of their children, and that the majority of fathers of children with Downs Syndrome did not experience depression and/or personality difficulties (Hornby, 1995). Furthermore, fathers of disabled children did not experience higher than normal levels of marital distress.

The review of literature indicated that different types of parenting stress were associated with parenting a disabled child. For example, in an older study conducted by Cummings (1976) using a sample of 240 fathers, it was found that fathers of mentally retarded children had overall higher levels of psychological stress compared to fathers of chronically ill children. Fathers of children with mentally retarded children were clearly different from fathers with healthy children in that they experienced increased levels of depression, decreased enjoyment of their child, and decreased self-esteem (Cummings, 1976). Cummings (1976) claimed that the following factors needed to be considered when analyzing the apparent stressfulness of fathering a handicapped child:

1). the father’s confrontation in his daily living patterns of the child’s deficiency condition
2). the ameliorative child care-taking opportunities available to the father
3). the opportunities for stress modulation through sharing experiences with other fathers who bear a similar burden of loss-stress (p. 252).

Although fathers of disabled children were likely to be absent during the day due to occupational demands, paternal stress was still evident in the form of daily reminders such as personal observation, as well as family verbal reports (Cumming, 1976).

There are several intervening factors in the explanation of parenting stress related to rearing disabled children (Burbach, Fox, & Nicholson, 2004; Saloviita, Italinna, & Leinonen, 2003). In a 2003 research study conducted by Saloviita, Italinna, and Leinonen (2003), it was found that some of the important intervening factors in determining and understanding paternal stress included: spousal support, family resources, informal support, negative coping strategies, and family perception/meaning. In this particular study, negative coping strategies had a significant role in the prediction of parental stress. Fathers were more distressed by the negative attitudes of other people pertaining to their disabled children rather than the behaviors of their children. The definition of the child as a burden,
stressfulness of the experience, and the absence of experience of meaning were also associated with fathers’ high level of parenting stress. The way in which fathers defined their situation and the availability of resources were key components in predicting paternal stress.

Parenting stress for fathers with disabled children appeared to vary depending on the disability of the child. For example, fathers of children with Downs Syndrome tended to have less overall stress compared to fathers with children having other types of intellectual disabilities (Ricci & Hodapp, 2003). This particular finding may be related to fathers’ attributing more positive personality traits and fewer maladaptive behaviors to children with Downs Syndrome. Fathers reacted more positively and experienced less child-related stress when their children were more cheerful, loveable, and sociable. These meaningful results highlighted the importance of continued investigation of paternal stress and involvement with children with varying intellectual disabilities.

Other research found that fathers’ parenting stress was associated exclusively with child oppositional or aggressive behaviors, such as in the case of ODD (Oppositional Defiant Disorder) but not necessarily with ADHD symptom severity (Podolski & Nigg, 2001). Baker, McIntyre, Blacher, Crnic, Edelbrock, and Low (2003) concluded that child behavior problems also predicted subsequent paternal stress. Interestingly, these authors also found that parental stress predicted subsequent child behavior problems. Moreover, “. . . maladaptive child behavior and parenting stress have a mutually escalating effect on each other. . .” (Baker et al., 2003, p. 227). This finding is one that pervaded the present knowledge base pertaining to families, parenting stress, and disability (Baker et al., 2003). The authors of this study suggested that continued future research is required to understand the “mutually escalating effect” of parenting stress and maladaptive child behavior (Baker et al., 2003).

Several research studies have examined the comparison of mother/father stress in caring for an educationally disabled child. To date research studies produced only inconsistent results regarding differences between mother and father stress (Keller, 1999). In a recent study conducted by Keller and Honig (2004), it was found that fathers and mothers experienced similar levels of stress, however, the dimensions of stress were modeled differently for both. The path model developed for mothers revealed that increased care demands of a disabled child were related to increased stress. However, for fathers of disabled children, the path model suggested that
increased stress was related to difficulty in accepting the physical, cognitive, or emotional characteristics associated with the disability. Fathers of disabled children were more affected than mothers by the physical characteristics of a disabled child, “who may not meet the father’s expectation of an ideal child” (Keller & Honig, 2004, p. 344). The models in this research study indicated that social support was more helpful when a father perceived the characteristics of the child to be more acceptable. For mothers, social support was more helpful when the child’s needs were less demanding.

**Parenting Stress and Life Changes**

A review of the existing stress literature indicated that there has been widespread interest in the properties of events that make them stressful (Lazarus & Folkman, 1984; McCubbin & Patterson, 1987; Patterson, 1985; Patterson & McCubbin, 1983; Plummer & Koch-Hattem, 1986). Over time the most predominant and visible efforts have been in life events research. Several researchers applied the idea of accumulated life events and changes to the study of family behavior in response to stress (Patterson & McCubbin, 1983; Lazarus & Folkman, 1984). A stressor event was defined as, “an occurrence that is of significant magnitude to provoke change in the family system” (Boss, 1988, p. 36). In the pioneering work of Holmes and Rahe (1967), life events and changes are viewed as stressors which require change in the ongoing life pattern. Thus, major life events delineate a possible starting point for a process of change in a particular family system (Boss, 1988).

The literature review also indicated that several life event measures have developed over the years. An early instrument developed by Holmes and Rahe (1967) lists forty-three discrete events of a family, personal, occupational, or financial nature which require some change or readjustment (Sauers, 1993). Holmes and Rahe’s (1967) instrument was named “The Social Readjustment Rating Scale.” It became the precursor of numerous instruments which were developed to investigate the relationship between life events and the onset and severity of health problems, specifically mental and physical issues (Holmes & Rahe, 1967; Sauers, 1993). In 1972, an instrument was developed by Coddington (1972) to expand life stress research. In his questionnaire, specific life events were weighted in order to examine the relationship between life change units and age. The Family Inventory of Life Events and Changes (FILE) was developed several years later to assess the
pile-up of life events experienced by a family. Throughout the literature, the FILE as an index of family stress, appears to be the most widely utilized.

**Parenting Stress and Daily Hassles**

Over the years, nearly all of the stress research has been consumed with the overwhelming concern of major environmental changes and the impact of these life events on parenting (Crnic & Greenberg, 1990). Although major life events have indicated the ability to create profound adaptational consequences for parents, other researchers have sensed the value of looking at the ordinary daily hassles and occurrences of life which are often taken for granted (Crnic, Friedrich, & Greenberg, 1983; Crnic & Greenberg, 1990; Lazarus & Folkman, 1984). Fathers, like mothers, are presented with many unique circumstances throughout the course of an ordinary day that are not viewed necessarily as major life events, but nonetheless challenge their ability to effectively parent (Fagan, 2000).

Major life events, although important sources of stress, appear to have a long-term impact whereas daily hassles may not be experienced with the same degree of intensity from day to day (Fagan, 2000).

Microevents frequently repeated over long time spans and subconsciously experienced by the person have greater pathogenic potential than episodic dramatic events for which objective control and coping strategies may be more easily developed (Pancheri, De Martino, Spiomb, Biondi, & Mosticoni, 1979, p. 193).

In the review of literature, it appeared that family researchers neglected the common daily stresses of life since they seemed relatively unimportant compared with major family life events. Though it is clear that major life events are negatively related to various aspects of the family system, research also suggested that major life events were low-frequency occurrences for most families (Crnic & Greenberg, 1987). Other research studies indicated that daily hassles are somewhat better predictors of psychological well-being compared to major life events (DeLongis, Coyne, Dakof, Folkman, & Lazarus, 1982; Lazarus, Delongis, Folkman, & Gruen, 1985; Riposo, 1999). It should be noted that although daily hassles are far less dramatic and cataclysmic than major life events, they may be even more important in adaptation and health (Delongis, Coyne, Dakof, Folkman, & Lazarus, 1982).
According to Crnic and Greenberg (1990), significant sources of parental stress resided in the typical, but potentially annoying, tasks and behaviors of day to day life. Additionally, fathers’ appraisal of the cumulative impact of daily hassles over a day or longer represented a meaningful stressor and had important implications for parental, child, and family functioning (Crnic & Greenberg, 1990).

Daily hassles were conceptualized as those “irritating, frustrating, annoying, and distressing demands that to some degree characterize everyday transactions with the environment” (Crnic & Greenberg, 1990, p. 1629). They denoted “common annoyances,” “minor stresses,” “irritating practical problems,” and “daily challenges.” Some researchers defined daily hassles as the little things that irritated and distressed people (Lazarus & Folkman, 1984). The accumulation of minor daily irritations created stress for parents and contributed to the overall functioning of the family even after the effects of major life events were considered (Crnic & Greenberg, 1990).

In a recent study conducted by Fagan (2000) using thirty-seven male caregivers of pre-school children with mean age of 52 months, a significant relationship was found to exist between men’s daily hassles and their involvement with their children. Findings suggested that fathers interacted and played less with their children when they had experienced a bothersome day. This study also appeared to support the notion that contextual factors had a strong influence on fathers’ involvement with their children. For example, fathers who experienced negative interactions and hassles throughout the day were less inclined to approach their children with positive affect. The results of this particular study have possible implications for practitioners and program planners such that stress management approaches should be addressed with fathers in dealing with parental stress as it relates to minor daily annoyances (Fagan, 2000).

Crnic and Greenberg (1990) concluded from their research that minor parenting hassles appeared to be, “an important source of stress, not only in their ability to contribute additively to major life stress predictions, but also as a meaningful independent construct for assessing stress within the parent-child context” (p. 1634). Minor hassles have the potential to influence microsocial processes within parent-child relationships and contribute to problematic functioning in children and families (Crnic & Booth, 1991; Crnic & Greenberg, 1990). Therefore, the study of minor stresses or daily hassles may be a particularly meaningful and relevant context for conceptualizing stress (Crnic & Booth, 1991). It is no longer
acceptable to assume that life events must only be major in order to create stress, since research now suggests that daily hassles of living can also evoke significant stress responses in individuals, parents, and families.

**Life Satisfaction**

According to Diener, Suh, and Oishi (1997), subjective well-being (SWB) is a field of psychology that attempts to understand people’s evaluations of their lives. Such evaluations may be primarily cognitive (e.g. life satisfaction or marital satisfaction) or may consist of the frequency with which people experience pleasant emotions (e.g., joy) and unpleasant emotions (e.g., depression). Theory and research from fields outside of rehabilitation have suggested that subjective well-being has at least three components: positive affective appraisal, negative affective appraisal, and life satisfaction (Diener, 1991; Diener, Emmons, Larsen, & Griffin, 1985; Pavot & Diener, 1993; Diener et al., 1997).

Life satisfaction is distinguished from affective appraisal in that it is more cognitively than emotionally driven and refers to a judgmental process in which individuals assess the quality of their lives on the basis of their own unique set of criteria (Shin & Johnson, 1978). Diener et al., (1997) believe that life satisfaction can be assessed specific to a particular domain of life (e.g., work, family); however, since individuals may have different standards in determining success and contentment in life, it is necessary to assess their global judgement rather than only their satisfaction with specific domains (Diener, 1993).

It has long been recognized that exposure to stressors at various stages along the life course has long-term consequences for well-being and overall quality of life (Diener, 1991; Diener, 1993; Pavot & Diener, 1993; Shin & Johnson, 1978). A child with educational disabilities is generally considered to have a profound impact on overall paternal life satisfaction. Thus, the effects should be readily recognized in life satisfaction of fathers having these children. The review of literature indicated that there was little research available on factors that related to stress for fathers in parenting disabled children and their overall satisfaction with life (Sloper, Knussen, Turner, & Cunningham, 1991) since most studies that examined families of children with disabilities concentrated on the mother as the main respondent.

One of the few studies assessing overall quality of life in disabled
families was conducted by Sloper, Knussen, Turner, and Cunningham (1991) whereby factors related to stress and satisfaction with life in families of children with Downs Syndrome were examined. It was found that fathers had higher satisfaction with parenting and family life, but lower satisfaction with finances. These findings were apparently consistent with prior suggestions related to lesser effects of the child on the father, but more effects of external, instrumental considerations (Gunz & Gubrium, 1972). The findings in this study also pointed to important differences between fathers and mothers in terms of perceived level of satisfaction with life (Sloper, Knussen, Turner, & Cunningham, 1991).

Conclusion

The findings of the literature review suggested that over the last 20 to 25 years, fatherhood has developed into a legitimate area of academic study. Growing out of this time period, both fathers of typically developing children and fathers of educationally disabled children have gradually been included in ongoing research endeavors within the family science arena (Riposo, 1999). More specifically, the review of literature emphasized that parents of children with a disability experienced heightened levels of stress in many areas associated with daily family functioning (Keller, 1999; Keller & Honig, 2004; Riposo, 1999; Walker, 2000). In addition, parenting stress appeared to vary as a result of the magnitude and intensity of certain educational disabilities and familial influences (Brotherson, 1985; Foster, 1995; Haskin, 1994; Houser, 1987; Huang, 1996; Keller, 1999; Lillie, 1991; Riposo, 1999; Walker, 2000).

While research studies on fatherhood dimensions and child functioning have increased over the last several years, many of these studies have continued to focus only on typically developing children. Although it is the case that stress typifies many families having children with educational disabilities, limited research studies have attempted to explore specific determinants that may possibly reduce paternal stress in coping with a family member with a disability (Brotherson, 1985; Foster, 1995; Haskin, 1994; Houser, 1987; Huang, 1996; Keller, 1999; Lillie, 1991; Riposo, 1999; Walker, 2000). Within the domain of fatherhood literature, very few studies focused exclusively on fathers’ perceptions of parenting stress and life satisfaction as it related to children with disabilities (Walker, 2000). Throughout the family science literature, mothers have typically played a predominant role
pertaining to children with disabilities. However, there now appears to be a current interest in father participation in contemporary research studies involving educationally disabled children (Brotherson, 1985; Foster, 1995; Haskin, 1994; Houser, 1987; Huang, 1996; Keller, 1999; Lillie, 1991; Riposo, 1999; Walker, 2000). Although several studies within the literature review have analyzed family coping resources related to disabled family members, few studies emphasized the unique, individual responses and coping styles/patterns of fathers.

Existing literature regarding parenting stress and families of children with disabilities focused on toddlers or preschool children (Beckman, 1991; Bosch, 1996; Dyson, 1991; 1993; 1997) and ignored elementary and older age children with disabilities (Cullen, MacLeod, Williams, & Williams, 1991; Dyson, 1991; 1993; 1997). Some researchers found that fathers demonstrated greater levels of stress with young disabled children, while others noted that fathers of older children with disabilities experienced slightly lower levels of stress. Findings suggested that fathers adaptation to girls was better compared to boys with disabilities.

The review of literature indicated that some research endeavors have made significant strides toward acknowledging a possible connection between family events (both major and minor), parenting stress, coping strategies, and overall life satisfaction (Brotherson, 1985; Foster, 1995; Haskin, 1994; Houser, 1987; Huang, 1996; Keller, 1999; Lillie, 1991; Riposo, 1999; Walker, 2000). However, due to the continued lack of information on fathering roles and dimensions pertaining to disabled children, a more detailed examination of stress, coping, and life satisfaction was recommended (Brotherson, 1985; Foster, 1995; Haskin, 1994; Houser, 1987; Huang, 1996; Keller, 1999; Lillie, 1991; Riposo, 1999; Sloper et al., 1991). The literature review also suggested that more studies are required, which focus on fathers with school-aged children having disabilities. Therefore, the questions set forth in this study seem to be not only relevant, but also needed.
CHAPTER 3: METHODOLOGY

This study focused on major family life changes/events, as well as, minor parenting daily hassles experienced by fathers having disabled and non-disabled children (between the ages of 5 and 12 years old) and the impact of these events on their perceived levels of coping (family and individual), stress (health and parenting), and life satisfaction. In addition, differences between fathers with disabled children and fathers with non-disabled children were examined. A survey research design was utilized in this study which included a representative sample of fathers. The methodological section of this investigation has been structured with the following pertinent sections in mind: Sample, Instrumentation, Data Collection, and Data Analysis.

Sample

The city of Paducah, Kentucky nestled on the Ohio River and Tennessee River, was selected as the sample location in this study since it functions as the predominant urban center of western Kentucky. Although Paducah only contains an approximate population of 65,000 people, there are 15 other surrounding counties totaling 250,000 people (US Census, 2003). Many of the people from the surrounding counties interact daily in the city of Paducah. The sample location was also selected because it is the major focal point not only of important commercial activity, but also educational undertakings in western Kentucky. McCracken County School Board officials claim that Paducah, Kentucky contains the largest school system within a 100 mile radius. In addition, this sample location was chosen since it has the largest special education system in western Kentucky. According to the Kentucky Department of Education (2003), race ratio make-up in Paducah relating to elementary school-children is uniquely different compared to statewide findings. Approximately 86% of school children in the state of Kentucky are white and approximately 10% are black. In the city of Paducah, approximately 49% of school-children are white and 44% are black.

The sample for this particular study consisted of two groups: fathers
with non-disabled children ages 5 to 12 years old and fathers with disabled children ages 5 to 12 years old, who met criteria for special education services and held an Individualized Education Plan [IEP] in the state of Kentucky. A sample of fathers of young, elementary school-age children with disabilities was recruited for this research because, it is during this time that many types of disabilities surface, are recognized, and are formally diagnosed. In addition, according to the literature related to fathering, school-age is a time frame when additional research is needed (Dyson, 1997; Russell & Matson, 1998). The elementary school years fall into a critical time frame when fathers/parents are often confronted with test results which support disability-related findings. A comparison sample of fathers with typically developing children was also selected from the same school system.

Permission was received from both the Director of Special Education Services and the Superintendent of the McCracken County School District in Paducah, Kentucky to invite fathers of disabled and non-disabled children to participate in this study. Permission was also received from the Human Subjects Committee, Florida State University (Appendix A). Five local schools in the city of Paducah were randomly selected for the study. The criteria for inclusion in this sample were: (a) fathers lived with their children, and (b) fathers were able to speak and understand English.

For this study, 3075 questionnaires were sent via the school system to fathers having children ages 5 to 12 years old. Of the 3075 questionnaires sent out, 224 were returned. Of those returned questionnaires, 12 were unusable for the following reasons: (a). 10 subjects did not complete questions without explanation and (b). 2 questionnaires were partially destroyed in the mail. From the 224 questionnaires returned, 212 were complete, resulting in the final sample. Any items left blank were coded as missing data.

Several formulas were reviewed to determine an acceptable sample size for this research. According to Kirk (1982), a sample “should be large enough - but not too large” (p. 62). Moreover, for practical reasons, such as limitations on the availability of research funds, time, and the difficulty of securing subjects, a researcher does not want “to specify a larger sample size than is needed” (Kirk, 1982, p. 62). Determining sample size depends on many factors, including the size of the model, distribution of the variables, reliability of the variables, and strength of relations among the variables (Muthen & Muthen, 2002). According to Cohen (1992), “. . . there are ample accessible resources for estimating sample sizes in
research planning using power analysis" (p. 155). Cohen (1992), in some of his most seminal work, claimed that in order to have a medium difference effect based on 7 predictor variables with alpha set at .05, approximately 100 persons per group would be an appropriate sample size. Over the years, various rules of thumb have also been proposed in determining sample size. Using Kirk (1982) and Cohen’s (1988) recommendations as a guide, as well as reviewing several rules of thumb, a sample size of no less than 80 subjects per group was found to be acceptable for this study.

Instrumentation

For the purposes of this study, seven scales were incorporated into the questionnaire to measure the following variables: major family life events, minor parenting daily hassles, family and individual coping, health and parenting stress, and life satisfaction. The questionnaire also contained questions to obtain demographic and respondent information, as well as to determine the child’s educational eligibility category and other pertinent information. The scales, which were selected to measure the study variables, are discussed in the following section with a description of each instrument.

Parent Data Sheet/General Information

The Parent Data Sheet/General Information, which was designed by the writer/researcher, was used to determine demographic information such as age, marital/relationship status, ethnic background, level of education, economic status, occupation, and number of children in the home. In addition to the above data, information regarding the child’s condition/disability (mild to severe), medical diagnosis, medication, type of disability (educational eligibility), and present resources utilized was obtained (Appendix B; items 1-21).

Family Inventory of Life Events and Changes (FILE)

The Family Inventory of Life Events and Changes (FILE) (Appendix B; items 22-92) evaluated the pile-up of life events experienced by a family (the aA factor of the Double ABCX model) and was originally designed by McCubbin, Patterson and Wilson as an index of family stress (McCubbin, Patterson & Wilson, 1979). Over a period of time, FILE (Form C) has been
reduced to a 71-item self-report instrument which is designed to record the normative and non-normative life events and changes experienced by a family unit in the past 12 months (Lund, 1999; Sauers, 1993). Since families are typically dealing with several stressors simultaneously, FILE provides an index of family vulnerability related to the resulting pile-up. The 71 items in FILE (Form C) are categorized into nine subscales and the conceptual dimensions are as follows:

1. **Intra-Family Strains**: This subscale is made up of 17 items, which combine the following two dimensions [Appendix B; items 22-38]:
   (a) **Conflict**: 12 items which reflect sources of tension and conflict between family members. Several items are worded to reflect “an increase” in normative sources of intra-family strain.
   (b) **Parenting Strains**: 5 items related specifically to increased difficulties in enacting the parenting role.

2. **Marital Strains**: There are 4 items in this subscale, which measure stressors in the marital role arising from sexual or separation issues [Appendix B; items 39-42].

3. **Pregnancy and Childbearing Strains**: The subscale has 4 items, which relate to pregnancy difficulties or adding a new member to the family [Appendix B; items 43-46].

4. **Finance and Business Strains**: This 12-item subscale is comprised of the following two dimensions [Appendix B; items 47-58]:
   (a) **Family Finances**: 9 items which assess sources of increased strain on a family’s money supply.
   (b) **Family Business**: 3 items which reflect strains arising from a family-owned business or from investments.

5. **Work-Family Transitions and Strains**: There are 10 items in this subscale, which is comprised of the following two dimensions [Appendix B; items 59-68]:
   (a) **Work Transitions**: 4 items related to moving in or out of the work force.
   (b) **Family Transitions and Work Strains**: 6 items which focus on changes occurring at work or moves made by the family or one of its members.

6. **Illness and Family “Care” Strains**: This 8-item subscale has three dimensions as follows [Appendix B; items 69-76]:
(a) **Illness Onset and Child Care**: 4 items reflecting dependency needs arising from injury or illness of a family member or friend or problems with child care.

(b) **Chronic Illness Strains**: 2 items related to the onset of or increased difficulty with chronic illness.

(c) **Dependency Strains**: 2 items reflecting the strain of a member or relative requiring more help or care.

7. **Losses**: The 6 items in this subscale reflect losses due to the death of a member or friend and due to broken relationships [Appendix B; items 77-82].

8. **Transitions “In and Out”**: This subscale has 5 items, which reflect a member’s moving out or moving back home, or beginning a major involvement outside the family. [Appendix B; items: 83-87].

9. **Legal**: The 5 items of this subscale focus on a member breaking society’s laws or mores (McCubbin & Patterson, 1987) [Appendix B; items 88-92].

According to McCubbin and Patterson (1987), FILE was designed to be administered to either one or both adult members of the family unit. The respondent is asked to indicate if a life event or strain happened to any member of the family unit or to the family as a group during the past 12 months (Sauers, 1993). Scoring of the FILE may be conducted in five ways, depending upon the purpose and ultimate use of the statistical information in research and/or counseling. The five possible scores are described as follows: (a). Family Life Events score; (b). Family-Couple Life Events score; (c). Family-Couple Discrepancy scores; (d). Family Readjustment score; and (e). Family-Couple Readjustment score.

Because family research on development, transitions, and stress has acknowledged that stressful life events and strains are partly a function of the family’s life cycle stage, McCubbin and Patterson (1987) claim it is possible to determine a family stress score in relation to a particular life cycle stage. Interpretation of the family stress scores occurs between three classifications: (a). High-Stress scores which indicate that a family unit has experienced an unusual number of stressors and strains that may have taxed the family’s psychological and interpersonal resources; (b). Moderate-Stress scores which indicate families falling within the normal range of stressors and strains and are usually viewed as non-problematic. However, problematic versus non-problematic depends on the family’s ability to manage stress and the amount of adequate coping resources; and (c). Low-Stress
scores which indicate families who would appear to be unburdened by life changes and strains and face an unusually low number of demands (McCubbin & Patterson, 1987). The following table lists the categories of low, moderate, and high stress:

<table>
<thead>
<tr>
<th>Category</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Couple</td>
<td>0-210</td>
<td>211-719</td>
<td>720+</td>
</tr>
<tr>
<td>Preschool</td>
<td>0-220</td>
<td>221-839</td>
<td>840+</td>
</tr>
<tr>
<td>School Age</td>
<td>0-265</td>
<td>266-734</td>
<td>735+</td>
</tr>
<tr>
<td>Adolescent</td>
<td>0-240</td>
<td>241-849</td>
<td>850+</td>
</tr>
<tr>
<td>Launching</td>
<td>0-320</td>
<td>321-949</td>
<td>950+</td>
</tr>
<tr>
<td>Empty Nest</td>
<td>0-160</td>
<td>161-689</td>
<td>690+</td>
</tr>
<tr>
<td>Retirement</td>
<td>0-75</td>
<td>76-699</td>
<td>700+</td>
</tr>
</tbody>
</table>

In order to examine the degree to which each life event was stressful for the participants in this study, the FILE was modified to include a Likert-type scale ranging from 1-4: “1” = none; “2” = low; “3” = moderate; and “4” = high. This modification allowed the researcher to examine the stressors and changes that had an impact on the fathers and their perception of the level of stress resulting from them.

