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The concerns, needs and coping strategies of fathers when their children have cancer

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THE CONCERNS, NEEDS AND COPING STRATEGIES
OF FATHERS WHEN THEIR CHILDREN
HAVE CANCER

by

Judy Anne Christensen Scott

Bachelor of Science in Nursing
University of Nevada, Las Vegas
1991

A thesis submitted in partial fulfillment
of the requirements for the degree of

Master of Science

in

Nursing

**Department of Nursing
University of Nevada, Las Vegas
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Thesis Approval
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The Concerns, Needs, and Coping Strategies of Fathers

When Their Children Have Cancer

is approved in partial fulfillment of the requirements for the degree of

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ABSTRACT

The Concerns, Needs and Coping Strategies of Fathers When Their Children have Cancer

by

Judy Anne Christensen Scott

Dr. Susan Rush Michael, Examination Committee Chair
Assistant Professor of Nursing
University of Nevada, Las Vegas

Numerous families have discovered that trying to live with pediatric cancer demands all the energy they can produce. Many studies have been conducted to ascertain the feelings and needs of families in this crisis however, there is a paucity of research focusing on the father's feelings and the father's needs. The purpose of this study was to explore the fathers' concerns, needs and coping strategies as they are experiencing pediatric cancer. A convenience sampling (n=48) of fathers involved in cancer treatment for their child was obtained from the records of the Candelighters Group of America the Las Vegas, Nevada Chapter. The top concerns were regarding the children's current and future wellbeing. The main questions the fathers needed answered were questions about the current and future development of their children. The number one most frequently utilized, as well as the most helpful coping strategy was prayer. An increase in yearly income was related to seeking more information and reading more about the problem. Also, an increased frequency in church attendance was related to a decreased use of looking for options as a way to cope.

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CHAPTER 1

INTRODUCTION

Cancer constitutes a physically, mentally and emotionally devastating illness.

Numerous individuals have discovered that trying to live with this disease demands all the energy that they can produce. Thoughts of "Why did this happen to me?" and "God must be punishing me!" often cause feelings of depression and hopelessness. As difficult as receiving a diagnosis of cancer can be for an adult, when this cancer strikes a child, feelings of depression and hopelessness are greatly magnified for the families. (Brett & Davies, 1988; Ferrell, Rhiner, Shapiro, & Dierkes, 1994; Nelson, Miles, Reed, Davis, & Cooper, 1994; Ruccione, Kramer, Moore, & Perin, 1991; Sterken, 1996; Reed, 1991).

Many studies have been conducted to ascertain the needs of families faced with childhood cancer. Most of the studies focus on the mothers' feelings and needs. (Evans, & Kelly, 1995; Frankel, 1993). Some studies (Barret & Robinson, 1986; Aitken & Hathaway, 1993; Bearison, Sadow, Granowetter, & Winkel, 1993; Brown & Baebarin, 1996; Leventhal-Belfer, Bakker, & Russo, 1993; Lynam, 1987) have provided data gained from surveys of both mothers and fathers. However, this latter research did not focus specifically on the unique needs of the father. There is a scarcity of research that focuses strictly on the fathers' feelings and the fathers' needs. (Berland, 1987; Cayse, 1994; Sterken, 1996). Perhaps one of the reasons for this paucity of information is society's

view of the father as the breadwinner and the mother as the care-giver. Even though the role of women has changed and expanded, the role of men has remained more constant. Fathers have been labeled as ‘helpers’ in the rearing of their own children and often are not seen as essential to their children’s emotional lives. (Osherson, 1995, p. 286).

Problem

The problem is that the unique concerns and needs of the father of a child diagnosed with cancer have not been thoroughly assessed. Most of the research has focused on the mother as the primary care giver, and ignored the important and special role of the father. There is little research describing the experience of being a father of a child with cancer.

Purpose

The purpose of this study was to describe the fathers’ concerns, needs and coping strategies utilized when their child is experiencing cancer.

Significance to Nursing

The nurse is the health care provider who most closely and most frequently interacts with the fathers, and has the opportunity to plan care recognizing and embracing the uniqueness of the fathers. The information gained from this research adds to the small, but growing, body of knowledge that can be utilized by the nurse in planning interventions focused on supporting the fathers of the children experiencing cancer.

