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A COMPARATIVE STUDY OF THE MARITAL RELATIONSHIPS OF PARENTS OF CHRONICALLY ILL AND NON CHRONICALLY ILL CHILDREN

Molly Smith Allen

1992

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UNIVERSITY OF NORTHERN COLORADO

Greeley, Colorado

The Graduate School

A COMPARATIVE STUDY OF THE MARITAL RELATIONSHIPS OF PARENTS OF CHRONICALLY ILL AND NONCHRONICALLY ILL CHILDREN

A Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Psychology

Molly Smith Allen

College of Education
Division of Professional Psychology

August 1992

THIS DISSERTATION WAS SPONSORED

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Examination Date of Dissertation 10-24-91

ABSTRACT

Allen, Molly Smith. A Comparative Study of the Marital Relationships of Parents of Chronically Ill and Nonchronically Ill Children. Published Doctor of Psychology dissertation, University of Northern Colorado, 1992.

This study investigated the marital expectations, satisfaction, and frequency of serious disagreements of 20 parents of asthmatic children and 60 parents of non-asthmatic children. The research was conducted in northern Colorado. Subjects were drawn from an urban support group for parents of asthmatic children, school nurse lists, and school district mailing lists. An adapted version of Walsh's (1987) Couples' Survey was administered by mail.

Based upon the review of literature pertaining to chronic illness and family dynamics, it was expected that there would be differences between the two groups in overall marital style (egalitarian or traditional), 15 specific marital expectations, overall marital satisfaction, 17 specific areas of marital satisfaction, and frequency of serious marital disagreements regarding 18 family related issues. The level of significance was set at .05.

T-tests and proportions were used to compare the two groups' demographic characteristics. The two groups were similar for age, years of education, years married, number of children, age group of children, ethnicity, number of marriages, employment status, family income, and

personal income. There were differences between the groups in regards to religious preference and size of community.

ANOVA was used to determine differences between mean scores for the two groups. Two of the five null hypotheses were rejected. The asthma group had significantly less overall marital satisfaction and significantly less satisfaction with seven specific areas of their marriages. No difference was found between the two groups' marital style, expectations, or frequency of serious disagreements. Multiple regression results suggest that for the asthma group there is a tendency for traditional marital characteristics to be associated with marital satisfaction.

Recommendations for further research include further investigation of the marital style, satisfaction, and conflicts of parents of children with other chronic illnesses. Early psychosocial assistance for the marriages of parents of chronically ill children is strongly encouraged.

ACKNOWLEDGEMENTS

Any project of this size is the result of the efforts of more than one person. I am indebted to a number of persons for support and encouragement while completing this dissertation. First of all, I am honored that so many couples allowed me to glimpse part of their lives. And, my thanks go to my teacher, adviser and friend, William Walsh, who guided my studies and gave me opportunities to participate in research, thus helping me acquire the skills and confidence necessary to achieve my goals. I would like to formally thank Phillip Blumstein and Pepper Schwartz, whose work inspired this and other research conducted by William Walsh and myself. I am grateful for the help of those persons who assisted me in planning and data collection: Laurie Schumann, of the Metro Denver Parents of Allergic/Asthmatic Children; Fred Wamboldt, of the National Jewish Center for Immunology and Respiratory Medicine in Denver; Jean Littman and Jane Weber, of the UNC Laboratory School; Donald Burger, Director of Research and Evaluation for Weld County (Colorado) School District #6; and my dissertation committee members: Sue Spooner, Sally Shaw, and Richard Trahan.

Finally, I would like to acknowledge my family and friends who have shown their support when they weren't quite sure what I was so worked up about: Jane and Norman Allen, Linda Smith, Jeff Thomas, Keith Cowie, Kathy Quinn, James Anthony, Jill Matheson, Ken Galpin-Plattner, Kelly Caswell, and the staff and interns of the Wichita Collaborative Psychology Internship Program.

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CHAPTER I

INTRODUCTION

Advancements in modern medicine have made it possible for individuals who suffer from serious illnesses to live longer, more satisfying lives. For those who suffer from chronic illnesses such as asthma and other respiratory illnesses this has meant treatments which offer the hope of normal or near-normal functioning.

But for parents whose children suffer from asthma or other respiratory illnesses, the time and energy demands of the process of treatment can mean the disruption of family life. For example, parents must arrange for child-care when their children are too ill to go to school. Parents may have to rearrange their work schedules when children must be transported to and from doctors' visits. In many instances, parents must monitor their children's activities, in order to make sure that the children do not come into contact with environmental conditions which would aggravate the asthma. Time must be taken to administer and monitor daily medications. Some parents may choose to quit their jobs in order to care for ill children. In some cases, members of the family may have to relocate temporarily in order to access adequate medical care for the ill child. Additionally, parents may be unable to offer adequate attention to other members of the family.

During the chronic phases of a disease, the family's energies are redirected to care for the ill member. The parents may reorganize their marital roles such as wage-earner, housecleaner, etc., in order to deal with the demands of their child's illness. This reorganization of

priorities may mean that the parents have little or no time available to maintain a satisfying relationship.

Statement of the Problem

Although it is almost certain that some chronically ill children have a single parent in the home, this study assesses the differences between the parents of chronically ill children and parents of nonchronically ill children as regards marital role assignment (marriage style), marital expectations, overall marital satisfaction and areas of marital satisfaction (lack of, or minimal conflict within the marriage). Individual parents' responses were combined to provide means for the two groups, parents of chronically ill children, and parents of nonchronically ill children.

Similarities and dissimilarities between these two populations were of interest as regards the possible relationship between the demands of caring for an ill child and the nature of the parents' marriages. Understanding the differences between these populations should contribute to the psychosocial treatment offered to parents whose children are chronically ill. Any lack of differences describes those dynamics which are particular to parents' marriages during the developmental stage of child rearing. The dynamics of this stage may include preoccupation with the child's needs at the expense of the parents' marital needs.

Importance of the Study

The findings of this study contribute to literature regarding the relationship between family dynamics and chronic illness. In a broader sense, this research adds to the understanding of the concept of the distribution of power in American marriages. Further, this study

assesses specific areas of marital expectation and satisfaction, instead of depending upon only global scores or subjective overall assessments of marital expectations and satisfaction.

The information provided by this study is most likely of benefit to those practitioners in medical settings who focus on the psychosocial needs of families with chronically ill children. These families face a complex set of challenges. Because of this study, treatment personnel will be able to clarify and pinpoint more quickly the types of role distribution, expectations, and dissatisfaction which may be present in the marriages of parents with a chronically ill child. As pointed out by Kelso, Stewart, Bullers, and Eginton (1984), if left unaddressed, dysfunctional role assignments and marital dissatisfactions may negatively impact the child's treatment.

This study was an extension of previous work, including Blumstein and Schwartz's (1986) wide-ranging descriptive study of American couples' dealings with money, work, and sex. These researchers gathered data on a wide variety of types of couples. Blumstein and Schwartz's survey was adapted by Walsh (1987) for use with an Irish population. Walsh added to this instrument the concept of scoring the respondents' reported values for various roles to assess the overall marriage style: egalitarian or traditional.

Craddock's (1983) definitions of traditional and egalitarian marriages were used in this study. Craddock describes traditional marriages as being marked by role assignment on the basis of gender. In this type of relationship the male is generally in a position of power and authority. The female maintains control over the details of the family's domestic life. In Craddock's conceptualization of egalitarian

relationships the roles are determined by personal preference, not by gender. Power is shared equally by both partners. With this study, the use of Walsh's (1987) adaptation of Blumstein and Schwartz's (1986) original instrument was extended to assess a more specific population: the marital style and satisfaction of parents of asthmatic children.

This researcher speculates that the demands of dealing with a child's chronic illness affects the parents' marriage. But as Margolin (1981) points out, one-time assessments are not equipped to fully explain directionality regarding the influence of one dynamic upon another. Therefore the possible role that emotional stressors play in the etiology of asthma and other respiratory illnesses was not considered in this study.

Also of note is the use of the terms "marriage" and "parents" within this study. For the purposes of this research, parental figures engaged in a long-term, committed relationship without benefit of a legal or ceremonial recognition qualified for inclusion in this study. In this study, individual parents' responses were considered. Some consideration was given to the correlations between parents. Further, due to the confounding effects of divorce and remarriage upon the family system, all efforts were made to include primarily intact (non-divorced) families in this study.

Purpose and Objectives of the Study

The purpose of this study was to gather descriptive information regarding parents' marital expectations, roles, and satisfaction. Parents who have a chronically ill child were compared to parents who do not have a chronically ill child. The research questions answered were:

1. Do parents of chronically ill children have a tendency towards an overall traditional marital style vs. an overall egalitarian marital style?

2. Do parents of chronically ill children have a tendency to have specific traditional expectations of their marital relationship vs. egalitarian expectations of other parents?

3. Do parents of chronically ill children experience less overall satisfaction with their marriage as compared to other parents?

4. Do parents of chronically ill children experience more specific areas of dissatisfaction within their marital relationship, as compared to other parents?

5. Do parents of chronically ill children experience increased frequencies of serious marital disagreements, as compared to other parents?

Definition of Terms

Asthma. A respiratory illness which is chronic, but usually not life-threatening. Asthma is characterized by episodic difficulty in breathing, caused by obstruction of the bronchial airways.

Chronic Illness. Refers to the course of the illness. The chronic phase follows the acute, crisis phase, in which diagnosis is made. The chronic phase is characterized by adjustment to the illness. For asthmatics and others with respiratory illness, the chronic phase is typified by episodes of acute illness, separated by periods of stabilization of the illness.

Egalitarian Marriage. Decisions are made equally by both partners. There is total sharing of labor and equality of careers. Both partners

express equality of choice concerning lifestyle. Negotiation is a major part of the relationship.

Family Dynamics. Interactions between family members which may be carried out in verbal or nonverbal behaviors.

Marital satisfaction. Lack of continuing conflict, minimal continuing conflict, or successfully resolved conflict within a committed, intimate, long-term relationship.

Marital style. Relates to role distribution within the marriage. A traditional marriage is characterized by the man as primary wage-earner, the woman as caretaker of the household and children. In an egalitarian marriage, each partner contributes to the maintenance of domestic life without regard to sex-specific role assignment.

Respiratory Illness. Illness involving the lungs and airways.

Traditional Marriage. Decisions are made separately or independently by husband or wife. The husband earns the family income. The wife cares for the home and children. The wife has more responsibility for the emotional needs of the family.

Limitations

This study is limited in that almost all of the survey volunteers were drawn from a 65 mile radius of Denver, Colorado. Thus, the generalizability of the results from these volunteers to others who could not or would not participate is unknown.

In this study, the children of parents in both the target group and the comparison group were under the age of 18 (siblings of the children may have been over 18 years of age). Thus, the results of this study should not be generalized to families made up of adult children, or families in which only a parent suffers from a chronic illness. This

point is stressed by Schumm and Bugaighis (1986), who point out that the strong effects of the family life cycle upon marital adjustment require that we avoid overgeneralizing research results to the wrong types of families.

Other uncontrolled factors include the current living situation of the couples assessed, and the participation of one, but not both parents. In addition, generalization of the results of this study to parents of children suffering from simply acute, or nonchronic illness, is not applicable.

Summary

This study was an attempt to apply recent work in marriage assessment in further clarifying issues related to the marriages of parents with chronically ill children. It offers a look at what makes the marriage of parents with a chronically ill child different from the marriages of other parents. Walsh's (1987) Couples' Survey was used to examine the two groups' overall marriage style (egalitarian or traditional), specific role expectations, overall and specific areas of satisfaction (lack of, or minimal marital conflict), and frequency of serious marital disagreements.

CHAPTER II

REVIEW OF THE LITERATURE

Chronic Childhood Illness and its Effects upon the Family

This century's improvements in medical care have meant that parents of chronically ill children can expect more effective treatments for even the most severe of illnesses. Based on a review of epidemiological studies, Kazak (1989) estimates that 11.4% of the population under age 21 can be classified as handicapped. In addition, she points out that the survival rates for childhood cancer have risen dramatically in recent years. Thus, mental health professionals can expect to deal with children who have chronic health problems and the impact of these children upon the family.

Illnesses vary according to symptoms and severity. Therefore, it is helpful to conceptualize illness according to some of these characteristics. For example, Rolland (1987) classifies three main phases of illness: crisis, chronic, and terminal. The crisis phase includes pre-diagnosis symptoms, diagnosis, and an initial adjustment period. The chronic phase is the "long haul" of dealing with the illness. Thus, the stresses of living with chronic illness vary according to the type of illness experienced by the family. For example, there are differences in the experiences of children who suffer from asthma, cancer, mental retardation, diabetes, and other chronic illnesses. Ferrari, Matthews, and Barabas (1983) argue that well-

designed studies of the psycho-social implications of illness take into account the unique nature of each chronic disease, including visibility and social restrictions.

Psychosocial consultation for the family of a chronically ill child is often requested in response to behavioral problems exhibited by the ill child. But, the entire family must deal with the stress a child's long term illness produces for all members of the family. This stress is produced by both the emotional responses to the child's condition and the demands of long-term treatment (Friedrich & Copeland, 1983). This point is stressed by Croake and Myers (1984), who suggest that a child's chronic illness places him or her in a unique position to act out within the family system. A child's tendency towards normal self-centered behavior is exacerbated by adults' preoccupation with the child's physical condition. Some children may capitalize upon this imbalance of power by manipulating their families to perform tasks for them, or to treat them in a "special" way. The long term effects of this family imbalance may be the child's failure to master normal developmental tasks.

Research on the family dynamics of chronically ill children focuses primarily upon the mother (Koocher & O'Malley, 1981). But, as Kazak (1989) points out, according to family systems theory, the stresses experienced by an ill child no doubt have an effect on the entire family system. Margolin (1981) echoes this point when she notes that traditionally we have assumed that the parent has the role of influencing the child. Instead, family systems theory recognizes that the child also strongly impacts the family as a whole.

Rolland (1987) uses the concept of family development to explain the two ways in which chronic illness is experienced within the family. He explains that during family development there are those forces which pull family members into the family system (centripetal), and those forces which push members out of the system (centrifugal). A family experiences centrifugal dynamics when children reach adolescence and develop interests and skills in the world outside the family. Rearing younger children is a centripetal process marked by each member's emphasis upon family life. The centripetal force is described by Rolland as, "External boundaries around the family (which) are tightened while personal boundaries between members are somewhat diffused to enhance family teamwork." (p. 214). Rolland theorizes that centripetal dynamics occur not only during phases in the family life cycle, but during those times when the family is faced with a member's chronic illness.

Early in the chronic phase of a disease, marital cohesion is high. However, as the disease progresses, the stress of frequent hospitalizations and other care issues cause the quality of the marriage to decrease (Barbarin, Hughes, & Chesler, 1985). Reiss, Gonzalez, and Kramer (1986) claim that during the early phase of a disease, a family tends to pull together to deal with the situation. However, if this high level of interaction and focus continues too long after the medical emergency, the family may become vulnerable to creating problems for the entire family system. When the family fails to move on, needs remain unmet and relationships are not developed adequately. The researchers imply that these enmeshed dynamics may, in fact, have negative effects upon the medical prognosis of the ill family member.

Chronic Childhood Illness and its Effects upon the Parent's Marriage

For those parents dealing with a child's illness, stress in the marital relationship comes, in large part, from the need for parental attention to the child's daily health maintenance. In addition, grief may be the logical response of some parents to the loss of the perfect, "ideal" child as a result of illness (Cummings, 1976).

Margolin (1981) suggests that the connection between a child's problems and the parents' marriage is a complex relationship. She notes that:

> A child's problems that drain the family's resources, time, and energy are likely to strain even the marriage of parents who possess extraordinary coping skills. However, it is more likely that the stress is transmitted through the parent-child relationship to the marital relationship by the parent who bears the daily responsibility of caring for the disturbed child. (p. 148).

The relationship between chronic illness and the marital subsystem of the family has been conceptualized by some researchers as a push and pull between dynamics. The marriages of parents of chronically ill children may include a conflicting set of expectations and demands upon time and resources. Margolin (1981) points to this theory of push and pull of roles theory as an explanation for how one relationship affects another. She describes role strain as: ". . .the stress generated within a person when she/he has difficulty complying with the expectation of a role, or when the demands of one role interfere with the demands of another role." (p. 148) She goes on to point out that the demands of

being both a parent and a spouse are difficult under the best of situations. When a stressor such as chronic illness of a child is added, the role of spouse may suffer. Margolin points out that an individual may perceive one role, such as spouse, to be expendable. However, that adult may not feel free to leave another role, such as primary caregiver for their children.

Rolland's (1987) concept of role demands explains that the crisis phase of a child's illness is a period of the parents' growing familiarity with the daily demands of dealing with an illness. As he points out, "During this phase, other life plans are frequently put on hold by the family in order to accommodate its socialization to illness" (p. 208). Thus, parents of a child in the midst of a chronic medical condition may alter their roles, postponing education or career opportunities in order to deal with crises related to the condition.