According to McCubbin and Patterson (1987), validity assessments of FILE were made by correlating the ten scales from FILE (nine subscales and Total Recent Life Changes) with a measure of family functioning (the Family Environment Scales, FES). McCubbin and Patterson (1987) hypothesized that an accumulation/pile-up of life changes would be negatively correlated with desirable dimensions of the family environment and positively correlated with undesirable characteristics of the family environment. Total Recent Life Changes, as predicted by McCubbin and Patterson (1987), correlated negatively with the FES dimensions of cohesion (−.24), independence (−.16), and organization (−.14), and correlated positively with conflict (+ .23) (Sauers, 1993).

Construct validity was supported by moderately high correlations in the predicted direction between the FILE scale, Intra-Family Strains and six indices of family functioning (cohesion, expressiveness, conflict, independence, organization, and control) in that strains within the family would be expected to impact upon the way the family unit functions together (McCubbin & Patterson, 1987; Sauers, 1993). Additional validity checks,
using the scales on Form C of FILE, were made by doing discriminant analyses between low conflict and high conflict families who had a child with: (a) cerebral palsy or (b) myelomeningocele. High conflict families with a child with cerebral palsy experienced a significantly higher pile-up of life changes in three areas: (a) intra-family strains; (b) work-family transitions and strains; and (c) total life changes. For families of children with myelomeningocele, similar significant differences with intra-family strains and total life changes were revealed, discriminating high and low conflict families (McCubbin & Patterson, 1987).

In order to indicate internal consistency for FILE, alpha reliabilities were computed using a sample of 322 families with a chronically ill child. Overall reliability of the FILE was .72. McCubbin and Patterson (1987) claimed that, “while scales for FILE were created on the basis of factor analysis, they are not normally used alone as reliable indices of stress, given the wide variance in the frequency of occurrence of family life events” (p. 83). Cronbach’s alpha was computed on the total (N=2740) and subscale groupings with Sample #1 (N=1330) and Sample #2 (N=1410). Overall scale reliability was found to be .81, with subscale scores varying from .73 to .30. McCubbin and Patterson (1987) claim that internal consistency is soundly established by the total scale, with the subscales (except for intra-family strains) being less stable. Thus, McCubbin and Patterson (1987) recommended that only the total scale score be utilized, rather than separate subscales (Sauers, 1993).

In 1981 a test-retest reliability study, with a time lapse of four to five weeks between first and second administration, was conducted using 150 participants. Not only were Pearson correlations for each of the nine scale factors calculated, but also percent agreements on all individual items. Percent agreements ranged between .72 and .77. Pearson correlations for the total scale were .80. McCubbin and Patterson (1987) claimed that both analyses suggested acceptable reliability over time (Sauers, 1993). In this study, the reliability of the Family Inventory of Life Events and Changes scale (as modified) was .96.

**Parenting Daily Hassle Scale (PDH)**

The Parenting Daily Hassles (PDH) scale (Appendix B; items 94-113), developed by Crnic (Crnic, 1990; Crnic & Greenberg, 1990), was used to measure the amount of stress related to child-care that parents perceived
they had experienced over a specified time. The PDH scale was designed to assess minor daily stresses experienced by parents in routine interactions with their children, as well as routine tasks involving child rearing (Crnic, 1990; Crnic & Booth, 1991; Crnic & Greenberg, 1990). Various research studies have suggested that daily hassles, even more than major life events, can be perhaps somewhat better predictors of psychological well-being due to the cumulative impact over a day, several days or longer (DeLongis, Coyne, Dakof, Folkman & Lazarus, 1982; Lazarus, DeLongis, Folkman & Gruen, 1985).

Daily hassles are conceptualized as, “the irritating, frustrating, annoying, and distressing demands that to some degree characterize everyday interactions with the environment” (Crnic & Greenberg, 1990, p. 1629). This conceptualization appears to be particularly applicable to families with young children, as children’s behavior often creates situations that test, hamper, or interfere with parental responsibilities (Crnic & Greenberg, 1990).

The PDH scale is a 20-item Likert-type questionnaire on which parents reported a series of typical everyday events in parenting and parent-child interactions, which occurred during transactions with their children. This scale was rated along two important dimensions:

1. **Frequency**: Measured how often the event happens. This scale was designed to provide an objective measure of the frequency with which a particular event transpired in families.

2. **Intensity**: Measured degree or “hassle” the parent perceived the event to be. This scale was designed to assess parents’ subjective appraisal of the significance of the event.

Items pertaining to the frequency index are recorded on a 5-point scale with options which include: never, rarely, sometimes, a lot and constantly. Frequency scores ranged from 20 to 100. Items pertaining to the intensity index are recorded on a 5-point scale having answers that range from “1 = no hassle” to “5 = big hassle.” Intensity scores ranged from 20 to 100. It should be noted that the researcher provided a time frame for the respondent’s response (e.g. “over the past several days,” “over the last 12 months,”). The time frame should be set by the individual researcher according to the purpose of the study. In this particular study, the time frame was set at 12 months to coincide with the FILE’s time frame.

Crnic and Greenberg (1990) conducted a factor analysis of the original 20 items, which resulted in an assignment of 8 items to parenting tasks and 7 items to what was originally two factors measuring types of challenging
behavior. Later the challenging behaviors factors were combined, which resulted in two distinct factors for each dimension: parenting tasks (i.e. difficulties getting kids ready for outings on time) and challenging behavior (i.e. children interrupting adult conversation or interaction).

The PDH scale’s internal consistency was reported to be good (Crnic, 1990). Based on three data sets, Cronbach alphas for the frequency scale ranged from .80 to .89 and for the intensity scale, .89 to .93. Crnic (1990) found the frequency and intensity scales to be highly correlated (r=.75). According to Crnic and Greenberg (1990), Cronbach alpha for ratings of all 20 items was .81 for frequency and .90 for intensity. The two scales were correlated (r=.78). The Cronbach alpha score for parenting tasks was not reported, but was .86 for challenging behavior (Touliatos, Perlmutter, & Holden, 2001). In this particular study, the reliability of the Parenting Daily Hassles scale was .90 for the frequency dimension and .92 for the intensity dimension.

**Family Crisis Oriented Personal Evaluation Scales (F-COPES)**

The Family Crisis Oriented Personal Evaluation Scales (F-COPES), developed by McCubbin, Olson, and Larsen (1981), was created to identify problem-solving and behavior strategies utilized by families in exacting or troublesome situations (Appendix B; items 114-143) (Lund, 1999; Sauers, 1993). This particular instrument consisted of 30 coping behavior items, which examined the two levels of interaction outlined in the Resiliency Model of Family Stress: (1) individual to family system, or the ways a family member internally handles difficulties and problems among its members; and (2) family to social environment, or the ways in which the family externally handles problems or demands that emerge outside its boundaries, but affect the family system. F-COPES scale items are categorized into two dimensions: internal family coping patterns and external family coping patterns (Lund, 1999; Sauers, 1993). Within these two dimensions are five subscales: 1). Reframing, 2). Passive Appraisal, 3). Acquiring Social Support, 4). Seeking Spiritual Support and, 5). Mobilizing Family to Acquire and Accept Help.

1. **Internal Family Coping Patterns**: defined the way individual family members handle difficulties by using resources residing within the nuclear system. Internal family coping patterns were made up of two subscales:
(a) Reframing: This subscale had eight items and assessed the family’s capability to redefine stressful events in order to make them more manageable [Appendix B; items: 116, 120, 124, 126, 128, 132, 135, 137].

(b) Passive Appraisal: This subscale was comprised of four items that assessed the family’s ability to accept problematic issues minimizing reactivity. These items must be reversed when scoring [Appendix B; items 125, 130, 139, 141].

2. External Family Coping Patterns: defined as the active behaviors the family employed to acquire resources outside the nuclear system. External family coping patterns were made up of three subscales:

(a) Acquiring Social Support: This subscale had nine items which measured a family’s ability to actively engage in acquiring support from relatives, friends, neighbors, and extended family [Appendix B; items 114, 115, 118, 121, 123, 129, 133, 138, 142].

(b) Seeking Spiritual Support: This subscale had four items and focused on the family’s ability to acquire spiritual support [Appendix B; items 127, 136, 140, 143].

(c) Mobilizing Family to Acquire and Accept Help: This subscale had four items and measured the family’s ability to seek out community resources and accept help from others [Appendix B; items 117, 119, 122, 134].

Respondents recorded their answers on a five-point Likert-type scale regarding how often they utilized a particular coping behavior to deal with problems. The procedure for scoring this scale consisted of obtaining a sum score for each subscale and total scale by carefully summing the participant’s score (number circled) for each of the items. A total coping score was obtained by summing the number circled by the respondent (i.e. 1 = “Never,” 2 = “Seldom,” 3 = “Sometimes,” 4 = “Frequently,” and 5 = “Always”) for each item in the instrument. However, four specific items (125, 130, 139, and 141) had scores reversed to ensure that all items were weighted in the same positive direction for both the analysis and the interpretation of results (McCubbin, Thompson & McCubbin, 1996). Subscale scores were obtained by summing the number circled by the respondent for items in each scale (Lund, 1999; Sauers, 1993).

According to McCubbin, Thompson and McCubbin (1996), a pilot instrument comprising 49 items was initially created and administered to a sample of 119
students drawn from a university class of undergraduate and graduate students. Factor analysis with varimax rotation was completed on the 49 items with eight strong factors emerging. The 49-item list was reduced to 30 items. The eight factors had eigenvalues greater than one and each of the 30 items had a factor loading greater than .38. Cronbach’s alpha was calculated on each factor separately and on the total scale. The alpha reliability for the entire scale was .77. In the early 1980’s, a test-retest reliability study was conducted with a time lapse of four to five weeks. In order to prevent contamination problems with item responses, the questionnaire was administered to 150 respondents who were not involved in family studies coursework. The alpha reliability of the total scale was .71 (Lund, 1999; McCubbin, Thompson & McCubbin, 1996; Sauers, 1993).

With a fairly large sample (N=2740), results were replicated along with reliability and validity checks. The total sample (husbands, wives, and adolescents who were pooled) was randomly split into two halves, Sample #1 and Sample #2. Factor analysis using varimax rotation was completed first on Sample #1. The factor structure for Sample #2 replicated the initial factor analyses. The overall reliability for Sample #1 was found to be .86. For Sample #2, the overall reliability was .87 (McCubbin, Thompson & McCubbin, 1996; Sauers, 1993). In this study, the overall reliability of the Family Crisis Oriented Personal Evaluation Scales was .87.

**Coping Scale for Adults/Short Form (CSA/SF)**

The Coping Scale for Adults (CSA), designed by Erica Frydenberg and Ramon Lewis (Appendix B; items 144-163), was developed to assist both researchers and clinicians in considering issues surrounding coping and to facilitate the development of coping strategies at any point during life (Frydenberg & Lewis, 1997). “The CSA is both a research instrument and a clinical tool which enables people to examine their own coping behavior” (Frydenberg & Lewis, 1997, p. 8). According to Frydenberg and Lewis (1997), the CSA assesses a very broad range of coping strategies, giving attention to what people do, rather than what they believe they should be doing.

This particular instrument has been developed for use with an adult population ranging in age from 18 years upward. Theoretically and conceptually, the CSA was derived from work with adults; however, there were links to the Adolescent Coping Scale (ACS), which was also devised by Frydenberg and Lewis in 1993. It became quite obvious, after publication of
the Adolescent Coping Scale (ACS), that a coping scale was needed to measure adult coping strategies. According to Frydenberg and Lewis (1997), three steps were taken to develop the CSA:

1. Using a sample of 235 adults, empirical structure of the CSA was determined. Each item on the ACS was reviewed to establish if any modifications were required for use with adults.

2. Coping behaviors used by adults were requested from 250 people working in education, psychology, and community environments. This was to determine if any additional items would be needed to capture familiar adult coping strategies.

3. A trial coping scale for adults was administered to sample 371 adults. (Ultimately, a total sample of 856 adults facilitated the research version of the adult coping instrument).

In order to establish appropriateness of the ACS for use with adults, item responses were subjected to factor analysis. In a similar fashion, as with the initial validation of the ACS, oblique factor analysis was conducted (Frydenberg & Lewis, 1997). Investigation of the factor patterns supported the suitability of various ACS items for use with an adult population. In order to determine stability of CSA item responses, 25 subjects were administered the instrument approximately 10-14 days after the initial administration. Test-retest correlations were computed for items. Frydenberg and Lewis (1997) reported test-retest reliability coefficients, which were generally high for each of the 18 scales.

Nineteen structured items, plus an open-ended response item, were selected from the CSA long-form to create the CSA/SF. Each item was based on the following criteria: (a) its wording appeared to assess one of the nineteen dimensions of coping and, (b) its relationship with the other items comprising the scale, of which it was a part, was substantial enough to justify its independent use as an indicator of its particular coping dimension (Frydenberg & Lewis, 1997). To assess the degree to which each of the items in the CSA/SF adequately measured its respective coping strategy, the correlation of the item with the scale of which it was a part was computed. Items in the short form of the CSA together with the item-test correlations have been recorded. All correlations are .73 or greater (see below). The nineteen items on the CSA/SF which measured a specific coping strategy as reported in the CSA long-form are as follows:

1. Seek Social Support. . . . . . . . . . . . . . . . Item 17
2. Focus on Problem Solving. . . . . . . . . . . . . . . Item 36
Item-test correlations for each of the 18 subscales are as follows: .78, .81, .87, .85, .81, .81, .83, .80, .88, .87, .84, .95, .82, .93, .77, .87, .73, .90, and .80. Frydenberg and Lewis (1997) claimed that all items on the CSA/SF “appear to be very useful indicators of the dimensions they were designed to measure and appear substantial enough to justify their independent usage” (p. 34). Frydenberg and Lewis (1997) also proposed that the instrument was a comprehensive one which contained a very high degree of face validity.

The CSA/SF is utilized when time does not permit administration of the CSA long-form version of the scale (Frydenberg & Lewis, 1997). There are two available versions of the CSA/SF: general and specific. In this study, the general form of the instrument was utilized, which addressed how an individual copes with concerns in general. The general form contains identical questions found on the specific form (Frydenberg & Lewis, 1997).

Administration of the CSA/SF is rather quick. Generally it takes a respondent approximately two to three minutes to complete. The 19 structured items are rated by the respondent using a 5-point Likert-type scale ranging from ”Doesn’t Apply or Don’t Do It” to ”Used a Great Deal” (1 = Doesn’t Apply or Don’t Do It; 2 = Used Very Little; 3 = Used Sometimes; 4 = Used Often; 5 = Used a Great Deal). Scoring of the CSA/SF was not required electronically or manually since it contained one item from each of the scales in the long
version. The answer sheet itself actually becomes the subject’s profile chart (Frydenberg & Lewis, 1997). The CSA/SF questionnaire can also be used as an aid to investigate the conceptualization of coping styles. The authors point out that it would not be sound to obtain a total scale score but rather subscale scores. Four subscales were created from the basic 19 items on the CSA/SF:

(a) **Dealing With The Problem**: Comprised Focus on Solving the Problem, Seek Relaxing Diversions, Physical Recreation, Humor, Work Hard, Protect Self, and Improve Relationships (Appendix B; items 144, 146, 149, 151, 152, 154, and 162).

(b) **Non-Productive Coping**: Comprised Worry, Wishful Thinking, Not Cope, Ignore the Problem, Tension Reduction, Keep to Self, and Self-Blame (Appendix B; items 148, 153, 156, 157, 158, 159, and 161).

(c) **Optimism**: Comprised Focus on the Positive, Seek Relaxing Diversions, Wishful Thinking, and Seek Spiritual Support (Appendix B; items 147, 150, 156, and 162).

(d) **Sharing**: Comprised Seek Social Support, Seek Professional Help, Social Action, and a negative contribution from Keep to Self (Appendix B; items 145, 155, 160, and 158).

These subscales appeared to discriminate quite satisfactorily and they successfully measured the dimensions “Dealing with the Problem” and the “Non-Productive Coping.” Alpha coefficients for “Dealing with the Problem” and “Non-Productive Coping” were .65 and .73. Due to the low reliability for both the “Optimism” and “Sharing” (.45 and .42) subscales of the CSA/SF, Frydenberg and Lewis (1997) reported that these dimensions should be interpreted with caution. When possible, these two subscales should be measured using the CSA full-length. In this study, the reliabilities for the four subscales in order were as follows: .71, .52, .44, and .46 respectively.

**Family Health Status Inventory (FHSI)**

Developed by Norem, Malia and Garrison (1988), the Family Health Status Inventory (FHSI) [Appendix B; items 164-179], measured both emotional and physical symptoms for family members. With this scale, respondents were requested to report the frequency of both physical and emotional health-related items (Garrison & Hira, 1992). This scale contained the following items and respondents were requested to mark how often these health-related...
According to Garrison and Hira (1992), the scale items were developed from a review of the literature and theoretical considerations.

The FHSI was a 16-item Likert-type questionnaire, in which subjects were asked to reveal how often they have experienced each item on the instrument using a 5-point scale with options ranging from “never” to “almost always” (1 = Never, 2 = Seldom, 3 = Sometimes, 4 = A Lot, and 5 = Almost Always). Individual scores were obtained by summing the 16 items. Overall scores for each item ranged from 16 to 80. There were two subscales within the FHSI:

1). **Physical/physiological health**: this subscale contained 10 items (Appendix B; items 164, 165, 166, 169, 170, 171, 174, 175, 176, 177) and focused on physical health indicators.

2). **Emotional/psychological health**: this subscale contained 6 items (Appendix B; items 167, 168, 172, 173, 178, 179) and focused on emotional health indicators.

According to Touliatos (2001), the FHSI was used as part of a larger investigation of well-being among rural families. Based on this rural population, Cronbach alpha for the one-dimensional 16-item FHSI was found to be .92 for women and .90 for men. The reliability coefficient (Cronbach’s alpha), reported by Garrison and Hira (1992), on the respondent items only was found to be .87. Results of separate confirmatory factor analyses for
responses by men and women indicated that all items load on a single factor, with item loadings ranging from .51 to .80 for women and from .48 to .78 for men (Garrison & Hira, 1992). The physical and emotional health subscale reliabilities in this study were .87 and .89. The overall reliability of the Family Health Status Inventory for this study was .92.

**Parenting Stress Index, Short Form (PSI/SF)**

The Parenting Stress Index (PSI/SF), a direct derivative of the Parenting Stress Index full-length test, was created by Abidin (1983) [Appendix B; items 180-215] at the request of clinicians and researchers seeking a valid measure of stress in the parent-child system that could be administered within a limited amount of time (Abidin, 1995). The PSI was developed on the theory that the total stress a parent experienced is a function of certain significant child behavioral characteristics, parental personality characteristics, and stresses within the family milieu that are directly related to the role of being a parent (Abidin, 1995; Larissa & Loyd, 1986). The PSI Short Form was a 36-item measure, containing questions with identical wording, taken directly from the 101-item original PSI full-length. The scale was designed to measure overall stress, as well as three subdomains of parent stress.

The PSI/SF was developed through a series of replicated factor analyses. These factor analyses resulted in a three-factor solution as the best description of the data. Inspection of individual test items suggested that the appropriate factor labels be: (a) Factor 1: Parental Distress [PD]; (b) Factor 2: Parent-Child Dysfunctional Interaction [PCDI], and (c) Factor 3: Difficult Child [DC]. The final descriptive statistics and normal ranges for the 36 items were produced by combining an initial and a replicative sample. The first sample consisted of 530 mothers who presented with their children to a group pediatric practice in Virginia for a one-year well-care visit. The full-length PSI was administered as part of the routine healthcare services. The second sample consisted of 270 mothers from the same group pediatric practice. Again, the full-length PSI was administered during a well-check. Results of the initial factor analysis and the replication suggested that the factor structure of the PSI/SF was relatively stable (Abidin, 1995).

Questions on the PSI/SF were divided into three distinct and separate subscales:
1. Parental Distress [PD]: This subscale determined the distress a parent is experiencing in his or her role as a parent as a function of personal factors directly related to parenting (Abidin, 1995). Some of the questions in this subscale were: (a) I often have the feeling that I cannot handle things very well, (b) I feel trapped by my responsibilities as a parent, and (c) There are quite a few things that bother me about my life (Appendix B; items 180-191).

2. Parent-Child Dysfunctional Interaction [PCDI]: This subscale focused on the parent’s perception that his or her child does not measure up to the parent’s expectations, and the interactions with his or her child are not reinforcing to him or her as a parent (Abidin, 1995). Some of the questions in this subscale were: (a) My child rarely does things for me that make me feel good, (b) My child smiles at me much less than I expected, and (c) My child is not able to do as much as I expected (Appendix B; items 192-203).

3. Difficult Child [DC]: This subscale focused on some of the basic behavioral characteristics of a child that make him or her either easy or difficult to manage (Abidin, 1995). Some of the questions in this subscale are: (a) My child gets upset easily over the smallest thing, (b) My child turned out to be more of a problem than I had expected, and (c) My child makes more demands on me than most children (Appendix B; items 204-215).

The PSI/SF requires approximately 10 minutes to complete. Respondent’s were instructed to select an answer to all but three items on a 5-point Likert-type scale ranging from “strongly agree” to “strongly disagree” (1 = Strongly Agree; 2 = Agree, 3 = Not Sure, 4 = Disagree; and 5 = Strongly Disagree). Subscale scores were calculated by grouping each of the 12 items and summing. (For example, summing items 1 through 12 produces the PD score, summing items 13 through 24 produces the PCDI score, and finally summing items 25 through 36 produces the DC score). For interpretational purposes, raw scores can be converted into percentile scores where normal range scores generally fall within the 15th to 80th percentile. In order to obtain the Total Stress score, all three subscale scores were summed and a percentile score was determined. According to Abidin (1995), “parents who obtain a Total Stress score above a raw score of 90 (at or above the 90th percentile) are experiencing clinically significant levels of stress” (p. 55). In this study, the scale was reverse scored in the path analysis for ease of interpretation.
The defensive responding score assessed the extent to which the respondent approached the questionnaire with a strong bias to make a good parental impression or minimize problems or stresses and is determined by the summation of items 180, 181, 182, 186, 187, 188, and 190. In order to create a profile form for each respondent, the defensive responding score along with the subscale scores and Total Stress scores were required.

Although presently there is no independent research supporting the Short Form’s validity, Abidin (1995) still purports the PSI/SF shares in the validity of the full-length PSI because it is a direct derivative. Concurrent validity with the combined score from the original 101-item PSI full-length was .95 (Abidin, 1995). The PSI has been utilized as an outcome measure in various studies addressing the impact of having a child with a disability in the family (Beckman, 1992; Margalit, Raviv & Ankonina, 1992; Boyce, Behl, Mortenses & Akers, 1991; Innocentis, Huh & Boyce, 1992).

The PSI/SF has been subjected to normative and reliability studies. Estimates of both test-retest and internal consistency reliability are available for the subscales. Alpha for the combined scale is reported to be .91 (Abidin, 1995). Test-retest reliability was assessed using the first sample of 530 mothers over a 6-month retest interval and was found to be .84 for Total Stress. Coefficient alpha was calculated based on the entire normative sample of 800 subjects for the “Total Stress” scale and was found to be .91. Using the same sample, the alpha coefficients for the PD scale, the PCDI scale, and the DC scale were .87, .80, and .85, respectively. In a study conducted by Roggman, Moe, Hart, and Forthun (1994) of 103 Head Start parents, PSI/SF reliabilities were found to be .79 for the PD scale, .80 for the PCDI scale, .78 for the DC scale, and .90 for Total Stress. Total Stress on the full-length PSI correlated .94 with the PSI/SF Total Stress. According to Abidin (1995), this is “exceptionally high and comparable to the 2-week test-retest reliability of the full-length PSI which is .95” (p. 61). The reliability of the Parenting Stress Index/Short form was .96 in this study.

**Satisfaction With Life Scale (SWLS)**

The Satisfaction With Life Scale (Appendix B; items 216-220), developed by Deiner (1985), was created during a very active period of research on subjective well being. According to Diener, Emmons, Larsen and Griffin (1985), general life satisfaction in the early 1980’s did not receive much
attention thus providing the impetus for research that led to the creation of the SWLS. In the past, general life satisfaction scales have been developed; however, these scales were not, strictly speaking, measures only of life satisfaction (Diener et al., 1985; Pavot, Diener, Colvin, & Sandvik, 1991). The SWLS was designed around the notion that one must ask participants for an overall judgment of their life in order to measure the concept of life satisfaction. Pavot and Diener (1993) claimed that the SWLS was designed, “to assess a global judgement of life satisfaction, which was theoretically predicted to depend on a comparison of life circumstances to one’s standards” (p. 165).

The Satisfaction With Life Scale (SWLS) was a short, 5-item instrument designed to measure global cognitive judgment of one’s life. SWLS items were global rather than specific in nature, allowing respondents to weight domains of their lives in terms of their personal subjective values (Pavot & Diener, 1993). Alfonso and Allison (1992) claimed that the SWLS was at the reading level of the 6th to 10th grades which was usable with most adults. This particular scale was not copyrighted and can be used without permission by all researchers and practitioners. It usually requires about one minute of respondent time.

Using a scale ranging from 1 to 5 (1 = Strongly Disagree, 2 = Disagree, 3 = Neither Agree or Disagree, 4 = Agree, and 5 = Strongly Agree), respondents indicated their agreement of a particular item by placing the appropriate number on the line preceding that item. Each item was scored from 1 to 5, with a total score ranging from 5 to 25, with higher scores reflecting greater satisfaction with life. SWLS scores can be interpreted in terms of both absolute and relative life satisfaction.

Deiner, Emmons, Larsen and Griffin (1985) have consistently shown correlation coefficients of .8 and higher for short term (two weeks to two months) test-retest methods. Longer term efforts, ten weeks and four years, have shown fairly good results with correlations of .50 and .54, respectively (Pavot & Diener, 1993). According to Diener and Pavot (1993), the SWLS has been examined for both reliability and sensitivity and has shown strong internal reliability and moderate temporal stability. In initial validity testing of the SWLS, results appeared to be quite promising. Diener’s (1985) two month test-retest of 176 undergraduates from the University of Illinois showed a correlation coefficient of .82 and the coefficient alpha was .87 (Diener et al., 1985).