CHAPTER 2

REVIEW OF LITERATURE AND CONCEPTUAL FRAMEWORK

Introduction

From earliest recorded history, the roles of men and women have been different. In the Bible, Eve was told “I will greatly multiply thy sorrow and thy conception: in sorrow thou shalt bring forth children; and thy desire shall be to thy husband, and he shall rule over thee.” (Holy Bible, 1979, Genesis 3:16). As God described the man’s role, Adam was told “cursed is the ground for thy sake; in sorrow shalt thou eat of it all the days of thy life . . . In the sweat of thy face shalt thou eat bread, till thou return unto the ground.” (Holy Bible, 1979, Genesis 3:17, 19). Historically, this pattern has continued. In the 1920's, only 23% of all women were in the labor force. Most of these women were young, unmarried, and childless. The societal norms were for women to work only until marriage. Then women were to stop working, go home, have a family and let the man support the family (Sochen, 1974). Recently, some of these rigid role definitions have become flexible. Fathers are beginning to evolve into more of a nurturing parent in their children’s lives. As their role expands and changes, there is a need to examine men’s concerns, needs, and coping strategies. What are the differences between the concerns, needs and coping strategies of men and women? How do men interact with the health care industry in regard to their children?

There are many studies (Barret & Robinson, 1986; Aitken & Hathaway, 1993; Bearison et al., 1993; Brown & Baebarin, 1996; Leventhal-Belfer et al., 1993; Lynam, 1987) that report the needs and coping mechanisms of families as they have dealt with the diagnosis of childhood cancer. However, almost all of this research has focused on the mother and the child with only an ancillary mention of the fathers. (Evans & Kelly, 1995; Frankel, 1993) There was a great lack of research supporting fathers and their unique needs.

Historical View of The Fathers' Role

Historically, fathers have been labeled the “breadwinners” and the “emotionally detached” head of the home. Their duties have been to provide for the family and to protect them from harm. (Barna, 1995). During the twentieth century, the father has been portrayed as strong and in control, and as the person in the family who could fix anything. The man worked outside of the home and was the “head of the home” (Jarema, 1994; May, 1996; Osherson, 1995; Pruett, 1987; Shanley, 1996). During this same period of time, mothers had been the primary care-givers of children. Women kept the house clean, cooked the meals, and cared for the children. The women worked inside of the home and were the “heart” of the home. (Barna, 1995).

In the seventies and the eighties, mothers took off their aprons and sought jobs outside the home. In 1970, the average woman worker was married and thirty-nine years old (Sochen, 1974). “By 1980, 51.5% of all adult women held jobs outside the home including more than 60% of women with children between the ages of six and sixteen and 45% of women with children less than six. By 1985, 53.4 percent of women with preschool children were in the labor force” (Evans, 1989, p. 301). Mothers experienced a

role revolution as society allowed them to be at home and at work. Women were granted the right to function in the traditionally masculine role of the breadwinner, as well as the traditionally feminine role of the nurturer.

The Modern Father's Role

While the woman's role was evolving, society would not support men in the same evolutionary process. If a man was loving and nurturing, he was often considered to be less of a man, "a sissy." The traditional roles of "working" father and "homemaker" mother still exist in a few homes. However, even in this traditional setting, the nurturing of the children is almost always shared. Fathers are still considered by much of society to be only "helping" by watching the baby when the mom needed to leave the home to shop, to run errands or go to work (Singer, Shechtman, & Singer, 1983). This view ignores the vital role fathers can play in the lives of their children.

Pruett (1987) discusses the numerous problems encountered by "stay-at-home fathers" as they faced the normalcy of society. The men, in many cases, hid their stay-at-home status from their parents and friends to avoid negative feedback. Some men, according to Barna's study (1995) feel that their role as the "breadwinner," which was synonymous with masculinity and power, had been eroded. They were expected to evolve quickly and effortlessly into a family situation contrary to this role. As some men became primary, stay-at-home care givers, they experienced feelings of social isolation, loss of self esteem and loss of self confidence. May (1996) found that men who choose to rear their children while their wives work, encountered added strain and confusion. Fathers were educated to do the "three P's: provide, protect and procreate (and barbecue on the side)" (p. 244). There are few male role models for fathers who wanted to be the primary care

givers for their children. This situation is complicated by a great lack of child-rearing information and training geared toward men.

Many men were surprised at the fulfilment they felt in caring for their children. Osherson (1995) took twelve months off from the office to write a book and take care of his children. His wife went to work full time to provide the family's income. Osherson gives the following example of the interaction between himself and children:

...the book is done, it's time to go play with my children. I'm filled with wonder at it all, how much my children have given to me, how the love in their eyes kindles the love in my own, how constantly learning and relearning to be there with them reminds me of what's important in life, how grateful I am to have a wife who encourages, even demands, that I explore this world . . . I think about renewal in men's lives, how often we attempt to find renewal outside our families-with new cares, new projects, new plans, moving this, changing that. Now I see that my family had itself been a constant source of renewal for me as well, I feel blessed for that . . . so, with deep gratitude and delight, Solomon the Sea Monster, trying to look scary but unable to suppress a smile, crawls toward his children, who giggle with pleasure, their eyes merry with anticipation at being pounced on, rolling around the floor with their father over and over again (p. 286).