Research regarding the psychosocial consequences of chronic childhood illness for the parents has become quite common. Studies vary widely in their use of illness categories and marital assessment tools. However, as Kazak (1989) points out, there are mixed results arising from recent research regarding the quality of the marriages of parents of chronically ill children. Further, as Ferrari, Matthews, and Barabas (1983) indicate, in the literature relating specifically to the effects of a child's illness upon the parents, there are few studies using comparison group designs.

The stresses endured by the parents of a chronically ill child may involve the peripheral activities related to caring for the child. These

concurrent stresses in a couple's life may affect the roles they take on within the family's life. Kalnins, Churchill, and Terry (1980) studied the experiences of parents of leukemic children. These researchers found that along with the child's illness, this group of parents tend to be coping simultaneously with life factors which may be indirectly related to treatment of the child's illness. These factors may include death or serious illness of extended family members or of friends, occupational changes, financial problems, moving, and changes in recreational plans. Mulder and Suurmeijer (1977) note that parents of epileptic children tend to report a lack of spare time for themselves. Kazak, Reber, and Carter (1988) found low social network density for parents of children with phenylketonuria (PKU), a congenital metabolic disorder. These researchers suggest that this may imply a lack of social supports which the families can depend upon to deal with crises. In addition, these parents are less likely than other parents to name family members as being among their social support system, implying that they are less engaged with each other on an emotional level.

For pediatric cancer patients, the ongoing stress of dealing with the chronic illness may cause the parents and other family members to create a wall, shutting out the ill child. This is done so that these individuals can go on with their lives, protecting themselves from the emotional pain that is involved in caring for a dying child (Reiss, Gonzalez, & Kramer, 1986).

Many parents dealing with the specific stresses of their child's cancer tend to rely upon behaviors such as information-seeking, intellectualization, physical activity, and religious involvement in

order to cope. In regards to the long term effects of the child's leukemia upon the family system, few family members emerge from the experience without developing personal problems which had not existed prior to the illness. These problems include: health crises, alcoholism, the need for psychiatric care, poor school performance, and poor parent-child communication or relationship (Kalnins, Churchill, & Terry, 1980).

Parents dealing with a child's cancer describe financial stresses relating to lost wages, transportation costs to and from the hospital, food and lodging costs during the child's clinic treatments, and numerous long distance telephone calls associated with the child's care. Typically, these types of financial burdens are not covered by medical insurance (Kalnins, Churchill, & Terry, 1980).

It is important for the parents of a chronically ill child to exhibit flexibility in order for their coping efforts to actually help the child and themselves. Thus, the parents who are successful in dealing with the stresses of various chronic illnesses review their coping efforts on an ongoing basis (Gonzalez, Steinglass, & Reiss, 1989).

Parents of chronically ill children have been considered by some researchers to be at risk for divorce. But, as Zimand and Wood (1986) propose:

> There are two lines of reasoning regarding the likelihood of marital breakdown in families of children with chronic illness. The first is that stress of chronic illness interferes with normal functioning of the marital relationship. . .The second line of reasoning is that childhood chronic illness induces nurturance and mutual support among the family members, which brings the parents closer together. (pp. 385-386)

The literature is full of published papers arguing both sides of this debate. Sabbeth and Leventhal's (1984) review of the literature revealed that those studies of marital adjustment to a child's chronic illness which do find elevated divorce rates generally lack a comparison group. They suggest that it is not sufficient to simply observe how many of these marriages fail. Instead, it is more informative to observe the marital satisfaction of these couples by looking at the quality of various aspects of the marriage, such as communication, decision-making, and role flexibility. For example, although researchers have assumed frequent arguing is a sign of marital distress, this factor may not, in fact, be a weakness of the marriage of couples who have a chronically ill child. Sabbeth and Leventhal found that some parents in this group see their arguments as a way of engaging and encouraging each other to do their best to care for their child. Therefore, these researchers point out that it may be helpful to know more about how these parents adapt and cope. Indeed, their review of family therapy literature supports this claim that too little conflict may be harmful to any marriage.

Kalnins, Churchill, and Terry (1980) surveyed the literature regarding divorce and separation rates for parents of chronically ill

children. They found that marital breakup rates are no higher for parents of chronically ill children than for the general population. In addition, they found that overt family discord (divorce, separation, or a reported poor relationship among family members) was present for only 22% of their sample. In half of these situations, the problems in the relationships had begun before the child's illness. Several of these couples chose to live together amicably for the sake of their ill child. These researchers conclude that,

> The implication of the various studies on the effect of chronic and life threatening illness on the family is that the illness rarely precipitates family disintegration but rather exacerbates already existing problems or unstable relationships. (pp. 89-90).

Kalnins (1983) conducted an in depth comparison of the rates of separation and divorce of parents of children with three life threatening illnesses: leukemia, spina bifida, and cystic fibrosis. The heavy time commitment involved in the care of a chronically ill child was found to be among the most obvious links to distress in the parents' marriage. But, as compared to a group of parents of "normal" children, the rates of divorce were not significantly higher for these parents of chronically ill children. Kalnins suggests that conflicting findings of divorce rates for parents of chronically ill children imply that there are some family related variables which contribute to the divorce potential of these families. These variables may include: marital distress pre-dating the child's diagnosis, prenatal conception of the ill child, birth of the ill child within one and one-half years after the parents' marriage,

birth of the ill child as a result of unplanned pregnancy, or ill child as the firstborn.

Kazak's (1989) review of the literature noted no differences in regards to overall marital adjustment and divorce rates between couples who have a chronically ill child and couples who do not have a chronically ill child. She proposes that reports in the literature of differences between divorce rates for specific illness groups suggest some discrete marital-related variables may be present for different illnesses.

Zimand and Wood (1986) contrasted the divorce rates of couples who have children with serious gastrointestinal disorders. They suggest that having a chronically ill child may produce psychosomatic family functioning which, in some cases, insulates the parents from the risk of divorce. This psychosomatic family functioning includes: increased mutual involvement, overprotection, rigidity, and avoidance of conflict. Thus, the parents are engaged in a problem-filled relationship which tends to lead not to divorce, but towards increasing dysfunctional contact with one another.

Published papers in this area which do not depend upon divorce rates to assess marital satisfaction target instead either global assessments of marital satisfaction, or various facets of marital satisfaction. Phillips, Bohannon, Gayton, and Friedman (1985) used semi-structured interviews to assess the impact of cystic fibrosis upon the quality of the parental marital relationship. Independent raters identified responses which described "major," "minor," or "no problems." Of 62 issues presented to the parents, eight were identified by more than ten

percent of the couples to be a major problem. Parental communication was ranked as the second most common overall major problem. Communication was mentioned as a major problem by 28% of the mothers and only three percent of the fathers. Ten to fifteen percent of the parents listed major problems including: their overall marital relationship, not being able to give adequate attention to other children in the family, and problematic relationships with the ill child's grandparents.

Kazak, Reber, and Snitzer's (1988) use of the Dyadic Adjustment Scale, yielded no differences for marital satisfaction between parents of children with PKU and a comparison group of parents of "normal" children. However, in their study, the researchers found that the mothers of PKU children experience significantly low cohesion, or lack of connection with their families. In addition, both mothers and fathers of PKU children have low levels of adaptability. Thus, parents of PKU children have developed rigid family structures. The researchers suggest that this rigidity may be due to the strict dietary demands of treatment for PKU.

In contrast to Kazak, Reber, and Snitzer's (1988) findings of lack of cohesion in the families of chronically ill children, Kalnins (1983) found that 20-50% of the parents studied felt that their child's illness had brought them closer together. Kalnins suggests that, "These families should be studied in depth to discover the social and economic factors and the coping mechanisms which enable them to manage so well" (p. 76).

In Barbarin, Hughes, and Chesler's (1985) study, wives were identified by most participants as the primary caretaker of the ill child. For the husbands, wives' time spent at the hospital, at the

expense of time spent at home, was negatively associated with perceived support. For wives, the husbands' participation in care for the child was positively associated with perceived support.

Cook (1984) lists 18 discrete areas of potential problems for the parents of a chronically ill child. These include: arranging for care of the ill child and siblings, discipline problems with the ill child or siblings, parental feelings of helplessness, loss of confidence in parenting ability, financial problems, avoidance by other persons, inability to give support to others, feeling excluded from the ill child's life, growing apart from one's spouse or other family members, loss of religious faith, protecting one's spouse from knowledge of details of the child's medical condition, preoccupation and coping, and denial.

As noted, differences in the experiences of parents seem to be related in some ways to gender. Kalnins, Churchill, and Terry (1980) found that all parents in their sample were prone to make occupational changes during the course of their child's illness. Fathers reported difficulty dealing with jobs which were demanding or which had inflexible hours. Mothers described difficulty with working outside the home at all. Although, many of these mothers reported that they missed their jobs, due to the distractions from illness that the jobs provided.

Mothers may experience social pressures to assume the major responsibility for a terminally ill child. Fathers, on the other hand, fear the intense emotions involved in dealing with the potential loss of a child. Fathers are expected to control their emotions and take on an economic provider role. Thus, fathers and mothers experience different

pressures upon their time. Fathers tend to feel pressed by job demands vs. desire to be with their ill child. On the other hand, fathers are more likely than mothers to retain their individual recreational activities. The result of this isolation of fathers from the rest of the family is that many men either retreat from or are pushed out of the family interactions involving the ill child. Mothers tend to feel conflicted between time spent with their ill child vs. time spent with their other children (Cook, 1984).

Fathers tend to report more sexual dissatisfaction than do mothers. Mothers are more active and knowledgable than fathers about their child's medical care, and they clearly communicate to the fathers that they consider the needs of the child before considering spousal duties. Overall, the mothers appear to experience a wider range of difficulties during the child's illness (Cook, 1984).

For parents of chronically ill children, there appears to be a significant positive relationship between marital satisfaction and:

1. anticipating the diagnosis,
2. reframing the illness-related hardships as positive,
3. being able to fit the illness into a preexisting philosophy of life, and
4. sharing the burdens of the illness amongst family members.

(Venters, 1981).

Longitudinal studies tend to produce encouraging results regarding the satisfaction of parents who endure their child's chronic illness. Kupst et al. (1984) found that, two years postdiagnosis, parents of children with leukemia had weathered severe emotional upsets, anxiety,

and anger during the peak of the illness. These parents often used denial of their own issues to cope. However, their overall family relationships tended to emerge functional and healthy.

Asthma, Respiratory Illness and their Effects upon the Family and the Parents' Marriage

"Asthma" comes from the Greek word "to pant." "Asthma" is not a disease, but a description of the primary symptoms of wheezing and shortness of breath. Thus, asthma is not a single disease, but syndromes defined by "reversible constriction of the airways" (Mrazek 1985, p. 17).

Ramsdell (1985) outlines the nature of asthma as,

> . . . a disorder characterized by (hyperactivity of airways) to various stimuli and by resultant bronchial smooth muscle contraction and obstruction. Bronchial. . . hypersecretion. . . often (accompanies) these changes and may contribute to the ventilory obstruction. These changes result in respiratory distress, which is usually rapidly reversible (either spontaneously or with appropriate therapy). . . Asthma is a relatively common disorder affecting nearly 3 percent of respondents to the National Health Survey. It may present in childhood or later in adult life and, in general, affects both sexes equally.
>
> The etiology of asthma is unknown. . . Many stimuli (e.g., physical factors, environmental pollutants, infections) can precipitate bronchospasm. . . Most likely, bronchospasm results from an interaction of several mechanisms (p. 184).

Asthma is a chronic, generally nonfatal, acute, relapsing, nonincapacitating illness (Ellis, 1988). Rolland (1987) points out that the psychosocial implications of asthma are thus different than that for illnesses which are progressive, constant, fatal, or incapacitating. According to Mrazek (1986), children who develop asthma frequently do so in the first three years of life. The symptoms and treatment of severe childhood asthma often dominate the lives of these children. For example, Mrazek (1985) points out that asthma is considered to account for 25% of all primary school absences.

Treatment of asthma varies. However, according to Mrazek (1985), those children who do not have to rely upon steroids for treatment tend to fare better than those who need this medication to reverse bronchoconstriction. Ramsdell (1985) notes that, "a primary goal of management (of asthma) is patient education" (p. 188). He comments that behavior modification is seldom helpful in combatting symptoms of asthma. However, he points out that psychological counseling may be helpful for reducing stress levels for some individuals.

The family's encounter with the entire progression of a chronic illness such as asthma is crucial to how the illness will be experienced by the family. The course taken by any chronic illness falls into one of three forms: progressive, constant, or relapsing/episodic. Illnesses such as asthma are considered to be relapsing or episodic. In other words, asthma is marked by stable periods of uncertain length, punctuated by crises involving flare ups of symptoms. The family experiences strain from two factors in the course of this illness: the repeated transitions from crisis to noncrisis, and the uncertainty of exactly when a flare up

will occur. Thus, the family of an asthmatic child must be characterized by flexibility of family organization, and possession of crisis mobilization skills in order to cope with the strains of the illness (Rolland, 1987). As Rolland states, "The separate developmental tasks of 'living with chronic illness' and 'living out the other parts of one's life' must be brought together and forged into one coherent life structure" (p. 208).

Although we know asthma is stressful, there are few published papers on chronic asthma and its relationship to family functioning (Onnis, Tortolani, and Cancrini, 1986). One exception is a retrospective study by Dirks, Paley, and Fross (1979) which involved requesting the subject to report past attitudes, experiences, etc. The researchers assessed the relationship between childhood conflicts and the development of asthma. Their results indicate that parental overprotection was not a significant environmental factor for many of the asthmatic children studied. Although, Reddihough, Laundau, Jones, and Rickards (1977) discovered that half of their sample of mothers of children with severe asthma exhibited overprotectiveness by staying close to their ill child, fearing the child would die during an acute attack. In addition, over half of parents in Reddihough et al's sample felt that caring for their asthmatic child had caused considerable strain for the whole family.

McAndrew's (1976) research in Australia linked emotional stressors to exacerbation of asthmatic symptoms. In a summarization of a seven year study, he reported that there were no significant differences between asthmatic and nonasthmatic families in regards to

psychopathology. However, there were significant differences between the groups for presence of stressors or current burdens.

For families with an asthmatic child it is important to analyze the adult and spousal subsystems of the family (Masterson, 1985). For example, Davis (1977) found that 65% of mothers of asthmatic children were depressed. Steinhausen, Schindler, and Stephan (1983) used a multivariate design, finding that 70% of psychopathology in moderately asthmatic children was associated with family and marital problems, disturbed parental behavior, paternal psychopathology, and the child's lifetime experience of stress.

Certainly, if the parent's capacity to cope with the stress of the child's asthmatic condition and treatment is overwhelmed, this may impact the entire family system. Masterson (1985) points out that, "The presence of a chronic illness such as asthma poses a major threat to the psychosocial equilibrium of the child and the family. The resultant stress may overwhelm the family's coping capacity" (p. 244).

Measurement of Couples

The development of marital/couple relationship assessment instruments has made it possible for social scientists to look "inside" a marriage or significant intimate relationship, to explore its nature and to see how it works or does not work. Thus, as Sabbeth and Leventhal (1984) point out, it is important to exercise care and caution in the design and interpretation of marital assessments so that constructs are identified and measured appropriately.

Borg and Gall (1989) categorize psychological/sociological research into four categories: qualitative, causal-comparative, correlational,

and experimental. Each method has its unique benefits in regards to expanding our understanding of marital/couple relationships. Qualitative research focuses upon the subjective impressions of the nature of relationships. Causal-comparative and correlational methods analyze the ways that various specific factors, such as income and age, relate to other specific factors, such as the partners' satisfaction with their relationships. Experimental methods of research involve subjecting couples to certain environmental conditions, then measuring the couples on some criterion, such as communication or adjustment to change.

This review will focus upon causal-comparative and correlational methods. These types of assessments relate most closely to the issues involved in this study. In addition, marital satisfaction inventories, which lend themselves to causal-comparative methods, appear to be the most frequently used assessment tools due to their easy translation to couple and family counseling.

Fitzpatrick (1988) identifies Spanier's (1976) Dyadic Adjustment Scale as being the most frequently used marital satisfaction assessment tool. It is a self-report marital inventory, measuring cohesion, affection, consensus, and satisfaction. Other marital instruments reviewed by Fitzpatrick include: Norton's Quality Marriage Index (QMI) (1983), and the classic Locke-Wallace inventory (1959). These instruments, and many others which are used to assess couple relationships, focus upon aspects of the couples' satisfaction with their relationship. The QMI asks the couples to evaluate aspects of their marriage along a continuum from "good" to "bad." The Locke-Wallace depends upon a global score to evaluate the couples' satisfaction with

their relationship. A score above 100 indicates "happily married." A score below 100 indicates that the the couple is "unhappily married."