A number of other investigations have also reported both internal
consistency and temporal reliability data for the scale. Pavot, Diener, Colvin and Sandvik (1991) compared the SWLS to other related scales and found that it was valid and reliable and could be used in a variety of age groups and applications. They also found a high level of convergence on self and peer reported measures on subjective well-being and life satisfaction. Interestingly, the SWLS was recommended by Diener and Pavot (1993) as a complement to scales that, “focus on psychopathology or emotional well-being because it assesses an individual’s conscious evaluative judgment of his or her life by using the person’s own criteria” (p. 164). The reliability of the Satisfaction With Life Scale was .91 in this study.

Data Collection

Due to confidentiality, the fathers for this study were recruited through the local McCracken County school system within Western Kentucky. Prior to conducting the study, school board officials (i.e. Superintendent of McCracken County School Board, Director of Special Education Services and School Principals) were personally contacted by the researcher in order to gain approval for obtaining participants. The study was described to school officials and they were asked for their approval for parent participation. Since school administrators did not permit any direct contact with the fathers/parents, teachers were also contacted (via an arranged faculty meeting) and agreed to send home questionnaires in student communication folders to request participation of fathers of the children. Research materials were distributed to each father with a child receiving special education services, as well as fathers of typically developing children. There was no way to determine the number of teachers who actually sent the questionnaires in the children’s communication folders nor was there any way to determine how many questionnaires actually reached the fathers.

Interested fathers returned (to a confidential post office box) the questionnaire via a prepaid envelope. In order to encourage completion of the questionnaire and to promote honesty of subject responses, the research materials contained a cover letter (Appendix C) assuring anonymity and confidentiality to the participants. A description of the pending study and the researcher’s interest and intent were addressed in the cover letter. Return of the completed questionnaire was considered to be the respondent’s consent to participate in the study.
Data Analysis

Data collected in this research study were analyzed using the latest version of SPSS (Statistical Package for the Social Sciences, 12.0). Various statistical analyses were included such as: frequency distributions, means, ranges, standard deviations, and significance tests such as analysis of variance (ANOVA). A confirmatory factor analysis was also conducted in order to verify that the measurement indicators were valid measures of the latent constructs in the proposed model. Additionally, a path analysis procedure was utilized on this particular model to determine the underlying relationships among specific variables.

Analysis of variance is a statistical procedure which is commonly used in research studies as a preferred technique for analyzing data (Runyon, Haber, Pittenger, & Coleman, 1996). According to McGuigan (1993), analysis of variance tests the significance of the difference between the means. Tate (1996) claims that the “ANOVA design allows the comparison of means of a dependent variable across different populations” (p. 119). Thus, with the study hypothesis in mind, ANOVA was used to determine the differences between the two groups of fathers, those with disabled children and those with non-disabled children, regarding (a) family life changes; (b) parenting daily hassles; (c) family and individual coping strategies; (d) health and parenting stress; and (e) life satisfaction.

A confirmatory factor analysis is typically used to establish a model with the closest fit to the data and is an application of Structural Equation Modeling (SEM). The objective of factor analysis is to explain the variability among a number of observable variables in terms of a smaller number of unobservable random variables (Tate, 1996). “A satisfactory solution from such an analysis may suggest potentially useful theoretical constructs and contribute to parsimony in theory” (Tate, 1996 p. 89). In this study, a confirmatory factor analysis was conducted on the restricted model for both groups.

For purposes of this study a clear conceptualization of the relationship among the variables, specifically those mediating between stressor and stress, was necessary. A familiar approach to clarify this relationship is the use of causal modeling, exemplified by the structural equation modeling or the path analysis technique (Orr, Cameron, & Day, 1991). Loehlin (1987) claims that path analysis is a statistical method that permits researchers to make statements about patterns of causation among a set of
variables. Thus, in this study, relationships among the variables in the Double ABCX model were examined using path analysis.

Not only is path analysis a statistical method that permits researchers to generate statements about patterns of causation among a set of variables, but it is also a method that evaluates the plausibility of the model as a whole (Orr, Cameron, & Day, 1991). Focusing on a model one equation at a time provides little information about the model in its entirety and may weaken the examination of the theory (Orr, Cameron, & Day, 1991; Specht, 1975). Path analysis also provides a way to assess the compatibility of alternate models, such as one with a reduced number of paths, thereby creating a more careful explanation of the data (Orr, Cameron, & Day, 1991). “The motivation for deciding to conduct a SEM [Structural Equation Modeling] study is an interest in testing a hypothesized causal model for some single ultimate outcome of interest” (Tate, 1993, p. 116). Therefore, in this study, a path analysis technique was conducted on the entire model in research questions 1 and 2 to determine the underlying relationships among the configuration of proposed variables.
CHAPTER 4: FINDINGS

Introduction

The purpose of this study was to investigate the effects of stress and coping on the life satisfaction of fathers with disabled children ages 5 to 12 years. Fathers with disabled children were compared to fathers with non-disabled children as to their perception of family life changes (major life events), parenting daily hassles (minor life events), levels of individual and family coping, parenting and health stress, and life satisfaction. In addition, the study integrated family life changes (major life events), parenting daily hassles (minor life events), levels of individual and family coping, as well as parenting and health stress to predict overall life satisfaction of fathers with and without disabled children.

This particular chapter is organized into four main sections. The first section includes a description of the demographic characteristics of the sample. The second section presents the statistical analyses for the research hypothesis and research questions. The third section includes statistical analyses for related findings. The final section provides a summary of all the findings in this study.

Sample Demographics

A summary of relevant demographic characteristics of the total sample in this study is presented in Table 1. A total of 212 respondents were included in the sample, 85 fathers with disabled children and 127 fathers with non-disabled children. A detailed description of these characteristics is provided below.

The ages of the fathers with disabled children ranged from 24 to 65 years, mean age being 39.8 years. For fathers with non-disabled children, the age range was 22 to 60 years with the mean age being 39.1 years. For the total sample, the mean age was 39.4 years. Regarding age, no significant difference was found between the two groups of fathers ($F= .05$, df=208, $p=.530$). The majority of the sample consisted of biological fathers: 76.5%
Table 1
Demographic Characteristics of the Sample

<table>
<thead>
<tr>
<th>Variable</th>
<th>Fathers with Disabled Children</th>
<th>Fathers with Non-Disabled Children</th>
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of fathers with disabled children and 81.7% of fathers with non-disabled children. For the total sample, 79.6% were biological fathers. Regarding marital status, most of the fathers in the disabled children and non-disabled children groups were married, 89.4% and 94.4% respectively. Of the total sample of fathers, 92.4% were married, 1.4% separated, 3.3% divorced, and 2.8% cohabitating. The majority of respondents in the total sample were white (96.2%), while .9% were black, .9% were Asian, .9% were Hispanic, and .9% Native American.

The education levels of the total sample included 2.9% having less than a high school education, 37.1% having a high school education, 18.1% with an associate degree, 26.7% college graduates, with 10.5% having completed graduate school, and 4.8% having obtained an advanced degree such as a doctorate or medical degree. The median educational level for the total sample was an associate degree. The education levels of the fathers with disabled children consisted of less than high school education (6%), high school graduates (36.9%), associate degree (19%), college graduates (29.8%), completed graduate school (4.8%), and advanced degrees (3.6%). The fathers with non-disabled children consisted of .8% having less than a high school education, 37.3% high school graduates, 17.5% associate degree, 24.6% college graduates, 14.3% completed graduate school, and 5.6% having obtained an advanced degree.

Family income levels for the total sample ranged from below $15,000 to over $110,000 with $60,001 - $75,000 being the modal range income for the total sample. The modal family income range reported by the fathers of disabled children was $30,001 - $45,000 with a median of $60,001 - $75,000 and for fathers of non-disabled children the modal family income was $60,001 - $75,000 with a median of $60,001 - $75,000. The difference in incomes between fathers with disabled children and fathers with non-disabled children was not significant (F = .05, df=209, p=.495).

Overall, the total sample represented a variety of interesting occupations. For those respondents in the total sample who responded regarding occupation, almost one third (29.4%) indicated skilled laborer as their career choice, followed by administration/management (22.7%) and professional (18.0%). Medical and unemployed (6.2%) ranked fourth under the occupation category, followed by other (5.7%), sales (5.2%), clerical (3.3%), education (1.9%), government services (.9%), and lastly retired (.5%). Interestingly, the most frequent occupation choice, after skilled laborer for both fathers of disabled children and fathers of non-disabled children was
administration/management, at 20% and 24.6% respectively.

Of the respondents in this study who reported employment status, 91% were employed fulltime and 2.4% were employed part-time. On the other hand, 6.2% of the respondents reported they were unemployed and .5% were retired. Both fathers with disabled children and fathers with non-disabled children reported fulltime employment status as the most frequent work status at 91.8% and 90.5% respectively. Part-time employment for the fathers with disabled children and the fathers with non-disabled children included 1.2% and 3.2% respectively, and unemployed fathers comprised 7.1% and 5.6% respectively. Approximately half of the total sample (50.5%) reported working a 40 hour week. In the fathers of disabled children group, 68.2% had spouses/partners who were employed compared to 60.6% of working spouses/partners in the fathers of non-disabled children group.

Additional data are included in Table 2 regarding specific information related to both father groups. For the total sample of fathers having children who reside in the same household, it was found that 18.9% had one child at home, 51.9% had two children at home, 20.8% had three children at home, 7.1% had four children at home, and 1.4% had five children at home. The median number of children living at home for both father groups was two. Both the fathers of the disabled children group and the fathers of the non-disabled children group reported having two children as the modal number of children residing in the household, at 49.4% and 53.5% respectively. For the fathers of non-disabled children, the second most frequent number of children living at home was three, while for the fathers of disabled children it was both one child and three children equally ranked. Only three fathers in the total sample responded as having five children in the home. Of the 212 fathers who responded to the survey, 85 fathers lived with their disabled children and 127 fathers resided with their non-disabled children.

Table 2 also presents reported medical diagnosis for the total sample. The most common medical diagnoses for fathers with non-disabled children was asthma, whereas for fathers with disabled children asthma, cerebral palsy, and Tourette’s Syndrome, were equally ranked as the most common.

Since this study focused predominantly on fathers of disabled children, further data on this group are presented in Table 3. For these fathers, the modal age of their children was 8 years old, whereas the median age of their children was 9 years old. Of the 85 fathers who participated in this study, 7 reported having a disabled child aged 5 (8.2%), 7 reported having a disabled child aged 6 (8.2%), 13 reported having a child aged 7 (15.3%), 15
Table 2  
Specific Information of the Sample

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<tbody>
<tr>
<td></td>
<td>n %</td>
<td>n %</td>
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**NUMBER OF CHILDREN IN THE HOME**

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<td>24 18.9</td>
<td>40 18.9</td>
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<td>2</td>
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<td>68 53.5</td>
<td>110 51.9</td>
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<td>28 22.0</td>
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**RESIDE WITH CHILDREN**

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**MEDICAL DIAGNOSIS**

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### Table 3

**Information Related to Fathers of Disabled Children**

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## Table 3---continued

### Fathers of Disabled Children

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<td>Celexa</td>
<td>2</td>
<td>2.4</td>
</tr>
<tr>
<td>Depakote</td>
<td>2</td>
<td>2.4</td>
</tr>
<tr>
<td>Imipramine</td>
<td>2</td>
<td>2.4</td>
</tr>
<tr>
<td>Desmorphin</td>
<td>1</td>
<td>1.2</td>
</tr>
<tr>
<td>Klonidine</td>
<td>1</td>
<td>1.2</td>
</tr>
<tr>
<td>Lexapro</td>
<td>1</td>
<td>1.2</td>
</tr>
<tr>
<td>Prozac</td>
<td>1</td>
<td>1.2</td>
</tr>
<tr>
<td>Pulmicort</td>
<td>1</td>
<td>1.2</td>
</tr>
<tr>
<td>Risperdol</td>
<td>1</td>
<td>1.2</td>
</tr>
<tr>
<td>Seroquel</td>
<td>1</td>
<td>1.2</td>
</tr>
<tr>
<td>Singulair</td>
<td>1</td>
<td>1.2</td>
</tr>
<tr>
<td>Baclopin</td>
<td>1</td>
<td>1.2</td>
</tr>
</tbody>
</table>

| **ELIGIBILITY CATEGORIES**            |    |    |
| Other                                 | 31 | 36.5 |
| Emotion-Behavior Disability           | 30 | 35.3 |
| Speech/Language Disability            | 21 | 24.7 |
| Developmental Disability              | 15 | 17.6 |
| Autism                                | 8  | 9.4 |
| Specific Learning Disability          | 8  | 9.4 |
| Other Health Impairment               | 5  | 5.9 |
| Hearing Impaired                      | 5  | 5.9 |
| Multiple Disabilities                 | 5  | 5.9 |
| Functional Mental Disability          | 4  | 4.7 |
| Mild Mental Disability                | 3  | 3.5 |
| Visual Impairment                     | 2  | 2.4 |
| Deaf/Blind                            | 2  | 2.4 |
| Orthopedic Impairment                 | 1  | 1.2 |
| Traumatic Brain Injury                | 0  | --- |
reported having a disabled child aged 8 (17.6%), 11 reported having a
disabled child aged 9 (12.9%), 9 reported having a disabled child aged 10
(10.6%), 13 reported having a disabled child aged 11 (15.3%), and 10 reported
having a disabled child aged 12 (11.8%). Fathers’ also rated the severity of
their child’s condition/disability and it was found that 40% reported it as
mild, while 41.2% rated moderate severity, and 18.8% severe. All 85 disabled
children, having an IEP, lived with their fathers. The number of
disabilities per child ranged from 1 to 6 with 57.6% of the fathers reporting
one disability per child and 30.6% reporting two disabilities for their
child.

A variety of medications were noted for the fathers of the disabled
children group. In this group, the most frequently reported medications were
Concerta (12.7%), followed by Adderall (9.4%), followed by Ritalin (8.2%) and
Strattera (8.2%). The most common disability category was “other,” (36.5%)
which consisted of children having Attention Deficit Disorder. The
emotional-behavior disability (35.3%) was found to be the second most common
eligibility category, followed by the speech-language disability (24.7%).

Hypothesis and Research Questions

Description of the Variables

Life Satisfaction served as the dependent variable in this study
involving fathers having either disabled children or non-disabled children.
It was measured using the Satisfaction With Life Scale (SWLS) which was
developed to assess satisfaction with the respondent’s life as a whole (Pavot
& Diener, 1993). The SWLS was also designed to measure life satisfaction as
a subjective and global cognitive-judgmental process of one’s life. The
independent variables utilized in this study consisted of level of stress,
level of coping, family life changes, and parenting daily hassles. These
particular variables were selected because they reflected Family Stress
Theory, which was the underlying theoretical framework used in this study.

The independent variable, level of stress, was measured utilizing the
Family Health Status Inventory (FHSI) and the Parenting Stress Index
(PSI/SF). On the FHSI, respondents were requested to rate (on sixteen items)
how often they experienced a specific psychological/emotional or
physiological/physical health symptom. A higher score on this scale
indicated decreased health due to increased negative emotional and physical
health symptomatology. The potential range of scores for the total scale was
16 to 80; however, for the physical stress subscale the potential range of scores was 10 to 50 and for the emotional stress subscale it was 6 to 30.

The Parenting Stress Index (PSI/SF) was utilized to measure stress level pertaining to the role of parenting as it related to significant child behavioral characteristics, parental personality characteristics, and overall familial milieu stressors. The total stress score for the PSI provided an indication of the overall level of parenting stress a father experienced. This score also reflected the stresses reported in the areas of personal parental distress, stresses associated with interaction with children, and stresses which result from a child’s behavioral characteristics. Therefore, a higher score indicated increased parental stress and a lower score indicated less overall parental stress. Potential range of scores for this particular scale were 36 to 180. It should be noted that this scale was reverse scored for correlations and structured equation modeling for ease of interpretation.

Another independent variable focused on level of coping, which indicated the degree of individual and family resources, coping methods, problem-solving techniques, and behavioral strategies that could be employed by fathers when faced with difficult situations. The Family Crisis Oriented Personal Evaluation Scales (F-COPES), a 30-item scale, was utilized to measure the level of family coping and the Coping Scales for Adults (CSA), a 19-item scale, was utilized to measure the level of individual coping. The F-COPES scale consisted of two dimensions: internal family coping patterns and external family coping patterns. Internal coping patterns, comprised reframing, which was the family’s capability to redefine stressful events in order to make them more manageable and, passive appraisal, which was the family’s ability to accept stressful circumstances with minimal reactivity. The second dimension included external family coping patterns which are defined as the active behaviors utilized by the family to acquire resources from outside the nuclear family system. This dimension measured the family’s ability to acquire social support from outside the family, as well as seek spiritual support, and mobilize the family to seek community resources to deal with stressful situations. A higher score on the F-COPES scale signified the use of a greater number and variety of coping strategies and ultimately translated into a higher level of coping. The potential range of scores for this 30-item scale was 30 to 150.

The Coping Scale for Adults (CSA) was the tool utilized to measure the level of individual coping. This short-form instrument focused on four
particular dimensions: “dealing with the problem,” “non-productive coping,” 
“optimism,” and “sharing.” “Dealing with the Problem” included a focus on 
solving the problem, seeking relaxing diversions, physical recreation, humor, 
work hard, self protection, and improvement of relationships. “Non-
Productive Coping” included worry, wishful thinking, not coping, ignoring the 
problem, tension reduction, keeping to self, and self-blame. “Optimism” 
comprised focus on the positive, seeking relaxing diversions, wishful 
thinking, and seeking spiritual support. “Sharing” contained seeking social 
support, seeking professional help, social action, and a negative 
contribution from keeping to oneself. According to the developers of this 
scale, the potential range of scores for dealing with the problem was 21 to 
105, for non-productive coping 21 to 105, for optimism 20 to 100, and for 
sharing 20 to 100. Through this tool, it was possible to obtain an 
assessment of individual coping strategies based on the four subscales 
mentioned above.

Parenting Daily Hassles was determined by the Parenting Daily Hassles 
scale (PDHS) which was designed to assess minor daily stresses experienced by 
parents in typical interactions with their children and in ordinary tasks 
involving childrearing (Crnic & Greenberg, 1990). This 20-item scale was 
composed of two dimensions: (1). the frequency with which the event occurs 
and (2). the intensity or degree of hassle the father perceives the event to 
be. Both frequency scores and intensity scores ranged from 20 to 100. It 
should be noted that higher scores on the frequency scale were associated 
with increased occurrences of an event and higher scores on the intensity 
scale were indicative of a greater degree of hassle perceived by the 
respondent on a given event.

For this present study, family life changes, as measured by the Family 
Inventory of Life Events (FILE), was designed to measure life events and 
changes encountered by fathers during the past 12 months. Family life 
changes and transitions were divided into nine general categories: intra-
family strains, marital strains, pregnancy and childbearing strains, finance 
and business strains, work-family transitions and strains, illness and family 
care strains, losses, transitions “in and out,” and legal violations. The 
FILE scale emphasizes change, either positive or negative, and serves as an 
index of the stress fathers experience within a set time frame. For purposes 
of this study, the scale was modified to include a Likert-type scale ranging 
from 1-4 (1 = none, 2 = low, 3 = moderate, and 4 = high) in order to
determine the level of fathers’ stress as it related to life transitions and changes. This 71-item scale had a potential range of scores from 71 to 284.

**Research Hypothesis**

1). There will be no differences between fathers with disabled children and fathers with non-disabled children regarding:
   a). family life changes due to the pile-up of major stressors as measured by the Family Inventory of Life Events and Changes (FILE).
   b). frequency of daily parenting hassles due to minor daily stresses as measured by the Parenting Daily Hassle scale (PDH).
   c). intensity of daily parenting hassles due to the fathers’ perception of minor daily stresses as measured by the Parenting Daily Hassles scale (PDH).
   d). family level of coping as measured by the Family Crisis Oriented Personal Evaluation Scales (F-COPES).
   e). individual level of coping with dealing with the problem as measured by the Coping Scale for Adults (CSA).
   f). individual level of coping with non-productive coping as measured by the Coping Scale for Adults (CSA).
   g). individual level of coping with optimism as measured by the Coping Scale for Adults (CSA).
   h). individual level of coping with sharing as measured by the Coping Scale for Adults (CSA).
   i). physical health status as adaptation to the stress of fathering children as measured by the Family Health Status Inventory (FHSI).
   j). emotional health status as adaptation to the stress of fathering children as measured by the Family Health Status Inventory (FHSI).
   k). overall parenting stress as measured by the Parenting Stress Index (PSI).
   l). life satisfaction as measured by the Satisfaction With Life Scale (SWLS).

Analysis of variance was used to determine whether the mean scores of fathers with disabled children and fathers with non-disabled children were
different relative to the twelve variables in the research hypothesis. The results of these analyses are presented in Table 4. The potential ranges of scales for each variable are presented in Table 5. In order to provide protected testing, multivariate testing was conducted to find if differences existed between the two groups of fathers [Hotelling’s Trace = .904; df = (12, 199); F = 14.99; p < .001].

In the testing of hypothesis 1a, a difference between the mean scores of fathers with disabled children and fathers with non-disabled children on family life changes as measured by the Family Inventory of Life Events and Changes (FILE) was found [F = 15.22; df = (1, 210); p = .000]. For fathers with disabled children the mean score was 108.8, whereas the mean score for fathers with non-disabled children was 94.1. Therefore, major family life changes and events were more frequent for the fathers with disabled children than for the fathers with non-disabled children. The null hypothesis 1a was rejected.

For research hypothesis 1b, frequency of parenting daily hassles as measured by the Parenting Daily Hassles scale (PDHS), results of the analysis of variance indicated that there was a difference between the two groups of fathers. The mean scores for fathers with disabled children was 56.3 compared to a mean score of 48.9 for fathers with non-disabled children [F = 18.74; df = (1, 210); p = .000]. Thus, fathers with disabled children reported a greater occurrence of parenting daily hassles and minor stresses, than did fathers with non-disabled children. Therefore, research hypothesis 1b related to frequency of parenting daily hassles was rejected.

In testing hypothesis 1c, a difference between the mean scores of fathers with disabled children and fathers with non-disabled children on the intensity of parenting daily hassles was found [F = 28.13; df = (1, 210); p = .000]. For fathers of disabled children the mean score was found to be 51.7, whereas the mean score for fathers of non-disabled children was 41.3. Thus, fathers with disabled children perceived a greater degree of difficulty related to parenting daily hassles and minor stresses than did fathers with non-disabled children. Therefore, the null hypothesis 1c was rejected.

The results of the analysis of variance for hypothesis 1d, family level of coping as measured by the Family Crisis Oriented Personal Evaluation Scales (F-COPES), indicated a mean score of 92.5 for fathers of disabled children a mean score of 100.7 for fathers of non-disabled children [F = 15.57; df = (1, 210); p = .000]. The results of the analysis of variance revealed that a difference existed between the two groups for family level of
Table 4

Comparison of Dependent and Independent Variable for Fathers with Disabled Children and Fathers with Non-Disabled Children Groups

<table>
<thead>
<tr>
<th>Variable</th>
<th>Fathers With Disabled Children Mean (n=85)</th>
<th>Fathers With Non-Disabled Children Mean (n=127)</th>
<th>F Value</th>
<th>Degrees of Freedom</th>
<th>F Prob</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. STRESSORS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A1 Family Life Changes</td>
<td>108.8</td>
<td>94.1</td>
<td>15.22</td>
<td>(1,210)</td>
<td>.000*</td>
</tr>
<tr>
<td>A2 Frequency of Parenting Daily Hassles</td>
<td>56.3</td>
<td>48.9</td>
<td>18.74</td>
<td>(1,210)</td>
<td>.000*</td>
</tr>
<tr>
<td>A3 Intensity of parenting Daily Hassles</td>
<td>51.7</td>
<td>41.3</td>
<td>28.13</td>
<td>(1,210)</td>
<td>.000*</td>
</tr>
<tr>
<td><strong>B. RESOURCES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B1 Level of Family Coping</td>
<td>92.5</td>
<td>100.7</td>
<td>15.57</td>
<td>(1,210)</td>
<td>.000*</td>
</tr>
<tr>
<td>B2 Level of Individual Coping</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a Dealing With Problems</td>
<td>62.3</td>
<td>64.9</td>
<td>1.70</td>
<td>(1,210)</td>
<td>.194</td>
</tr>
<tr>
<td>b Non-Productive Coping</td>
<td>52.3</td>
<td>48.9</td>
<td>2.29</td>
<td>(1,210)</td>
<td>.132</td>
</tr>
<tr>
<td>c Optimism</td>
<td>60.0</td>
<td>60.9</td>
<td>.21</td>
<td>(1,210)</td>
<td>.649</td>
</tr>
<tr>
<td>d Sharing</td>
<td>45.1</td>
<td>49.4</td>
<td>5.31</td>
<td>(1,210)</td>
<td>.022**</td>
</tr>
<tr>
<td><strong>C. DEFINITION OF THE EVENT</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C1 Physical Stress</td>
<td>27.4</td>
<td>24.6</td>
<td>12.15</td>
<td>(1,210)</td>
<td>.000*</td>
</tr>
<tr>
<td>C2 Emotional Stress</td>
<td>18.3</td>
<td>15.8</td>
<td>14.54</td>
<td>(1,210)</td>
<td>.000*</td>
</tr>
<tr>
<td>C3 Parenting Stress</td>
<td>98.1</td>
<td>75.2</td>
<td>46.34</td>
<td>(1,210)</td>
<td>.000*</td>
</tr>
<tr>
<td><strong>X. STRESS/CRISES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X Life Satisfaction</td>
<td>11.3</td>
<td>18.4</td>
<td>162.50</td>
<td>(1,210)</td>
<td>.000*</td>
</tr>
</tbody>
</table>

*p<.001
**p<.05
Table 5

**Potential Ranges of Scales for Each Variable**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Scale</th>
<th>Ranges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life Satisfaction</td>
<td>Satisfaction With Life Scale</td>
<td>5-25</td>
</tr>
<tr>
<td>Level of Stress</td>
<td>Family Health Status Inventory:</td>
<td>10-50</td>
</tr>
<tr>
<td></td>
<td>Physical Stress</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emotional Stress</td>
<td>6-30</td>
</tr>
<tr>
<td>Level of Family Coping</td>
<td>Family Crisis oriented Personal Evaluation Scales</td>
<td>30-150</td>
</tr>
<tr>
<td>Level of Individual Coping</td>
<td>Coping Scales for Adults:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dealing with the Problem</td>
<td>21-105</td>
</tr>
<tr>
<td></td>
<td>Non-productive Coping</td>
<td>21-105</td>
</tr>
<tr>
<td></td>
<td>Optimism</td>
<td>20-100</td>
</tr>
<tr>
<td></td>
<td>Sharing</td>
<td>20-100</td>
</tr>
<tr>
<td>Parenting Daily Hassles</td>
<td>Frequency of Parenting Daily Hassles Scale</td>
<td>20-100</td>
</tr>
<tr>
<td></td>
<td>Intensity of Parenting Daily Hassles Scale</td>
<td>20-100</td>
</tr>
<tr>
<td>Family Life Changes</td>
<td>Family Life Inventory of Life Events and Changes</td>
<td>71-284</td>
</tr>
</tbody>
</table>
coping, such that fathers with disabled children used a lesser number of resources, lesser variety of family members to help with concerns, and lesser degree of coping strategies (lower level of coping) compared to fathers with non-disabled children. The null hypothesis 1d was rejected.