Fathers' Influence on Their Childrens' Lives

In today's society, the importance of the fathers in the lives of children is just beginning to be realized. Many books, magazines and discussions center around how to be a good father, (Barna, 1995; Barret & Robinson, 1986; Berland, 1987; Jarema, 1994),

as well as how much children need their fathers to be involved in their lives (Hakulinen & Paunonen, 1995; Pruett, 1987; Shanley, 1996; Shields & Sparling, 1993; Singer et al., 1983). Mack and Trew (1991) found that mothers view their children's behaviors as significantly more problematic than do fathers. Koniak-Griffin and Verzemnieks (1995) observed that fathers reported behavior problems to be less intense in comparison to mothers. Also, in the same study, regular interaction between father and child seems to influence paternal behavior problem ratings positively. This research suggests that fathers may help to balance the negative view of "rowdy" childhood behaviors often held by mothers. Children with chronic illnesses need that balance too. May (1996) makes the following observation about fathers who are involved with their children with special needs.

The positive results of father involvement are endless. Research tells us family communication is enhanced: there is reduced depression and fatigue, improved sharing of parental responsibilities, and increased acceptance of the child . . . Literally thousands of men have commented to me that they are less competitive, more patient, receptive to and understanding of peoples' differences, and more willing to live in the moment than in the future. Such are the lessons of being the dad of a child with special needs. (p. 245).

Shields and Sparling (1993) studied, the touching behaviors of twenty-one fathers and their three-month-old infants. The study defined two types of touch: first, instrumental-touch which is some physical contact during the provision of care or safety; and second, affectional-touch which is physical contact that suggests fondness or includes

playfulness. The descriptive analysis suggests that as instrumental touch increased, (the touch used for support, caretaking, or safety of the child), the quality of play and the general impression of the quality of the father's interaction decreased. Concurrent instrumental-touch and affectional-touch were more frequently observed by fathers of later born and healthy infants than fathers of first born and special needs infants. Also, educational level of the father was positively related to the sensitivity and increased use of affectional-touch of the fathers.

Castledine (1981) conducted an informational study examining the effects of the fathers' sudden absence from the home because of a hospital stay. He found this absence has a prolonged, significant effect on the family. Twenty families (the wives and the older children) were interviewed at three intervals: first, soon after the father's hospitalization; second, midway through the hospital stay; and third, one week after the father's discharge from the hospital. The fathers' hospitalization was due to accidents (seven cases), medical reasons (four cases), surgery (four cases) and mental illness (five cases). Ten of the wives noted that their husbands' absence had a great impression on the children, seven noted some difference, and only three reported no effects. Many mothers reported that their children became more disobedient and more aggressive during their father's absence. Each child said that they missed their fathers during the hospitalization.

Fathers' Concerns

As fathers begin to live with the diagnosis of cancer for their child many concerns evolve. Most parents try to understand the cause of the cancer. Bearison, et al (1993) found that all the parents in their study had been told that the cause of pediatric cancer was unknown. However, 70 percent of the parents formulated their own causes for the

cancer. Contagion, environment, fate, trauma, constitutional susceptibility, and heredity were all identified by the parents as reasons for “catching” cancer. Brett and Davies (1988) developed a “parental reappraisal time line” to identify different stages of concern: first is Alarm, when survival is seen as impossible; second is Vigilance, when survival is seen as possible; and third, Relaxed Vigilance, when survival is seen as probable but not certain (p. 331).

Leventhal-Belfer, et al. (1993) studied the concerns and needs of parents of childhood cancer survivors (twenty-four mothers and thirteen fathers). The number one concern for both mothers (91.7%) and fathers (100%) was the child’s health complications. Fathers were also concerned about the child’s relapse (61.5%) and the child’s social development (53.8 %). Mothers were more concerned about increased professional support (62.5%) possible relapses (50.0%) and social development (41.7%).

Cayse (1994) selected a convenience sample (twenty-three fathers) from an outpatient hematology clinic located in a large Midwestern city. The fathers all had children diagnosed with cancer within the past two years. The instrument used was the Parents Perception Inventory (PPI) which was developed to measure the impact of chronic illness on parents. The PPI contains a Likert scale ranging from 0=Do not do this to 3=very often. The data were analyzed using descriptive statistics. The researcher found that the two most frequent concerns were the child’s future (mean=2.26) and the child’s health (mean=2.23). Concerns about their spouse’s health (mean=1.91) and having enough time alone with my spouse (mean=1.77) were ranked as number three and four by the men. Two of the most commonly utilized coping strategies reported were to pray (mean=2.14) and to get information (mean=2.10). Prayer was also identified as the most helpful coping

mechanism (mean=2.10). Ninety-six percent of the fathers named the doctors as their source of information, with 86% naming the nurses as a source of information.