Long term marital interaction studies contribute to the analysis of changing roles over the course of a marriage. For example, studies such as those conducted by Gottman and Krokoff (1989), investigate those factors which predict satisfaction at various points of one's marriage. The researchers found that newly formed couples who had both the ability to express anger towards each other, and the proclivity to engage in disagreements, tended to be more satisfied with their marriage or relationship during later stages of their relationship.

In view of the issues involved in this study, Sabbeth and Leventhal (1984) reviewed the use of marital/couple assessment instruments used with families of chronically ill children. Included among those instruments which have been used in published research are scales which measure agreement between the couple on various issues, such as Farber's Index of Marital Integration, the WRU Goal Scale, and the Parental Acceptance Scale, which measures the parents' agreement about the child's behavior. Also reviewed are more qualitative measures, such as Rutter and Brown's semistructured interview and rating scales. Some research has used the Arnold Sign Indicator Subscale of the MMPI, which enables one to distinguish between couples in marital therapy, and couples not in marital therapy. In addition, Sabbeth and Leventhal point out that the literature is full of research using informal instruments designed to measure factors specific to that particular research project.

Blumstein and Schwartz (1986) developed an extensive survey and interview format to study American couples' attitudes towards money,

work, and sex. The result is an analysis of the variety of ways in which couples regard and handle the details of their married lives. The researchers' survey was adapted for use with an Irish population by Walsh (1987). Blumstein and Schwartz's collection of subscales was pared down, producing an instrument which focuses upon marital satisfaction and expectations. A marital style component (traditional roles vs. egalitarian roles) was added to Walsh's instrument to further examine relationships. The results of use of this survey in international research indicate that the Irish couples of various ages tend to value family-related developmental tasks equally, with the exception of tasks involving career decisions (Walsh & Allen, 1991 A).

This research also suggests that the differences between egalitarian and traditional couples are significant. As opposed to traditionalists, egalitarians believe both partners should evenly divide the household tasks. Traditionalists believe more strongly in the man working and the woman staying at home. As opposed to egalitarians, traditional couples believe that the man should have major responsibility for the family's financial plans, even when the wife is working. Traditionalists place a higher value on the woman remaining at home, particularly when there are small children (Walsh & Allen, 1991 B).

In addition, this research indicates that egalitarians of both sexes have more satisfaction than traditionalists with the following aspects of their marital relationship: how they communicate, their partners' attitude about having children, the amount of influence they have over family decisions, the amount of money coming in, how they express affection to each other, their sexual relationship, the amount of time

they spend together, their overall satisfaction with the relationship, and their partner's overall satisfaction with the relationship (Walsh & Allen, 1991 B).

This research also found significantly higher rates of disagreement for traditionalists on ten items related to marital and family life: how their partner's job affects the relationship, their social life, how their own job affects the relationship, relations with relatives, how they communicate, the amount of money coming in, how they raise the children, the amount of time spent together, their leisure and recreational activities, and their relationship in general (Walsh & Allen, 1991 B),

As pointed out by these researchers:

> Generally speaking, those reporting as traditional had a much higher level of disagreement and conflict in their marriage than those reporting as egalitarian. It appears that those individuals in egalitarian marriages are significantly more satisfied and had significantly less conflict than those in traditional marriages. (Walsh & Allen, 1991 B).

Walsh's Couples' Survey (1987) was chosen for this study due to its ability to identify aspects of the couples' marital roles, expectations, satisfaction, and frequencies of disagreements. In addition, the information it provides about marital style is illuminative for the issues facing couples with a chronically ill child.

Summary

The literature suggests that there is a complex relationship between caring for a chronically ill child and the nature of the parents' marriage. Although there is no question that caring for such a child affects the family system, and thereby, the parents' relationship, there is considerable debate as to how exactly these stresses impact the parents' marriage. In order to investigate these issues, research in this field must take into account: the type of illness experienced by the family, the type of measure used, and the constructs under examination.

The issues dealt with in this section have covered a wide range of concerns related to families. Stressors which face any couple may include: finances, free time, interactions with extended family, and sexual relations. Having a child with a chronic illness adds unique stressors to these couples' lives. Research is varied regarding the specific effects of chronic illness upon the nature and satisfaction of the parents' marriages.

The nature of conditions such as childhood asthma and chronic respiratory illness require specific treatment considerations, including the attention of one or both parents to the child's needs. This undoubtedly may affect the marital roles, expectations, satisfaction, and frequency of disagreements for the parents. The marital dyads of families affected by childhood asthma and respiratory illness have received little research attention to date.

Measurement of couples is a challenging undertaking. Those instruments which yield the most useful information describe not only

divorce rates or overall satisfaction, but those particular dynamics which may contribute to couples' adapting to challenges, or breaking up.

CHAPTER III

METHODOLOGY

This chapter includes sections on research design, statement of the null hypotheses, population and sample, instrumentation, data collection, and data analysis.

Research Design

This is a descriptive study comparing the marriage style and satisfaction of parents of chronically ill children with those of parents of nonchronically ill children. The groups are defined by several variables. Parents of asthmatic children aged 18 or less were assigned to the target group. Those parents whose children were not in treatment for a chronic illness were assigned to the comparison group.

Members of both groups of parents were asked to complete Walsh's Couples' Survey (1987). This questionnaire includes demographics and items related to the couples' marital style, expectations, satisfaction, and frequency of marital disagreements. In most cases, the participants completed the surveys in their homes, returning the completed surveys to the researcher by mail.

Parents were given the right to terminate their participation in the study at any time between survey completion and the final analysis of the data. Anonymity of the participants was ensured by numerical coding of data.

Statement of the Null Hypotheses

$H_0 1$: There will be no difference in overall marital style (egalitarian or traditional), as measured by the subscale score of question #22, and according to self report, between parents of chronically ill children and parents of nonchronically ill children.

$H_0 2$: There will be no differences in reported values for 15 marital expectations, as measured by subscale items of question #22, between parents of chronically ill children and parents of nonchronically ill children.

$H_0 3$: There will be no difference in overall marital satisfaction, as measured by the subscale score of question #23, between parents of chronically ill children and parents of nonchronically ill children.

$H_0 4$: There will be no differences in reported satisfaction with 17 aspects of marriage and family life, as measured by subscale items of question #23, between parents of chronically ill children and parents of nonchronically ill children.

$H_0 5$: There will be no differences in reported frequency of serious disagreements regarding 18 family related issues, as measured by subscale items of question #27, between parents of chronically ill children and parents of nonchronically ill children.

Population and Sample

The results of this marital research were generalized to a population of parents whose minor children suffer from asthma or related chronic respiratory illness, and parents whose minor children suffer from no chronic illnesses. The targeted sample group was twenty parents of children with chronic respiratory illness living temporarily or permanently within a 65 mile range of the Denver, Colorado, area. These parents are adults over the age of 18, and were recruited from the membership list of the Metro Denver (Colorado) Parents of Allergic/Asthmatic Children support group, and from the nurse's list of the University of Northern Colorado (Greeley) Laboratory School. Target group volunteers were solicited by a variety of methods, including: verbal requests from asthma support network coordinators, appeals in the

network newsletters, written requests mailed to support network members, visits by the principal researcher to support group meetings, and solicitation through primary, middle, and high school parent mailing lists. 40 surveys were mailed out to parents of asthmatic children. 50% of the parents contacted returned their completed surveys.

The comparison sample group of 60 parents of nonchronically ill children was also drawn from a variety of sources within a 65 mile range of the Denver area. These sources included: the University of Northern Colorado (Greeley) student and staff community, and parents of children attending local preschools, elementary schools, middle schools, and high schools. 330 surveys were mailed to potential volunteers for the comparison group. 23% of these surveys were completed and returned.

To increase the power of the statistics used, each member of the target group was matched to 3 members of the comparison group on the basis of gender, age of the parent, family size, and age group of the child (preschooler, elementary school age, middle school age, high school age). This combination of the target group and the comparison group equals a group of 80 persons.

To protect against the intrusion of extraneous variables, several considerations were made in the selection of subjects. Children of parents in both groups were under the age of 18 (some siblings may have been over 18). This selection controlled the extraneous variable of differing developmental stage of the family system. More specifically, parents of primarily adult children who have chronic respiratory illness were not included. In addition, in order to control for the confounding effects of divorce and remarriage, only intact families or families which have been reconstituted for over 5 years were included in this study.

As a result of these controls, fifteen potential subjects for the comparison group were not included. Two women did not fit the marriage classification, two women and five men had family sizes considerably larger than the rest of the sample, one man was considerably older than the rest of the sample, and there were seven more men than were needed for matches with the target group.

Instrumentation

One instrument, Walsh's Couples' Survey (1987) was used in this research. This survey gathers various kinds of data including demographics and responses to likert type subscale questions. This survey was adapted partially from Blumstein and Schwartz's (1986) marital inventory used with over 3,000 couples in the late 1970s and early 1980s. The adaptation of this survey provides marital data concerning egalitarian and traditional marital styles, roles and expectations, overall marital satisfaction, specific areas of marital satisfaction, and frequencies of disagreement. Subjects were asked to respond to the questions on this survey based on the current quality and nature of their relationship.

The likert subscales of this inventory enabled average responses to be compared across groups. Two subscales of this survey were scored to provide numerical T-score indicators of respondents' overall marital style and satisfaction relative to the rest of the sample. Previous use of this instrument by Walsh and this researcher (1991 B) suggests that these scores provide useful information regarding marital style and satisfaction.

Reliability of the adapted instrument has been assessed by the Kuder-Richardson split-half statistical test to be in the high .80s. This indicates that the instrument is consistent in its ability to ascertain marital style, expectations, satisfaction, and frequency of disagreements.

Any risks to subjects as a result of completing this survey were unlikely. But, two areas which may have been of concern were: responses to items related to sexual behavior, and any insight which subjects may have acquired as a result of completing the survey. These concerns were addressed by two means. First of all, the procedures used to insure confidentiality of survey materials safeguarded participants' survey responses regarding sexual behavior and other marital related information. Further, the opportunity for subjects to debrief with the researcher was intended to address any concerns which may have arisen on the subjects' part as to new information about themselves which they may have acquired as a result of completing the survey.

These risks were outweighed by the benefits of the results of this research. Literature in this area is crucial to how professionals assess the psychosocial needs of families facing chronic illness. Psychosocially focused treatment of families with a chronically ill member has increased in the past few years. The literature in this area is growing. But, there is scant literature related to the marital styles and expectations of parents of chronically ill children in general. Marital style literature pertaining to parents of children with chronic respiratory illness is particularly lacking.

Data Collection

All potential volunteers were contacted in person, by telephone, or by mail. They were given the option of completing the survey and returning it to the researcher in person, or postage-paid through the mail. In some cases, one, but not both, parents agreed to take part in the study, even though both parents were encouraged to participate. Therefore, data from one half of some couples was used in this study.

Initially, parents were informed of their right to volunteer. And, they were asked to sign a consent form prior to completion of the survey instrument. This form included a description of the overall nature and purpose of the project: to collect information on the marital style, expectations, and satisfaction of parents of chronically ill children and parents of nonchronically ill children. A separate information sheet provided the participants with the name, telephone number, and University address of the researcher. Participants were given the option to contact the researcher if they requested feedback on the results of their completed surveys. In addition, this separate information sheet provided the participants with information for contacting the appropriate authorities at the University in case of a grievance regarding data collection procedures.

Confidentiality was ensured by the numerical coding of each completed survey. Individual surveys were identified in the data file by number only. A list of names and survey numbers was kept separate from the completed surveys and all other related research materials. This list was kept in a secure manner by the researcher at the University of Northern Colorado, Division of Professional Psychology. This list provided the researcher with the names of each subject returning a

survey, in order to enable follow-up of unreturned surveys. This list was also kept to provide the participants with both the opportunity to withdraw from participation, and the opportunity to receive feedback on the results of their completed surveys. In addition, if participants chose to be informed of the results, they identified themselves on the final page of the surveys. Debriefing was done by providing the subjects with the information outlined in the methods above.

Data Analysis

The data collected was in several forms: categorical, dichotomous and continuous demographic information, and a dichotomous choice of marital style. In addition, this instrument uses likert type subscales of attitude measures with ranges of 5-1. For example, for question #22 this range indicates an answer of strongly agree to strongly disagree regarding marital expectations, for question #23, extremely satisfied to very unsatisfied with aspects of the marriage, and for question #27, daily to never regarding frequency of severe marital disagreements.

The overall expectations subscale scores ranged from a possible minimum of 15 to a possible maximum of 75. For the expectations subscale, a lower score indicates a tendency towards an egalitarian marital style, whereas a higher score indicates a tendency towards a traditional marital style. Summing the expectation subscale score involves inverting the numerical value of some expectation subscale items, in order to follow the criterion of lower scores associated with egalitarian marital style and higher scores associated with traditional marital style.

The overall satisfaction subscale scores ranged from a possible minimum of 15 to a possible maximum of 85. For the satisfaction subscale, a lower score indicates marital dissatisfaction (significant conflict in the relationship), whereas a higher score indicates marital satisfaction (lack of, or minimal conflict in the relationship). Analysis of the distribution of these expectations and satisfaction subscale scores yields indications of marital style and overall marital satisfaction relative to the distribution of scores of the sample.

Parents' survey data were not analyzed by couple. Instead, data for individual parents was combined, yielding means for the sample groups for the various survey items.

Data were analyzed by the use of parametric methods including descriptive statistics such as frequencies, means, and proportions of certain demographic and subscale data including age, and scores of the expectations and satisfaction subscales. Two factor analysis of variance (ANOVA) and individual T-tests were used to determine significant differences between the two groups for likert scale means and subscale score means. This information is presented in the form of source tables. The level of significance for determining differences between means was set at the .05 level (Glass & Hopkins, 1984).

The inferential statistics used to analyze the survey results determined whether or not significant differences existed in the means between the target and comparison group for survey items relating to attitudes about marital style, expectations, overall satisfaction, specific areas of marital satisfaction, and frequency of marital disagreements.

A post hoc multiple regression statistic was used to analyze the relationship of marital style and satisfaction to variables including parents' ages, age groups of the children, health status of the children, length of the parents' marriages, parents' employment status, families' community size, and parents' religiosity. In addition, since Terhune's (1974) review of family related literature suggests it is advantageous to take into account family size when performing these types of comparisons, this variable was also considered.

Data collection began in January, 1991. The cooperation of a Denver support group for parents of asthmatic children was secured for the target population. Cooperation of other parents' support groups was obtained for further recruitment of target group members. Cooperation of Greeley and Denver area preschools, elementary schools, middle schools, and high schools was also obtained for recruitment of comparison group members.

CHAPTER IV

RESULTS AND DISCUSSION

This chapter presents a description of the sample, findings of this study, and a discussion of the findings. The results are presented in three major sections including marital style and expectations, marital satisfaction, and frequency of serious marital disagreements. Three additional sections include factors predicting marital style and satisfaction, values regarding family related developmental tasks, and frequency of tasks performed together by the couple.

As noted by Kalnins, Churchill, and Terry (1980) gender is considered to be a very important variable in the experience of parents of chronically ill children. Therefore, In addition to the contrasts between the asthma and comparison group, differences between male and female subjects in the entire sample are considered.

Description of the Sample

Characteristics of the 20 parents of asthmatic children and 60 parents of non-asthmatic children are presented in Tables 1-13. The groups were comparable for all characteristics except size of community and religious preference. Each individual in the asthma group was matched to three people in the comparison group on the basis of gender, approximate age, and approximate family size. Thus, eight fathers of asthmatic children were matched to 24 fathers of non-asthmatic children,

and 12 mothers of asthmatic children were matched to 36 mothers of non-asthmatic children. Results are listed in Table 1.

Table 1

Number of Women and Men in the Asthma and Comparison Group

	Asthma Group		Comparison Group	
	n	%	n	%
Male	8	40	24	40
Female	12	60	36	60
Total	20		60	

The two groups were similar for the four characteristics of age, years of education, years married, and number of children. The average age of the asthma group was 38, while the average age for the comparison group was 38.4. Both groups had an average of several years of college. The asthma group averaged 15.4 years of education, or approximately one semester short of a bachelors degree. The comparison group averaged slightly more education, or 16.1 years of education (just over four years of college). However, this difference was not significant. The asthma group averaged 14.7 years of marriage, while the comparison group averaged 14.8 years. Both groups averaged three children. The asthma group parents had an average of two asthmatic children. The number of asthmatic children in these families ranged from one to four. Results are listed in Table 2.

Table 2

A Comparison of the Mean Demographic Values for Asthma Group and Comparison Group

	Asthma Group		Comparison Group	
	Mean	Range	Mean	Range
Age[a]	38.4	31 - 50	38	28 - 53
Years of Education[b]	15.4	12 - 20	16.1	10 - 26
Years married[c]	14.7	5 - 32	14.8	3 - 26
Number of Children[d]	3	2 - 4	3	1 - 5
Number of Asthmatic Children	2	1 - 4	0	

a. t test, P<.62
b. t test, P<.83
c. t test, P<.07
d. t test, P<.42

For both populations, age groups, or developmental stages of the family, were determined by the age group of the majority of the family's children. The asthma group and comparison group parents did not differ significantly in the age group distribution of their children. Tables 3 and 4 list the developmental stages of the families of asthma group and comparison group. Thus, for the asthma group, two of the parents have primarily preschool age children (under age five), 14 have children who are mostly between the ages of five and twelve and four have mostly adolescent children. Likewise, in the comparison group, four parents have mostly preschoolers, 32 have school age children, and 24 have adolescents. Table 4 gives similar information for the developmental stages of the asthma group.