In testing hypotheses 1e, no difference existed between the father groups on solving problems as measured by the subscale “Dealing with the Problem” on the Coping Scales for Adults (CSA). The mean score for fathers with disabled children was 62.3 and for fathers with non-disabled children 64.9 as an indication of the level of individual coping utilized pertaining to solving a problem while maintaining a relaxed social dimension. Thus, hypothesis 1e was not rejected.

The results for analysis of variance for hypothesis 1f indicated no difference between the two father groups related to non-productive coping. The mean scores on the “Non-Productive Coping” subscale of the Coping Scale for Adults was 52.3 for fathers with disabled children and 48.9 for fathers with non-disabled children. These mean scores reflected ineffective and unhealthy coping strategies utilized by these two father groups. Since there was no significant difference, the null hypothesis 1f was not rejected.

In the testing of hypothesis 1g, no difference existed between the two father groups on the utilization of healthy coping strategies as measured by the “Optimism” subscale of the Coping Scale for Adults (CSA). The mean score for the fathers with disabled children was 60.0 and for fathers with non-disabled children 60.9 as an indication of positive and relaxing coping strategies utilized by both father groups. Therefore, the null hypothesis 1g was not rejected.

As shown in Table 4, the ANOVA results for hypothesis 1h revealed that there was a difference between fathers of non-disabled children and fathers of non-disabled children on keeping problems to oneself as measured by the “Sharing” subscale of the Coping Scale for Adults (CSA). The results indicated that fathers with disabled children tended to share problems less with outside sources compared to fathers of non-disabled children. The mean for fathers with disabled children was 45.1 compared to a mean of 49.4 for fathers with non-disabled children [F = 5.31, df = (1, 201); p = .022]. Thus, the null hypothesis 1h was rejected.

As depicted in Table 4, physical health stress as measured by the Family Health Status Inventory (FHSI), resulted in a mean score of 27.4 for fathers of disabled children and 24.6 for fathers of non-disabled children [F = 12.15; df = (1, 210); p = .000]. Therefore, a difference existed between
the two groups for physical health status. The analysis of variance results indicated that fathers of disabled children experienced more physical symptoms than did fathers with non-disabled children. Thus, the null hypothesis 1i was rejected.

Similarly, the results for the analysis of variance for hypothesis 1j revealed that there was a difference between the two father groups regarding emotional health status. The results indicated that fathers of disabled children experienced more emotional health symptoms than fathers of non-disabled children. The mean score for fathers of disabled children was 18.3 and 15.8 for fathers of non-disabled children [F = 14.54; df = (1, 210); F = .000]. The null hypothesis 1j was also rejected.

In the testing of hypothesis 1k, a difference was found between the two groups on the Parenting Stress Index (PSI). Higher scores on the Parenting Stress Index indicated greater levels of parenting stress. Therefore, the mean scores of 98.1 for fathers of disabled children and 75.2 for fathers of non-disabled children demonstrated that fathers of disabled children experienced a higher degree of overall parenting stress [F = 46.34; df = (1, 210); p = .000]. Therefore, the null hypothesis 1k was rejected.

For research hypothesis 1l, life satisfaction as measured by the Satisfaction With Life Scale (SWLS), resulted in a mean score for fathers with disabled children of 11.3 and for fathers with non-disabled children a mean score of 18.4 [F = 162.50; df = (1, 210); p = .000]. Therefore, a difference was found to exist between the two father groups for life satisfaction, with fathers of disabled children experiencing a lesser degree of satisfaction with life as a whole. Thus, the null hypothesis 1l was rejected.

**Causal Modeling**

For research questions one and two, confirmatory factor analyses and path analyses were conducted to assess the relationships of the variables in the model. The regression analysis produced a measure of the explained variance for the model, as well as path coefficients. Correlation coefficients, means, and standard deviations are presented in Table 6.

**Research Question One:** Can family life changes and parenting daily hassles in conjunction with family and individual coping, health and parenting stress be integrated to predict life satisfaction of fathers with disabled children
**Table 6**

**Correlation Matrix, Means and Standard Deviations for Fathers with Disabled Children and Fathers with Non-Disabled Children**

<table>
<thead>
<tr>
<th>Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family</td>
<td>1.0</td>
<td></td>
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<tr>
<td>Life Changes</td>
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<tr>
<td>Frequency of Parenting</td>
<td>.67**</td>
<td>1.0</td>
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<tr>
<td>Daily Hassles (.50)**</td>
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<tr>
<td>Intensity of Parenting</td>
<td>.67**</td>
<td>.87**</td>
<td>1.0</td>
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<tr>
<td>Daily Hassles (.54)** (.79)**</td>
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<tr>
<td>Level of Family Coping(-.28)<strong>(-.11) (-.27)</strong></td>
<td>-.51**</td>
<td>-.37**</td>
<td>-.40**</td>
<td>1.0</td>
<td></td>
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</tr>
<tr>
<td>Dealing with Non-Productive Coping (.21)* (.23)<strong>(-.29)</strong>(.24)**</td>
<td>-.46**</td>
<td>-.40**</td>
<td>-.44**</td>
<td>.66**</td>
<td>1.0</td>
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<tr>
<td>The Problem (-.19)<strong>(-.14) (-.15) (.32)</strong></td>
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<tr>
<td>Non-Productive Coping (.05) (.01) -.002 -.11** .15</td>
<td></td>
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<tr>
<td>Coping (.21) * (.13) (.23)<strong>(-.29)</strong>(.24)**</td>
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<tr>
<td>Optimism -.42** -.32** -.36**</td>
<td>.53** -.75** .14</td>
<td>1.0</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>(.16) (-.17) (-.15) (.33)** (.64)** (.34)**</td>
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<tr>
<td>Sharing .05 .03 .07 .38** .18 -.21* .22*</td>
<td>1.0</td>
<td></td>
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<tr>
<td>(.04) (.14) (.08) (.37)** (.36)<strong>(-.10) (.32)</strong></td>
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<tr>
<td>Physical Health Status (.46)** (.29)** (.29)<strong>(-.16) (-.03)</strong> (.41)** (.04) (.08)</td>
<td>.68**</td>
<td>.61**</td>
<td>.58**</td>
<td>-.45**</td>
<td>-.41**</td>
<td>.22*</td>
<td>-.37*</td>
<td>-.05</td>
<td>1.0</td>
<td></td>
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</tr>
<tr>
<td>Health Status (.46)** (.41)** (.41)<strong>(-.19)</strong>(-.19)<strong>(-.19)</strong>(-.19)<strong>(-.19)</strong>(.41)<strong>(-.02) (.17) (.73)</strong></td>
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<tr>
<td>Emotional Parenting -.62** -.59**</td>
<td>.69** .52** .51**</td>
<td>-.04</td>
<td>.43*</td>
<td>.02</td>
<td>-.62**</td>
<td>.56**</td>
<td>1.0</td>
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<tr>
<td>Stress # (-.53)<strong>(-.40)</strong>(-.50)** (.48)** (.23)** (-.38)** (.18)** (.19)<strong>(-.46)</strong>(-.46)**</td>
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<tr>
<td>Life -.45**</td>
<td>.30**</td>
<td>.46**</td>
<td>.33**</td>
<td>.30**</td>
<td>-.10</td>
<td>.25*</td>
<td>.04</td>
<td>-.47**</td>
<td>-.41**</td>
<td>.58**</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>Satisfaction (-.39)<strong>(-.30)</strong>(-.30)<strong>(-.30)</strong>(-.39)<strong>(-.39)</strong>(-.30)<strong>(1.7) (.19) (-.34)</strong>(-.47)<strong>(.64)</strong></td>
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</tr>
</tbody>
</table>

Mean 108.8 56.3 51.7 92.5 62.3 52.3 60.0 45.1 27.4 18.3 98.1 11.3 11.3
(94.1) (48.9) (41.3) (100.7) (64.9) (48.9) (60.9) (49.4) (24.6) (15.8) (75.2) (18.4)

**Note:** Values for Fathers with Non-Disabled Children are shown in Parentheses.

**Correlation is significant at the p<.01 level**

*Correlation is significant at the p<.05 level*

# Variable has been reverse coded for ease of interpretation
as measured by the Family Inventory of Life Events and Changes (FILE), Parenting Daily Hassles scale (PDH), Family Crisis Oriented Personal Evaluation Scales (F-COPES) and Coping Scale for Adults (CSA), Family Health Status Inventory (FHSI) and Parenting Stress Index (PSI), and Satisfaction With Life Scale (SWLS)?

**Research Question Two:** Can family life changes and parenting daily hassles in conjunction with family and individual coping, health and parenting stress be integrated to predict life satisfaction of fathers with non-disabled children as measured by the Family Inventory of Life Events and Changes (FILE), Parenting Daily Hassles scale (PDH), Family Crisis Oriented Personal Evaluation Scales (F-COPES) and Coping Scale for Adults (CSA), Family Health Status Inventory (FHSI) and Parenting Stress Index (PSI), and Satisfaction With Life Scale (SWLS)?

Analyses were employed in order to investigate the integration of family life changes, parenting daily hassles, family coping, individual coping, health stress, and parenting stress as they accounted for the dependent variable of life satisfaction. Path analyses were conducted on both groups for the saturated model: fathers with disabled children and fathers with non-disabled children. A confirmatory factor analysis was restricted model for both groups. A description and discussion of the confirmatory factor analyses on the restricted model and path analyses for life satisfaction on the saturated model is presented next.

**Restricted Model: Fathers with Disabled Children**

Factor Analysis can be utilized in an exploratory attempt to find underlying factors that explain observed relationships. The hypothesized restricted model for this study specified that the stressor event latent variable was represented by the indicators of frequency of parenting daily hassles (PDHS1), intensity of frequency of parenting daily hassles (PDHS2), and family life changes (FILE), the level of family coping latent variable was reflected by the family coping (F-COPES) indicator and the level of individual coping was reflected by dealing with the problem (CSA1), non-productive coping (CSA2), optimism (CSA3), and sharing (CSA4) indicators, the level of stress latent variable was reflected by the parenting stress (PSI) and physical stress (FHSI1) and emotional stress (FHSI2) indicators, and the life satisfaction latent variable was represented by the life satisfaction (SWLS) indicator (Figure 4). The scale of each latent variable was fixed by assuming that the variance of each latent variable was equal to one.

Due to poor model fit and low factor loadings, parenting stress (PSI),
Figure 4: Restricted Model for the Fathers with Disabled Children Group
non-productive coping (CSA2), and sharing (CSA4) measurement indicators were removed. Global fit indices were also noted before the above measurement indicators were finally removed. It was determined that these indicators did not adequately measure the latent variables in the model.

The hypothesized restricted model was supported by a confirmatory factor analysis. The fit of the model to the data was good. The estimated structure co-efficient loadings, reflecting the validity of each observed variable as a measure of the latent variable, were generally high, ranging from .71 to .99. Lambda values were significant at $z > 2$ level. The reliability of each observed variable as a measure of the latent variable, represented by the R2 for the observed variable, ranged from .50 to .98. Finally, the estimated correlations among the latent variables were all positive with magnitudes consistent with expectations based on the literature.

The conclusion from the confirmatory factor analysis for the latent variables with multiple indicators was that the hypothesized restricted model for fathers with disabled children was acceptable and could be used in the complete Structured Equation Modeling (SEM) for latent variables. Results are presented in Table 7.

**Restricted Model: Fathers with Non-Disabled Children**

The hypothesized restricted model for fathers with non-disabled children specified that the stressor event latent variable was represented by the following indicators: frequency of parenting daily hassles (PDHS1), intensity of frequency of parenting daily hassles (PDHS2), and family life changes (FILE). The level of family coping latent variable was reflected by the family coping (F-COPES) indicator and the level of individual coping was reflected by dealing with the problem (CSA1), non-productive coping (CSA2), optimism (CSA3), and sharing (CSA4) indicators. The level of stress latent variable was reflected by the parenting stress (PSI) and physical stress (FHSI1) and emotional stress (FHSI2) indicators. And finally, the life satisfaction latent variable was represented by the life satisfaction (SWLS) indicator (Figure 5). The scale of each latent variable was fixed by assuming that the variance of each latent variable was equal to one.

Similar to the restricted model for fathers with disabled children, parenting stress (PSI), non-productive coping (CSA2), and sharing (CSA4) measurement indicators were removed due to poor model fit and low factor loadings. Global fit indices were also noted. It was also determined that these indicators did not adequately measure the latent variables in this
<table>
<thead>
<tr>
<th>Variables</th>
<th>Level of Coping</th>
<th>Level of Stress</th>
<th>Life Satisfaction</th>
<th>Family Life Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>L</td>
<td>R2</td>
<td>L</td>
<td>R2</td>
</tr>
<tr>
<td>Family Coping</td>
<td>.71*</td>
<td>.50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dealing With the Problem</td>
<td>.93*</td>
<td>.86</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Optimism</td>
<td>.80*</td>
<td>.64</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Stress</td>
<td></td>
<td></td>
<td>.88*</td>
<td>.78</td>
</tr>
<tr>
<td>Emotional Stress</td>
<td></td>
<td></td>
<td>.85*</td>
<td>.73</td>
</tr>
<tr>
<td>Life Satisfaction</td>
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<tr>
<td>Family Life Changes</td>
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</tr>
<tr>
<td>Frequency of Parenting Daily</td>
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<td>Hassles</td>
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<tr>
<td>Intensity of Parenting Daily</td>
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<tr>
<td>Hassles</td>
<td></td>
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</tr>
</tbody>
</table>

*Statistically significant (z statistic > 2)
Figure 5: Restricted Model for Fathers with Non-Disabled Children
model and they were not retained.

The hypothesized restricted model was supported by a confirmatory factor analysis. Model fit to the data was good. The estimated structure co-efficient loadings for the fathers with non-disabled children, reflecting the validity of each observed variable as a measure of the latent variable, were generally high, ranging from \( .44 \) to \( .99 \). Lambda values were significant at \( z > 2 \) level. The reliability of each observed variables as a measure of the latent variable, represented by the R2 for the observed variable, range from \( .20 \) to \( .99 \). Estimated correlations among the latent variables were all positive.

The conclusion from the confirmatory factor analysis for the latent variables with multiple indicators was that the hypothesized model for fathers with non-disabled children was acceptable and could be used in the complete Structured Equation Modeling (SEM) for latent variables. Results are presented in Table 8.

**Goodness of Fit**

The overall fit of the model to the data was marginal. Goodness of fit indices suggested that the saturated model for fathers with disabled children was acceptable and appropriately hypothesized (RMSEA = \( .121 \); Chi-Square/degrees of freedom ratio = \( 2.24 \); NFI = \( .935 \); CFI = \( .96 \); GFI = \( .885 \); AGFI = \( .764 \)). The saturated model for fathers of non-disabled children was also acceptable and appropriately hypothesized as evidenced by the following goodness of fit indices (RMSEA = \( .108 \); Chi-Square/degrees of freedom ratio = \( 2.47 \); NFI = \( .901 \); CFI = \( .935 \); GFI = \( .912 \); AGFI = \( .821 \)).

**Saturated Model: Fathers with Disabled Children**

In the saturated model for fathers with disabled children, family stressor event(s), level of coping, and level of stress were regressed on life satisfaction (Figure 6). One predictor variable, level of stress, had a direct relationship to life satisfaction (-.405). The relationship between level of stress and life satisfaction was inverse, which means, decreased physical and health symptoms experienced by the participant, resulted in greater satisfaction with life. In addition, family stressor event(s) and level of coping were each found to have a direct relationship to level of stress, indicating that fathers who had lower levels of coping and a greater pile-up of family stressor event(s) experienced increased physical and emotional health symptoms. Family stressor event(s) had a direct positive relationship with level of stress (.669), but an inverse relationship with level of coping (-.181). In other words, a greater pile-up of family stressor event(s) was associated with increased physical and emotional health symptoms.
Table 8

Restricted Model Factor Loadings for Fathers with Non-Disabled Children

<table>
<thead>
<tr>
<th>Variables</th>
<th>Level of Coping</th>
<th>Level of Stress</th>
<th>Life Satisfaction</th>
<th>Family Life Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>L R^2</td>
<td>L R^2</td>
<td>L R^2</td>
<td>L R^2</td>
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<tr>
<td>Family Coping</td>
<td>.44* .20</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dealing With the Problem</td>
<td>.83* .69</td>
<td></td>
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</tr>
<tr>
<td>Optimism</td>
<td>.75* .57</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Stress</td>
<td>.74* .54</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional Stress</td>
<td>.99* .98</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life Satisfaction</td>
<td></td>
<td>.99* .99</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Life Changes</td>
<td></td>
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<td>.61* .37</td>
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<tr>
<td>Frequency of Parenting Daily</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Hassles</td>
<td></td>
<td></td>
<td></td>
<td>.87* .75</td>
</tr>
<tr>
<td>Intensity of Parenting Daily</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Hassles</td>
<td></td>
<td></td>
<td></td>
<td>.90* .81</td>
</tr>
</tbody>
</table>

*Statistically significant (z statistic > 2)
Figure 6: Saturated Model for Fathers with Disabled Children
stressor event(s) in the fathers’ lives resulted in a greater amount of physical and health stress; but was inversely associated with the amount and variety of coping strategies utilized by the fathers.

No direct relationship was found between family stressor event(s) and life satisfaction (-.082). However, there was an indirect relationship with level of coping and level of stress as mediating variables. Although results revealed no direct relationship from level of coping to life satisfaction, there was an indirect relationship with level of stress as a mediating variable.

When examining the direct, indirect and total effects of the variables in this model on life satisfaction, the greatest total effect was family stressor event(s) with a total significant effect of -.434. The second greatest effect was level of stress followed by level of coping. Level of stress contributed a total significant effect of -.405, which was entirely a direct effect. Level of coping had a non-significant effect on life satisfaction (.305). The determinants in this model accounted for 74% of the variance of life satisfaction (Table 9).

**Saturated Model: Fathers with Non-Disabled Children**

In the saturated model for fathers with non-disabled children, both level of coping and level of stress had a direct relationship to life satisfaction (Figure 7). There was an inverse relationship between level of stress and life satisfaction (-.374) suggesting that greater health symptomatology (both emotional and physical) produced lower satisfaction with life. The effect of coping on life satisfaction revealed that a positive relationship existed, that is, as level of coping increased, life satisfaction increased at a rate of .275 units. In this model, the relationship effect between family stressor event(s) and level of coping was inverse (-.242), meaning that the greater the pile-up of family stressors, the lower the utilization of coping strategies/resources. The relationship between family stressor event(s) and level of stress was positive (.479), suggesting that greater pile-up of family stressors resulted in increased health symptomatology.

Similar to the model for fathers with disabled children, no direct relationship was found between family stressor event(s) and life satisfaction (-.113). However, the saturated model for fathers with non-disabled children had two indirect causal relationships with life satisfaction. One indirect relationship consisted of family stressor event(s) via level of coping on life satisfaction. Another indirect relationship existed between family
Table 9

Direct, Indirect, and Total Effects on Life Satisfaction for the Saturated Model for Fathers with Disabled Children and Fathers with Non-Disabled Children

Fathers with Disabled Children Group

<table>
<thead>
<tr>
<th>Independent Variable</th>
<th>Direct</th>
<th>Indirect</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Stressor Event(s)</td>
<td>-.082</td>
<td>-.352*</td>
<td>-.434*</td>
</tr>
<tr>
<td>Level of Coping</td>
<td>.232</td>
<td>.073</td>
<td>.305</td>
</tr>
<tr>
<td>Level of Stress</td>
<td>-.405*</td>
<td>------</td>
<td>-.405*</td>
</tr>
</tbody>
</table>

(R-Square = .740)

Fathers with Non-Disabled Children Group

<table>
<thead>
<tr>
<th>Independent Variable</th>
<th>Direct</th>
<th>Indirect</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Stressor Event(s)</td>
<td>-.113</td>
<td>-.250*</td>
<td>-.363*</td>
</tr>
<tr>
<td>Level of Coping</td>
<td>.275*</td>
<td>.019</td>
<td>.295*</td>
</tr>
<tr>
<td>Level of Stress</td>
<td>-.374*</td>
<td>------</td>
<td>-.374*</td>
</tr>
</tbody>
</table>

(R-Square = .515)

*Effect statistically significant (z statistic >2)
Figure 7: Saturated Model for Fathers with Non-Disabled Children
stressor event(s) via level of stress on life satisfaction.

In reviewing the direct, indirect, and total effects of the variables in this model, the greatest effect/determinant of life satisfaction was level of stress with a significant total effect of -.374. The second greatest effect was family stressor event(s) followed by level of coping. Family stressor event(s) had a significant total effect of -.363 and level of coping had a significant total effect of .295. The determinants in this model accounted for 52% of the variance of life satisfaction (Table 9).

**Related Findings**

In order to more clearly understand the types and degree of family life changes fathers experienced, each dimension of family life change was examined by conducting analysis of variance on all nine dimensions of family life change as measured by the Family Inventory of Life Events (FILE) Results are presented in Table 10. A significant difference was found between the fathers with disabled children group and the fathers of non-disabled children group on the following areas:

(a) intra-family strains \([F = 19.43; \ (df = 1, 210); \ p = .000]\). The fathers with disabled children group had a mean of 32.81 and the fathers with non-disabled children group had a mean score of 27.57 which indicated the fathers with disabled children experienced more conflict between family members.

(b) marital strains \([F = 9.00; \ (df = 1, 210); \ P = .003]\). The fathers with disabled children group had a mean of 6.17, whereas the fathers of non-disabled children had a mean score of 5.12. This indicated that fathers of disabled children experienced more stressors in their marriage pertaining to sexual or separation issues.

(c) pregnancy and childbearing strains \([F = 4.22; \ (df = 1, 210); \ p = .041]\). The fathers with disabled children had a mean score of 4.82 and 4.26 for fathers with non-disabled children indicating that fathers with disabled children experienced more stress as it related to adding a new member to the family.

(d) finance and business strains \([F = 16.60; \ (df = 1, 210); \ p = .000]\). The fathers of disabled children had a mean score of 19.21, whereas the fathers of non-disabled children had a mean score of 16.09. This indicated that fathers of non-disabled
Table 10

Summary of Analysis of Variance for Fathers with Disabled Children and Fathers with Non-Disabled Children for Family Life Changes

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Fathers with Disabled Children Mean (n=85)</th>
<th>Fathers with Non-Disabled Children Mean (n=127)</th>
<th>F Value</th>
<th>Degrees of Freedom</th>
<th>F Prob.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intra-Family Strains</td>
<td>32.81</td>
<td>27.57</td>
<td>19.43</td>
<td>(1, 210)</td>
<td>.000*</td>
</tr>
<tr>
<td>Finance and Business Strains</td>
<td>19.21</td>
<td>16.09</td>
<td>16.60</td>
<td>(1, 210)</td>
<td>.000*</td>
</tr>
<tr>
<td>Work-Family Transitions and Strains</td>
<td>15.25</td>
<td>13.81</td>
<td>4.81</td>
<td>(1, 210)</td>
<td>.029*</td>
</tr>
<tr>
<td>Illness and Family Care Strains</td>
<td>11.08</td>
<td>9.50</td>
<td>8.41</td>
<td>(1, 210)</td>
<td>.004*</td>
</tr>
<tr>
<td>Losses</td>
<td>7.62</td>
<td>6.91</td>
<td>3.85</td>
<td>(1, 210)</td>
<td>.052</td>
</tr>
<tr>
<td>Legal</td>
<td>5.91</td>
<td>5.43</td>
<td>2.47</td>
<td>(1, 210)</td>
<td>.117</td>
</tr>
<tr>
<td>Transitions In and Out</td>
<td>5.91</td>
<td>5.38</td>
<td>3.88</td>
<td>(1, 210)</td>
<td>.051</td>
</tr>
<tr>
<td>Marital Strains</td>
<td>5.90</td>
<td>5.12</td>
<td>9.00</td>
<td>(1, 210)</td>
<td>.003*</td>
</tr>
<tr>
<td>Pregnancy and Childbearing Strains</td>
<td>4.82</td>
<td>4.26</td>
<td>4.21</td>
<td>(1, 210)</td>
<td>.041*</td>
</tr>
</tbody>
</table>

*P ≤ .05
children experienced increased stress related to financial issues, such as a strain on the family’s money supply.