Horn, Feldman, and Ploof (1995) interviewed thirteen families (thirteen mothers and five fathers), of children with chronic illness, regarding concerns and coping strategies. These children were each hospitalized for a minimum of thirty days. All thirteen families discussed “their own emotional reactions to their child’s hospitalization” as a primary concern. “Communication problems with professionals” was named as the secondary concern with “changes in family routine during the child’s hospitalization” as the third concern (p. 116).

Fathers’ Needs

Because men were supposed to be ‘tough,’ they were not seen as needing emotional support. They needed to be strong and in control for their wives and their children. When their child has cancer, this need to be strong and in control is difficult to meet. Ferrell, et al. (1994) described the father’s sense of loss of control over their family and their life.

The experience for fathers was indicative of the frustration they felt at not being able to function in their role as protector and provider. Men who were accustomed to having employee subordinates respond to their requests found themselves not taken seriously or being at the mercy of physicians who were clearly in charge. Not being able to provide physical comfort to a child with pain or being unable to “fix it and make it better” were extremely difficult experiences for the fathers. Fathers described other burdens in addition to maintaining an income. Fathers were also

expected to manage the household while the spouse was in the hospital.

Such personal relationships as those mentioned were described by one

father who said, “I felt like I was losing my wife to my kid” (p. 377).

Many fathers expressed a feeling of being ‘left out’ in the physical care of their children, especially if they lived far from the treatment center and could only visit on weekends. In an article outlining the support systems offered to parents and families of children with cancer, Forsyth (1992) points to the “great deal of strain . . . put upon a marriage when a child is diagnosed as having cancer . . . One partner may desire physical contact and intimacy for reassurance while the other resents it because of the child’s vulnerability.” Forsyth also states that because fathers usually need to continue working, they may develop feelings of helplessness particularly if they live some distance from the hospital (p. 26-27). Most of the medical care, teaching, and treatments happen during the day (May, 1996). Doctors do rounds and schedule most testing to be done during the day. Often, the father’s presence is not considered to be important, especially if the mother was nearby to ask questions and to comfort the child. The needs of the fathers work schedules, distance, and the dad-can-fix-anything attitudes are left unmet. The fathers’ questions were asked second-handed through the mothers. (Barna, 1995; May, 1996). This method of transferring information can lead to misunderstandings and confusion regarding their child’s care. Leventhal-Belfer, et al (1993) give the following example:

One explanation may stem from the fact that fathers are usually not as involved as mothers in their child’s treatments. Fathers work to maintain insurance coverage and provide income while mothers accompany the child

on hospital visits. American fathers may not exhibit a strong desire for increased interaction because of culturally instilled values regarding masculinity. (Fathers) desire to be strong for their partner and the family, to be a supportive provider, and to assume a role of family leadership. They often neglect their own unspoken need to ask for help from the professional community (p. 32-33).

For fathers, who were only able to come to the hospital on the weekends, because the family lived out of town, and who cared for the other children at home, the implications of this “lack of involvement” took on another meaning. Not only did they find it difficult to fit into the situation when visiting at the hospital, but also they felt that there was a diminished awareness on the mother’s part of the problems and worries encountered at home. These men perceived that no one really understood this situation. (Lynam, 1987).

Father’s Coping Strategies

Methods utilized to deal with the concerns and needs of the fathers are called coping strategies. Bearison, et al. (1993) identified both positive and negative types of coping strategies when dealing with childhood cancer. Use of humor, decreasing negative impact through comparison, mastering, seeking support, taking mind off, and religious reframing were all positive methods of coping. Negative types of coping strategies were impulsive discharge, denial/blocking, ruminating, and avoidance of talking about it. Horn, et al. (1995), in interviews with thirteen parents of chronically ill children in the hospital, demonstrated that the two most helpful coping strategies were “gaining information and obtaining support from hospital professionals” (p. 118).