Table 3

A Comparison of the Age Group of Children per Parent

	Asthma Group		Comparison Group	
	n	%	n	%
Preschoolers (under age 5)	2	10	4	7
School age (ages 5-12)	14	70	32	53
Adolescents (ages 12-18)	4	20	24	40

Table 4

A Comparison of the Age Group of Asthmatic Children per Parent

	Asthma Group	
	n	%
Preschoolers (under age 5)	2	10
School age (ages 5-12)	14	70
Adolescents (ages 12-18)	4	20

Both groups were primarily caucasian. The asthma group included one hispanic individual, one black, and one asian. In the comparison group there were 3 hispanic individuals. Results are listed in Table 5.

Table 5

A Comparison of Ethnicity by Group

	Asthma Group		Comparison Group	
	n	%	n	%
Caucasian	17	85	57	95
Hispanic	1	5	3	5
Black	1	5	0	
Asian	1	5	0	

Most members of both groups of parents had been married only once. Two individuals in the asthma group had been married twice, whereas nine of the comparison group subjects were on their second marriage. One individual in the comparison group had been married three times. In each case of remarriage, individuals had been in their current marriage for over five years. Results are listed in Table 6.

Table 6

A Comparison of Number of Marriages by Group

	Asthma Group		Comparison Group	
	n	%	n	%
1st Marriage	18	90	50	83
Married twice	2	10	9	15
Married 3 times	0		1	2

The majority of individuals in both groups were employed full time. The next most common employment pattern for both groups was part time, followed by homemaking and self-employment. One individual in the comparison group reported unemployment. Results are listed in Table 7.

Table 7

A Comparison of Employment Status by Group

	Asthma Group		Comparison Group	
	n	%	n	%
Full Time	13	65	36	60
Part Time	2	10	12	20
Homemaker	3	15	6	10
Self Employed	2	10	5	8
Unemployed	0		1	2

Middle family income ($15,000 - $60,000 annually) was the norm for both groups. This was followed in order by high family income (over $60,000 annually), and low family income (under $15,000 annually). Subjects were also asked to report personal income status. Again, middle income was reported most frequently by both groups. But, for personal income status, low income was reported by both groups as second most common. The third most frequently reported category was high personal income. And, a minority of respondents reported no personal income at all. Results are listed in Tables 8 and 9.

Table 8

A Comparison of Family Income by Group

	Asthma Group		Comparison Group	
	n	%	n	%
High (over $60,000/year)	7	35	14	23
Middle ($15,000 - $60,000/year)	12	60	43	72
Low (under $15,000/year)	1	5	3	5

Table 9

A Comparison of Personal Income by Group

	Asthma Group		Comparison Group	
	n	%	n	%
High (over $60,000/year)	3	15	4	7
Middle ($15,000 - $60,000/year)	10	50	29	48
Low (under $15,000/year)	5	25	21	35
None	2	10	6	10

As mentioned, the groups did differ in terms of size of community. The majority of individuals (50%) in the asthma group live in suburbs followed in order by large towns (population over 10,000), cities, rural (not farm), and small towns (population under 10,000). None of the asthma group reported living on a farm. In contrast, over half of the comparison group live in large towns; over one quarter of this group live in cities. The minority were divided among small towns, rural areas, and farms. None of the comparison group reported living in suburbs. Results are listed in Table 10.

Table 10

A Comparison of Size of Community by Group

	Asthma Group		Comparison Group	
	n	%	n	%
Farm	0		2	3
Rural (not farm)	2	10	2	3
Small Town (population under 10,000)	1	5	4	7
Large Town (population over 10,000)	4	20	35	58
City	3	15	17	29
Suburb	10	50	0	

The groups also differed in their reported religious preference. The majority of the asthma group was almost evenly divided between Catholics and "Other" type of religious preference (usually no preference at all). The remaining quarter of this group reported a Protestant preference. The comparison group was predominantly Protestant. The remaining third of this group was divided between Catholics and "Other". Results are listed in Table 11.

Table 11

A Comparison of Religious Preference by Group

	Asthma Group		Comparison Group	
	n	%	n	%
Catholic	8	40	11	18
Protestant	5	25	40	67
Other	7	35	9	15

The final two sets of figures in Tables 12 and 13 refer to the distribution of the entire sample's scores for two scored subscales - question 22, which included 15 questions regarding marital expectations, yielding a marital style Score, and question 23, which included 17 questions regarding marital satisfaction, yielding a general marital satisfaction score.

Table 12

Frequency Distribution of Marital Style Scores

	15 - 41	25% very egalitarian
	42 - 46	25% somewhat egalitarian
	47 - 52	26% somewhat traditional
	53 - 75	24% very traditional
actual range	27 - 72	

(groups combined)

Table 13

Frequency Distribution of General Satisfaction Scores

	17 - 59	34% relatively dissatisfied
	60 - 68	31% satisfied
	69 - 85	35% relatively very satisfied
actual range	40 - 85	

(groups combined)

Discussion

Because the comparison group subjects were selected on the basis of age, family size and age of children, the similarities between this group

and the asthma group were expected. The asthma and comparison groups did not differ for nine categories: age, years of education, years married, number of children, age group of children (developmental stage of the family), ethnicity, number of marriages, employment status, family income, and personal income. The similarity in age group of the children is especially important in that characteristics of family development exert a significant influence upon the experiences of all members of a family (Rolland, 1987).

It is interesting to note that both groups were well-educated, with each group averaging several years of college. Members of the asthma group tended to be professionals, while members of the comparison group were drawn from a college community. The comparison group had slightly more education, although the difference was not significant.

The two groups differed in regards to two categories: size of community and religious preference. This difference in the type of community probably reflects, in part, the data collection focus. Most of the asthma group subjects were drawn from an urban asthma support group, while the comparison subjects were primarily drawn from parents lists of Greeley Colorado (population 60,000) schools. In addition, parents of asthmatic children may choose to live in urban areas and suburbs due to the availability of medical care for their children.

It is not clear what impact the difference in specific religious preference has upon the results of this study. Certainly, spiritual and religious activities are important to the coping efforts of parents of chronically ill children (Kalnins, Churchill, and Terry, 1980). But, it may be that in the culture of the 1990's, religious preference and values

may not exert the influence upon lifestyles and decisions that they once did.

Marital Style and Expectations

Results from question #22 regarding scored marital style, and responses to fifteen individual items are included in this section.

$H_0$1: There will be no difference in overall marital style (egalitarian or traditional), as measured by the subscale score of question #22, and according to self report, between parents of chronically ill children and parents of nonchronically ill children.

The data are summarized in Tables 14 and 15, and 16.

Table 14

Two way ANOVA of overall subscale #22 score - Marital Style

Style score	F	P
Group	.003	.95
Gender	.91	.34
Group X Gender	.36	.55

Table 15

Mean Marital Style Scores by Group & Gender

Asthma Group	Comparison Group
48.5	45.7

Men	Women
46.9	46.7

Table 16

Self-Classification of Marriage Style by Group

	Asthma Group		Comparison Group	
Traditional	10	50	27	45
Egalitarian	10	50	33	55

The results of the ANOVA indicate that no significant differences were found for marital style scores or for reported marital style between both the groups and between genders. Thus, the asthma group was evenly divided between those who identified their marriage as traditional, and those who identified their marriage as egalitarian. For the comparison group, those who reported an egalitarian marriage slightly outnumbered those who reported a traditional marriage. This difference was not significant. For the groups, the null hypothesis was retained.

$H_0 2$: There will be no differences in reported values for 15 marital expectations, as measured by subscale items of question #22, between parents of chronically ill children and parents of nonchronically ill children.

These data are summarized in Tables 17, 18, and 19.

Table 17

Two Way ANOVA - Significant Results for Subscale #22 Item Scores - Marital Expectations

	F	P
J. Even if the wife works the man should have major responsibility for the couple's financial plans.		
Group	.005	.94
Gender	4.61	.03
Group X Gender	.005	.94

For nonsignificant results, see Table 46.

Table 18

Mean Marital Expectations by Group

"The following are general questions about couples. How much do you agree or disagree with each statement?"
5 = strongly agree
3 = neutral
1 = strongly disagree

	Asthma Group	Comparison Group
A. Both partners in a relationship should evenly divide the household tasks.	3.6	3.9
B. It is very difficult for a relationship to last more than ten years.	1.2	1.1
C. If both partners work full-time, both of their career plans should be considered equally in determining where they will live.	3.1	3.1
D. The two partners should share the responsibility for earning a living for the household.	1.8	2.1
E. The two partners should pool all their property and financial assets.	4.3	4.4
F. A member of a couple that has been together a long time should not accept a job he/she wants in a distant city.	2.9	2.7
G. Couples should try to make their relationship last a lifetime.	4.5	4.7
H. It is better if the man works to support the household and the woman takes care of the home.	3.0	2.7
I. Marriage is a life-time relationship and should never be terminated except under extreme circumstances.	3.6	4.1
J. Even if the wife works the man should have major responsibility for the couples' financial plans.	2.6	2.6

Table 18 --- continued

K. When there are small children in the home, it is better for the mother not to work.	3.8	3.4
L. It is better for parents to break up than to expose children to an unhappy marriage.	2.5	2.2
M. Extramarital sexual relationships are always wrong.	4.1	4.2
N. There are times when I am with friends and I don't want my partner along.	2.8	2.6
O. It is important to me that my partner spend some time without me.	3.2	3.0

Table 19

Mean Marital Expectations by Gender

"The following are general questions about couples. How much do you agree or disagree with each statement?"
5 = strongly agree
3 = neutral
1 = strongly disagree

	Males	Females
A. Both partners in a relationship should evenly divide the household tasks.	2.6	2.9
B. It is very difficult for a relationship to last more than ten years.	1.3	1.1
C. If both partners work full-time, both of their career plans should be considered equally in determining where they will live.	3.1	3.1
D. The two partners should share the responsibility for earning a living for the household.	1.8	2.2
E. The two partners should pool all their property and financial assets.	4.5	4.3
F. A member of a couple that has been together a long time should not accept a job he/she wants in a distant city.	2.9	2.7

Table 19 --- continued

G. Couples should try to make their relationship last a lifetime.	4.6	4.7
H. It is better if the man works to support the household and the woman takes care of the home.	3.1	2.6
I. Marriage is a life-time relationship and should never be terminated except under extreme circumstances.	3.9	4.0
J. Even if the wife works the man should have major responsibility for the couples' financial plans.	3.1	2.3 ($P<.02$)
K. When there are small children in the home, it is better for the mother not to work.	3.6	3.4
L. It is better for parents to break up than to expose children to an unhappy marriage.	1.9	2.6
M. Extramarital sexual relationships are always wrong.	4.1	4.2
N. There are times when I am with friends and I don't want my partner along.	2.6	2.7
O. It is important to me that my partner spend some time without me.	3.1	3.1

The ANOVA for the 15 marital expectations revealed no significant differences between the asthma group and comparison group, and one significant difference between genders. Men placed significantly more importance upon their retaining control of family finances than did the women.

Based upon the above results for the asthma and comparison groups, null hypothesis 2 is retained on this measure of marital expectations for the asthma and comparison groups.

Discussion

Marital style is defined as the way in which roles are assigned within a marriage. Thus, couples who have a traditional marriage value the division of chores according to gender, while couples in an egalitarian relationship value negotiating the assignment of tasks and responsibilities for the man and the woman (Walsh, 1987; Walsh & Allen, 1991 B). Walsh's (1987) Couples' Survey provides a subscale (question #22) which is scored, producing a marital style score. This score, therefore, reflects a continuum of degrees of marital style, from very egalitarian (low scores), to very traditional (high scores).

In this study, the lack of difference in the parents' scored marital style is best explained by Rolland's (1987) concept of family developmental stages. Thus, because both groups are involved in child rearing, these parents' marital values tend to be similar regarding the ways tasks are distributed between the husband and wife. Therefore, parents of asthmatic children appear to have no more traditional or egalitarian values overall than do parents of nonchronically ill children. And, as measured by the self report for marital style, parents of asthmatic children do not classify their marital style any differently than do parents in the comparison group.

In addition, there was no difference in value between the groups for the 15 marital expectations which constitute marital style. This indicated that parents of asthmatic children have similar specific expectations for their marriages, regardless of the presence of a chronically ill child in their family. This is an important finding, since most studies of parents of chronically ill children, including Kalnins, (1983), Zimand and Wood (1986), Kazak, Reber, and Snitzer

(1988), Cook (1984), McAndrew (1976), Davis (1977), and Steinhausen, Schindler, and Stephan (1983), focus upon outcomes (i.e., divorce, stresses, etc.) and do not look at what these parents expect out of marriage. On the other hand, Margolin (1981) focuses upon role conflict, or conflicting expectations, such as that of spouse and parent. Thus, she implies that stresses for parents of chronically ill children may be alleviated by altering roles, or perhaps expectations. In this study it is apparent that these parents do not differ from other parents in regards to their ideal roles or their expectations. Therefore, as implied by Kelso, Stewart, Bullers, and Eginton (1984), and by Gonzalez, Steinglass, and Reiss (1989), any maintenance of marital style and expectations which does not meet the reality of caring for an asthmatic child, may be a compounding source of stress for parents of these children.

Men and women in the entire sample were remarkably similar for marital style and for all but one of the marital expectations. Again, this may be explained by Rolland's (1987) concept of the demands which raising a family places upon both parents. The one exception for marital expectations indicates that women feel more strongly than do men that women should play an equal role in family finances. Thus, for this value, men appear to maintain more of a traditional stance, while women hold an egalitarian attitude towards family financial decision making.

Marital Satisfaction

$H_0 3$: There will be no difference in overall marital satisfaction, as measured by the subscale score of question #23, between parents of chronically ill children and parents of nonchronically ill children.

The data are presented in Tables 20 and 21.

Table 20

Two Way ANOVA of Overall Subscale #23 Score - General Marital Satisfaction

General Satisfaction score	F	P
Group	6.33	.01
Gender	.15	.70
Group X Gender	.48	.49

Table 21

Mean General Marital Satisfaction Scores by Group & Gender

Asthma Group	Comparison Group
59.0	65.2 ($P<.01$)

Men	Women
63.6	63.7

The ANOVA results indicate that the mean general satisfaction score for the the asthma group is significantly lower than that for the comparison group. Thus, the third null hypothesis is rejected.

$H_0 4$: There will be no differences in reported satisfaction with 17 aspects of marriage and family life, as measured by subscale items of question #23, between parents of chronically ill children and parents of nonchronically ill children.

The data are reported in Tables 22, 23, and 24.

Table 22

Two Way ANOVA - Significant Results for Subscale #23 Item Scores - Marital Satisfaction

	F	P
B. how my partner's job affects our relationship		
Group	4.12	.04
Gender	.10	.76
Group X Gender	1.32	.25
C. how we communicate		
Group	6.44	.01
Gender	.22	.64
Group X Gender	1.01	.32
E. my partner's attitudes about having children		
Group	10.22	.002
Gender	3.78	.05
Group X Gender	.05	.82
F. how the house is kept		
Group	3.95	.05
Gender	5.37	.02
Group X Gender	.44	.51
J. how we express affection for each other		
Group	7.69	.007
Gender	.06	.81
Group X Gender	.06	.81
N. the amount of time we spend together		
Group	5.73	.02
Gender	5.73	.02
Group X Gender	2.92	.09
Q. how would your partner rate his/her overall satisfaction with the relationship?		
Group	5.89	.02
Gender	.17	.68
Group X Gender	.87	.35

For nonsignificant results, see Table 47

Table 23

Mean Marital Satisfaction Item Scores by Group

"How satisfied are you with these parts of your relationship?"
5 = extremely satisfied
3 = average
1 = very unsatisfied

	Asthma Group	Comparison Group
A. our moral and religious beliefs and practices	3.9	4.1
B. how my partner's job affects our relationship	3.2	3.7 (P<.04)
C. how we communicate	3.2	3.7 (P<.01)
D. how my job affects our relationship	3.4	3.5
E. my partner's attitudes about having children	3.8	4.5 (P<.002)
F. how the house is kept	3.3	3.8 (P<.05)
G. the amount of influence I have over the decisions we make	3.7	4.1
H. our social life	3.2	3.5
I. the amount of money coming in	3.4	3.5
J. how we express affection for each other	3.2	3.9 (P<.007)
K. how we manage our finances	3.3	3.6
L. how we raise our children	4.1	4.2
M. our sexual relationship	3.6	3.9
N. the amount of time we spend together	3.1	3.6 (P<.02)
O. our leisure and recreational activities	2.8	3.3
P. your overall satisfaction with the relationship	3.6	4.1
Q. how would your partner rate his/her overall satisfaction with the relationship?	3.6	4.0 (P<.03)

Table 24

Mean Marital Satisfaction Item Scores by Gender

"How satisfied are you with these parts of your relationship?"
5 = extremely satisfied
3 = average
1 = very unsatisfied

	Male	Female
A. our moral and religious beliefs and practices	3.9	4.1
B. how my partner's job affects our relationship	3.6	3.5
C. how we communicate	3.7	3.5
D. how my job affects our relationship	3.4	3.5
E. my partner's attitudes about having children	4.6	4.2 (P<.05)
F. how the house is kept	4.0	3.5 (P<.02)

Table 24 --- continued

G. the amount of influence I have over the decisions we make	4.1	3.9
H. our social life	3.3	3.5
I. the amount of money coming in	3.4	3.5
J. how we express affection for each other	3.7	3.7
K. how we manage our finances	3.5	3.6
L. how we raise our children	4.1	4.2
M. our sexual relationship	3.8	3.8
N. the amount of time we spend together	3.2	3.6 (P<.02)
O. our leisure and recreational activities	3.0	3.3
P. your overall satisfaction with the relationship	4.1	4.0
Q. how would your partner rate his/her overall satisfaction with the relationship?	4.0	3.9

The ANOVA reveals that for the asthma group, seven of the 17 aspects of marital satisfaction were rated significantly lower than those of the comparison group. Thus, the parents of asthmatic children were significantly less satisfied with the following: the effect of their partner's job upon the relationship, how they communicate as a couple, their partner's attitude towards having children, how the house is kept, the affection within their relationship, the amount of time they spend together as a couple, and how satisfied they believe their partner to be with the marriage.