(e) Work-family transitions and strains \[F = 4.81; \text{df} = (1, 210); p = .029\]. The fathers of disabled children had a mean score of 15.25 and 13.81 for fathers if non-disabled children. This indicated that fathers of disabled children had a higher level of stress associated with work moves or moves of a family member.

(f) Illnesses and family care strains \[F = 8.41; \text{df} = (1, 210); p = .004\]. The fathers of disabled children had a mean score of 11.08, compared to 9.50 for fathers with non-disabled children, suggesting that fathers of disabled children experience higher levels of stress associated with family illness and care demands.

A comparison was also made regarding level of coping for the two father groups. Analysis of variance was conducted on each of the five dimensions as measured by the Family Crisis Oriented Personal Evaluation Scales (F-COPES). Results are presented in Table 11. The data are provided for all 5 subscales, but only “reframing,” “acquiring social support” and “seeking spiritual support” had acceptable reliability. A difference was found between the two father groups with regard to internal family coping on passive appraisal, which acknowledges the family’s ability to accept problematic issues with minimal reactivity. The mean score for the fathers of disabled children was 14.68, whereas the mean score for the fathers of non-disabled children was 15.59. According to these findings, fathers of non-disabled children were more likely to accept problems and utilize coping strategies to assist with reactivity. There was also a significant difference found between the two father groups with regard to external family coping on the following dimensions:

(a) Acquiring social support: mean score for fathers of disabled children was 22.34, while the mean score for fathers of non-disabled children was 25.85. This indicated that fathers of non-disabled children were more likely to seek support from friends, neighbors, and extended family.

(b) Seeking spiritual support: mean score for fathers with disabled children was 13.51 and 14.73 for fathers with non-disabled children. This indicated that fathers of non-disabled children were more likely to seek support from a minister or church activities.
Table 11

Summary of Analysis of Variance for Fathers with Disabled Children and Fathers with Non-Disabled Children for Level of Coping

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Fathers with Disabled Children</th>
<th>Fathers with Non-Disabled Children</th>
<th>F Value</th>
<th>Degrees of Freedom</th>
<th>F Prob.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reframing</td>
<td>29.07</td>
<td>30.44</td>
<td>3.06</td>
<td>(1, 210)</td>
<td>.081</td>
</tr>
<tr>
<td>Acquiring Social Support</td>
<td>22.34</td>
<td>25.85</td>
<td>15.27</td>
<td>(1, 210)</td>
<td>.000*</td>
</tr>
<tr>
<td>Passive Appraisal</td>
<td>14.68</td>
<td>15.59</td>
<td>4.68</td>
<td>(1, 210)</td>
<td>.032*</td>
</tr>
<tr>
<td>Seeking Spiritual Support</td>
<td>13.51</td>
<td>14.73</td>
<td>4.42</td>
<td>(1, 210)</td>
<td>.037*</td>
</tr>
<tr>
<td>Mobilizing Family to Acquire and Accept Support</td>
<td>10.44</td>
<td>11.58</td>
<td>5.89</td>
<td>(1, 210)</td>
<td>.016*</td>
</tr>
</tbody>
</table>

*P<.05
(c) mobilizing family to acquire and accept support: mean score for fathers of disabled children was 10.44, while the mean score for fathers of non-disabled children was 11.58. This indicated that fathers of non-disabled children were more likely to seek out help from community resources. In other words, fathers of disabled children were less likely to acquire social support, seek spiritual support, or mobilize the family to acquire and accept support.

The F-COPES subscales were also rank ordered by determining the mean score of each subscale (based on the number of items per subscale) to find out the rank order of coping strategies/mechanisms utilized by each of the father groups. Interestingly, it was found that each group utilized coping strategies in the same way. For example, the most popular coping strategy for both groups was passive appraisal, followed by reframing, seeking spiritual support, mobilizing family to acquire and accept help, and then acquiring social support.

A comparison, between fathers with disabled children and fathers with non-disabled children, was also made regarding health stress symptoms (Table 12). Differences were found between the two father groups regarding specific health items. Fathers of disabled children reported experiencing pressure, tension, and stress more often with a mean score of 3.58, 3.49, and 3.49 compared to fathers with non-disabled children who had mean scores of 3.17, 3.07, and 3.02 on the same health stress items. Symptoms of backaches and neckaches, feeling down, feeling restless, and feeling nervous were also experienced more often by the fathers of disabled children with mean scores of 3.04, 2.94, 2.89, and 2.85 compared to the mean scores of fathers with non-disabled children at 2.65, 2.54, 2.52, and 2.50 respectively. Trouble getting asleep and difficulty relaxing were more often reported by the father with disabled children group with mean scores of 2.82 and 2.82 compared to the fathers of non-disabled children group having mean scores of 2.46 and 2.46 respectively.

Fathers of disabled children also indicated experiencing more headaches and upset stomachs with mean scores of 2.79 and 2.58 compared to 2.48 and 2.20 for the fathers of non-disabled children. Feeling lonely, having sore throats, and shortness of breath were also reported more frequently for the fathers of disabled children with mean scores of 2.59, 2.31, 2.00 compared to the fathers of non-disabled children who had mean scores of 2.09, 2.02, and
### Table 12

**Difference in Health Stress Symptomatology reported by Fathers with Disabled Children and Fathers with Non-Disabled Children**

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Fathers with Disabled Children</th>
<th>Fathers with Non-Disabled Children</th>
<th>Total Mean</th>
<th>Degrees of Freedom</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feel pressure</td>
<td>3.58</td>
<td>3.17</td>
<td>3.33</td>
<td>1</td>
<td>.001*</td>
</tr>
<tr>
<td>Feel tension</td>
<td>3.49</td>
<td>3.07</td>
<td>3.24</td>
<td>1</td>
<td>.002*</td>
</tr>
<tr>
<td>Feel stressed</td>
<td>3.49</td>
<td>3.02</td>
<td>3.21</td>
<td>1</td>
<td>.001*</td>
</tr>
<tr>
<td>Backaches or Neckaches</td>
<td>3.04</td>
<td>2.65</td>
<td>2.81</td>
<td>1</td>
<td>.024*</td>
</tr>
<tr>
<td>Feel down</td>
<td>2.94</td>
<td>2.54</td>
<td>2.70</td>
<td>1</td>
<td>.002*</td>
</tr>
<tr>
<td>Feel restless</td>
<td>2.89</td>
<td>2.52</td>
<td>2.67</td>
<td>1</td>
<td>.015*</td>
</tr>
<tr>
<td>Feel nervous</td>
<td>2.85</td>
<td>2.50</td>
<td>2.64</td>
<td>1</td>
<td>.031*</td>
</tr>
<tr>
<td>Trouble staying asleep</td>
<td>2.79</td>
<td>2.50</td>
<td>2.62</td>
<td>1</td>
<td>.258</td>
</tr>
<tr>
<td>Low energy</td>
<td>2.73</td>
<td>2.53</td>
<td>2.61</td>
<td>1</td>
<td>.185</td>
</tr>
<tr>
<td>Trouble getting asleep</td>
<td>2.82</td>
<td>2.46</td>
<td>2.60</td>
<td>1</td>
<td>.031*</td>
</tr>
<tr>
<td>Difficulty Relaxing</td>
<td>2.82</td>
<td>2.46</td>
<td>2.60</td>
<td>1</td>
<td>.022*</td>
</tr>
<tr>
<td>Headaches</td>
<td>2.79</td>
<td>2.48</td>
<td>2.60</td>
<td>1</td>
<td>.031*</td>
</tr>
<tr>
<td>Upset stomach</td>
<td>2.58</td>
<td>2.20</td>
<td>2.35</td>
<td>1</td>
<td>.008*</td>
</tr>
<tr>
<td>Feel lonely</td>
<td>2.59</td>
<td>2.09</td>
<td>2.29</td>
<td>1</td>
<td>.001*</td>
</tr>
<tr>
<td>Sore throat</td>
<td>2.31</td>
<td>2.02</td>
<td>2.14</td>
<td>1</td>
<td>.028*</td>
</tr>
<tr>
<td>Shortness of Breath</td>
<td>2.00</td>
<td>1.68</td>
<td>1.81</td>
<td>1</td>
<td>.025*</td>
</tr>
</tbody>
</table>

*p<.05

Rank-ordered by total mean
Both father groups reported feeling pressure, tension, and stress as the three most common symptoms experienced. Overall, for the majority of health items, fathers of disabled children indicated experiencing greater degrees of health symptoms than did the fathers of non-disabled children.

A comparison was also made between the two father groups pertaining to the degree of satisfaction on four created items: leisure/recreational time, marital relationship, financial status, and overall relationship with children. Differences were found between the two father groups on these four dimensions. Results are found in Table 13. Mean scores for fathers of disabled children were 3.14, 3.11, 2.51, and 2.48 compared to 4.35, 4.18, 3.27, and 3.25 for fathers of non-disabled children. Overall, fathers of disabled children reported lower levels of satisfaction in all four of these areas compared to fathers with non-disabled children.

Both fathers of disabled children and fathers of non-disabled children were asked several open-ended questions on the survey. The fathers’ responses were collapsed to identify major themes related to these specific open-ended questions. The first question asked respondents to respond to other ways in which they coped with their concerns. For question one, both father groups were similar in their responses by indicating that they coped with concerns by staying busy, followed by talking to their wife, and using their religious faith. The responses were rank ordered and the results are presented in Table 14. According to the qualitative comments reported, fathers of disabled children and fathers of non-disabled children were just as likely to cope with concerns using the same methods.

- Father of Disabled Child: I stay busy with home projects.
- Father of Disabled Child: I like to fix and improve something in the home or at my work office.
- Father of Non-Disabled Child: I usually keep busy with exercise and working out.
- Father of Non-Disabled Child: Taking action and being busy helps me.

Another common theme among both groups consisted of the fathers talking to their wives about their concerns. It appeared that the fathers of disabled children were just as likely as the fathers of non-disabled children to discuss concerns with spouses. Moreover, both father groups sought spouse communication and directive about how to resolve daily life stressors and problems.
Table 13

**Difference in Satisfaction reported by Fathers with Disabled Children and Fathers with Non-Disabled Children**

<table>
<thead>
<tr>
<th>Item</th>
<th>Fathers with Disabled Children</th>
<th>Fathers with Non-Disabled Children</th>
<th>Total Mean</th>
<th>Degrees of Freedom</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall relationship with your children</td>
<td>3.14</td>
<td>4.35</td>
<td>3.86</td>
<td>1</td>
<td>.000*</td>
</tr>
<tr>
<td>Martial relationship</td>
<td>3.11</td>
<td>4.18</td>
<td>3.75</td>
<td>1</td>
<td>.000*</td>
</tr>
<tr>
<td>Financial status</td>
<td>2.51</td>
<td>3.27</td>
<td>2.96</td>
<td>1</td>
<td>.000*</td>
</tr>
<tr>
<td>Leisure/Recreational time</td>
<td>2.48</td>
<td>3.25</td>
<td>2.94</td>
<td>1</td>
<td>.000*</td>
</tr>
</tbody>
</table>

*p<.05
Table 14

Qualitative Findings: Fathers of Disabled and Non-Disabled Children

<table>
<thead>
<tr>
<th>ITEM</th>
<th>Fathers with Disabled Children</th>
<th>Fathers with Non-Disabled Children</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>COPING WITH CONCERNS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staying Busy</td>
<td>12</td>
<td>13</td>
<td>25</td>
</tr>
<tr>
<td>Talk to Wife</td>
<td>11</td>
<td>13</td>
<td>23</td>
</tr>
<tr>
<td>Use Religious Faith</td>
<td>4</td>
<td>9</td>
<td>13</td>
</tr>
<tr>
<td>Unhealthy Coping</td>
<td>2</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Find a Solution</td>
<td>2</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Family Time</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>OTHER FATHERING INFO.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Church, God, &amp; Faith</td>
<td>7</td>
<td>9</td>
<td>16</td>
</tr>
<tr>
<td>Takes a lot of patience</td>
<td>5</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td>Unconditional love</td>
<td>4</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>Nurture them</td>
<td>3</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Consistency</td>
<td>2</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Positive role model</td>
<td>2</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Be involved</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Quality time is important</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Supportive wife</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

(Respondents could report multiple responses)
- Father of Disabled Child: I sit down with my wife and have a talk about the current situation and resolve it.
- Father of Disabled Child: My wife helps me handle things.
- Father of Non-Disabled Child: My wife and I talk until we figure it out.
- Father of Non-Disabled Child: I talk to my wife and let her help me.

Another trend highlighted in the qualitative data pertaining to how both father groups coped with their concerns was that of religious faith. Again, both groups relied on their religious faith to help deal with current stressors/concerns.

- Father of Disabled Child: I pray and have faith things will work out.
- Father of Disabled Child: Reading the Bible gives me faith. I know that God is in control. He knows what I am going through and why.
- Father of Non-Disabled Child: Attending church on a regular basis and reading and studying my Bible helps me.
- Father of Non-Disabled Child: Relying on my faith, reading my Bible and praying all help me tremendously.

Another open-ended question asked both father groups to respond to what other information we should know regarding fathering children. In a similar fashion, responses were collapsed into major themes and categorized as such. Response items are also presented in Table 14. The two father groups again responded similarly and reported that religious faith, church, and God were important factors in parenting children, followed by patience, and unconditional love.

- Father of Disabled Child: Children should be in a loving home, disciplined, encouraged to succeed, attend church regularly, have Christian parents actively involved in their lives.
- Father of Disabled Child: Being a father means sacrificing one's own needs for your children and being patient - placing your children as a very high priority is essential in shaping the father’s mind toward providing the emotional, spiritual, and physical support necessary.
- Father of Non-Disabled Child: Fatherhood isn’t easy in today’s world but when you look into your child’s eyes it is more than
worth it. Love God, your spouse, yourself, and thus loving your children becomes easy. Teach your children to love themselves and respect others. Have faith in God.

• Father of Non-Disabled Child: Be prepared to exercise patience, understanding and unconditional love.

Fathers of disabled children were then asked what resources they presently used to help with their disabled children. As above, these responses were rank ordered and major themes were categorized and presented in Table 15. The most frequent response given by the fathers of disabled children group included visiting with a counselor or family therapist, followed by seeking assistance from the school system, and visiting with a physician or medical personnel.

Fathers of disabled children were also requested to respond to a question regarding what some of the stressful issues are related to parenting a child with special needs. Again, responses were categorized into predominant themes and the results are presented in Table 15. The most common response regarding stressfulness was lack of understanding from others, followed by time constraints, and dealing with varying abilities of children/siblings in the family. A major theme that prominently emerged was the notion of lack of understanding and unpredictable reactions and behaviors received from the public concerning the disabled child.

• Father of Disabled Child: There is lack of understanding from others.
• Father of Disabled Child: My child is not able to learn at the rate of other children. It is frustrating. Sometimes people don’t understand.
• Father of Disabled Child: Certain subjects take a long time for my child to grasp the concepts and others might not understand why.
• Father of Disabled Child: Constantly helping other kids and adults understand the disability.
• Father of Disabled Child: Teaching others what the special needs are can be stressful. You never know how others are going to react.

Another open-ended question was posed to the fathers of disabled children group regarding when they found out about their child’s disability. Response results are presented in Table 15. A conjoint part of this question
Table 15
Qualitative Findings: Fathers of Disabled Children

<table>
<thead>
<tr>
<th>ITEM</th>
<th>Fathers with Disabled Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>RESOURCES UTILIZED BY FATHERS TO HELP DISABLED CHILDREN</td>
<td></td>
</tr>
<tr>
<td>Counselor/Family Therapist</td>
<td>11</td>
</tr>
<tr>
<td>School System</td>
<td>10</td>
</tr>
<tr>
<td>Physician/Medical</td>
<td>7</td>
</tr>
<tr>
<td>Therapy/Rehabilitation</td>
<td>6</td>
</tr>
<tr>
<td>Church</td>
<td>4</td>
</tr>
<tr>
<td>STRESSFUL ISSUES IN PARENTING A CHILD WITH DISABILITIES</td>
<td></td>
</tr>
<tr>
<td>Lack of Understanding from Others</td>
<td>12</td>
</tr>
<tr>
<td>Time Consuming</td>
<td>8</td>
</tr>
<tr>
<td>Dealing with Varying Children Abilities</td>
<td>7</td>
</tr>
<tr>
<td>Respite Problems</td>
<td>6</td>
</tr>
<tr>
<td>Uncertainties/Fears</td>
<td>3</td>
</tr>
<tr>
<td>FINDING OUT ABOUT THE DISABILITY</td>
<td></td>
</tr>
<tr>
<td>Birth</td>
<td>4</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>COPING WITH THE INFO REGARDING YOUR CHILD’S DISABILITY</td>
<td></td>
</tr>
<tr>
<td>Used School Resources</td>
<td>7</td>
</tr>
<tr>
<td>Prayed</td>
<td>6</td>
</tr>
<tr>
<td>Researched the Disability</td>
<td>5</td>
</tr>
<tr>
<td>Found a Physician</td>
<td>4</td>
</tr>
<tr>
<td>Found a Counselor/Family Therapist</td>
<td>3</td>
</tr>
</tbody>
</table>
asked fathers of disabled children how they coped with finding out about their child’s disability status. The most frequent response was utilization of school resources, followed by prayer, and research of the newly diagnosed disability. Response results are found in Table 15.

The last section of this chapter is a summary of the findings in this study on the hypothesis and research questions pertaining to both father groups. Table 16 summarizes the statistical findings of the data reported in this chapter.
**Summary of Hypothesis and Research Questions**

**Hypothesis:** There will be no difference between fathers with disabled children and fathers with non-disabled children regarding:

<table>
<thead>
<tr>
<th>Significance Level Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Family Life Changes</td>
</tr>
<tr>
<td>(b) Frequency of Daily Parenting Hassles</td>
</tr>
<tr>
<td>(c) Intensity of Daily Parenting Hassles</td>
</tr>
<tr>
<td>(d) Family Level of Coping</td>
</tr>
<tr>
<td>(e) Individual Level of Coping with Dealing with the Problem</td>
</tr>
<tr>
<td>(f) Individual Level of Coping with Non-Productive Coping</td>
</tr>
<tr>
<td>(g) Individual level of coping with optimism</td>
</tr>
<tr>
<td>(h) Individual Level of Coping with Sharing</td>
</tr>
<tr>
<td>(i) Physical Health Stress</td>
</tr>
<tr>
<td>(j) Emotional Health Stress</td>
</tr>
<tr>
<td>(k) Parenting Stress</td>
</tr>
<tr>
<td>(l) Life Satisfaction</td>
</tr>
</tbody>
</table>
Research Questions:

Research Question 1: Can family life changes and parenting daily hassles in conjunction with family and individual coping, health and parenting stress be integrated to predict life satisfaction of fathers with disabled children?

**FINDINGS**

**Restricted Model for Fathers with Disabled Children**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Lambda</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency of Parenting Daily Hassles to Family Stressor Event</td>
<td>.92*</td>
</tr>
<tr>
<td>Intensity of Parenting Daily Hassles to Family Stressor Event</td>
<td>.93*</td>
</tr>
<tr>
<td>Family Life Changes to Family Stressor Event</td>
<td>.74*</td>
</tr>
<tr>
<td>Family Coping to Level of Coping</td>
<td>.71*</td>
</tr>
<tr>
<td>Dealing with the Problem to Level of Coping</td>
<td>.93*</td>
</tr>
<tr>
<td>Optimism to Level of Coping</td>
<td>.80*</td>
</tr>
<tr>
<td>Physical Stress to Level of Stress</td>
<td>.88*</td>
</tr>
<tr>
<td>Emotional Stress to Level of Stress</td>
<td>.85*</td>
</tr>
<tr>
<td>Life Satisfaction to Crisis/Adaptation</td>
<td>.99*</td>
</tr>
</tbody>
</table>

**Saturated Model for Fathers with Disabled Children** (R-Square = .52)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Beta</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Stressor Event to Level of Coping</td>
<td>-.512*</td>
</tr>
<tr>
<td>Family Stressor Event to Level of Stress</td>
<td>.669*</td>
</tr>
<tr>
<td>Family Stressor Event to Crisis/Adaptation</td>
<td>-.082</td>
</tr>
<tr>
<td>Level of Coping to Level of Stress</td>
<td>-.181*</td>
</tr>
<tr>
<td>Level of Coping to Crisis/Adaptation</td>
<td>.232</td>
</tr>
<tr>
<td>Level of Stress to Crisis/Adaptation</td>
<td>-.405*</td>
</tr>
</tbody>
</table>
### Research Question 2: Can family life changes and parenting daily hassles in conjunction with family and individual coping, health and parenting stress be integrated to predict life satisfaction of fathers with non-disabled children?

#### FINDINGS

**Restricted Model for Fathers with Non-Disabled Children**

<table>
<thead>
<tr>
<th>Variable Description</th>
<th>Lambda</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency of Parenting Daily Hassles to Family Stressor Event</td>
<td>0.44*</td>
</tr>
<tr>
<td>Intensity of Parenting Daily Hassles to Family Stressor Event</td>
<td>0.83*</td>
</tr>
<tr>
<td>Family Life Changes to Family Stressor Event</td>
<td>0.75*</td>
</tr>
<tr>
<td>Family Coping to Level of Coping</td>
<td>0.74*</td>
</tr>
<tr>
<td>Dealing with the Problem to Level of Coping</td>
<td>0.99*</td>
</tr>
<tr>
<td>Optimism to Level of Coping</td>
<td>0.99*</td>
</tr>
<tr>
<td>Physical Stress to Level of Stress</td>
<td>0.61*</td>
</tr>
<tr>
<td>Emotional Stress to Level of Stress</td>
<td>0.87*</td>
</tr>
<tr>
<td>Life Satisfaction to Crisis/Adaptation</td>
<td>0.90*</td>
</tr>
</tbody>
</table>

**Saturated Model for Fathers with Non-Disabled Children**

<table>
<thead>
<tr>
<th>Variable Description</th>
<th>Beta</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Stressor Event to Level of Coping</td>
<td>-0.242*</td>
</tr>
<tr>
<td>Family Stressor Event to Level of Stress</td>
<td>0.479*</td>
</tr>
<tr>
<td>Family Stressor Event to Crisis/Adaptation</td>
<td>-0.113</td>
</tr>
<tr>
<td>Level of Coping to Level of Stress</td>
<td>-0.051</td>
</tr>
<tr>
<td>Level of Coping to Crisis/Adaptation</td>
<td>0.275*</td>
</tr>
<tr>
<td>Level of Stress to Crisis/Adaptation</td>
<td>-0.374*</td>
</tr>
</tbody>
</table>
CHAPTER 5: DISCUSSION AND IMPLICATIONS

Introduction

The purpose of this study was to add to the growing body of literature on fathering by investigating the effects of stress and coping on the life satisfaction of fathers with disabled children, ages 5 to 12 years old. In this research project, fathers of disabled children were compared to fathers with non-disabled children as to their perception of family life changes (major life events), parenting daily hassles (minor life events), level of coping, level of stress, and life satisfaction. Additionally, similarities and differences between the two father groups were examined. The results of this study have brought about a variety of interesting and significant issues pertaining to fathers having children ages 5 to 12 years old. This particular chapter addresses these issues and is structured through four major sections: 1) a brief summary of the study design; 2) a discussion of the findings; 3) implications for research, theory, and professional practice; and 4) conclusion.

Summary of Research Design

For the purpose of this study, a survey research design was employed in order to collect data regarding stress factors, coping, and life satisfaction. This method utilized a sample of fathers having disabled and non-disabled elementary-school-aged children. After research approval was granted by the Human Subjects Committee at The Florida State University and the McCracken County School Board in Paducah, Kentucky, the sample was obtained. Due to the school board’s policy on parental confidentiality, the sample was collected with the assistance of classroom teachers via the student. Fathers of local students were asked to complete an anonymous questionnaire that indicated the amount of family life changes, the frequency and intensity of parenting daily hassles, the level of coping in their current family and the level of coping in their individual life, the level of parenting stress and the level of health stress, and the life satisfaction of
each respondent. Within the questionnaire there was also a section on demographic and family information. The total sample consisted of 212 fathers: 127 fathers with non-disabled children and 85 fathers with disabled children.

The questionnaire contained seven standard scales:

1). Family Inventory of Life Events (FILE): this scale was modified to measure the amount of family life changes/stress resulting from the pile-up of stressors which had occurred over the last twelve months.

2). Parenting Daily Hassles (PDH): this scale was used to measure two important dimensions of frequency of daily hassles and intensity of daily hassles.

3). Family Crisis Oriented Personal Evaluation Scale (F-COPES): this scale was used to measure level of family coping based on the stressors.

4). Coping Scale for Adults (CSA): the four subscales were used to measure levels of individual coping based on the stressors.

5). Family Health Status Inventory (FHSI): this scale was used to measure the frequency of occurrence of two important dimensions: physical stress indicators and emotional stress indicators.

6). Parenting Stress Index (PSI): this scale was used to measure the level of parenting stress.

7). Satisfaction With Life Scale (SWLS): this scale was used to measure the global cognitive judgment of satisfaction with one’s life.

In order to guide the process of investigating the study variables, two underlying conceptual frameworks were integrated to address change in the family over time associated with stress factors:

1). Family Stress Theory identifies possible variables that may account for the differences among families as they adjust and adapt to typical life events and stressors (Crosbie-Burnett, 1989). This theory views transitions as somewhat “normal” and expected. However, it should be noted that the pile-up of stressful demands on the family can increase the effect of a particular crisis leading to higher levels of stress. Therefore, since families typically endure more than one stressor, the concept of pile-up of multiple demands was incorporated into family stress theory (McCubbin & Patterson, 1982; 1983).
2). Family Resiliency Theory addresses not only the family’s ability to bounce back from disruptive life challenges but also the family’s ability for growth and development through such adversity (Walsh, 2003).