In one of the few research studies directed toward men, Sterken (1996) wanted to describe uncertainty and consequential coping patterns in fathers of children with cancer. The Mishel's Parent Perception of Uncertainty Scale (PPUS) and the Jalowiec Coping Scale (JCS) were the instruments used. Demographic and individual scale scores were evaluated using descriptive statistics while the relationship between the scores on the PPUS and the JCS were analyzed by Pearson's Product Moment Correlational Coefficient. Thirty-one of 150 eligible fathers completed the study. The results showed negative correlation between age and uncertainty ($r = -.4815$; $P = .003$). 'Uncertainty' was defined as ambiguity, lack of clarity, and lack of information. These young fathers tended to use optimistic, evasive and emotive mechanisms to cope. Some of the avoidant activities used were drugs, alcohol, food, yard work, driving alone and putting increased energy into work. The length of diagnosis was also negatively correlated with uncertainty ($r = -.3004$; $P = .050$) and coping ($r = -.3141$; $P = .043$). In other words, the longer the time period since the date of diagnosis, the less uncertainty was expressed the young fathers. Time to have questions answered and to experience the disease process all can decrease the uncertainty and anxiety associated with the pediatric cancer experience.

Gender-Role Differences

Some differences in the needs of mothers versus the needs of fathers have been observed. Brown & Barbarin (1996) conducted a study of 124 parents (fifty-six couples and twelve mothers) and identified several gender differences in their perceived roles. Both fathers and mothers gave their highest ratings of personal responsibility and effectiveness to dealing with the medical aspects of the illness. However, mothers gave significantly higher ratings than fathers with regards to the importance, stress, time spent

and effectiveness in this act. Fathers experienced the most personal responsibility and spent the most time on obtaining money. They were also more effective than mothers in taking care of the expenses. Spending time with other family members was significantly more important and stressful for mothers than fathers but was rated as the most time-consuming task by the fathers. Spending time with immediate family was given the highest rating of importance by fathers while keeping extended family and friends informed was much less important.

Heaman (1995) sampled 203 parents of children with developmental disabilities (seventy fathers and 133 mothers), comparing mothers with fathers. She utilized Hymovich's Parent Perception Inventory (PPI): Concerns, and The Ways of Coping questionnaire developed by Folkmann and Lasarus. The purpose of the study was to first describe perceived stressors and coping strategies of parents and second to ascertain similarities and differences between mothers and fathers. Frequencies and percentages were calculated to describe stressors, coping strategies and demographics. Multiple regression analysis was used to compare gender differences. The data showed that the greatest concern of the mothers (88.8%) and the fathers (85.2%) was the child's future. Both mothers (79.3%) and fathers (75.3%) reported "having enough money to meet family needs" as another stressor. Interestingly, more than three fourths (78.2%) of the fathers rated "not being able to get out of the house with spouse or partner without the child" as a stressor. The number one coping strategy for mothers was trying to keep feelings about the problem from interfering with other things (92.5%) whereas fathers reported analyzing the problem to understand it better (92.5%) as their number one coping strategy. "Predominant coping strategies of mothers were categorized as seeking social

support, problem solving and positive reappraisal . . . Coping strategies reported by the largest number of fathers focused mostly on problem solving and self-controlling approaches . . . the need to have the right agencies to provide for the child's needs was associated more with mothers ($F=6.261$, $p=0.013$), whereas the child's health ($F=6.014$, $p=0.015$), sexual relationships with spouse or partner ($F=4.919$, $p=0.028$), and having enough insurance to meet expenses of child care ($F=3.946$, $p=0.049$) were identified as a need by fathers" (p. 315-6).

Riddle, Hennessey, Eberly, Carter and Miles (1989) conducted a study examining the mothers' and fathers' perceptions of stressors in a pediatric intensive care unit. Mothers and fathers, 155 of each, were asked to complete the Parental Stressor Scale: Pediatric Intensive Care Unit (PSS: PICU) and the Spielberger's State-Trait Anxiety Inventory. Mothers (mean=52.76) were found to have significantly higher ($p<0.002$) State Anxiety scores than fathers (mean=48.71). Other identified sources of stress included tubes in my child (45%), the sudden sounds of monitor alarms (36%), putting needles in my child (50%), crying or unable to talk/cry (48%), acting or looking as if in pain (40%), and being unable to protect my child from pain (46%). Two other sources of stress for both the fathers and the mothers were not being sure when I will see the doctor, and the staff looking worried.

Leventhal-Belfer, et al. (1993) studied the concerns and needs of parents of childhood cancer survivors (twenty-four mothers and thirteen fathers). They found that while fathers were fairly comfortable sharing with their partner (100%), few shared concerns with friends (8.5%). None of the fathers named friends as the person with whom they most frequently shared their concerns. Most of the mothers (83.3%) were fairly

comfortable sharing with their partner, and 62.5 percent shared concerns with friends. In fact, 20.8 percent identified friends as the person with whom they most frequently shared concerns.

Parents' Involvement in Health Care

Few studies have focused upon the needs and desires of fathers and the health care of their children. Coyne (1995) identified four main categories of reasons why parents chose to participate in the care of their children hospitalized in a general surgical pediatric ward. First, concern about relinquishing care to strangers; second, sense of parental duty; third, concern for consistency of care; and fourth, parents' experience of hospitalization as a child. All of the sixteen mothers and two fathers viewed their participation in the care as essential for their children's emotional and physical welfare.