The women in general were less satisfied with three aspects of their marriages: their partner's attitude towards having children, how the house is kept, and the amount of time they spend together as a couple.

Thus, for the asthma and comparison group, null hypothesis 4 is rejected.

Discussion

Much of the literature regarding parents of chronically ill children, including Kazak, Reber, and Carter (1988), Reiss, Gonzalez, Kramer (1986), and Zimand and Wood (1986) deals with the amount of

stressors endured, or visible signs of stress, such as divorce. However, it is somewhat more informative, and is increasingly more common for researchers to assess the parents' experiences of satisfaction or dissatisfaction for specific parts of their lives. This is particularly true for the studies of Phillips, Bohannon, Gayton, and Friedman (1985), Kazak, Reber, and Snitzer (1988), and Kalnins (1983). Although, the majority of such studies do not include a comparison group model.

In contrast with Kazak, Reber, and Snitzer's (1988) finding of lack of significant difference for marital satisfaction between parents of children with PKU and a comparison, and Kalnins (1983) finding of increased overall emotional intimacy, this study found that parents of asthmatic children were significantly less satisfied overall with their marriages. Thus, although the asthma group and the comparison group do not differ in regards to most characteristics including developmental stage, income, and age, and although their marital styles and expectations do not differ significantly, there are significant differences between the groups for marital satisfaction. Therefore, with the possible exception of the variables of community size and religious preference, it is almost certain that caring for an asthmatic child or children is related to some areas of marital dissatisfaction.

The seven areas of relative dissatisfaction can be broken down into two major categories. The first category has to do with the interaction of the couple or individual with persons or things outside the relationship, such as dissatisfaction with the interaction of the partner's job and the marital relationship, dissatisfaction with the

state of the family's housekeeping, and dissatisfaction with the partner's feelings about having children.

This last item is worded rather ambiguously, and can be open to interpretation. One possible reading of this question could indicate the couple's ongoing conflict over family size and family responsibilities. Thus, for couples who have asthmatic children, the responsibilities of caring for an ill child may mean that there may be relatively more ongoing conflict and dissatisfaction than other couples with nonchronically ill children about increasing the size of their family or caring for the children they already have. This interpretation corresponds to a finding by Cook (1984) which lists loss of confidence in parenting ability as one of the specific problem areas which is experienced by parents of fatally ill children.

The majority of the areas of significantly greater dissatisfaction for the parents of asthmatic children have to do with the marital relationship itself. These areas of relative dissatisfaction involve their communication as a couple, their affection for each other, the amount of time they spend together, and their estimation of their partner's satisfaction. This final aspect does, indeed correspond with the low mean general satisfaction score for the asthma group. Thus, it appears that the asthma group subjects are fairly accurate in their prediction of their partner's relatively low scores.

These areas of dissatisfaction are very similar to those found by Phillips, Bohannon, Gayton, and Friedman (1985). These researchers noted that in addition to the areas of dissatisfaction identified in this study, parents of children with cystic fibrosis experienced dissatisfaction with in-laws. Phillips et al do not list dissatisfaction

with partner's job among the major issues of concern to the parents in their sample.

Another marital aspect which Phillips, Bohannon, Gayton, and Friedman (1985) found to be of significant concern for parents of chronically ill children was significant for this study as well. The item dealing with satisfaction for the amount of time the parent spends with their spouse is worded ambiguously. But, a reasonable reading of the asthma group's relative dissatisfaction with this area of their relationship may be that they feel they do not spend enough time together. (Rather than feeling they spend too much time together.) This may be explained by the time-consuming responsibility of caring for a chronically ill child. It may be that these couples do not have enough time left over for each other. This conclusion was reached by Margolin (1981), who pointed out the stress of the process of the day-to-day caring for chronically ill children. Margolin hypothesizes that the competition for time and resources means that the demands of being a parent of a chronically ill child often win out over the demands of being a spouse.

It is interesting to note that women in the entire sample share three areas of relative dissatisfaction with the asthma group: their partner's attitude towards having children, how the house is kept, and the amount of time they spend together as a couple. Thus, mothers of asthmatic children may be particularly susceptible to marital dissatisfaction. This echoes Cook's (1984) findings, which suggest that since women shoulder the majority of the burden for caring for a

chronically ill child, they also experience many of the stresses and conflicts.

Frequency of Serious Marital Disagreements

$H_0 5$: There will be no differences in reported frequencies of serious disagreements regarding 18 family related issues, as measured by subscale items of question #27, between parents of chronically ill children and parents of nonchronically ill children.

The results are presented in Tables 25, 26, and 27.

Table 25

Two Way ANOVA - Significant Results for #27 Subscale Item Scores - Frequency of Serious Disagreements

	F	P
F. relations with my relatives		
Group	.02	.89
Gender	5.28	.02
Group X Gender	.13	.72
P. the amount of time we spend together		
Group	1.44	.23
Gender	4.14	.04
Group X Gender	.95	.33

For nonsignificant results, see Table 48

Table 26

Mean Frequency of Serious Disagreements Item Scores by Group

"Even though you may be quite satisfied with your relationship, you and your partner may sometimes have serious disagreements on some issues. How often do you and he/she disagree in the following areas?"

1 = never
2 = once a year
3 = once a month
4 = once a week
5 = daily

	Asthma Group	Comparison Group
A. how the house is kept	2.4	2.4
B. how my partner's job affects our relationship	2.4	2.3
C. our social life	2.3	2.3
D. how my job affects our relationship	2.6	2.4
E. my partner's attitudes about having children	1.5	1.4
F. relations with my relatives	2.1	2.1
G. relations with my partner's relatives	1.8	2.0
H. our moral and religious beliefs and practices	1.6	1.5
I. how we communicate	3.0	2.6
J. the amount of money coming in	2.7	2.3
K. how we manage our finances	2.7	2.4
L. how we express affection for each other	2.6	2.3
M. whether we both should work	1.4	1.7
N. how we raise the children	2.9	2.3
O. our sexual relationship	2.4	2.2
P. the amount of time we spend together	2.5	2.3
Q. our leisure and recreational activities	2.4	2.2
R. our relationship in general	2.2	2.2

Table 27

Mean Frequency of Serious Disagreements Item Scores by Gender

"Even though you may be quite satisfied with your relationship, you and your partner may sometimes have serious disagreements on some issues. How often do you and he/she disagree in the following areas?"

1 = never
2 = once a year
3 = once a month
4 = once a week
5 = daily

	Male	Female
A. how the house is kept	2.7	2.2
B. how my partner's job affects our relationship	2.3	2.3
C. our social life	2.6	2.2

Table 27 --- continued

D. how my job affects our relationship	2.6	2.3
E. my partner's attitudes about having children	1.4	1.4
F. relations with my relatives	2.4	1.9 (P<.02)
G. relations with my partner's relatives	2.0	2.0
H. our moral and religious beliefs and practices	1.7	1.4
I. how we communicate	2.9	2.6
J. the amount of money coming in	2.5	2.4
K. how we manage our finances	2.6	2.4
L. how we express affection for each other	2.6	2.2
M. whether we both should work	1.8	1.5
N. how we raise the children	2.7	2.3
O. our sexual relationship	2.2	2.1
P. the amount of time we spend together	2.6	2.2 (P<.04)
Q. our leisure and recreational activities	2.4	2.1
R. our relationship in general	2.3	2.2

For the asthma and comparison groups, the ANOVA results suggest that that there are no significant differences between these groups for the frequency of serious disagreements. However, men from both groups report more frequent arguments regarding relations with their relatives than do the women in this sample. And, as noted in table 48, the difference between the asthma group's and the comparison group's means for items N and O approach significance. This suggests that the asthma group have slightly more frequent arguments for the items "how we raise the children" and "our sexual relationship".

Thus, for the asthma and comparison groups, the fifth null hypothesis is retained.

Discussion

Distinguishing between conflict and satisfaction is not an easy task in marital research. These two aspects of a relationship are very much intertwined. It could be said that marital dissatisfaction is marked by ongoing, unresolved conflict. However, some conflict, or serious

disagreements, occur in practically every marriage. Thus, the purpose of this section is to focus specifically upon the differences between the two groups for frequency of manifested conflict, or the frequency of serious disagreements.

After considering the several areas of relative dissatisfaction for the asthma group, it is interesting to note that this group does not report any areas of significantly more or less frequent disagreements than does the comparison group. The fact that there are no differences between the groups for frequency of serious disagreements raises a question about Rolland's (1987) concept of a child's chronic illness bringing the family closer together. Rolland implies that disagreements and conflicts for this type of family would be less so than for their counterparts without chronically ill children. This finding was not borne out in the current study.

Other researchers, such as Barbarin, Hughes, and Chesler (1985) point out that high marital cohesion is more common during the early part of a serious illness. Often, they point out, as the illness progresses, the stress of care issues spills over into the parents' marriage, causing a decline in the quality of the marriage. Perhaps this decline would be experienced as increased marital conflict. Again, this increase in conflict was not found in this study.

Thus, of the two possibilities of either increased levels of marital cohesion, or increased marital conflict for the parents of a chronically ill child, as proposed by Zimand and Wood (1986), neither were supported by the results of this research. Instead, as Sabbeth and Leventhal (1984) imply, since more frequent arguing may be a sign that the couple

is engaging one another in a constructive attempt to deal with the stress of the illness, the lack of such conflict may mean that such a couple is having some difficulty coping.

However, as noted in the statistics, two areas of disagreements approached significant difference. The asthma group had slightly more frequent disagreements than the comparison group about how they raise the children and about their sexual relationship. These two possible areas of conflict may indicate that within these marriages, these couples are demonstrating some degree of what Sabbeth and Leventhal (1984) describe as flexibility, adaptability, or coping. Thus, it appears that the parents of asthmatic children may be dealing with some stress in their marital relationships and their parental relationships by engaging one another in slightly more frequent disagreements about these two areas.

Regarding the differences between men and women in the overall sample, there were two issues for which men reported significantly more frequent disagreement than did women: "relations with my relatives", and "the amount of time we spend together". On a pervious subscale, women reported significantly less satisfaction than men for the latter of these issues: "the amount of time we spend together". This suggests that although women are unhappy with this issue, it is men who perceive that the couple argues about their time together. Thus, the results suggest that women in general may be more comfortable than the men in arguing about certain issues.

Additional Comparisons

Factors Predicting Marital Style

This particular instrument provided data which was useful for analyzing other variables which shed further light on the differences between parents of asthmatic children and parents of nonasthmatic children. Particularly, it is interesting to note to what extent having an asthmatic child or children predicts marital style and general marital satisfaction. In addition, differences may exist in the characteristics which predict marital style, and general marital satisfaction for parents of asthmatic children and parents of non-asthmatic children. Table 28 lists those characteristics which correlate most highly with the the entire sample's marital style score. As noted in Table 29, these characteristics were used in a stepwise regression, forcing the variable of group category (asthmatic child[ren] or no asthmatic child[ren]), and number of children into the equation. For this regression, the F to retain was set at 4. Table 29 includes the constant, or slope, and the Beta weights for each variable.

Table 28

Characteristics Correlated with Marital Style Score for Entire Sample

Characteristic	R^2
attitude towards feminism	-.55
have sex 3-4 times per week	-.35[a]
number of children	.35
attend church 3-4 times per week	-.33[b]
presence of an asthmatic child in the family	-.003[c]

a. 1 = yes, 2 = no

b. 1 = yes, 2 = no

c. 1 = yes, 2 = no

Table 29

Results of Stepwise Regression for Entire Sample Marital Style Score

Marital Style = 80 - 8.1 (attend church 3-4 times per week)
- 5.1 (have sex 3-4 times per week)
- 3.3 (attitude towards feminism)
+ 1.9 (number of children)[a]
- 1.2 (presence of an asthmatic child in the family)[b]

a. number of children - forced variable in stepwise regression

b. presence of an asthmatic child - forced variable in stepwise regression

For this equation, the constant was 80. The slopes ranged from 8.1 for church attendance to -1.2 for presence of an asthmatic child. Thus, for the overall sample, the best predictor for a traditional, or high marital style score is church attendance 3-4 times per week, followed in

order of predicting value by: sexual relations with mate 3-4 times per week, low support for feminism, several children in the family, and presence of an asthmatic child in the family. An egalitarian, or low marital style score is not as easy to articulate, since it involves the absence of the three variables: church attendance 3-4 times per week, sexual relations 3-4 times per week, and presence of an asthmatic child. Thus, an egalitarian marital style score is best predicted by high support for feminism and few children in the family.

The variable "number of children" has a Beta weight one fourth that of church attendance 3-4 times per week. Therefore, it is one fourth as useful a predictor for marital style. In addition, the variable "presence of an asthmatic child in the family" has a Beta weight one eigth that of church attendance. Thus, it is less a predictor of marital style score.

It should be noted that the presence of an asthmatic child in the family has an extremely low correlation with marital style score, so its use as a predictor for marital style should be used with caution.

Tables 30 and 31 include the characteristics which predict marital style scores for the asthma group.

Table 30

Characteristics Correlated with Marital Style Score for Asthma Group

Characteristic	R^2
attitude towards feminism	-.71
homemaker	-.62[a]
man initiates sex most of the time	.59[b]
employed full time	.57[c]
number of sick children	.50
woman initiates sex most of the time	-.49[d]
has received marital counseling	-.48[e]
attend church 1X/year	.42[f]
number of children	.40

a. 1 = yes, 2 = no
b. 1 = yes, 2 = no
c. 1 = yes, 2 = no
d. 1 = yes, 2 = no
e. 1 = yes, 2 = no
f. 1 = yes, 2 = no

Table 31

Results of Stepwise Regression for Asthma Group Marital Style

Marital Style = 4.9 + 10.1 (attend church 1 time per year)
+ 5.6 (employed full time)
+ 5.4 (man initiates sex)
+ 2.2 (number of sick children)[a]
+ 1.1 (number of children)[b]

a. number of sick children - forced variable in stepwise regression

b. number of children - forced variable in stepwise regression

Thus, three variables predict marital style scores for the asthmatic group. A low marital style score, or an egalitarian marriage score, is predicted best by attending church one time per year, second by being employed full time, third by the man as the primary initiator of sexual relations within the relationship, fourth by the presence of fewer asthmatic children in the family, and fifth by fewer total

children. A high marital style score, or traditional marriage score is more difficult to articulate, since it involves the absence of the first three of these variables. Therefore, the frequency of church attendance, employment status, and initiator of marital sexual encounters does not predict a traditional marriage score. However, it could be said that more asthmatic children, and more children overall in the family predict that the parents will have a somewhat more traditional relationship.

The variable, "number of sick children", has a Beta weight of approximately one third that of the highest weighted variable, yearly church attendance. Therefore, it is approximately one third as important as infrequent church attendance for predicting marital style scores. The Beta weight for the variable "number of children" is half that of the Beta weight for "number of sick children".

Tables 32 and 33 have to do with the calculation of the stepwise regression for marital style score for the comparison group. The F to retain for this equation is set at 4. Number of children is entered as a forced variable.