The integration of these two related theories was appropriate since the underlying concepts of Resiliency Theory are already contained within the Family Stress Theory (Patterson, 2002). Moreover, the notion of resilience promotes an emphasis on family success, endurance, and strength-based qualities throughout difficult life situations.

The model utilized in this particular study was constructed based on an adaptation of Hill’s (1949) ABCX model of family stress and the Double ABCX model of family stress. Based on prior research and family stress theory, this study examined stressor pile-up associated with family life changes (major life events) and parenting daily hassles (minor life events), along with the integration of coping resources and the perception and meaning of the stressor event(s) to predict life satisfaction of fathers with children ages 5 to 12 years old.

In this study, one null hypothesis and two research questions were identified and tested to see if differences existed between the two father groups. The null hypothesis was: there would be no differences between the two groups of fathers (those with disabled children and those with non-disabled children) regarding family life changes, parenting daily hassles (both frequency and intensity), level of family coping and level of individual coping, health stress (both physical and emotional), overall parenting stress, and life satisfaction. The two research questions proposed by the study were: 1). can family life changes/events and parenting daily hassles in conjunction with level of family and individual coping, and health and parenting stress be integrated to predict life satisfaction for fathers with disabled children?; and 2). can family life changes/events and parenting daily hassles in conjunction with level of family and individual coping, and health and parenting stress be integrated to predict life satisfaction for fathers with non-disabled children?

In order to examine potential differences between fathers with disabled children and fathers with non-disabled children, analysis of variance was utilized. In addition, a confirmatory factor analysis was conducted on both father groups to determine if the observed variables were valid measurement indicators of the latent constructs. Furthermore, path analyses were conducted on both father groups to determine the relationships between the
The results of this study indicated that there were significant differences between the two father groups on family life changes, frequency and intensity of parenting daily hassles, level of family coping, level of individual coping pertaining to sharing problems, physical health and emotional health status, parenting stress, and life satisfaction. Overall, the two father groups appeared to be very different in terms of their responses. Fathers with disabled children reported higher amounts of family life changes, increased frequency of parenting daily hassles, increased intensity of parenting daily hassles, a less effective level of family coping, less likelihood to share problems, increased physical health symptomatology, increased emotional symptomatology, higher level of parenting stress, and less overall life satisfaction compared to fathers with non-disabled children. No differences were found within the level of individual coping pertaining to dealing with the problem, non-productive coping, and optimism.

Results of the confirmatory factor analyses of the restricted model for both father groups demonstrated that the specified indicators for the latent variables were acceptable and valid except for the parenting stress (PSI), non-productive coping (CSA2) and sharing (CSA4) indicators. Due to poor model fit and low factor loadings, these three measurement indicators did not adequately measure the latent variables proposed in the model and were therefore removed for both groups. The conclusion from the confirmatory factor analyses for the latent variables with multiple indicators was that the hypothesized model for both father groups was acceptable and was therefore used in the complete Structured Equation Modeling (SEM).

Results of the path analyses for the saturated model for fathers with disabled children demonstrated that one predictor variable, level of stress, had a direct relationship to life satisfaction. Additionally, family stressor event(s) and level of coping had direct relationships with level of stress for the fathers with disabled children group, as well as an indirect relationship to life satisfaction as mediated by level of stress. There was no direct relationship between family stressor event(s) and life satisfaction. However, there were two indirect relationships from family stressor event(s) to life satisfaction as mediated by level of coping and level of stress. The saturated model for the fathers with disabled children
accounted for 74% of the variance on life satisfaction.

Results of the path analyses for the saturated model for fathers with non-disabled children demonstrated that both level of coping and level of stress had a relationship to life satisfaction. There were two indirect causal relationships between family stressor event(s) and life satisfaction as mediated by level of coping and level of stress. The saturated model for fathers with non-disabled children accounted for 52% of the variance on life satisfaction.

Discussion

Research Methodology

In conducting this research, surveys were sent home by classroom school teachers via each student to solicit the participation of fathers as subjects in the study. This method was chosen, after various discussions with school board representatives, due to regulatory stipulations and confidential rules regarding access to family/child information. The researcher found that the method of sending surveys via the classroom teacher resulted in a fairly poor return rate. As reported earlier, only 224 of the 3075 surveys were returned. A more effective technique for this type of study might have involved mailing the survey directly to the father at his home address or being granted permission to contact the father and speak to him personally about the research.

There are several reasons why more fathers might not have responded to this research study. First, many fathers may not have received a survey due to the child loosing or misplacing the research package before it reached home. Second, it is possible fathers did not check the child’s backpack or communication folder since they are usually working when the child returns home from school. Furthermore, it is possible that fathers did not feel it necessary to participate in this research study since they did not know the researcher personally.

Although the research materials sent home clearly specified completion of the entire survey, several of the respondents in the study did not do so. Thus, several of the surveys could not be used in the data analyses, thereby ultimately reducing the sample size. Again, an important factor that may have helped increase the number of participants centered around the researcher having more convenient access to the respondents in order to explain the significance of this research.
As briefly mentioned earlier, the research materials were sent home by the classroom teacher via the student. Although sending the surveys in this manner was deemed the most appropriate method to gain access to fathers without violating confidentiality, it also contained some potential problematic aspects. For example, the passing of the surveys from “principal to classroom teacher to student to father” may have promoted some confusion, as well as possible loss of research materials. In addition, getting the research materials to the appropriate teachers was potentially a time-consuming process for school personnel.

Before distribution of the research materials to the classroom teachers, the researcher was permitted to briefly present his pending research at an informal faculty meeting. This meeting was found to be a very important element of the data collection since it permitted the researcher an opportunity to answer questions pertaining to the study, as well as clarify the role of the classroom teacher in the distribution of the questionnaires. Meeting with the school faculty avoided dealing with questions or potential problems that may have transpired at a later date. In addition, the informal faculty meeting allowed the researcher an opportunity to get the classroom teachers invested in the project.

The survey utilized in this study presented some advantageous aspects over a number of other research methods that could have been used to collect data (Lund, 1999). In the first place, the questionnaire was fairly quick to administer and took into consideration the fathers’ time constraints. Second, the use of the survey method permitted fathers to examine and complete the questionnaire in the comfort and familiarity of their own home, as well as, take the necessary time to complete it. Moreover, a third advantage of this survey method provided confidentiality and anonymity to all the respondents who participated in the study.

Due to the small number of fathers having disabled children, results of the study should be viewed with caution. Since the researcher was not permitted access to the sample, it is not known how many of the questionnaires were actually received by the fathers. In addition, the sample may have been larger if the researcher had been granted permission to contact the participants.

A limitation of the study may be associated with the small tokens that various classroom teachers offered (on their own behalf) as incentives to students if their father completed the questionnaire. The offering of incentives such as suckers or pieces of candy, although fun and exciting to
the student, may have influenced who participated in the study. It is also possible that these incentives may have influenced how participants responded and reacted to the questionnaire. It is not known exactly how many teachers chose to give “token” incentives, nor is it known how these tokens may have impacted the overall response rate.

Since the sample was obtained within the same county in rural Western Kentucky, the generalization potential of this study is limited and the results may not be indicative of all fathers who have disabled children. Moreover, the majority of fathers in the study were predominantly married, middle class, and Caucasian men. There was a limited representation of subjects with racially and economically diverse backgrounds. A more ethnically diverse and balanced sample may have had a significant impact on the findings.

Another potential limitation is related to the issues of measurement. Although the instruments utilized in this study are both well-known and published, they were all self-report measures. These types of scales lacked some of the more beneficial qualities of research techniques such as father-child interviews and father-child direct observations.

**Characteristics of the Final Sample**

In this study, respondents ranged in age from 22 to 60 years of age with a mean of 39.8 years for fathers with disabled children and 39.1 years of age for fathers with non-disabled children. Ages tended to be similar between the two father groups and this may be due to lack of diversity within the sample location. In reviewing the sample characteristics of both groups, it appeared that fathers were predominantly married, Caucasian, and held biological father status. Ninety-six percent of the total sample was Caucasian; .9% was African-American; .9% was Hispanic; .9% was Native-American; and .9% was Asian. It is possible to account for the majority of Caucasian fathers due to the poor representation of ethnic groups within the sample location. The larger numbers of biological father status may represent more commitment by these fathers to their children. This is a finding that warrants further study. Overall, demographic information such as income, education, and marital status pertaining to the two father groups appeared to be similar as well (see Table 1). Again, this may be due to lack of diversity associated with the sample location.

One of the most surprising findings in the demographic information was observed within the eligibility category where fathers of disabled children reported a modal eligibility category of “other” which consisted of Attention
Deficit Disorder. The literature supported the notion that this finding may be somewhat inflated due to the overdiagnosis of Attention Deficit Disorder within school systems (Lefever, Arcona, & Antonuccio, 2003; Richman, Ryan, Wilgenbusch, & Millard, 2004; Wolraich & Baumgaertel, 1996). There are several possible reasons why Attention Deficit Disorder may be overdiagnosed in the school-age population.

One important reason may be associated with schoolteachers’ inability to decipher symptoms of ADD and other clinical disorders. For example, the manifestation of clinical symptoms in a school-age child may “fit” the DSM IV criteria for ADD. However, it should be noted that similar clinical symptoms can be found in children with Bipolar Disorder, as well as other possible common childhood disorders. In addition, much of the recent onslaught of diagnoses for ADD/ADHD are based on subjective observations and may be more opinion than scientific. Although a number of attention problems are due to visual, auditory, motor, and special processing difficulties, children with these individual problems are often misdiagnosed as ADD (Greenberg, 1995).

In this study it would have been interesting to include ADD/ADHD as a separate category since it is often highlighted in the media. However, there is no individual special education eligibility category for ADD/ADHD in the state of Kentucky. Although ADD/ADHD typically falls under the “Other Health Impaired” eligibility category, it can also be found among the “Emotional-Behavioral Disability” category. Unfortunately, since ADD/ADHD can be found among several eligibility categories in Kentucky, it would be problematic to do further analyses in this present study.

The fathers of disabled children group reported that the most commonly reported medications prescribed for their disabled child(ren) was: Concerta (12.9%), Adderall (9.4%), and Ritalin and Strattera (8.2%) equally. It is no surprise these particular medications were reported by the fathers of disabled children due to the increased “Other” category which comprised children with ADD/ADHD. Consistent with previous findings (Strock, 2004), these medications are routinely utilized by medical professionals in the treatment of Attention Deficit Disorder. Within the demographic section several other medications were reported, which can serve dual purposes in children with disabilities. Trazodone is an anti-depressant and can be used not only for depression and low mood level, but also for sleep disturbances. In the medical field Depakote is recognized as an anti-psychotic medication, but can be used for stabilization of mood swings. Klonidone is a blood pressure medication, but has the capability in low dosages to help diminish
tics, which are part of Tourettes Syndrome. While various medications were reported on the demographic information, it would have been of interest to know the purpose of the medication pertaining to each disability.

**Hypothesis and Research Questions**

In this study, one null hypothesis was tested: there will be no difference between the two groups of fathers (those with disabled children and those with non-disabled children) regarding family life changes, parenting daily hassles (both frequency and intensity), level of family coping and level of individual coping, health stress (both physical and emotional), overall parenting stress, and life satisfaction. The results of the study revealed that significant differences did in fact exist between the two father groups regarding family life changes, frequency of parenting daily hassles, intensity of parenting daily hassles, level of family coping, sharing as a measure of individual coping, physical health status, emotional health status, overall parenting stress, and life satisfaction. No significant differences existed on the level of individual coping variables: dealing with the problem, non-productive coping, and optimism.

To no surprise fathers with disabled children experienced increased stress associated with family life changes compared to fathers of non-disabled children. The difference in family life changes between the two groups supported the idea that exposure to major events had more of an impact on fathers with disabled children because of additional considerations involved in rearing a child with special needs. For example, a family’s relocation would more than likely cause increased stress for fathers with disabled children due to having to find an adequate school, appropriate services, and other pertinent resources. Another major life event might be a promotion at work, which could reduce time spent at home helping out with caretaking duties related to the disabled child. As a result there would be more responsibilities given to other family members to care for the disabled child, and thus create other stressful situations.

Greater negative impacts have been found to exist for families with disabled children compared to families without disabled children on major life events and family finances (Baker, Blacher, Crnic, & Edelbrock, 2002). This finding was consistent with other research studies which indicated that life course events also negatively impact paternal stress due to resource and work-related strains (Keller & Honig, 2004; Saloviita, Italinna, Leinonen, 2003; Seltzer, Greenberg, Floyd, Pettee, & Honig, 2001).

According to the literature, the cumulative impact of minor life events
may also be viewed as significant sources of parenting and family stress since they characterize demanding, everyday transactions (Crnic & Greenberg, 1990). In this study, fathers of disabled children experienced more frequent occurrences of parenting daily hassles compared to fathers with non-disabled children, which may due to the unique difficulties posed by disabled children. For example, children with disabilities are often less independent than typically developing children resulting in more frequent daily responsibilities and demands being placed on fathers. When it comes to task completion and appropriate daily living skills, children with disabilities often rely on primary caretakers to assist with these events leading to increased daily demands on fathers. For fathers of disabled children there may be more difficulties related to finding a babysitter who would feel comfortable and familiar with a special needs child. Constantly having to change plans because of the unpredictability of a disabled child’s needs could also lead to increased minor daily hassles for fathers (Dyson, 1997). Concern over how others may react to a disabled child and the need to protect the child may promote increased daily distress as well. In addition, fathers of disabled children reported via the open-ended questionnaire that others may not fully understand how to deal with their child’s disability and as a result create more daily hassles for them.

Higher frequencies of parenting daily hassles appeared to be an important determinant of stress for fathers with disabled children (Crnic & Greenberg, 1990). Life stressors associated with a disabled child may contribute significantly to the ups and downs of everyday irritating and demanding interactions (Fagan, 2000). Fathers of disabled children may perceive more ongoing daily challenges associated with additional supervision or special caretaking duties. Additionally, daily parenting demands for fathers of disabled children may not necessarily be viewed as “typical.” Dealing with rehabilitative services, promoting medication compliance, visiting with school personnel and other such issues could be experienced by fathers of disabled children as somewhat challenging daily (or weekly) interactions/events.

In this study, fathers of disabled children also experienced minor life events to be more difficult and intense compared to fathers with non-disabled children. Naturally, it would stand to reason that fathers who experience higher frequencies of minor life events may also perceive higher degrees of intensity associated with those minor life events. Typically, there is no break from the daily demands of rearing a disabled child. Moreover, there is
limited respite care providers to assist fathers of disabled children (Dyson, 1997). Therefore, daily hassles, frustrations, and demands can be intensified for this group of fathers.

Since fathers of disabled children are less likely to share their problems and ask for assistance, it is also reasonable to say that the difficulty in dealing with daily demands is heightened. Moreover, these fathers may feel isolated or alone in dealing with daily demands which in turn causes them to experience greater intensity as they manage minor daily hassles involving a disabled child. The literature addressing minor life events suggests that parenting daily hassles are significant sources of stress, as well as contribute to major life stress predictions (Crnic & Booth, 1991; Crnic & Greenberg, 1990; Fagan, 2000). If fathers experienced less parenting daily hassles, as well as less intensity associated with these hassles, overall stress levels may be reduced significantly.

Fathers of non-disabled children reported higher levels of family coping compared to fathers with disabled children. This finding indicated that fathers with disabled children utilized a lesser amount and variety of family coping strategies in dealing with stressful issues related to their disabled children. The difference between the two groups may be attributed to fathers of disabled children being overly taxed and stressed so that they are not as able to problem-solve or cope with stressors in an effective and productive manner. Oftentimes family members do not want to burden other family members regarding a child’s disability (Grant & Whittell, 2000). It is possible that fathers of disabled children feel they should manage and cope with stressors individually rather than share them in a family or public setting. Other related findings also supported the notion that fathers of disabled children do not actively engage in acquiring support from others to assist with life stressors (Table 11).

Previous research indicated that fathers of disabled children may have few satisfactions from family relationships, and thus may not utilize them as a resource for coping with their disabled children (Cummings, 1976). Furthermore, research has consistently indicated that at times fathers of disabled children were cut off from sources of social support due to the lack of help from neighbors and workmates (Hornby 1992; 1994; 1995). In the open-ended questions, fathers of disabled children reported that they typically shared their thoughts and feelings individually with their spouses (as a coping strategy) rather than in a family setting. It could be the case that fathers of disabled children emotionally and physically distance themselves...
from daily life stressors associated with a disabled child (Carpenter, 2002; Hadadian, 1994). Thus, diminishing their utilization of constructive outlets like family coping strategies and other important resources.

The level of individual coping was determined by the following: “dealing with problems,” “non-productive coping,” “optimism,” and “sharing.” No differences were found on the scores of both groups in “dealing with problems.” This finding suggested that fathers of disabled children and fathers of non-disabled children appeared to (individually) cope with problems in a similar manner. Both father groups utilized some of the following strategies to cope individually: play sports, leisure activities, and work. When the two groups were compared, there was no difference in the level of individual coping pertaining to non-productive coping. This finding suggested that men/fathers utilize similar non-productive coping strategies and may prefer to deal with problems alone and not reach out to others for assistance. As hypothesized, there was no difference between the two father groups on optimism since both groups appeared to utilize similar individual coping strategies such as praying for guidance and help, making time for leisure activities, and looking at the positive side of things. These findings were consistent with comments reported by the fathers in the open-ended format of the questionnaire. In this study, men/fathers used more instrumental-type activities, such as individual coping strategies. Little emphasis was placed on expressive-type individual coping strategies such as sharing and talking to others in dealing with life stressors.

There was a difference between the two father groups regarding level of individual coping pertaining to sharing, which suggested that fathers of disabled children appeared to be less invested in asking outside sources for assistance as an individual coping strategy. Interestingly, fathers of disabled children were found to be less likely to express their thoughts and feelings with others. It is reasonable to say that fathers may not share thoughts and feelings since they typically have a negative reaction to professionals due to not having the time (nor the opportunity) to develop productive relationships with them (Hornby, 1992). Furthermore, it could be that fathers with disabled children may not share family information with outside sources due to past experiences related to “professional ignorance” (whereby one is referred from one resource to the next) or “the deaf ear syndrome” (whereby professionals do not seem to demonstrate an understanding of a particular disability or provide much assistance) (Hornby, 1992).

Consistent with other research evidence, fathers of disabled children
in this study may not share with others (in terms of individual coping) due to shame, sadness, grief, disappointment and/or ambivalence associated with their child’s disability (Bernier, 1990; Carpenter, 2002; Hadadian, 1994; Hornby, 1992; Roos, 1978; Spangenberg & Theron, 2001). This finding could also suggest that fathers of disabled children may internalize their thoughts and feelings associated with their child’s disability. Prior research indicated that fathers with disabled children have more difficulty in accepting their child’s disability (Dyson, 1997). Therefore, it is reasonable to assume that fathers may avoid sharing and seeking social support if they have negative feelings about their child (Keller & Honig, 2004). In addition, fathers of disabled children may feel embarrassed about their child’s disability, and thus, not want to share these feelings with others.

Differences were found between the two groups on physical health stress and emotional health stress as measured by the physical symptomatology subscale and emotional symptomatology subscale of the Family Health Status Inventory. These findings suggested that fathers with disabled children experienced higher levels of both physical and emotional health stress compared to fathers with non-disabled children. It is reasonable to predict that physical health symptoms may be more prevalent in fathers with disabled children due to overwhelming stress and anxiety, which can be manifested as somatic complaints. Fathers of disabled children reported increased physical symptoms on all health stress indicators except for “low energy” and “trouble staying asleep” (Table 12).

Another aspect to take into consideration with fathers of disabled children is the tendency to possibly internalize their thoughts and feelings perhaps resulting in external physical manifestations of stress and anxiety (Spangenberg & Theron, 2001). Although the research evidence is rather limited regarding fathers of disabled children and depression, in this present study the findings of emotional/psychological health symptoms may be associated with the tendency for fathers with disabled children to be more easily depressed and anxious compared to fathers with non-disabled children (Bristol & Gallagher, 1986; Brotherson, Turnbull, Summers, & Turnbull, 1986; Hornby, 1994; Lamb & Meyer, 1991; McConachie, 1982; Meyer, 1986; Spangenberg & Theron, 2001). The literature supported the idea that daily caregiving demands for long term conditions can lead to emotional and physical exhaustion, which may contribute to depression and other psychological symptoms (Patterson, 2002).
It is not surprising that fathers of disabled children experienced more overall parenting stress compared to fathers of non-disabled children. This finding was consistent with the review of literature that indicated higher levels of parenting stress appeared to be associated with children having disabilities (Baker, Blacher, Crnic, & Edelbrock, 2002; Dyson, 1997; Hastings & Taunt, 2002; Margalit, Raviv, & Ankonina, 1992). The literature addressing fathers of disabled children suggested that parenting stress stems from a number of sources such as: visibility of the disability, educational placement and difficulty in securing babysitters or respite care providers (Dyson, 1997). Based on research conducted by Chan and Sigafoos (2001), it was found that respite care is associated with significant reductions in overall parental stress, at least for mothers and perhaps also for fathers. Unfortunately, respite care is extremely limited and can be expensive. Therefore, fathers of disabled children may not have access to this type of assistance in helping to lower overall parental stress. In this present study, similar ideas as mentioned above relating to parenting stress were presented by fathers of disabled children in the open-ended section of the questionnaire. One father stated, “I feel stress because there is no respite care available and I need time to unwind.” Another father reported, “It is tough to find someone to look after your child.”

It would be reasonable to say that continuous and ongoing stresses and hardships faced by fathers of disabled children can lead to increased levels of parenting stress. Burden of increased care, modification in family activities, worry about a child’s prognosis, and financial strains can contribute to higher overall parenting stress (Chan & Sigafoos, 2001; Dyson, 1991; 1993; 1997). In this study several fathers reported feeling heightened stress as it related to their child’s ongoing development. One father stated, “I wonder if he [child] will lead a productive life.” A second father reported, “I worry that my child will ever be normal.”

It is likely that parenting stress increases over time (Dyson, 1993). As disabled children mature and develop, there are new and unique stressors that confront fathers. For example, disabled children may not be able to participate fully in age-appropriate activities as they develop and fathers may have to spend more time assisting their child. In an open-ended question one father stated, “There is a lot of time required in taking care of a disabled child and this is stressful because there are things I need to get done.” Fathers of disabled children may also feel an increase in parenting stress due to more mothers being employed outside the home. In the past,
mothers have traditionally stayed home and have assumed greater responsibility for overall child care (Dyson, 1997). However, over the years, changes in the U.S. workforce may have created increased levels of parenting stress for fathers of disabled children since they are now having to take on more responsibility in childcare.

Although rearing a typically developing child can generate stress for fathers (and mothers), children with disabilities typically present uniquely challenging aspects for fathers (and mothers). According to comments reported by fathers of children with disabilities (Table 15), it was evident that lack of understanding from others, time constraints, and dealing with children in the same family with varying abilities increased parenting stress. Therefore, it would be reasonable to say that fathers of children with disabilities would rate much higher in parenting stress because of greater amounts of time and resources required by the everyday cares and demands of a disabled child (Innocenti, Huh, & Boyce, 1992).

Finally, there was also a significant difference between the two father groups on the variable of life satisfaction. The fathers of non-disabled children indicated having a higher perceived life satisfaction compared to fathers with disabled children. As already reported, fathers of disabled children have higher levels of family stress, more frequent occurrences of parenting daily hassles, more intensity associated with parenting daily hassles, less effective family coping strategies, less likely to share individual problems, higher physical health stress symptomatology, higher emotional health stress symptomatology, and higher overall levels of parenting stress. The literature supported the idea that satisfaction with life is based on one’s subjective judgment of overall life circumstances (Pavot & Diener, 1993). Therefore, it is reasonable to predict that the conditions above appeared to contribute to a lower level of life satisfaction in fathers with disabled children.

In this study, two research questions were examined: 1). can family life changes/events and parenting daily hassles in conjunction with level of family and individual coping, and health and parenting stress be integrated to predict life satisfaction for fathers with disabled children?; and 2). can family life changes/events and parenting daily hassles in conjunction with level of family and individual coping, and health and parenting stress be integrated to predict life satisfaction for fathers with non-disabled children? A confirmatory factor analysis and path analysis of the proposed model were conducted for both groups. The confirmatory factor analysis was
conducted to estimate the validity of the specified indicators to the latent constructs. In addition, path analysis was determined to be an appropriate statistical procedure to estimate the relationships between the variables.

The findings of the restricted model based on the confirmatory factor analysis for both father groups revealed that the specified indicators were valid measures of the latent constructs, except for parenting stress and individual coping items: non-productive coping and sharing. Estimated structure co-efficient loadings for both father groups were generally high suggesting that variable specifiers had been well-chosen for this study. Since the specifiers were noted as valid indicators of the latent constructs, they were used in the path analyses for both groups.

The findings for the saturated path analyses revealed similar relationships for both fathers with disabled children and fathers without disabled children predicting life satisfaction. Level of stress, as a measure of physical and emotional symptoms or complaints, had an inverse relationship on life satisfaction. This means as greater occurrences of health symptoms/complaints for both father groups increased, their overall life satisfaction decreased.

A positive relationship also existed between family stressor event(s) and level of stress for both groups of fathers. This is to say, as family stressor event(s) (both major and minor) increased for both father groups, level of stress as measured by health status (physical and emotional symptoms) increased. The model demonstrated that both father groups experienced health symptomatology as an indication of the stress they experienced from the pile-up of family stressor event(s) (Avison & Gotlib, 1994). This finding emphasized the importance of health-related constructs as indicators of stress manifestations pertaining to stressful life course events (Farhood, 1999). It would be reasonable to expect that fathers in general would be impacted to some extent by family stressor event(s) (both major and minor) since they are exposed to them at some time or another during their lifetime (Dyson, 1997; Grant & Whittell, 2000; Keller & Honig, 2004; Rousey, Best, & Blacher, 1997). For example, most fathers go through similar life processes and experiences such as: illness in the family, work-related issues, difficulties with children, relocation, and possible marital and financial strains.