Calderwood and Koenen (1988) wanted to understand what specific nursing behaviors were important to parents. They sampled 184 parents whose children were seen in a hematology clinic every three months or less. The survey was a one-time-only, mailed questionnaire using a Likert scale (1-5 range), dealing with two situations: the current clinic situation and the 'ideal' situation. Only sixty-four of the questionnaires were completed and returned. Frequencies were calculated on that data. The parents noted that the four items most named in the ideal situation were: one, the nurse is skillful in assisting the physician with equipment or procedures (4.8); two, the nurse is skillful with equipment or procedures (4.7); three, the nurse treats my child as an individual and helps him or her with questions and problems (4.6); and four, the nurse spends time discussing questions and problems with me (4.6). The survey was not gender-specific, but reported all information as coming from parents.

Patterson, Jernell, Leonard, and Titus (1994) conducted a study regarding the relationships between parent and professional as the medically fragile child is cared for at home, the behaviors of home care providers that contribute to a positive relationship and the behaviors that contributed to a negative relationship were examined. Also, the child, family and community factors associated with the strain in the parent-professional relationship were collected. The sample comprised forty-eight families with a child who either needed a medical device to compensate for the loss of a vital body function or required skilled nursing care. Four positive aspects of home care were perceived, namely: (1) support to parents and family, (2) genuinely caring for the child, (3) competence and skill of the staff, and (4) respectful and collaborative with the family. The four identified negative aspects were (1) invasions of privacy, (2) unprofessionalism, inadequately trained staff, (3) lack of respect for the family, and (4) scheduling hassles, cancellations, and staff turnover. Decreased strain for the mothers occurred when there was support from the community ($r = -.48$, $p < 0.001$), while fathers identified family cohesion as the main factor decreasing strain ($r = -.54$, $p < 0.001$).

Williams (1992) in a pilot study examining perception of support, showed that parents defined support in affective terms. The ability to listen well and to show compassion were important aspects. Professionals defined support as available, sitting down, joking with the parent, helping to carry others through difficult emotional times and helping the parents to cope. Two prominent problems with support were professionals' lack of respect for parents' expertise in caring for their ill children, and conflict resolution between the staff and the parents.

Differences between the health care professional and the families can be a source of tension. Horn, et al. (1995) gave the following two examples of family/health professional interactions.

- #1: Professionals often may misinterpret the family's need to be absent from the hospital as disinterest in the welfare of their child. The insight of one medical professional captured the family's double bind regarding availability when she stated the following: The nurses think that the parents should think it's nice that while the kid is in the hospital they can stay home and rest. But the parents can't stay home and rest . . . because they're afraid of what will happen to their child. But if a parent does try staying home a couple days to rest, then everybody starts saying, 'They must be taking the weekend off.' Like a no-win situation (p. 125).
- #2: One attending physician demonstrated a sensitive understanding of the conflicts that develop between the medical staff and the families striving to be strong advocates for their children's health. He stated: These families are often vociferous advocates for their child, and can even make the professional's life miserable if the support that they have expectations for isn't available, and they demand it in some fashion. But in the long run they're not hard to deal with because what they want is someone to give them the things that they're entitled to. Moment to moment they can be demanding, but they are willing to share in the responsibility (p. 124).

The need for parental vigilance is evident in the results found by Lozowski, Chesler, and Chesney (1993). Fifty-six percent of 116 parents of children with cancer

reported intervening at some point in the treatment process to prevent or correct a medical mistake. Most of these interventions (37%) were to keep staff from giving the patient the wrong treatment or to stop the administration of an excessive amount of a drug. Thirty percent of the parents called the staff's attention to incorrect or excessive procedures and 17% intervened regarding problems specifically related to intravenous procedures.

There is little doubt that many fathers are becoming more of a nurturing parent in their children's lives. As this role expands and changes, there is a need to examine men's concerns, needs, and coping strategies. The scant amount of research about fathers is evidence that research targeting fathers is needed. The similarities and differences between the concerns, needs and coping strategies of men and women require examination. Also, the health care industry must respond to the concerns, needs and coping strategies of fathers of children with cancer.