Table 32

Characteristics Correlated with Marital Style Score for Comparison Group

Characteristic	R^2
attitude towards feminism	-.52
have sex 3-4 times per week	-.37[a]
attend church 3-4 times per week	-.37[b]
satisfaction with overall marital communication	.30
number of children	.35

a. 1 = yes, 2 = no

b. 1 = yes, 2 = no

Table 33

Results of Stepwise Regression for Comparison Group Marital Style Score

Marital Style = 59.4 - 8.8 (attend church 3-4 times per week)
- 3.5 (attitude towards feminism)
+ 3.0 (satisfaction with overall marital communication)
+ 1.9 (number of children)[a]

a. number of children - forced variable in stepwise regression

As opposed to the asthma group, this equation gives a picture of those characteristics which predict a traditional, or high marital style score for the comparison group. The highest of these characteristics is church attendance 3-4 times per week, followed by nonsupport of feminism, a high rating of their marital communication, and finally a large number of children as the last variable in the equation. An egalitarian, or low

score is predicted best by high support for feminism, low rating of marital communication, and few children.

Since the Beta weight for the number of children is one fourth that of church attendance, it is less predictive for marital style than is church attendance.

Discussion

It is interesting to note that, although there was no difference between the asthma group and the comparison group for marital style and expectations, having an asthmatic child did contribute towards predicting a traditional marital style. This provides some support for the conclusion that parents with chronically ill children may be slightly more prone than other parents towards having traditional marriage values.

Other factors to note include the similarities for the two groups regarding marital style. For both groups, church attendance was a primary factor in determining marital style. Thus, more frequent church attendance predicts a traditional style, while very infrequent attendance predicts an egalitarian style. Also for both groups, the larger the family, the more the tendency for the parents to have traditional marriage values. Thus, it appears that having traditional values means that one is prone to go to church more often and have a bigger family, regardless of whether or not there is an asthmatic child in the family.

The differences between the two groups are also interesting to note. For the asthma group, full time employment and man as the initiator of sexual relations predict egalitarian values. Therefore, if a parent of an asthmatic child is employed part time, is a homemaker, or is self employed, they are more likely to have traditional values. Since these

occupations might lend themselves more towards caring for the ill child, this gives weight to the conclusion that accomodating the ill child through one's less than full time job status is associated with a more traditional marital style.

For parents of asthmatic children, the variable of man as sexual initiator as a predictor for an egalitarian marriage values is less clear. It would make more sense for this variable to be associated with a traditional marital style. The fact that it is not suggests that for parents of asthmatic children there may be some discrete role assignments which did not appear in the marital style or expectations. Thus, it could be speculated that the man may be designated the caretaker of the sexual relationship, while the woman cares for the children. In any case, for the parents of asthmatic children, the conclusion from these analyses suggests some tendency for their marriages to have rather traditional characteristics, regardless of their expressed values. This suggests that the marriages of parents of asthmatic children may be a complicated mixed bag of expectations developed from the demands and stresses of caring for chronically ill children.

The predictors for the comparison group's marital style differed from the asthma group's for two variables: attitude towards feminism, and satisfaction with overall communication. The first of these factors is fairly easily understood. Thus, for the comparison group, a traditional marital style is strongly predicted by lack of support for feminism. The second factor echoes a conclusion by Walsh and Allen (1991 B), which asserts that traditional couples are generally more satisfied with their marital communication than are egalitarian couples.

Factors Predicting Marital Satisfaction

Tables 34 - 39 all deal with those factors which predict General Marital Satisfaction for this sample. Tables 34 and 35 relate to the characteristics used in the stepwise regression for the general marital satisfaction score for the two groups combined. The variables "number of children" and "presence of an asthmatic child in the family are forced into the equation.

Table 34

Characteristics Correlated with General Marital Satisfaction Score for Entire Sample

Characteristic	R^2
have sex 3-4 times per week	-.40[a]
both partners initiate sex with equal frequency	-.35[b]
have never discussed breaking up	-.35[c]
have discussed breaking up over 3 times	.35[d]
amount of chores partner does	.34
man receives most pleasure from sex	.32[e]
both partners receive equal pleasure from sex	-.31[f]
presence of an asthmatic child in the family	.28[g]
number of children	-.06

a. yes = 1, no = 2
b. yes = 1, no = 2
c. yes = 1, no = 2
d. yes = 1, no = 2
e. yes = 1, no = 2
f. yes = 1, no = 2
g. yes = 1, no = 2

Table 35

Results of Stepwise Regression for Entire Sample General Marital Satisfaction Score

Satisfaction Score = 61 - 8 (have sex 3-4 times per week)
+ 4.9 (man receives most pleasure from sex)
- 4.7 (have never discussed breaking up)
+ 4.6 (presence of an asthmatic child in the family)[a]
+ 1.9 (amount of chores partner does)
+ .8 (number of children)[b]

a. presence of an asthmatic child - forced variable in stepwise regression

b. number of children - forced variable in stepwise regression

Thus, for the groups combined, six variables predict the general marital satisfaction score. High marital satisfaction is predicted best by having sex 3-4 times per week. The next best predictors, in order, are: the man receives the most pleasure from their sexual relationship, the couple has never discussed breaking up, they do not have an asthmatic child, they believe their partner does a fair share of chores, and they have few children.

Low marital satisfaction is predicted best by having an asthmatic child, feeling that their partner does not do a fair share of chores, and having a large number of children.

It should be noted that for the general marital satisfaction score, having a sick child has a relatively low correlation. But, the number of children has an even lower correlation with satisfaction.

Tables 36 and 37 relate to the stepwise regression for the General Marital Satisfaction score for the asthmatic group. The variables,

number of children, and number of sick children are forced into the equation. The F to retain was set at 4.

Table 36

Characteristics Correlated with General Marital Satisfaction Score for Asthma Group

Characteristic	R^2
number of sick children	.56
years of education	-.56
attitude towards feminism	-.47
man initiates sex most of the time	.47[a]
man receives most pleasure from sex	.46[b]
both partners initiate sex with equal frequency	-.45[c]
attend church 2-3 times per month	-.42[d]
low family income	.42[e]
employed part time	.40[f]
number of children	.31

a. yes = 1, no = 2
b. yes = 1, no = 2
c. yes = 1, no = 2
d. yes = 1, no = 2
e. yes = 1, no = 2
f. yes = 1, no = 2

Table 37

Results of Stepwise Regression for Asthma Group General Marital Satisfaction Score

Satisfaction Score = 90.2 - 18.4 (attend church 2-3 times per month)
+ 9.9 (man receives most pleasure from sex)
+ 4.0 (number of children)[a]
+ 3.1 (number of sick kids)[b]
- 1.8 (years of education)

a. number of children - variable forced in stepwise regression

b. number of sick children - variable forced in stepwise regression

Higher satisfaction for parents of asthmatic children is predicted by attending church 2-3 times per month, having several kids overall,

having several asthmatic kids, and fewer years of parental education. Correspondingly, lower satisfaction for this group of parents is predicted by the man in the relationship being the primary one to enjoy their sexual relationship, having fewer kids overall, fewer asthmatic kids, and a higher number of years of parental education.

Tables 38 and 39 relate to the stepwise regression for the comparison group's general marital satisfaction score. The variable "number of children" was forced into the equation. The F to retain was set at 4.

Table 38

Characteristics Correlated with General Marital Satisfaction Score for Comparison Group

Characteristic	R^2
have never discussed breaking up	-.49[a]
have sex 3-4 times per week	-.42[b]
amount of chores partner does	.41
have sex once every few months	.36[c]
have sex once a month	.34[d]
low personal income	.37[e]
high family income	-.37[f]
low family income	.31[g]
have discussed breaking up 2-3 times	.30[h]
number of children	-.11

a. yes = 1, no = 2
b. yes = 1, no = 2
c. yes = 1, no = 2
d. yes = 1, no = 2
e. yes = 1, no = 2
f. yes = 1, no = 2
g. yes = 1, no = 2
h. yes = 1, no = 2

Table 39

Results of Stepwise Regression for Comparison Group General Marital Satisfaction Score

Satisfaction Score = 68.9 - 7.1 (have never discussed breaking up)
- 5.3 (have sex 3-4 times per week)
+ 5.2 (low personal income)
+ 2.8 (amount of chores partner does)
- .9 (number of children)[a]

a. number of children - variable forced into stepwise regression

Higher satisfaction for the comparison group is predicted by having never spoken of breaking up their marriage, having sex 3-4 times per week, feeling that their partner does a significant share of chores around the house, and having fewer children. Low satisfaction is particularly predicted by low personal income, feeling that the partner does not do their fair share of chores, and having several children.

Discussion

It is interesting to note that the factors predicting marital style are similar for the two groups. But the factors which predict satisfaction vary between the asthma group and the comparison group. Church attendance appears to be very important to the satisfaction of the asthma group. This could relate to their predominantly Catholic nature. Or, as noted by Venters (1981) it could reflect the maintenance of some values which help these families to cope with the challenges which face them.

It is further interesting to note that for the asthmatic group, having several children overall, and having several asthmatic children is a predictor of marital satisfaction. In contrast, for the comparison

group, marital dissatisfaction was predicted by a large number of children. For parents of asthmatic children, having several children appears to support Rolland's (1987) view that family cohesion is produced by turning towards childrearing. And, since large families are associated with a traditional marital style, this suggests that parents of asthmatic children who have traditional values are also more satisfied with their marital relationship.

The two factors which predict marital dissatisfaction for parents of asthmatic children include man as recipient of most of the sexual pleasure in their relationships, and a greater number of years of education. As noted in the section pertaining to marital style, egalitarian values for this group are associated with the man as the primary sexual initiator. If this means that the man also is more interested in the pleasures derived from sex, then a possible conclusion could be that those parents of asthmatic children with egalitarian values tend to be more dissatisfied with their marriages. This finding could be contrasted with that of study of a group of European couples (Walsh & Allen, 1991 B) which concluded that for the European couples, egalitarians tend to be more satisfied with their marital relationships than traditionals. This contrast suggests that for parents of asthmatic children, traditional marital values may provide for a smoother, more satisfactory family arrangement.

The variable relating to years of education also supports this conclusion. It could be argued that more education is generally thought to be associated with increased levels of openness to decision sharing within one's marriage. Thus, if more education predicts marital

dissatisfaction for the parents of asthmatic children, this also supports the conclusion that egalitarian marital values may be detrimental for marriage satisfaction.

Values Regarding Family Related Developmental Tasks

ANOVA was performed to evaluate the differences between the two groups and between males and females for specific tasks associated with raising a family. The results are presented in Tables 40, 41, and 42.

Table 40

Two Way ANOVA - Significant Results for #21 Subscale Item Scores - Values Regarding Family Related Developmental Tasks

	F	P
A. choosing the right partner		
Group	4.46	.04
Gender	1.74	.19
Group X Gender	.28	.60
F. maintaining a career		
Group	.01	.90
Gender	17.66	.0001
Group X Gender	.81	.37

For nonsignificant results see Table 45

Table 41

Mean Values Regarding Family Related Developmental Tasks by Group

"How important are the following to you?" 5 = very important
3 = average
1 = unimportant

	Asthma Group	Comparison Group
A. choosing the right partner	4.5	4.9 (P<.03)
B. learning to live with a marriage partner	4.9	4.8
C. starting a family	3.5	4.0
D. rearing children	4.8	4.8
E. managing a home	4.0	4.3
F. maintaining a career	3.7	3.8

Table 42

Mean Values Regarding Family Related Developmental Tasks by Gender

"How important are the following to you?" 5 = very important
3 = average
1 = unimportant

	Male	Female
A. choosing the right partner	4.7	4.8
B. learning to live with a marriage partner	4.7	4.8
C. starting a family	3.8	3.9
D. rearing children	4.6	4.9
E. managing a home	4.1	4.3
F. maintaining a career	4.4	3.3 (P<.0001)

One family related value or attitude, "choosing the right partner", was rated by the asthma group significantly lower than that for the comparison group. A different value, "maintaining a career", was rated significantly lower by women than by men.

Discussion

The significant difference between the asthma and comparison groups for all but one family related developmental value suggests that these two groups have comparable attitudes due to their similar status as parents of primarily school aged children. The asthma group's

Table 41

Mean Values Regarding Family Related Developmental Tasks by Group

"How important are the following to you?" 5 = very important
3 = average
1 = unimportant

	Asthma Group	Comparison Group
A. choosing the right partner	4.5	4.9 (P<.03)
B. learning to live with a marriage partner	4.9	4.8
C. starting a family	3.5	4.0
D. rearing children	4.8	4.8
E. managing a home	4.0	4.3
F. maintaining a career	3.7	3.8

Table 42

Mean Values Regarding Family Related Developmental Tasks by Gender

"How important are the following to you?" 5 = very important
3 = average
1 = unimportant

	Male	Female
A. choosing the right partner	4.7	4.8
B. learning to live with a marriage partner	4.7	4.8
C. starting a family	3.8	3.9
D. rearing children	4.6	4.9
E. managing a home	4.1	4.3
F. maintaining a career	4.4	3.3 (P<.0001)

One family related value or attitude, "choosing the right partner", was rated by the asthma group significantly lower than that for the comparison group. A different value, "maintaining a career", was rated significantly lower by women than by men.

Discussion

The significant difference between the asthma and comparison groups for all but one family related developmental value suggests that these two groups have comparable attitudes due to their similar status as parents of primarily school aged children. The asthma group's

significantly lower value for "choosing the right partner" suggests that this group has somewhat different expectations for their relationships. It appears that for this group "who" they marry is not as important as other parts of their marriages. And, this lowered value for choosing a partner may reflect, in part, this group's overall relative marital dissatisfaction. In respect to the significant difference between men and women in the entire sample for the value, "maintaining a career", this finding is similar to that of Walsh and Allen (1991 B), which found that European women in their sample tended to value maintaining a career less than did the men in the sample.

Frequency of Tasks Performed Together

Subjects rated how often they were accompanied by their spouses when accomplishing seven household tasks. The results are presented in Tables 43, 44, and 45.

Table 43

Two Way ANOVA - Significant Results for Subscale #24 Item Scores - Frequency of Tasks Performed Together

	F	P
A. cooking meals		
Group	3.60	.06
Gender	3.35	.07
Group X Gender	3.78	.05
C. doing household cleaning		
Group	3.88	.05
Gender	.002	.96
Group X Gender	.04	.84
F. doing the laundry		
Group	3.99	.05
Gender	.0007	.98
Group X Gender	.11	.74

Table 43 --- continued

G. playing with children		
Group	8.32	.005
Gender	1.12	.19
Group X Gender	.02	.90

For nonsignificant results see Table 50.

Table 44

Mean Frequency of Tasks Performed Together by Group

"How often do you and your partner perform these tasks together?
5 = always
3 = half
1 = never

	Asthma Group	Comparison Group
A. cooking meals	3.2	2.3
B. taking care of the garden	2.4	2.3
C. doing household cleaning	2.1	2.7 (P<.05)
D. doing the grocery shopping	2.1	2.3
E. making major purchases	4.5	4.4
F. doing the laundry	1.5	2.1 (P<.05)
G. playing with children	2.9	3.5 (P<.005)

Table 45

Mean Frequency of Tasks Performed Together by Gender

"How often do you and your partner perform these tasks together?
5 = always
3 = half
1 = never

	Male	Female
A. cooking meals	2.9	2.3
B. taking care of the garden	2.4	2.3
C. doing household cleaning	2.5	2.5
D. doing the grocery shopping	2.3	2.2
E. making major purchases	4.5	4.4
F. doing the laundry	2.0	1.9
G. playing with children	3.2	3.5

Subjects in the asthma group performed three tasks together less frequently than did the comparison group: doing household cleaning, doing the laundry, and playing with the children. No differences were noted between the genders. One interactive effect was noted for the task "cooking meals". Women in both groups scored similarly: women in the

asthma group averaged 2.3, while women in the comparison group averaged 2.4. However, there was a disparity between the scores of men. Men in the asthma group averaged 4.6, while men in the comparison group averaged 2.3.

Discussion

This subscale is a measure of relative "togertherness". Thus, the results point out that, related to the comparison group, the asthma group members are more likely to divide chores. This is further evidence that this group has a tendency towards lack of marital cohesion and towards traditional values. The most interesting difference of these three involves the relative infrequency with which members of the asthma group report joining or being joined by their spouses for the purpose of playing with their children. This indicates that, relative to the comparison group, the asthma group tends not to participate in playful activities as a family.

The interactive effect for the independent variables of group and gender upon the frequency of the tasks: "cooking meals" suggests that, with the exception of men in the asthma group, all the other subjects in the sample report that they cook meals together about one quarter of the time. Men in the asthma group report that they cook meals with their partners about three quarters of the time. This indicates that men in the asthma group perceive that they are more involved in the day to running of this part of the family life. It may be that some of the parental concern with possible dietary related allergies and restrictions may translate into the men's perception of sharing more in cooking tasks

Summary

Three major concepts were addressed in this research. First, traditional and egalitarian marital styles and expectations were compared for the group of parents of asthmatic children and a comparison group of parents. Second, overall marital satisfaction and specific areas of marital satisfaction for both groups were addressed. Third, conflict as expressed in frequency of serious disagreements for the two groups was compared.