There was a relationship between family stressor event(s) and level of coping for fathers of disabled children and fathers of non-disabled children. A greater pile-up of family stressor event(s) was associated with lower
utilization of coping strategies/skills by both father groups in dealing with life stressors. In other words, as family stressor event(s) increased, both groups of fathers tended to use less individual and family coping strategies such as: playing sports, making time for leisure activities, talking to family members, and asking for assistance with problems.

Since the sample for this study was comprised mainly of fathers with full-time employment status, it would be reasonable to assume that they are already somewhat burdened with life pressures. Therefore, as more stressful life events occur, they tended to internalize their feelings rather than utilizing coping methods from outside resources. This finding was connected to fathers’ tendency to deal with their problems in an individual manner without reaching out to others. It may be that fathers are so overwhelmed with typical life stressors that they do not have the time to process what specific coping strategies would be most effective in dealing with family stressors. It could also be that fathers assume a “stand-off approach” during the pile-up of life stressors whereby they distance themselves physically and/or emotionally (Carpenter, 2002; Hadadian, 1994). In this instance, fathers may need additional assistance in developing and learning coping skills to deal with stressful life events (McConachie, 1994; Burbach, Fox, & Nicholson, 2004).

In the saturated model for fathers with disabled children compared to fathers with non-disabled children, two dissimilarities were noticed. There was a relationship between level of coping and level of stress for fathers with disabled children. A higher level of coping for fathers with disabled children was associated with decreased amounts of health symptoms/complaints. This suggested that as fathers of disabled children used a variety of productive coping strategies, they were more likely to experience decreased levels of physical and emotional stress symptomatology, such as headaches, backaches, tension, restlessness, sore throats, and loneliness (Table 12).

There was no relationship between level of coping and level of stress for the fathers with non-disabled children. For fathers of non-disabled children, a relationship existed between level of coping and life satisfaction. This suggested that for fathers of non-disabled children, level of coping had an impact on life satisfaction. Therefore, a higher level of coping (in terms of utilization of a variety and greater number of coping strategies) resulted in greater satisfaction with life. Fathers of non-disabled children tended to utilize coping methods, which involved asking for support and assistance from extended family, friends, and neighbors, as
well as people in their church family. Attending church, having faith in God, and talking to a minister also appeared to be more prevalent coping methods for fathers of non-disabled children. Reaching out to others and asking for advice from a professional may alleviate stressful feelings and contribute to a higher degree of life satisfaction for fathers of non-disabled children.

In the saturated model, family stressor event(s) had the greatest total effect on life satisfaction for fathers with disabled children; whereas level of stress had the greatest total effect on life satisfaction for fathers with non-disabled children. This difference may be explained by the fact that major and minor life events had the most impact in the lives of fathers of disabled children. All fathers (those with disabled children and non-disabled children) deal with life stressors, however, it would be reasonable to say that fathers with disabled children perceive more intensified (family) stress as it relates to both family life changes, as well as parenting daily hassles.

Fathers with disabled children may experience increased stress when dealing with a relocation/move and finding the right school for a disabled child. In addition, there may be more overall financial expenses associated with a disabled child. In a similar fashion, it could be that fathers of disabled children are impacted more negatively by parenting daily hassles due to the unique everyday challenges in rearing a disabled child. Since fathers of non-disabled children do not have to deal with these unique challenges, it may be that family life changes are not experienced as being overwhelmingly stressful.

For fathers of non-disabled children, it could be that level of stress had the greatest total effect on life satisfaction because this group does not deal with the special needs and increased stresses associated with a disabled child. Since level of stress deals with perception, one might conclude that fathers of non-disabled children are more focused on personal reactions (both physical and emotional) to life events rather than the difficult stressors associated with having a disabled child. Furthermore, fathers of non-disabled children may not be consumed with the constant daily cares that arise in rearing a child with disabilities and have more time to devote to their own perception of life events in terms of physical and emotional health symptomatology.

The second greatest total effect for disabled fathers was level of stress, however, for fathers with non-disabled children the second greatest
total effect was family stressor event(s). Interestingly, these variables were reversed for both groups. It could be the case that once fathers of disabled children deal with family stressor event(s) connected to their disabled child, they then have the time and energy to focus on their own individual perception of stress (physical and emotional). In a similar fashion, once fathers of non-disabled children manage their own perception of emotional and physical stress, they then have time to focus on family stressor event(s). Fathers of disabled children had higher levels of stress on all health symptoms except for “low energy” and “trouble staying asleep” (Table 12). It could be that fathers of both groups feel low energy to a certain extent due to regular work schedules and life pressures. Similarly, both father groups may also have difficulty sleeping at times because of the various stressful experiences that all fathers encounter throughout life.

There was a difference between both father groups on all emotional health symptoms. Again, it is reasonable to conclude that fathers of disabled children had increased emotional symptoms due to possibly feeling more depressed and lonely regarding their unique circumstances.

Level of stress and family stressor event(s) had significant effects for both groups. It could be that the variables and paths proposed in the model hold true for both father groups. In other words, stress and life events (both major and minor) cut across all fathers with young children. It is well-known that parents’ perception of stress impacts the process of parenting for both disabled children and typically developing children (Boss, 2001; Creasey & Jarvis, 1994; Feldman, 1987; Noppe, Noppe, & Hughes, 1990; Pelchat, Bisson, Bois, & Saucier, 2001; Rodriguez & Murphy, 1997; Walker, 2000). Moreover, an accumulation of major and minor life changes have the ability to create stress for all fathers having school-age children (Crnic & Greenberg, 1990).

Explained variance calculations were somewhat different for the two father groups. In comparing both groups, overall the saturated model for fathers with disabled children explained more of the variance of life satisfaction (74%) than did the saturated model for fathers with non-disabled children (52%). Family stressor event(s), level of coping and level of stress appeared to be better predictors of life satisfaction for the fathers of disabled children compared to fathers of non-disabled children. This indicated that the variables utilized in this present study were successful in accounting for the life satisfaction for fathers of disabled children. The predictor variables in this study captured more succinctly the areas of
life stress, individual and family coping strategies, and perception of stress for fathers of disabled children. The difference in variance could also be attributed to the explanation that fathers of disabled children defined their circumstances and the available resources [based on stressor event(s)] as more important in the prediction of their life satisfaction.

Implications for Research, Theory and Professional Practice

In this study, an attempt has been made to investigate the relationship of family stress, level of family coping, level of individual coping, and health stress (both physical and emotional) on life satisfaction for fathers with disabled children and fathers with non-disabled children. Comparisons were also made in the study to determine if there were any differences between the two father groups on several variables. Results of this study in conjunction with the noticeable limitations indicated that further examination is required regarding the ways in which fathers of disabled children cope with stressful life events. Although the results of this study may not be broadly generalized to all fathers and must be treated with caution, they do indicate how fathers with disabled children perceive overall life satisfaction. In this particular study, the findings generated sufficient information to provide recommendations for areas which should be addressed in future research, theory, and professional practice with fathers of disabled children.

Implications for Research

Based upon the results of this study and the lack of attention to fathering issues in the review of literature, it seems that continued research efforts need to focus on the connection of stress and coping within father-child studies. Within the literature there appears to be little information regarding how stress and coping interact together to produce predictable outcomes related to crises in families with disabled children. The results of this study suggested that those fathers who utilized a larger amount and variety of family coping skills, as well as shared with others about their stressors, were more likely to be satisfied with life. Also, fathers who had decreased health stress symptomatology were more likely to be satisfied with life. Therefore, it is important to continue to do research on how coping and stress impact factors which influence life satisfaction and parental contentment.

Furthermore, additional information is needed on stress and coping of
fathers over time. For example, longitudinal studies would be especially helpful in examining fathers’ experiences of stress and coping dimensions at various stages related to child development and self development (Hornby, 1994). Longitudinal studies would also provide continuous monitoring of how fathers deal with stress and coping in the presence of a child with a disability (Dyson, 1993; 1997). In addition, longitudinal studies are necessary to discern if stressors and coping strategies change over time, since children with disabilities have a definite impact on the family system over time.

Another significant avenue for continued research might examine the similarities and differences between stress and coping for fathers in urban areas compared to fathers in rural areas (Houser & Seligman, 1991). This present study was comprised of participants within a predominantly agricultural area. However, there may be pertinent demands and resources associated with rural life and urban life for fathers with educationally disabled children (Houser & Seligman, 1991). This area of future research would be extremely helpful in identifying what unique services, support groups, appropriate resources, or coping strategies (if any) might be determined by geographic location (Houser & Seligman, 1991). In addition, it would be of interest to research the role of family members related to disabled children within a particular geographic area.

Due to the high number of fathers with children having Attention Deficit Hyperactivity Disorder (ADHD) in this study, future studies should investigate possible life/parental stressors associated with this specific disability along with stress and coping dimensions. In addition, it would be beneficial to conduct separate studies with fathers of children with other disabilities in order to investigate possible similarities and differences in their experiences (Hornby, 1994).

Since the fathers in the study reported the inclusion of their wives in dealing with stressors related to their disabled children, efforts should be made to include mothers/wives in research studies regarding families with disabilities. A collaborative approach in dealing with a disabled child may be beneficial in lowering levels of stress, as well as identifying similar or different coping strategies utilized by men/fathers and women/mothers. From the results of this study, it appeared that men/fathers tended to play sports, get involved in leisure activities, and/or become work oriented. Future research needs to investigate if there are differences between men and women’s coping styles as they relate to disabled children in order to
determine how both partners might work together in managing certain life stressors.

Another recommendation would be to replicate this study utilizing a larger sample area, as well as a larger sample size to determine if the findings in this study hold true. A one-time study may be limited in its ability to generalize findings based on unknown pre-existing factors versus acquired factors. Although this study made an attempt to incorporate some qualitative data through means of written comments from participants, further qualitative research is warranted to examine more thoroughly the rich and detailed life accounts of fathers and their disabled children.

Due to difficulty in recruiting participants related to issues of privacy and confidentiality, attempts at further research on father-child relations might involve educational agencies, intervention programs and/or support groups to access fathers more easily. It could be possible that fathers have generally been avoided and neglected in previous family-child research due to the reported difficulty in obtaining and accessing them for research purposes (Burbach, Fox & Nicholson, 2004).

Lacking in the literature, is the need for father-child studies involving a variety of ethnic and cultural backgrounds. Unfortunately, this study was unable to add much to the knowledge base related to fathers of disabled children and cultural issues. However, it would be helpful to know how fathers with different ethnic backgrounds cope with stressors associated with their disabled children. It could be the case that differences in culture and value systems have potential influences on specific coping strategies of fathers having children with disabilities (Li-Tsang, Yau & Yuen, 2001; Yau, & Li-Tsang, 1999).

**Implications for Theory**

Although Hill’s ABCX Model of Family Stress (1949; 1958) provided the overarching theoretical framework to structure this present study of stress and coping on fathers with disabled and non-disabled children, the Double ABCX Model of Family Stress (McCubbin & Thompson, 1983) and Family Resiliency Theory (McCubbin & McCubbin, 1996) were also utilized in understanding an important shift from “deficits” to “challenges” in family life events over time. The model did rather well in predicting the relationship and interaction between family stressor event(s), level of family coping, level of individual coping, and health stress and their influence on life satisfaction for fathers with and without disabled children. However, the results of this study indicated that the model was a better predictor and fit
for fathers with disabled children. Since the ABCX Model emphasizes stress, it could be the case that more stress was explained for the fathers of disabled children.

The results of this study indicated that family stressor event(s) was an indirect predictor of life satisfaction. The findings indicated that level of coping and level of stress were stronger predictor variables of life satisfaction. As previously mentioned, this study indicated that Family Stress Theory is an effective way of conceptualizing the processes of adaptation for fathers with disabled children. However, The Family Stress Theory’s predictive capacity may be enhanced if researchers were to incorporate more specific individual paternal coping skills and stressors in theory development. It should also be pointed out that Family Stress Theory may have more value if it could be ordered with reciprocal paths among the model variables (Lund, 1999).

It is possible that family coping may not have been the most suitable measure for this study since individual perceptions were involved. Unfortunately, the scale for individual/personal coping in this study did not have high reliability. Therefore, other more appropriate personal coping measures ought to be examined in light of the theoretical framework.

Family Resiliency Theory was utilized in this study and has much to offer the family science field. Continued efforts should be made to expand and modify the resiliency framework. Further clarification of family resiliency concepts and terms may lessen some of the confusion related to what it means to be resilient, as well as determining who is resilient (Patterson, 2002).

Prior research on stress and coping difficulties of fathers with disabled children have generally been studied from both negative and positive aspects. Unfortunately, many studies have tended to highlight the more negative aspects of having a child with a disability (Li-Tsang, Yau & Yuen, 2001; Yau & Li-Tsang, 1999). Some of these negative factors include: demands on the family’s resources and coping strategies, interruption of normal routines, and preventing personal growth opportunities (Hadadian, 1994; Li-Tsang, Yau, & Yuen, 2001). Although fathers of disabled children experience much stress, they may also experience some happiness and learn strengths and skills in parenting their children (Yau & Li-Tsang, 1999). Therefore, the utilization of the Resiliency framework needs to be explored further to account for why some fathers may be resilient despite having to face predictable life events and adversities.
Although the fathers of disabled children in this study reported higher levels of parenting stress and lower overall life satisfaction, there was some evidence of resilience as reported on the open-ended format of the survey. One of the most noticeable aspects of resiliency in this study centered around the ability of the fathers of disabled children to continue in their father role despite the ongoing stressors associated with their children. Some of the comments reported by these fathers included: "It is not always easy, but it is rewarding," "It is very stressful but a happy experience and a relationship I wouldn’t trade for anything," and "It is very time consuming, but very rewarding."

A further examination of those fathers with disabled children who are doing fairly well would be helpful in order to identify what factors influence their resilience. It could be that fathers in this study were resilient due to having spousal support, as well as full-time employment status to assist with financial demands of caring for disabled children. Prior research has supported the idea that spirituality as a resiliency factor permits families to endure and recover from hardships in life (McCubbin, McCubbin, Thompson, Han, & Allen, 1997). Both groups of fathers in this study also reported that their spiritual beliefs and practices were very important in dealing with life circumstances. Another area to consider is the perception of fathers in managing a stressful life event(s). Perception is a major element in the ABCX model of Family Stress and it has a large impact on how fathers cope and endure throughout difficult events. Therefore, continued theory development may look at how resilience may be promoted through specific protective factors associated with fathers of disabled children.

Traditionally, a stress and coping perspective has been the predominant approach for research dealing with short-term effects of parenting a disabled child (Seltzer, Greenberg, Floyd, Pettee, & Hong, 2001). However, it is possible that other theoretical frameworks may reveal new awareness and insight regarding stress and coping associated with father-child interaction. For example, a developmental perspective may help in understanding stress and coping dimensions related to life cycle stages through which fathers and children pass. Another theoretical framework to take into consideration is Family Systems Theory which proposes that parts (of a system) may only be understood as they relate to each another and the whole (Bertalanffy, 1968). Since a family system is more than the sum of its parts, this theory would attempt to examine disabled children from a systems perspective in order to
discover individual members’ interactions such as mother, father, and sibling effects related to stress and coping (Bernier, 1990).

**Implications for Professional Practice**

From the results of this study, several implications for professional practice clearly emerge. In the first place, it is crucial that family therapists, family life educators, counselors, clergy, and school personnel understand the complex process of stress and its impact not only on fathers, but also on the family as a whole (Keller & Honig, 2004). So that clinicians and social service professionals can be prepared to use appropriate interventions, it is necessary that they have a reasonable amount of knowledge and training regarding effective management of family stress. In understanding this process, beneficial information such as reliable and valid measures of family needs, strengths, social networks, coping strategies and other support group information would be helpful (McConachie, 1994). In addition, social service professionals, as well as lay individuals, may need specialty training as it relates to fathers (and families) of disabled children. Through specialty training, social service professionals and others may learn effective strategies in assisting with interventions for fathers (and families) of disabled children (McConachie, 1994).

Secondly, it is important that efforts are made to involve groups such as churches in fathering issues since the findings of this study indicated that fathers of disabled children turned to their personal faith and religious background as a resource and coping mechanism. Promoting clergy involvement and support for fathers of disabled children may help in dealing with increased levels of stress and ultimately increase overall life satisfaction for these fathers. Clergy may also provide assistance by supporting fathers to get involved in other support organizations beyond the scope of the church (Wintersteen & Rasmussen, 1997).

Thirdly, in counseling parents of disabled children, family therapists should involve fathers, as well as mothers. The findings of this study suggested that fathers tended to talk to their wives and search for assistance and direction in dealing with the stress associated in dealing with a disabled child. Not only is it important to include mothers in the counseling process (or treatment program) pertaining to a disabled child, but also to discuss the impact of this stressor on the marital relationship (Hornby, 1992). A family therapist can explore fathers and mothers’ perceptions of their child and how the child affects the family. From this type of discussion, the family and therapist can discuss the most essential
coping resource(s) to be employed to decrease overall stress levels and increase life satisfaction. Hopefully, family therapists can assist in discovering possible avenues of resilience and potential strengths not yet identified by the family. In addition, a family systems orientation allows the clinician to look at the influences outside and within the individual that may have a profound impact on stress and coping dimensions associated with parenting a disabled child (Bernier, 1990).

Another area which emerged from the results of this study emphasized the potential need for intervention programs such as: support groups, tailored workshops, counseling, and other community efforts targeting families and disabled children (Hadadian, 1994). It is possible that at times fathers’ typical sources of support may be insufficient to meet their needs and a larger support context may be required (Wintersteen & Rasmussen, 1997). Support groups allow for a personal touch where fathers with similar problems and stressors might be more willing to share one to one (Wintersteen & Rasmussen, 1997). This is an important implication since findings of this study suggested that fathers of disabled children tended to share less than fathers of non-disabled children. In a professionally-led support group, fathers of disabled children may be more likely to be engaged since they are surrounded by peers with common challenges and life difficulties. However, it should be noted that there may be some difficulty in attracting fathers to parent-education and support groups because historically they have not been present in this kind of setting (Burbach, Fox, & Nicholson, 2004). In addition, their lives are already full of daily hassles and stress and may not be able to afford the time to attend such sessions.

Respite care and stress management programs are two other potentially under-utilized resources available to families with disabled children (Chan & Sigafoos, 2001). Respite care is another potential avenue through which fathers, as well as mothers, may alleviate stress and pursue some of their own interests for short periods of time (Dumas, Wolf, Fisman & Culligan, 1991). Stress management programs may help fathers with disabled children handle their own psychological distress, as well as learn healthy coping skills to deal with their disabled child. Again, family therapists, counselors, and school personnel need to be aware of these types of assistance, as well as the many other resources available to fathers with disabled children.

Finally, an implication for practice is seen in the further development of the subscale measures of the Coping Scale For Adults (CSA) used in this
present study. There is a need for more improved and precise scales to measure dimensions of individual coping. Although the Coping Scale for Adults is a reasonable attempt to measure individual coping, it needs further development along with enhancements to its validity and reliability.

Conclusion

The findings of this study contained many contributions for the field of family science. For fathers with disabled children, one of the most interesting aspects of the findings highlighted the notion of chronic loss and sorrow, as well as grief-related reactions pertaining to their children. Within the research literature, the term “chronic sorrow” has been used to describe the bereavement process experienced by parents in response to life with a disabled child (Copley & Bodensteiner, 1987). Various authors claim that feelings of sorrow are often felt by parents having a chronically ill or disabled child in the family (Teel, 1991). It is well-known that parents of disabled children tend to be acutely aware of the differences between their children compared to typically-developing children (Bernier, 1990; Teel, 1991). These obvious differences can lead to life-long mourning associated with not having the “perfect” child or the “hoped-for child” (Bernier, 1990; Copley & Bodensteiner, 1987; Teel, 1991). In this study, one father responded to the open-ended questions by saying, “I love being a father, but I feel sad knowing that my child is not like the other kids in his class.” Another father stated, “I miss having a son who can do normal things.”

Fathers, as well as mothers, of disabled children deal with life-long implications as caregivers, such that feelings of loss and sorrow may be intensified during certain developmental stages. It is possible that fathers go through repeated periods of grieving as they approach significant milestones in their child’s life (Bernier, 1990).

It would appear from this present study that fathers of disabled children need someone with whom they can communicate, share feelings and problems, and gain understanding without blame or rejection (Wright, 1976). Although support groups and intervention programs may be a good place to start at reaching out to this population, fathers of disabled children need first to be understood more specifically at various community levels. Teachers, guidance counselors, family therapists, doctors, and clergy need to be educated on the underlying emotional ambivalence experienced by these fathers. An understanding of the unique meaning that fathers prescribe to
their exceptional parenting role would assist professionals in acknowledging and recognizing the unique challenges these men encounter throughout the life course. Specific knowledge about how prolonged mourning, connected to the disappointment of having a defective child, may lead to feelings of guilt, shame, depression, and rage and would be beneficial in comprehending the psychological context of fathers with disabled children (Bernier, 1990; Copley & Bodensteiner, 1987; Teel, 1991; Wright, 1976). Since fathers of disabled children are dealing with a variety of stress-related emotions, at times they may be directed toward a specific person or facility (Bernier, 1990; Copley & Bodensteiner, 1987; Teel, 1991; Wright, 1976). It is important that professionals develop strategies and clinical skills to deal with these types of situations.

Another contribution that surfaced from this study was the idea of emotional turmoil experienced by fathers in the rearing of their disabled children. Many of the fathers in this study were employed fulltime and most likely already dealing with typical work-related stresses. Therefore, adding a disabled child with Attention Deficit Hyperactive Disorder (ADHD) who has difficulty focusing and paying attention would likely increase stress and family turmoil for these fathers. Moreover, the administration of medication and time spent in structured discipline would only compound the family and emotional chaos for fathers with disabled children. It would also be reasonable to say that they are overtaxed and exhausted and this may contribute to the feelings of instability.

Marital satisfaction and overall life satisfaction are two other areas, which were identified within this study. Although marital satisfaction was not assessed in this study, responses from the fathers suggested that it warrants further investigation. In order to obtain reliable and valid information about how the family unit is functioning, researchers need to assess the family as a whole (Crowley & Taylor, 1994). In doing so, researchers may realize what contributes to increased marital and life satisfaction for families with a disabled family member. In this present study, a dramatic difference was found between the two father groups on life satisfaction.

Although the results of this study demonstrated that fathers of disabled children experienced increased stress associated with life changes, decreased levels of coping, increased levels of stress, and lower overall life satisfaction compared to fathers with non-disabled children, one should not necessarily assume this to be totally negative. There is clearly a
difference between fathers of disabled and non-disabled children. However, this study suggested that there are fathers with disabled children who experience family demands, stressors, and adversities as unpredictable events of life that should be realized and ultimately overcome. In addition, the findings supported the idea that fathers may respond to their disabled child with resilience and some adaptive functioning, despite the presence of major and minor life stressors. As researchers continue to work toward a clearer understanding of how stress and coping function, it will continue to be important for fathers with disabled children to find unique ways in which they can successfully manage ongoing stressful life situations.
APPENDIX A

Human Subjects Committee Approval
Florida State University

Office of the Vice President
For Research
Tallahassee, Florida 32306-2763
(850) 644-8673 · FAX (850) 644-4362

APPROVAL MEMORANDUM
Human Subjects Committee

Date: 12/18/2003

John Strachan
320 Ridgewood Street
Paducah, KY 42003

Dept.: Human Sciences

From: David Quadagno, Chair

Re: Use of Human Subjects in Research
Fathers of disabled children: The role of stress in parental contentment and life satisfaction

The forms that you submitted to this office in regard to the use of human subjects in the proposal referenced above have been reviewed by the Secretary, the Chair, and two members of the Human Subjects Committee. Your project is determined to be exempt per 45 CFR § 46.101(b) 2 and has been approved by an accelerated review process.

The Human Subjects Committee has not evaluated your proposal for scientific merit, except to weigh the risk to the human participants and the aspects of the proposal related to potential risk and benefit. This approval does not replace any departmental or other approvals, which may be required.

If the project has not been completed by 12/17/2004 you must request renewed approval for continuation of the project.

You are advised that any change in protocol in this project must be approved by resubmission of the project to the Committee for approval. Also, the principal investigator must promptly report, in writing, any unexpected problems causing risks to research subjects or others.

By copy of this memorandum, the chairman of your department and/or your major professor is reminded that he/she is responsible for being informed concerning research projects involving human subjects in the department, and should review protocols of such investigations as often as needed to insure that the project is being conducted in compliance with our institution and with DHHS regulations.

This institution has an Assurance on file with the Office for Protection from Research Risks. The Assurance Number is IRB00000446.

Cc: Carol Darling
HSC No. 2003.718
APPENDIX B

Questionnaire
SURVEY OF FATHERS

Please answer the following questions.