Conceptual Framework

Hymovich Contingency Model of Long-Term Care (Hymovich & Hagopian, 1992) focuses on family adjustment when there is a chronically ill child in the family. It was created through grounded theory. The theory is based upon Hymovich's research about assessing and intervening with families of chronically ill children. The basic components of this systems theory are the individuals, family, community, and society. These basic components are essentially stable over a period of time. Each system or group has identifying characteristics such as orientation to life, coping strategies, strengths and needs and level of functioning. A system's orientation to life includes "values, attitudes and beliefs of system members regarding pertinent issues such as life, death, healthy, illness, hospitalization and health care personnel" (p. 9). Coping strategies may be defined as

thoughts or actions performed by the system members to mediate stress or the effect of stress. Stressors are any stimuli that burden the system or its members. The strengths of the system are the assets and resources and the needs of the system are liabilities or the motivating forces to seek relief from some noxious stimuli. The level of functioning is defined as “the system’s current performance and is determined by the extent to which it is accomplishing its developmental and situational tasks.” (p. 14) All of these factors are examined over a period of time. The model was developed to “provide direction for understanding, conducting research, and working clinically with adults and children who have chronic conditions, and with others involved in their care” (p. 4).

This study has explored the basic unit of the family, as identified by the Contingency Model of Long-Term Care. The specific focus of this research was the identifying characteristics of fathers in a family in relation to having a child with cancer. The instrument used to collect data was supported by Hymovich’s Contingency Model. The instrument addressed the concerns, needs and coping strategies of the father’s experience during a chronic illness, which is pediatric cancer. Fathers have many concerns and needs as their families experience the stress of pediatric cancer. Also, the variety of coping strategies utilized by these men was explored.

Definitions

Systems: Four types; individual, family, community and society.

Individual: One person

Family: A unit of interdependent interacting individuals who are related to one another by marriage, birth, adoption, or mutual consent.

Father: The male parent who is related to the child by marriage, birth, adoption, or mutual consent.

Community: The neighborhood in which the family is living, including, friends, neighbors, and agencies.

Society: The global society in which the family is living

Identifying characteristics: Variables that the system identifies as important in its adjustment and response to the chronic illness such as orientation to life, coping strategies, strengths and needs and level of functioning.

Concerns: Thoughts or feelings which cause anxiety or uneasiness, which have an effect on or that is of interest or importance to system. This variable will be measured by Part II, Concerns and Resources of the Concerns Instrument.

Needs: Those conditions identified as requiring resources or relief and are generally based on perceived limitations in coping. This variable will be measured by Part I, Child Care Needs of the Concerns Instrument.

Coping Strategies: What the system does to minimize or relieve its perceived stressor or to prevent potential stressors. This variable will be measured by the Coping Instrument.

Assumptions

1. People will be truthful in answering the questionnaires of this study.
2. People function according to the facts as they perceive them.
3. Fathers are important participants in their children's lives.

Research Questions

The Questions that will be answered are:

1. What are the concerns of fathers' of children with cancer?
2. What are the needs of fathers' of children with cancer?
3. What are the coping strategies most utilized by the fathers' of children with cancer?
4. What is the relationship between demographics factors such as the age of the father, the educational status of father, and the economic status and the concerns, needs and coping strategies utilized by the fathers?

CHAPTER 3

METHODOLOGY

Research design

This study used a quantitative, non-experimental descriptive design. Quantitative research involves the collection of numerical information to be analyzed by statistical procedures. Data were collected through a questionnaire without introducing any additive treatments or changes to the subjects or to the environment. These actions were in keeping with a non-experimental descriptive design technique.

Sample

A convenience sample of three hundred fathers involved with a child experiencing pediatric cancer was obtained from the records of the Las Vegas, Nevada Chapter of Candlelighters Group of America. These records were screened by the Candlelighters to assure that there is a father figure in the home. The local Candlelighters Group is a nationally organized, nonprofit support group for children and families dealing with cancer. The goal of this organization is to assist families and children during treatment, both in and out of the hospital. They provide financial assistance, emotional support, information, and recreational activities for the target group. The target population was adult males (more than twenty-one years of age), whose children had been diagnosed with cancer. The child could be deceased or living, currently undergoing therapy or in

remission. These three-hundred fathers were further defined as adults who can read and understand English and who utilized the services of the Candlelighters Group of America in Las Vegas. The age range was mid-twenties to the mid-fifties. The race of the sample was to be congruent with the population in Clark County, Nevada. The population in Clark County in the 1990 census, showed that 49.8% of the population was Caucasian, 11% were Hispanic, 10% were Black, 4% were Asian, 9.6% were Native American and 2.6% were listed as other. In a 1997 newspaper article (McKinnon, 1997), the population reportedly had changed considerably. Overall, the population had increased 39% with the largest increase of 86% in the Hispanic population. The Hispanic group now constitutes 15% of the overall population. The second largest increase was 76% in the Asian population which constitutes 5% of the total population. The Black population increased 47% and is currently 10% of the overall population. The community has a large representation of the following religions: Catholic, Protestant, Latter-Day Saints, Lutheran, and Jewish. With this study, the religious affiliation is not as important as the use of religion as a coping strategy.