Taken together, the results of this study suggest that although the asthma group and comparison group do not differ significantly in regards to scored marital style and expectations, and as related to frequency of serious disagreements, they do differ significantly in overall marital satisfaction, and specific areas of marital satisfaction.

It appears that, as compared to other parents, the parents of asthmatic children hold the same expectations for their marriages, and do not argue any more frequently with their partners about various issues. But they are significantly less satisfied than other parents with their marriages overall and specifically with the effect of a partner's job upon the marriage, their marital communication and affection, their partner's attitudes about family size, the state of the family's housekeeping, and the amount of time they spend together.

This suggests that these parents have not changed their marital expectations or confrontation styles to deal with the stress of caring for a chronically ill child. Instead, it appears that this stress is being manifested by dissatisfaction with the marital relationship.

Other data collected in this study, especially those relating to characteristics which predict marital style and satisfaction for both

groups, suggest that the parents of asthmatic children actually do have some characteristics which could be considered to be traditional in nature. These include the slight positive relationship between having an asthmatic child and the parents' traditional relationship, the dominance of the man in the sexual relationship of these couples, the relationship between less than full time employment and a traditional marital style, and greater marital satisfaction related to increased family size.

In addition, further results from parents of asthmatic children indicate that these parents tend to operate on somewhat of a parallel track when it comes to taking care of their household. Of particular note is the couples' tendency to play with their children together significantly less frequently than the comparison group. This suggests that the mother is most likely the one designated to care for the children. This conclusion would confirm Cook's (1984) claim that chronic illness of a child often results in the father being pushed out of some of the family interactions.

In conclusion, it appears that although they hold similar expectations for marriage, the parents of asthmatic children may, in reality be living out a more traditional style of marriage. If this is true, it might explain some of the dissatisfaction with their marriages. There may be a great deal of conflict with what they believe is ideal, and what they actually experience. Added to this is their apparent similarity to other couples in regards to frequency of marital disagreements or conflicts. Sabbeth and Leventhal (1984) claim that too little conflict in a marriage is not good. If this is true, then considering the stress parents of asthmatic children endure, they may

engage in way too little marital conflict to adequately deal with their situation.

CHAPTER V

SUMMARY AND CONCLUSIONS

Statement of the Problem

For parents with an asthmatic child, the stress of caring for a chronically ill child is not limited to enduring medical procedures with their child. Instead, chronic illness disrupts the parents' and the family's life by redirecting time, energy, and money from other parts of their lives to those daily activities which are demanded by the care of the chronically ill child. These activities include, but are not limited to: visits to physicians, trips to the emergency room, alternate child care for the ill child, relocation to seek specialized medical care, and loss of wages while attending to the ill child.

Based upon the review of the literature on parents of chronically ill children and upon childhood asthma and parental functioning, it is clear that little research has been done to describe the marital satisfaction and role distribution of parents with asthmatic children. The marital relationships of parents with asthmatic children were compared in this study to those of parents with nonchronically ill children.

The effects of a family member's illness upon other members of the family is a topic which has received quite a bit of research interest. But there is little agreement amongst this body of research about the specific effects caring for chronically ill children have upon parents'

marriages. To some extent, these differences in opinion are due to illness-related discrete dynamics which impact upon family functioning and the parents' marital relationships. These dynamics include prognosis, illness visibility, and amount or type of medical procedures required.

Family and marital functioning can be characterized in several ways. Some studies, such as Sabbeth and Leventhal's (1984) have focused upon divorce rates as indicators of marital satisfaction for parents of chronically ill children. Although Sabbeth and Leventhal found elevated divorce rates for this group, others, such as Kalnins, Churchill, and Terry (1980) found no difference in divorce rates between parents of leukemic children and a comparison group.

Some researchers such as Rolland (1987) have suggested that distribution of roles for parents of chronically ill children tend to follow a specific pattern. Thus, as Rolland implies, for the parents of a chronically ill child, there is a shift of focus towards a more traditional, family-centered pattern of efforts.

Asthma is a syndrome with discrete characteristics which probably have some unique implications for parents of an asthmatic child. Unlike illnesses such as leukemia, asthma is not a progressive disease (Ellis, 1988). Instead, as Rolland (1987) describes, asthma is an episodic illness. Its course is marked by periods of stability, punctuated by intense episodes of dramatic symptoms which can be quickly and effectively treated.

Although asthma has been characterized by laypeople to be an illness born out of emotional instability and weakness of both the child and the

parents (particularly the mother), studies such as McAndrew's suggest that families with asthmatic children are no more and no less mentally ill than the population in general. Ramsdell (1985) suggests that emotional factors contribute to asthmatic conditions only by exacerbating the existing symptoms.

The current research was an extension of Walsh and Allen's (1991 A & B) work on marital styles (traditional v. egalitarian), marital expectations, and marital satisfaction. This study was designed to compare parents of asthmatic children under age 18 and parents with nonchronically ill children (also under age 18) in regards to role expectations, general and specific areas of marital satisfaction, and frequency of serious marital disagreements. In addition, for the two groups, demographic data and data related to tasks performed in the household were compared.

The purpose of this research was to contribute information on the marital relationships of parents of chronically ill children to the body of literature dealing with chronic illness and its effects upon the family. Further, these results may be of interest to professionals involved in the psycho-social care of these families.

Procedures

Twenty parents of asthmatic children and 60 parents of nonchronically ill children completed a survey regarding their marital and family relationships. Subjects for the asthma group were recruited from the Metro Denver Parents of Allergic/Asthmatic Children support group and from the nurses' list of asthmatic children attending the laboratory school at the University of Northern Colorado. Subjects for

the comparison group were recruited from a variety of sources, including parent mailing lists of Weld (Colorado) school district six, and the University of Northern Colorado laboratory school. Surveys were mailed to potential recruits. Postage paid envelopes addressed to the researcher were provided for return of the surveys.

Individuals in both groups completed a consent form in addition to the survey. The survey used was an adapted version of Walsh's (1987) Couple's Survey. Questions were added to this survey to screen for the presence of a chronically ill child, the type of chronic illness experienced, and the age group of the ill child or children. The demographic information required for inclusion in either group included: married or permanently co-habiting (if remarried, married for at least five years), and parent of a child or children under age 18. Each member of the asthma group was matched to three members of the comparison group on the basis of approximate age, age group of children, and approximate family size.

Walsh's (1987) Couple's Survey is an adaptation of Blumstein and Schwartz' (1986) marital survey instrument. Walsh's version consists of 42 questions dealing with a variety of marital and family characteristics, and attitudes. Question number 22 on this survey is a subscale of 15 items dealing with marital expectations. To score this subscale, seven items were flipped in value. Thus, for items A-D, L, N, and O, a response of 5 became a 1, 4 became a 2, 3 remained the same, 2 became a 4, and 1 became a 5. High scores were associated with traditional marital values, while low scores were associated with egalitarian values. (To determine the mean difference for these items, each was restored to its original value.)

Question number 23 is a subscale of 17 items dealing with marital satisfaction. No modification of item scores was necessary to score the entire subscale. A high score was associated with greater marital satisfaction. A low score was associated with marital dissatisfaction.

The data were compiled and tested at the .05 level of significance. Three types of analyses were used. T-tests were used on a few continuous demographic items, stepwise regression with forced variables was used to predict the two subscale scores by demographic data, and ANOVA was used to determine the differences between mean subscale scores and mean scores for individual items.

Five null hypotheses were tested by these statistical procedures. The research question dealt with the presence of any significant differences between the groups for marital style, specific marital expectations, general marital satisfaction, specific areas of marital satisfaction, and frequency of serious disagreements.

Findings and Conclusions

The asthma group and comparison group were comparable for all but two demographic categories: size of community and religious preference. Thus, the subjects were mostly caucasian, middle income, well-educated, employed full time, in their 30's, and parents of three school aged children. Over half of the entire sample was female. Most of the subjects had been married once. The subjects averaged almost 15 years of marriage. They were evenly distributed between those who identified their marriages as egalitarian, and those who identified as traditional.

The difference between the two groups for size of community was probably related to the data collection procedures. The asthma group was

drawn primarily from an urban support group. Thus, the majority of the asthma group reported living in suburbs. The comparison group was drawn from school district parent lists of a large town (population over 10,000). All subjects were drawn from a radius of 65 miles around the Denver (Colorado) area. For this study, the differences between residence in a suburb and a large town were considered to be negligible.

The differences in religious persuasion were also determined to not be a source of concern for this study. The asthma group was primarily Catholic, while the comparison group was Protestant.

Three of the null hypotheses were retained, two were rejected. This indicates that the groups are similar in terms of marital values, expectations, and frequency of disagreements. However, they differ significantly for general and specific marital satisfaction. More precisely, the asthma group was significantly less satisfied overall, and significantly less satisfied with several specific areas of their marital relationship, involving the effect of their partner's job upon the relationship, their marital communication, their partner's attitude about having children, how the house is kept, their marital affection, and the amount of time they spend together. In addition, the asthma group estimated their partner's marital satisfaction lower than did the comparison group. Thus, although parents of asthmatic children have the same marital values, expectations, and frequency of arguments as other parents of nonchronically ill children, these parents of chronically ill children are far less satisfied with their marital relationships.

These results suggest that parents of asthmatic children are experiencing the stress of caring for chronically ill children squarely

in their marital relationships. They apparently have not altered their expectations of their marriages to suit the circumstances. Nor have they increased their intra-couple conflicts in order to deal with the stress. The picture that emerges is of parents who quietly endure the stress as their satisfaction with their marriages erodes.

Other results propose that parents of asthmatic children live out a style of marriage that is very different than their values. Thus, this conflict between the ideal and the actual appears to be greater for these couples than for the comparison group.

The lack of differences between the two groups for expectations and frequency of arguments illustrates the similarities between two groups of parents of school aged children. The differences between the asthma and comparison groups highlight the impact of stress upon the marriages of parents of chronically ill children.

Thus, the 10 major findings of this research are as follows:

1. There is a lack of difference between the asthma and comparison group for self-classified marital style, marital style score, and 15 specific marital expectations.

2. The comparison group has significantly greater general marital satisfaction and significantly greater satisfaction with six specific areas of marital satisfaction, including: partner's job, communication, partner's attitudes towards having children, state of housekeeping, affection, and amount of time spent together. In addition, the comparison group's average estimate of their partner's marital satisfaction is significantly greater than that of the asthma group.

3. There is a lack of significant difference between the two groups for frequency of serious disagreements regarding 18 aspects of family life.

4. Having an asthmatic child is positively correlated with traditional marital expectations.
5. For parents of asthmatic children, data related to marital sexual activity and employment status suggest a tendency towards traditional marital characteristics for this group.
6. For the asthma group, an egalitarian marital style is predicted best by infrequent church attendance, full time employment, man in charge of marital sexual relationship, fewer asthmatic children, and fewer total children.
7. For parents of asthmatic children, larger family size is associated with more marital satisfaction. This finding and data related to marital sexual activity and years of education for the parents suggest a positive relationship between marital satisfaction and traditional marital characteristics for this group.
8. For the asthma group, greater marital satisfaction is predicted by frequent church attendance, having a larger family, having several asthmatic children, and having relatively fewer years of education. For this group, lower marital satisfaction is predicted by the man identified as the partner who enjoys their sexual relationship,
9. The asthma group has a significantly lower average rating than the comparison group for the family related developmental task of choosing the right partner.
10. The asthma group reports significantly lower frequency than the comparison group for how often the couples are together as partners when engaging in three family related activities: doing household cleaning, doing the laundry, and playing with the children.

Recommendations for Further Research

1. Replication of this study with a different serious illness group would help to further define the dynamics involved in parenting children who have various chronic illnesses. This would help to provide a consistent measure of the marital style, expectations, satisfaction, and serious marital disagreements for parents of chronically ill children.

2. Further research in the stages of serious childhood illness and their relationship to marital functioning would help to chart the psychosocial course of illness. Most of the subjects in the asthma group of this study were in the chronic phase of an illness. It would be helpful to look at the marital relationships of parents of children with a fatal disease: focusing upon initial diagnosis, the actual chronic phase, remission, and either survival or death. Answering questions about these phases could help professionals to better deal with the issues facing parents at each of these crucial points.

3. Applying this comparative method to family members other than parents would be helpful. Thus, how do siblings cope with a brother or sister who has chronic asthma?

4. Finally, applying this comparative method to groups which are not defined by illness would further shed light on the use of this type of instrument. These couples could be defined by characteristics including race, income, age, and education. For example, how are the marital styles of caucasian and hispanic couples different?

Recommendations for Treatment

1. Since it is apparent that parents of asthmatic children argue as often than their peers, and have similar expectations and values, yet

have greater marital dissatisfaction, it is recommended that they be encouraged through marital counseling to explore those issues which contribute to their dissatisfaction. Thus, if they are relatively dissatisfied with communication and affection within their relationship, it may be helpful for them to engage each other in discussion about these issues. It may be beneficial to prescribe periods of time that the couple sets aside to specifically air out disagreements about these issues. These couples should be encouraged to explore for themselves what marital style works for them in their circumstances. Thus, the therapist ought not assume that an egalitarian arrangement works equally well for every couple. Instead, the parents of an asthmatic child should be encouraged to evaluate whether or not dividing up chores and responsibilities in a more traditional fashion may help to alleviate stress.

2. It has been shown that dysfunctional dynamics in the parents' relationship adversely affect the child's condition (Reiss, Gonzalez, and Kramer, 1986). Therefore, upon diagnosis and treatment of childhood asthma, attention should be given by medical professionals to the specific marital needs of the parents of the child. This focus should be upon dealing adequately with new stressors, and upon continuously assessing the quality of the relationship, focusing upon the parents' satisfaction with their marriage.

Suggestions for Societal Change

One factor which became quite clear from a review of of the literature, and from professional contact with parents of chronically ill children is the need for realistic societal treatment of all parents. In

the past couple of decades there have been dramatic changes in the U.S. economy, affecting employment opportunities, housing prices, medical care, health insurance, and other cost of living considerations. For most two parent families these changes have made it economically necessary for both parents to work outside the home in order to support their families.

Although there have been welcomed changes in official sick leave policies in many major companies (i.e., allowing parents to use their own sick leave to care for an ill child), the demands of full time employment are felt especially hard by parents of chronically ill children. Strict 9:00 A.M. to 5:00 P.M., Monday through Friday, two weeks vacation per year schedules leave little flexibility for parents who must conform to the demands of physicians' appointments and who must respond their children's medical emergencies. For many of these parents, giving up a full time job means giving up health insurance benefits which help to cover the enormous expense of some chronic illnesses. In addition, giving up such a job means removing oneself from a professional track which offers opportunities for much needed self-esteem and personal growth for the parent of a chronically ill child.

In order to more realistically become a family centered nation, this society must embrace a philosophy of valuing child care as equally as it values the pursuit of economic profit. If the rigid expectations of many companies have not kept up with the reality of many parents' lives, a shift in focus will be necessary. This burden need not be put upon the parent (usually mother) who may be forced to choose between a salary and parenting a child with special needs. Nor should an employer suffer

APPENDIX A
WALSH'S COUPLES' SURVEY
(C) 1987

No. ____________________

1. How old are you? ________

2. Are you a:
   A. Male
   B. Female

3. What is your marital status?
   A. Married
   B. Co-habiting (unmarried, living together)
   C. Separated
   D. Divorced
   E. Single

4. How long ago did you get married?
   ________ years, ________ months

5. How many years of education have you had (completion of high school counts as 12 years, completion of college counts as 16 years, etc.)
   ____

6. Which of these best describes your current employment situation?
   A. Employed full-time
   B. Employed part-time
   C. Unemployed
   D. Retired
   E. Taking care of the household is my full-time job.
   F. Self-employed

7. If you are currently employed, what kind of work do you do?
   Give specific description ________________________________
   (for example, farmer of over 70 acres)

8. What is your race?
   A. White
   B. Black
   C. Hispanic
   D. Asian
   E. Other ________________________

9. What is your religious affiliation?
   A. Catholic
   B. Protestant
   D. Jewish
   E. Other ________________________

10. About how often do you attend religious services?
    A. Daily
    B. Three/four times a week
    C. One/two times a week
    D. Two/three times a month
    E. Once a month
    F. Once a year
    G. Less than once a year
    H. Never

11. What city or town do you live in? (closest) ______________________

12. Which of the following best describes the community you live in?
    A. Farm
    B. Rural area (not farm)
    C. Small town (under 10,000 population)
    D. Large town
    E. City
    F. Suburb

13. Which of the following best describes your family's total yearly income?
    A. Upper income (over $60,000)
    B. Middle income ($15,000 - $60,000)
    C. Lower income (under $15,000)

14. Which of the following best describes your own yearly income?
    A. Upper income (over $60,000)
    B. Middle income ($15,000 - $60,000)
    C. Lower income (under $15,000)
    D. None

15. Is this your first marriage?
    A. Yes
    B. No

16. How many times altogether have you been married? _________

17. If you have children, what is the age and sex of each?

SEX	AGE	SEX	AGE
_______	_________	_______	________
_______	_________	_______	________
_______	_________	_______	________

The following three questions have to do with chronic or serious illnesses your children may have.