1. What is your age? _____

2. Are you: (Check one)
   _____ Biological father       _____ Step-father       _____ Both
   _____ Never Married          _____ Married           _____ Divorced
   _____ Widowed               _____ Cohabiting

3. Present marital status? (Check one)
   _____ Never Married  _____ Separated
   _____ Married       _____ Divorced
   _____ Widowed       _____ Cohabiting

4. What is your highest educational level? (Check one)
   _____ Less than High School    _____ Bachelors Degree
   _____ High School or GED       _____ Masters Degree
   _____ Associate Degree            _____ Ph.D. / M.D. / Advanced Degree

5. What is your employment status? (Check one)
   _____ Fulltime       _____ Part time      _____ Unemployed

6. Number of hours you are involved in paid employment per week? _____

7. What is your occupation? ____________________________

8. What is your approximate yearly family income, which includes the combined income of you and your spouse or partner? (Check one)
   _____ Below $15,000
   _____ $15,001 – $30,000
   _____ $30,001 – $45,000
   _____ $45,001 – $60,000
   _____ $60,001 – $75,000
   _____ $75,001 – $80,000
   _____ $80,001 – $95,000
   _____ $95,001 – $110,000
   _____ Over $110,000

9. Is your spouse/partner employed? (Check one)
   _____ Yes       _____ No

10. What is your spouse or partner’s occupation? ______________________

11. How many hours per week is your partner/spouse involved in paid employment? _____

12. Which of the following best describes your racial/ethnic background? (Check one)
   _____ Black       _____ Asian
   _____ Hispanic    _____ Native American (American Indian)
   _____ Other       _____ White (Caucasian)

13. How many children reside in your household? _____

14. Do you reside in the same household as your biological or step children?
   _____ Yes       _____ No

15. Please list the age, sex, and school grade of each child living in your home:
   
   Age   _____   _____   _____   _____   _____   _____   _____   _____
   Gender   _____   _____   _____   _____   _____   _____   _____   _____
   Grade   _____   _____   _____   _____   _____   _____   _____   _____

16. Do any of your children have an IEP? (Individualized Educational Plan)
   (If more than one child with IEP, please list them all)
   _____ Yes       _____ No

   If you do not have a child with an IEP, GO TO QUESTION 20.

   _____ Child’s Age       _____ Child’s Gender
   _____ Child’s Age       _____ Child’s Gender
   _____ Child’s Age       _____ Child’s Gender

17. For the child who has an IEP, how do you rate their condition? (If more than one child with an IEP, mark ages by the category)
   _____ Mild       _____ Moderate       _____ Severe

18. Do the children with the IEP live in your home?
   _____ Yes       _____ No

19. What is your child’s educational eligibility category? (Check all that apply). (If more than one child, please put child’s age next to the disability)
   _____ Autism
   _____ Deaf / Blind
   _____ Orthopedic Impairment
   _____ Developmental Disability
   _____ Other Health Impairment
   _____ Emotional-Behavior Disability
   _____ Specific Learning Disability
   _____ Functional Mental Disability
   _____ Speech / Language Disability
   _____ Hearing Impaired
   _____ Traumatic Brain Injury
   _____ Mild Mental Disability
   _____ Visual Impairment
   _____ Multiple Disabilities
   _____ Other ______________________________________

20. Does your child have a chronic medical diagnosis? (If more than one child, please identify them by age).
   _____ Yes       _____ No

   If yes, what is the diagnosis?

21. Is your child presently taking medications? (If more than one child, please identify them by age).
   _____ Yes       _____ No

   If yes, what are the medications?
For each of the following statements, indicate the level of stress experienced by your family in the last year by circling the corresponding number.

<table>
<thead>
<tr>
<th>Intra-Family Strains</th>
<th>1=None</th>
<th>2=Low</th>
<th>3=Moderate</th>
<th>4=High</th>
</tr>
</thead>
<tbody>
<tr>
<td>22. Increase of husband/father’s time away from family</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>23. Increase of wife/mother’s time away from family</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>24. A member appeared to have emotional problems</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>25. A member appeared to depend on alcohol or drugs</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>26. Increase in conflict between husband and wife</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>27. Increase in arguments between parent(s) and children</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>28. Increase in conflict among children in the family</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>29. Increased difficulty in managing teenage child(ren)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>30. Increased difficulty in managing school-age child(ren) (6 – 12 yrs)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>31. Increased difficulty in managing preschool child(ren) (2½ - 6 yrs)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>32. Increased difficulty in managing toddler(s) (1 – 2½ yrs)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>33. Increased difficulty in managing infant(s) (0 – 1 yr)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>34. Increase in the amount of “outside activities” which the child(ren) are involved in</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>35. Increased disagreement about a member’s friends or activities</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>36. Increase in number of problems or issues which don’t get resolved</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>37. Increase in the number of tasks or chores which don’t get done</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>38. Increased conflict with in-laws or relatives</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Marital Strains</th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>39. Spouse / parent was separated or divorced</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>40. Spouse / parent had an affair</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>41. Increased difficulty in resolving issues with a “former” or separated spouse</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>42. Increased difficulty with sexual relationship between husband and wife</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pregnancy and Childbearing Strains</th>
<th></th>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>43. A family member had an unwanted or difficult pregnancy</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>44. An unmarried member became pregnant</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>45. A member had an abortion</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>46. A member gave birth to or adopted a child</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Finance and Business Strains</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>47. Took out a loan or refinanced a loan to cover increased expenses</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>48. Went on welfare</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>49. Changes in conditions (economic, political, weather) which hurt the family business</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>50. Change in Agriculture Market, Stock Market, or Land Values which hurt family investments and/or Income</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>51. A member started a new business</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>52. Purchased or built a new home</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>53. A member purchased a car or other major item</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>54. Increased financial debts due to over-use of credit cards</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>55. Increased strain on family “money” for medical/dental expenses</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>56. Increased strain on family “money” for food, clothing, energy, home care</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>57. Increased strain on family “money” for child(ren)’s education</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>58. Delay in receiving child support or alimony payments</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Work-Family Transitions and Strains</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>59. A member changed to a new job/career</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>60. A member lost or quit a job</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>61. A member retired from work</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
62. A member started or returned to work
63. A member stopped working for extended period (e.g. laid off, leave of absence, strike)
64. Decrease in satisfaction with job/career
65. A member had increased difficulty with people at work
66. A member was promoted at work or given more responsibilities
67. Family moved to a new home/apartment
68. A child/adolescent member changed to a new school

**Illness and Family “Care” Strains**
69. Parent/spouse became seriously ill or injured
70. Child became seriously ill or injured
71. Close relative or friend of the family became seriously ill
72. A member became physically disabled or chronically ill
73. Increased difficulty in managing a chronically ill or disabled member
74. Member or close relative was committed to an institution or nursing home
75. Increased responsibility to provide direct care or financial help to husband’s and/or wife’s parents
76. Experienced difficulty in arranging for satisfactory child care

**Losses**
77. A parent/spouse died
78. A child member died
79. Death of husband’s or wife’s parents or close relative
80. Close friend of the family died
81. Married son or daughter was separated or divorced
82. A member “broke up” a relationship with a close friend

**Transitions “In and Out”**
83. A member was married
84. Young adult member left home
85. A young adult member began college (or post high school training)
86. A member moved back home or a new person moved into the household
87. A parent/spouse started school (or training program) after being away from school for a long time

**Family Legal Violations**
88. A member went to jail or juvenile detention
89. A member was picked up by police or arrested
90. Physical or sexual abuse or violence in the home
91. A member ran away from home
92. A member dropped out of school or was suspended from school

93. What is your degree of satisfaction with the following:

    1 = Very Dissatisfied  2 = Dissatisfied  3 = Neither Satisfied nor Dissatisfied  4 = Satisfied  5 = Very Satisfied

  a) Leisure/Recreational Time
  b) Marital Relationship
  c) Financial Status
  d) Overall Relationship with your child(ren)
The following statements describe daily events that occur in families with young children. These events may cause you stress. Please circle how often this event happens in your family AND then circle the degree of hassle you perceive them to be.

<table>
<thead>
<tr>
<th>HOW OFTEN IT HAPPENS</th>
<th>DEGREE OF HASSLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>Rarely</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

94. Continually cleaning up messes of toys or food.  
95. Being ragged, whined at, complained to.  
96. Mealtime difficulties (picky eaters, complaining, etc.).  
97. The kids don’t listen – won’t do what they are asked without being nagged.  
98. Baby-sitters are difficult to find.  
99. The kids’ schedules (e.g., preschool, school naps, other activities) interfere with meeting your own or household needs.  
100. Sibling arguments or fights that require a “referee.”  
101. The kids demand that you entertain or play with them.  
102. The kids resist or struggle over bedtime with you.  
103. The kids are constantly under foot, interfering with other chores.  
104. The need to keep a constant eye on where the kids are and what they’re doing.  
105. The kids interrupt adult conversations or interactions.  
106. Having to change your plans because of an unpredicted child need.  
107. The kids get dirty several times a day, requiring changes of clothes.  
108. Difficulty getting privacy (e.g., in the bathroom).  
109. The kids are hard to manage in public (grocery store, shopping center, restaurant).  
110. Difficulties in getting kids ready for outings and leaving on time.  
111. Difficulties in leaving kids for a night out or at school or day care.  
112. The kids have difficulties with friends (e.g., fighting, trouble getting along, or no friends available.)  
113. Having to run extra errands to meet kids’ needs.  

When facing problems / difficulties in the family, we respond by:

<table>
<thead>
<tr>
<th>1= Strongly disagree</th>
<th>2= Moderately disagree</th>
<th>3= Neither agree or disagree</th>
<th>4= Moderately agree</th>
<th>5= Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>Moderately Disagree</td>
<td>Neither Agree or Disagree</td>
<td>Moderately Agree</td>
<td>Strongly Agree</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

114. Sharing our difficulties with relatives.  
115. Seeking encouragement and support from friends.  
116. Knowing we have the power to solve major problems.  
117. Seeking information and advice from persons in other families who have faced the same or similar problems.  
118. Seeking advice from relatives (grandparents, etc.)  
119. Seeking assistance from community agencies and programs designed to help families in our situation.  
120. Knowing that we have the strength within our own family to solve our problems.  
121. Receiving gifts and favors from neighbors (e.g., food, taking in mail, etc.)  
122. Seeking information and advice from the family doctor.  
123. Asking neighbors for favors and assistance.  
124. Facing the problems “head-on” and trying to get solution right away.  
125. Watching television.  
126. Showing that we are strong.  
127. Attending church services.  
128. Accepting stressful events as a fact of life.
When facing problems / difficulties in the family, we respond by:

<table>
<thead>
<tr>
<th>Question</th>
<th>Strongly Disagree</th>
<th>Moderately Disagree</th>
<th>Neither Agree or Disagree</th>
<th>Moderately Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>129. Sharing concerns with close friends.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>130. Knowing luck plays a big part in how well we are able to solve family problems.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>131. Exercising with friends to stay fit and reduce tension.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>132. Accepting that difficulties occur unexpectedly.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>133. Doing things with relatives (get-togethers, dinners, etc.)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>134. Seeking professional counseling and help for family difficulties.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>135. Believing we can handle our own problems.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>136. Participating in church activities.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>137. Defining the family problem in a more positive way so that we do not become too discouraged.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>138. Asking relatives how they feel about problems we face.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>139. Feeling that no matter what we do to prepare, we will have difficulty handling problems</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>140. Seeking advice from a minister.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>141. Believing if we wait long enough, the problem will go away.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>142. Sharing problems with neighbors.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>143. Having faith in God.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Consider each of the following statements about how you might deal with your individual stress. Using the scale provided, please circle one answer for each question.

1= Doesn’t apply or don’t do it    2= Used very little    3= Used sometimes    4= Used often    5= Used a great deal

<table>
<thead>
<tr>
<th>Question</th>
<th>Doesn’t apply or don’t do it</th>
<th>Used very little</th>
<th>Used sometimes</th>
<th>Used often</th>
<th>Used a great deal</th>
</tr>
</thead>
<tbody>
<tr>
<td>144. Play sport.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>145. Talk to others and give each other support.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>146. Put effort into my work.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>147. Pray for help and guidance so that everything will be all right.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>148. I get sick; for example, headache, stomach ache.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>149. Work on my self image.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>150. Look on the bright side of things and think of all that is good.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>151. Develop a plan of action.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>152. Try to be funny.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>153. Find a way to let off steam; for example, cry, scream, drink, take drugs.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>154. Improve my relationship with others.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>155. Go to meetings which look at the problem.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>156. Daydream about how things will turn out well.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>157. Blame myself.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>158. Don’t let others know how I am feeling.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>159. Consciously ‘block out’ the problem.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>160. Ask a professional person for help.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>161. Worry about what will happen to me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>162. Make time for leisure activities</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>163. What other things do you do to cope with your concern(s)?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
Please answer the following questions using the scale provided. Please circle one number for each question.

<table>
<thead>
<tr>
<th>HOW OFTEN DO YOU:</th>
<th>1 = Never</th>
<th>2 = Seldom</th>
<th>3 = Sometimes</th>
<th>4 = A lot</th>
<th>5 = Almost Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>164. Have headaches</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>165. Have a sore throat</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>166. Feel tension</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>167. Feel down</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>168. Feel pressure</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>169. Have an upset stomach</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>170. Have trouble getting asleep</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>171. Have trouble staying asleep</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>172. Feel lonely</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>173. Feel restless</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>174. Have shortness of breath</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>175. Feel low energy/motivation</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>176. Have difficulty relaxing</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>177. Have backaches or neckaches</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>178. Feel nervous</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>179. Feel stressed</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

The following statements are about stress you might be feeling. Please read each statement carefully. For each statement circle the number that fits you best.

<table>
<thead>
<tr>
<th>1= Strongly agree</th>
<th>2= Agree</th>
<th>3= Not sure</th>
<th>4= Disagree</th>
<th>5= Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>Agree</td>
<td>Not Sure</td>
<td>Disagree</td>
<td>Strongly Disagree</td>
</tr>
<tr>
<td>180. I often have the feeling that I cannot handle things very well.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>181. I find myself giving up more of my life to meet my children’s needs than I ever expected.</td>
<td>1</td>
<td>2</td>
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<td>4</td>
</tr>
<tr>
<td>182. I feel trapped by my responsibilities as a parent.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>183. Since having children, I have been unable to do new and different things.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>184. Since having children, I feel that I am almost never able to do things that I like to do.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>185. I am unhappy with the last purchase of clothing I made for myself.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>186. There are quite a few things that bother me about my life.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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</tr>
<tr>
<td>187. Having children has caused more problems than I expected in my relationship with my spouse (male/female friend).</td>
<td>1</td>
<td>2</td>
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</tr>
<tr>
<td>188. I feel alone and without friends.</td>
<td>1</td>
<td>2</td>
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<tr>
<td>189. When I go to a party, I usually expect not to enjoy myself.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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</tr>
<tr>
<td>190. I am not as interested in people as I used to be.</td>
<td>1</td>
<td>2</td>
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</tr>
<tr>
<td>191. I don’t enjoy things as I used to.</td>
<td>1</td>
<td>2</td>
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<tr>
<td>192. My children rarely do things for me that make me feel good.</td>
<td>1</td>
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<tr>
<td>193. Sometimes I feel my children do not like me and do not want to be close to me.</td>
<td>1</td>
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<tr>
<td>194. My children smile at me much less than I expected.</td>
<td>1</td>
<td>2</td>
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<tr>
<td>195. When I do things for my children, I get the feeling that my efforts are not appreciated very much.</td>
<td>1</td>
<td>2</td>
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<td>196. When playing, my children do not often giggle or laugh.</td>
<td>1</td>
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<tr>
<td>197. My children do not seem to learn as quickly as most children.</td>
<td>1</td>
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<tr>
<td>198. My children do not seem to smile as much as most children.</td>
<td>1</td>
<td>2</td>
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</tr>
<tr>
<td>199. My children are not able to do as much as I expected.</td>
<td>1</td>
<td>2</td>
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</tr>
<tr>
<td>200. It takes a long time and it is very hard for my children to get used to new things.</td>
<td>1</td>
<td>2</td>
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</tr>
</tbody>
</table>
201. I feel that I am: 1. Not very good at being a parent. 2. A person who has some trouble being a parent. 3. An average parent. 4. A better than average parent. 5. A very good parent.

<table>
<thead>
<tr>
<th>Item</th>
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Strongly Agree | Agree | Not Sure | Disagree | Strongly Disagree

202. I expected to have closer and warmer feelings for my children than I do and this bothers me.

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<tr>
<th>Item</th>
<th>1</th>
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203. Sometimes my children do things that bother me just to be mean.

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<th>Item</th>
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204. My children seem to cry or fuss more often than most children.

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<th>Item</th>
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205. My children generally wake up in a bad mood.

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<th>Item</th>
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206. I feel that my children are very moody and easily upset.

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<tr>
<th>Item</th>
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207. My children do a few things which bother me a great deal.

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<th>Item</th>
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208. My children react very strongly when something happens that my children do not like.

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<th>Item</th>
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209. My children get upset easily over the smallest thing.

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210. My children’s sleeping or eating schedule was much harder to establish than I expected.

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211. I have found that getting my children to do something or stop doing something is:

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212. Think carefully and count the number of things which your children do that bother you. For example: dawdles, refuses to listen, overactive, cries, interrupts, fights, whines, etc. Please circle the number which includes the number of things you counted.

<table>
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<tr>
<th>Item</th>
<th>1</th>
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</table>

213. There are some things my children do that really bother me a lot.

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</table>

214. My children turned out to be more of a problem then I had expected.

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</table>

215. My children make more demands on me than most children.

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<tr>
<th>Item</th>
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</table>

Using the scale below, indicate your agreement with each item by circling the appropriate number.

<table>
<thead>
<tr>
<th>Item</th>
<th>1 = Strongly Disagree</th>
<th>2 = Disagree</th>
<th>3 = Neither Agree or Disagree</th>
<th>4 = Agree</th>
<th>5 = Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>216.</td>
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<td>219.</td>
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<td>220.</td>
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</tbody>
</table>

221. What resources do you presently use to help with your disabled child/children? (for example, home care assistance, support groups, therapy, counseling, etc.)

222. In your opinion, what are some of the particularly stressful issues in parenting a child with special needs?

223. When did you find out that your child/children had special needs and how did you cope with this new information?

224. Is there anything else you feel we should know about fathering children?
APPENDIX C

Letter to Fathers
Dear Father/Step-Father:

I am a doctoral candidate completing my dissertation in Marriage and Family Therapy under the direction of Dr. Carol A. Darling, Department of Child and Family Sciences, The Florida State University. I am conducting a research study to investigate several aspects of parenthood that may be related to perceptions of fathering stress. I am collecting information from fathers/step-fathers of children between the ages of 5 years and 12 years old.

Your participation will involve filling out a paper and pencil survey. The total time commitment will be approximately 30 to 45 minutes. Your participation in this study is voluntary. The results of my research study may be published; however, your name will not be used. Since there are no identifying marks on the survey, your privacy will be maintained throughout the project as all of your answers are anonymous. The enclosed survey can be completed in your home.

The return of the survey will imply your consent to participate in this important study. Please use the enclosed prepaid envelope to return the survey. (DO NOT return the survey to the school). Information based on your experiences will add to our knowledge about factors associated with parenting stress and overall life satisfaction of fathers with elementary age children.

If you have any questions concerning this study, please call me at (270) 444 2845. You may also contact Dr. Carol A. Darling at The Florida State University, (850) 644 3217 for further information.

If you could return the completed survey this week, it would be most beneficial. Thank you very much for your time and consideration of this very important research project. Your help is greatly appreciated.

Sincerely,

John Strachan, LMFT
Doctoral Candidate

Carol A. Darling, Ph.D., CFLE
Margaret Sandels Professor of Human Sciences
APPENDIX D

Permission For Use of Scales
October 21, 2003

John Strachan  
320 Ridgewood Street  
Paducah, Kentucky 42003

Dear Mr. Strachan:

This letter is to give you my written permission to use the FILE (Family Inventory of Life Events) and the F-COPES (Family Crisis Oriented Personal Evaluation Scales) in your dissertation research on “Fathers of Disabled Children” at Florida State University. Please note that because you are now a registered user of our instruments on the CD, you have permission to use any of the other instruments on the CD as well. You may reformat the instruments (i.e., larger type, combine with other study instruments into a booklet, etc.) to suit the specific needs of your study and sample population too.  

We would appreciate receiving an abstract of your research when it is completed for our files. You can mail to me at the address below as the previous Wisconsin & Kamehameha Schools addresses are no longer valid.

Best wishes to you on your research study.

Sincerely yours,

Marilyn A. McCubbin, PhD, FAAN  
Professor  
University of Hawaii at Manoa  
School of Nursing & Dental Hygiene  
Webster Hall 403  
2528 McCarthy Mall  
Honolulu, Hawaii 96822  
Phone: 808-956-5469  
FAX: 808-956-3257  
E-mail: mccubbin@hawaii.edu
September 12, 2003

John Strachan
320 Ridgewood Street
Paducah, KY 42003

Dear Mr. Strachan,

I am happy to grant you permission to use the Parenting Daily Hassles measure in your research. Good luck with your dissertation.

Sincerely,

[Signature]

Keith A. Crnic, Ph.D.
Professor
Invoice 15230-1

<table>
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<th>Page</th>
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Bill To: 4061
JOHN STRACHAN
320 RIDGEWOOD STREET
PADUCAH, KY 42003

Ship To: 4061
JOHN STRACHAN
320 RIDGEWOOD STREET
PADUCAH, KY 42003
USA
Phone: 270-534-8393

Ship Via: GROUND - GENERIC
Payment Terms: CREDIT CARD PAYMENT

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JOHN STRACHAN HAS PAR'S PERMISSION TO USE THE PSI SHORT FORM FOR HIS DISSERTATION AS LONG AS HE IS BEING SUPERVISED BY CAROL A. DARLING

Additional Charges / Credits
Shipping & handling
8.00

Amount Paid via Check or Credit Card
-38.00

Carrier: DHL GROUND US
Tracking Number: 8735371820

SALES REP: MARIE MITCHELL
Thank you for placing your order with us!!

If Balance Due, Please Remit Payment to:
PAR, Inc
16204 N Florida Avenue
Lutz, FL 33549

As Condition of Sale, Purchaser agrees not to reproduce or adapt the materials in any way.

Due 10-01-03 $0.00
John Strachan Jnr.
320 Ridgewood Street
Paducah Kentucky 42003
United States of America

23 September 2003

NON-EXCLUSIVE LICENCE TO USE COPYRIGHT MATERIAL

Dear John,

Re: Coping Scale for Adults (CSA)

The licensor agrees to grant a non-exclusive licence for use of the material in your dissertation on 'fathers of disabled children in relation to stress and coping', solely and specifically as detailed herein subject to the following terms and conditions:

(a) That you pay no fee for the licence.

(b) You must only use original answer forms and manuals in your dissertation and when collecting data from respondents.

(c) You must purchase every copy whether for surveying or research purposes.

(d) ACER Press does not allow any part of the CSA to be photocopied, scanned electronically, written out, rekeyed or by any other means copied for use in your dissertation or research.

(e) That no deletions from, additions to, or other changes in the material shall be made.

(f) You must attach an original copy of the scale to your dissertation, and an original copy of the relevant answer form must be attached to the other scales in your questionnaire for respondents to fill out.

(g) That should any details change from those outlined in the request, the licensor must be advised prior to any use of the material, as a new licence will have to be issued. A copy of your request is attached to this licence.

Yours sincerely,

Amanda Pinches
Editorial Assistant
September 21, 2003

John W. Strachan, Jr.
320 Ridgewood Street
Paducah, Kentucky 42003

Dear John:

I hereby grant you permission to use the Family Health Status Inventory in your dissertation. Good luck with it. Rosalie Norem, Betsy Garrison, and I would appreciate letting me know what you find when you’re done (I’ll pass the info on to them).

Sincerely,

[Signature]

Julia A. Malia, Ph.D.
Associate Professor
Dear Requester:

Thank you for requesting the Satisfaction with Life Scale. As you may know, there is an article in the 1985, Volume 45, issue of Journal of Personality Assessment, which reports on the validity and reliability of the scale. In addition, we currently have another article titled, "Review of the Satisfaction With Life Scale" in Psychological Assessment*. The results reported in this second article are extremely encouraging. The SWLS correlates substantially with reports by family and friends of the target person's life satisfaction, with number of memories of satisfying experiences, and with other life satisfaction scales. The SWLS was examined in both a college student and elderly population. In both populations the scale was valid and reliable (internally consistent and stable).

The SWLS is in the public domain (not copyrighted) and therefore you are free to use it without permission or charge. You will, however, have to type or reproduce your own copies.

Best wishes,

Ed Diener, Ph.D.
Professor


Daly, K. J. (1996). Spending time with the kids: Meanings of family time for fathers. *Family Relations, 45*, 466-476.


Kentucky Administrative Regulations (2000). The Department of Education, Louisville, KY.


McCubbin, H. I., Patterson, J., & Wilson, L. (1979). *Family Inventory of Family Life Events (FILE)*, University of Minnesota.


Shapiro, J. L. (1993). The measure of a man: Becoming the father you wish your father had been. New York: Delacorte.


BIOGRAPHICAL SKETCH

John Weir Strachan, Jr. was born in Peterhead, Scotland on July 31st, 1968. From seven years of age, he grew up in East Kilbride, Scotland (a suburb of Glasgow, Scotland) where he completed his high school education. In 1989 he immigrated to the United States where he enrolled as a student at the Florida School of Biblical Studies in Lakeland, Florida. His undergraduate studies were completed at Freed Hardeman University in Henderson, Tennessee where he received a Bachelor of Arts Degree in both Psychology and Theology. In 1996 he received a Masters Degree in Marriage and Family Therapy from Abilene Christian University in Abilene, Texas. During his time in Abilene he briefly worked as a Marriage and Family Therapist.

In the fall of 1996, John enrolled as a student in The Florida State University where he received his Doctorate Degree in Marriage and Family Therapy from the College of Human Sciences, Interdivisional Program. During his doctoral coursework, John was employed as a Teaching Assistant in the College of Human Sciences where he taught undergraduate level courses. While continuing the pursuit of his doctorate, John was employed by Arnette House, Inc. as Clinical Supervisor in Orlando, Florida. Presently, he is employed with Horizon Health Corporation as Program Manager and Chief Clinician in the Centerpoint Partial Hospital Program where he treats patients with psychiatric disorders. He holds licensure as a Marriage and Family Therapist in the state of Kentucky and is pursuing certification as Sex Therapist. He resides with his wife and two young children in Paducah, Kentucky.