18. Do you have a chronically or seriously ill child? Yes No
    If so, what sort of chronic or serious illness does your child have?
    ____

19. How many of your children have a chronic or serious illness? _______

20. What are the ages of the children who have a chronic or serious illness? _____ _____ _____ _____ _____ _____ _____ _____

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21. How important are the following to you?

	very important		average		unimportant
A. choosing the right partner	5	4	3	2	1
B. learning to live with a marriage partner	5	4	3	2	1
C. starting a family	5	4	3	2	1
D. rearing children	5	4	3	2	1
E. managing a home	5	4	3	2	1
F. maintaining a career	5	4	3	2	1

22. The following are general questions about couples. How much do you agree or disagree with each statement?

	strongly agree		neutral		strongly disagree
A. Both partners in a relationship should evenly divide the household tasks.	5	4	3	2	1
B. It is very difficult for a relationship to last more than ten years.	5	4	3	2	1
C. If both partners work full-time, both of their career plans should be considered equally in determining where they will live.	5	4	3	2	1
D. The two partners should share the responsibility for earning a living for the household.	5	4	3	2	1
E. The two partners should pool all their property and financial assets.	5	4	3	2	1
F. A member of a couple that has been together a long time should not accept a job he/she wants in a distant city.	5	4	3	2	1
G. Couples should try to make their relationship last a lifetime.	5	4	3	2	1
H. It is better if the man works to support the household and the woman takes care of the home.	5	4	3	2	1
I. Marriage is a life-time relationship and should never be terminated except under extreme circumstances.	5	4	3	2	1
J. Even if the wife works, the man should have major responsibility for the couples' financial plans.	5	4	3	2	1

K. When there are small children in the home, it is better for the mother not to work.	5	4	3	2	1
L. It is better for parents to break up than to expose children to an unhappy marriage.	5	4	3	2	1
M. Extramarital sexual relations are always wrong.	5	4	3	2	1
N. There are times when I am with friends and I don't want my partner along.	5	4	3	2	1
O. It is important to me that my partner spend some time without me.	5	4	3	2	1

23. How satisfied are you with these parts of your relationship?

	extremely satisfied		average		very unsatisfied
A. our moral and religious beliefs and practices	5	4	3	2	1
B. how my partner's job affects our relationship	5	4	3	2	1
C. how we communicate	5	4	3	2	1
D. how my job affects our relationship	5	4	3	2	1
E. my partner's attitudes about having children	5	4	3	2	1
F. how the house is kept	5	4	3	2	1
G. the amount of influence I have over the decisions we make	5	4	3	2	1
H. our social life	5	4	3	2	1
I. the amount of money coming in	5	4	3	2	1
J. how we express affection for each other	5	4	3	2	1
K. how we manage our finances	5	4	3	2	1
L. how we raise our children	5	4	3	2	1
M. our sexual relationship	5	4	3	2	1
N. the amount of time we spend together	5	4	3	2	1
O. our leisure and recreational activities	5	4	3	2	1
P. your overall satisfaction with the relationship	5	4	3	2	1
Q. how would your partner rate his/her overall satisfaction with the relationship	5	4	3	2	1

24. How often do and your partner perform these tasks together?

	always		half		never
A. cooking meals	5	4	3	2	1
B. taking care of the garden	5	4	3	2	1
C. doing household cleaning	5	4	3	2	1
D. doing the grocery shopping	5	4	3	2	1
E. making major purchases	5	4	3	2	1
F. doing the laundry	5	4	3	2	1
G. playing with children	5	4	3	2	1

25. Considering the chores in your household, do you feel your partner does his/her fair share?

much more		average		much less
5	4	3	2	1

26. How sympathetic do you feel towards the Women's Movement?

very		average		none
5	4	3	2	1

27. Even though you may be quite satisfied with your relationship, you and your partner may sometimes have serious disagreements on some issues. How often do you and he/she disagree in the following areas?

	daily	once a week	once a month	once a year	never
A. how the house is kept	5	4	3	2	1
B. how my partner's job affects our relationship	5	4	3	2	1
C. our social life	5	4	3	2	1
D. how my job affects our relationship	5	4	3	2	1
E. my partner's attitudes about having children	5	4	3	2	1
F. relations with my relatives	5	4	3	2	1
G. relations with my partner's relatives	5	4	3	2	1
H. our moral and religious beliefs and practices	5	4	3	2	1
I. how we communicate	5	4	3	2	1
J. the amount of money coming in	5	4	3	2	1
K. how we manage our finances	5	4	3	2	1
L. how we express affection for each other	5	4	3	2	1
M. whether we both should work	5	4	3	2	1
N. how we raise the children	5	4	3	2	1
O. our sexual relationship	5	4	3	2	1
P. the amount of time we spend together	5	4	3	2	1
Q. our leisure and recreational activities	5	4	3	2	1
R. our relationship in general	5	4	3	2	1

28. How often have you and your partner seriously discussed ending the relationship?
    A. never
    B. once
    C. two or three times
    D. more than three times

29. Compared to one year ago, how would you rate your relationship with your partner?

much better		same		much worse
5	4	3	2	1

30. Have you ever had counseling for problems connected with your relationship?
    A. yes
    B. no

31. Indicate your satisfaction or dissatisfaction with the following aspects of your relationship.

	very satisfied		average		very dissatisfied
A. Affection	5	4	3	2	1
B. Communication	5	4	3	2	1
C. Sex	5	4	3	2	1

32. Who has the most responsibility for the discipline of the children?
    A. me
    B. my spouse
    C. equally shared
    D. not applicable

33. Have you had a love affair since you and your partner have been living together?
    A. yes
    B. no

34. If you had the opportunity, would you have an affair now?
    A. yes
    B. no

35. About how often during the last year have you and your partner had sexual relations?
    A. Daily or almost every day
    B. Three or four times a week
    C. Once or twice a week
    D. Two or three times a month
    E. Once a month
    F. Once every few months
    G. Never

36. Who do you feel gets the most pleasure from lovemaking?
    A. Men
    B. Women
    C. Both sexes enjoy lovemaking equally

37. In your relationship, who gets more pleasure from lovemaking?
    A. Man
    B. Woman
    C. Both equally

38. In your relationship, who initiates lovemaking most often?
    A. me
    B. my spouse
    C. about the same for each

39. How often do you think that most couples make love?
    A. Daily or almost every day
    B. Three or four times a week
    C. Once or twice a week
    D. Two or three times a month
    E. Once a month
    F. Once every few months
    G. Almost never

40. What kind of relationship do you consider yourself to have with your partner? Choose the one that best describes your relationship.

    A. Traditional
    B. Equalitarian/Egalitarian

    Use the following definitions to aid in your choice:

    Traditional: Decisions are made separately or independently by husband or wife; husband earns the family income; wife cares for the home and children; wife has more responsibility for the emotional needs of the family.

    Equalitarian: Decisions are made equally by both partners; total sharing of labor; equality of careers; equality of choice concerning lifestyle. Negotiation is a major part of the relationship.

41. List the physical and emotional things from your partner that you:

Need	Receive
A. ____________	A. ____________
B. ____________	B. ____________
C. ____________	C. ____________
D. ____________	D. ____________
E. ____________	E. ____________

42. Would you be interested in participating in a personal interview in the future - as a part of the second phase of the research project?

    A. Yes
    B. No
    C. If yes, name ____________
       address ____________

APPENDIX B

SUBJECT CONSENT FORM FOR PARTICIPATION OF HUMAN SUBJECTS IN RESEARCH

SUBJECT CONSENT FORM FOR
PARTICIPATION OF HUMAN SUBJECTS IN RESEARCH
UNIVERSITY OF NORTHERN COLORADO

Project Title: A Comparative Study of the Marital Relationships of Parents of Chronically Ill and Nonchronically Ill Children
Researcher: Molly Allen, Division of Professional Psychology

Description: If you volunteer for this research study, you will be asked to complete a survey relating to aspects of your marital relationship. The total time for your participation is 1 hour.

Please answer all of the questions by yourself. Your personal, individual responses are extremely important as a parent of either a chronically ill or nonchronically ill child. Do not compare your responses to those of your partner. All of your answers will be kept in strict confidence. Your cooperation in this study will assist counselors in helping couples and families in the future.

Respond to the following questions in the manner indicated for each item. For some questions, you are to circle the letter or number that corresponds to your choice. Other questions ask you to fill in the blank on the appropriate line. There are no right or wrong answers. The correct answer for each item is the one that you believe or feel is true for you.

All answers will be kept completely confidential. The number on each questionnaire will be used only to match the partners in each family. Your name will be matched to your questionnaire only if you request feedback on your responses.

When you have completed the survey, place it in the stamped and addressed envelope and seal it completely. It will be opened only by the research staff. Your responses will be combined with many others', and the information will be used for research purposes only.

The risks to you are minimal, though you may encounter some increased insight regarding your relationship with your partner. In case this is disturbing for you, you are urged to contact the researcher at the telephone number provided for you.

If you so request, a summary report and explanation of the results of this research will be made available to you when the study is completed.

AUTHORIZATION: I have read the above and understand the nature of this study, and agree to participate. I understand that by agreeing to participate in this study I have not waived any legal or human rights. I also understand that I have the RIGHT TO REFUSE TO PARTICIPATE, and that MY RIGHT TO WITHDRAW FROM PARTICIPATION AT ANY TIME during the study WILL BE RESPECTED with no coercion or prejudice.

______________________________ ____________
Participant Signature Date

If you would like to have feedback concerning your survey responses, you may contact the researcher: Molly Allen, Doctoral Student, Division of Professional Psychology, McKee Hall, University of Northern Colorado, Greeley CO 80631 (phone: 303-351-2731 or 303-356-3981).

If you have any concerns for how you were treated in this study, please contact: Dr. William A. Barnard, Chair of the Internal Review Board, Department of Psychology, University of Northern Colorado, Greeley CO 80639 (phone: 303-351-2508).

APPENDIX C

TABLES OF NONSIGNIFICANT RESULTS

Table 46

Two Way ANOVA - Nonsignificant Results for Subscale #22 Item Scores - Marital Expectations

	F	P
A. Both partners in a relationship should evenly divide the household tasks.		
Group	1.11	.29
Gender	.84	.36
Group X Gender	.002	.96
B. It is very difficult for a relationship to last more than ten years.		
Group	.16	.69
Gender	1.33	.25
Group X Gender	.97	.32
C. If both partners work full-time, both of their career plans should be considered equally in determining where they will live.		
Group	.06	.81
Gender	.06	.81
Group X Gender	.38	.54
D. The two partners should share the responsibility for earning a living for the household.		
Group	.84	.36
Gender	1.10	.30
Group X Gender	.02	.89
E. The two partners should pool all their property and financial assets.		
Group	.04	.84
Gender	1.02	.31
Group X Gender	.14	.71
F. A member of a couple that has been together a long time should not accept a job he/she wants in a distant city.		
Group	.26	.61
Gender	.10	.75
Group X Gender	.24	.62
G. Couples should try to make their relationship last a lifetime.		
Group	.49	.49
Gender	.008	.93
Group X Gender	.49	.49

Table 46 --- continued

H. It is better if the man works to support the household and the woman takes care of the home.		
Group	.76	.38
Gender	3.34	.07
Group X Gender	.31	.58
I. Marriage is a life-time relationship and should never be terminated except under extreme circumstances.		
Group	1.78	.19
Gender	.31	.58
Group X Gender	.05	.83
J. (see Table 17)		
K. When there are small children in the home, it is better for the mother not to work.		
Group	1.08	.30
Gender	.05	.86
Group X Gender	.20	.65
L. It is better for parents to break up than to expose children to an unhappy marriage.		
Group	1.21	.27
Gender	3.60	.06
Group X Gender	1.42	.24
M. Extramarital sexual relations are always wrong.		
Group	.009	.93
Gender	.03	.85
Group X Gender	.54	.46
N. There are times when I am with friends and I don't want my partner along.		
Group	.46	.50
Gender	.30	.58
Group X Gender	1.85	.18
O. It is important to me that my partner spend some time without me.		
Group	.65	.42
Gender	.10	.75
Group X Gender	.65	.42

Table 47

Two Way ANOVA - Nonsignificant Results for Subscale #23 Item Scores - Marital Satisfaction

	F	P
A. our moral and religious beliefs and practices		
Group	.74	.39
Gender	2.26	.14
Group X Gender	1.15	.29
B. (see Table 22)		
C. (see Table 22)		
D. how my job affects our relationship		
Group	.31	.58
Gender	.03	.86
Group X Gender	.05	.82
E. (see Table 22)		
F. (see Table 22)		
G. the amount of influence I have over the decisions we make		
Group	.91	.34
Gender	2.25	.14
Group X Gender	3.14	.08
H. our social life		
Group	.82	.37
Gender	.82	.37
Group X Gender	.007	.93
I. the amount of money coming in		
Group	.09	.77
Gender	.02	.88
Group X Gender	0	1.00
J. (see Table 22)		
K. how we manage our finances		
Group	1.47	.23
Gender	1.12	.29
Group X Gender	1.23	.27
L. how we raise our children		
Group	.10	.70
Gender	.0008	.98
Group X Gender	.02	.88

Table 47 --- continued

	F	P
M. our sexual relationship		
Group	2.22	.14
Gender	.50	.48
Group X Gender	2.22	.14
N. (see Table 22)		
O. our leisure and recreational activities		
Group	3.76	.06
Gender	1.88	.17
Group X Gender	.11	.74
P. your overall satisfaction with the relationship		
Group	3.12	.08
Gender	.05	.82
Group X Gender	2.28	.13
Q. (see Table 22)		

Table 48

Two Way ANOVA - Nonsignificant Results for Subscale #27 Item Scores - Frequency of Serious Disagreements

	F	P
A. how the house is kept		
Group	.03	.86
Gender	1.39	.24
Group X Gender	.40	.53
B. how my partner's job affects our relationship		
Group	.08	.78
Gender	.0007	.98
Group X Gender	.02	.90
C. our social life		
Group	.05	.82
Gender	2.19	.14
Group x Gender	.01	.91
D. how my job affects our relationship		
Group	.05	.83
Gender	.08	.77
Group X Gender	2.28	.13

Table 48 --- continued

E. my partner's attitudes about having children		
Group	.0005	.98
Gender	.60	.44
Group X Gender	1.74	.19
F. (see Table 25)		
G. relations with my partner's relatives		
Group	.68	.41
Gender	.03	.87
Group X Gender	.24	.62
H. our moral and religious beliefs and practices		
Group	.25	.61
Gender	1.59	.21
Group X Gender	.25	.61
I. how we communicate		
Group	3.37	.07
Gender	2.77	.10
Group X Gender	.84	.36
J. the amount of money coming in		
Group	1.51	.22
Gender	.11	.74
Group X Gender	.001	.97
K. how we manage our finances		
Group	1.43	.23
Gender	.75	.39
Group X Gender	.01	.91
L. how we express affection for each other		
Group	1.43	.24
Gender	3.30	.07
Group X Gender	.46	.50
M. whether we both should work		
Group	.79	.38
Gender	1.82	.18
Group X Gender	.51	.47
N. how we raise the children		
Group	3.53	.06
Gender	1.01	.32
Group X Gender	.18	.67

Table 48 --- continued

	F	P
O. our sexual relationship		
Group	3.55	.06
Gender	1.13	.29
Group X Gender	.81	.37
P. (see Table 25)		
Q. our leisure and recreational activities		
Group	1.19	.28
Gender	3.13	.08
Group X Gender	2.04	.18
R. our relationship in general		
Group	.16	.69
Gender	2.34	.13
Group X Gender	2.86	.09

Table 49

Two Way ANOVA - Nonsignificant Results for Subscale #21 Item Scores - Values for Family Related Developmental Tasks

	F	P
A. (see Table 40)		
B. choosing the right partner		
Group	1.09	.30
Gender	.48	.49
Group X Gender	.12	.72
C. starting a family		
Group	2.49	.12
Gender	.75	.39
Group X Gender	.45	.50
D. rearing children		
Group	.69	.41
Gender	1.36	.25
Group X Gender	2.25	.14
E. managing a home		
Group	.91	.34
Gender	.14	.70
Group X Gender	.91	.34
F. (see table 40)		

Table 50

Two Way ANOVA - Nonsignificant Results for Subscale #24 Item Scores - Frequency of Tasks Performed Together

	F	P
A. (see Table 43)		
B. taking care of the garden		
Group	0	1.00
Gender	0	1.00
Group X Gender	.22	.64
C. (see Table 43)		
D. doing the grocery shopping		
Group	.84	.36
Gender	.007	.93
Group X Gender	.34	.56
E. doing the laundry		
Group	.50	.48
Gender	.50	.48
Group X Gender	.50	.48
F. (see Table 43)		

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