Procedure

Research questionnaires and a cover letter explaining the study, were mailed to three hundred individuals. The goal of this research was to have approximately one hundred surveys returned. The names and addresses were provided by the Candlelighters Group of America the Las Vegas, Nevada Chapter. To insure anonymity and confidentiality, these addresses stayed in the possession of the Candlelighter's office and the questionnaires were provided by the researcher. The fathers returned the questionnaires to the Candlelighter's office where the researcher can then obtained them.

Ethical Considerations

This research proposal was examined by both the University of Nevada at Las Vegas Department of Nursing, Human Subjects Rights Review Committee and the University of Nevada at Las Vegas Human Subjects Institutional Review Board. The anonymity of each respondent was protected by the Candelighters Group retaining the addresses and mailing the surveys. The Las Vegas, Nevada Chapter of The Candelighters Group of America gave permission for the use of their mailing lists. The cover letter explained the reason for the study and that the return of the questionnaire signified informed consent.

Instrument

The Hymovich's Parent Perception Inventory (PPI) consists of six instruments for use in families with long-term disabilities or chronic illnesses (Hymovich, 1983). These six instruments are General Information, Concerns, Coping, Beliefs and Feelings, Spouse Concerns and Coping, and Siblings. The PPI is an updated version of the Chronicity Impact and Coping Instrument: Parent Questionnaire (CICI: PQ) and is congruous with the concepts of the Hymovich's Contingency Model for Long-Term Care. In this systems model, families and individuals have identifying characteristics such as orientation to life, strengths, needs, and coping strategies which, over time, affect the systems level of functioning. These six instruments were developed through open-ended interviews with parents of chronically ill children assessing the impact of the child's illness on the parents and the family, the family stressors/problems, and how family members coped with the illness. These six instruments are designed to be used individually or collectively. Because this study focused on the needs of the fathers, the first three instruments were utilized.

Also, the instrument entitled “beliefs and feelings” was not needed to answer the research questions. The objectives of each of the three remaining PPI instruments were utilized to obtain information from parents about varying aspects of the chronic illness and are outlined:

General information (26 items) The purpose of this questionnaire was to find out general information. Included were questions about personal and family composition. Question number one was related to the child with cancer. Questions number two through six were about the other children in the home and their health status. Number seven asked about the health of the father and his spouse and number’s eight and nine were about religious preferences. The rest of the questions were about work, age, schooling, nationality, income, and marital status.

Concerns (71 items) This tool has in two parts. Part one is titled Child Care Needs and started with seven questions about the child with cancer, the severity of the illness and the respondent’s relationship to the child. Because of the lack of personal follow-up with each participant in the survey, question number eight on the Concerns instrument was changed from: “Parents have asked for help with many aspects of their child’s

development and care, including those listed below. Please let us know if you want to discuss any of the following topics.”

to: “Parents have many questions about their child’s development and care, including those listed below. Do you have questions regarding any of the following topics? (You may want to discuss these questions with your physician or health-care provider)”

Following the above question were eighteen topics about which the model indicates that

the parents may want information or help regarding the development and care of their child. These items used a Likert type scale with 1=Do not have questions now, 2=Not Sure, and 3=Have questions. The last question in part one was an open-ended question “Is there anything else you would like information about? What?” that allowed the fathers to express any other needs not listed. The second part of the Concerns survey was thirty-four general questions about concerns related to relationships with the spouse and significant others, concerns related to resources, concerns related to child care, and concerns related to respondents’ needs. The answers were given as a five-part Likert type scale with 0=Does Not Apply, 1=Not Sure, 2=Little Bit, 3=Quite a Bit, and 4=Great Deal. The rest of the Concerns questionnaire was a section with eight questions about parent associations, emergency child care, and number of hours spent caring for the child.

Coping (40 items) This questionnaire investigated the frequency of selected coping strategies used by the fathers and the helpfulness of these coping strategies. Thirty-three coping strategies were listed with the answer given as a two-part Likert type scale. The first part of the scale, “How Often” was a quantitative measurement with 0=Do Not Do This, 1=Very Rarely, 2=Sometimes, and 3=Very Often. The second part of the scale was not answered if “0=Do Not Do This” was chosen on the first scale. If any of the other three answers were chosen, then, the “How Helpful” section of the scale was to be completed. The choices are 0=Never Helps, 1=Sometimes Helps, 2=Almost Always Helps, and 3=Always Helps. The last seven questions explored how well parents believed that they were coping and what sources they had used for information of help. Because of the lack of personal follow-up with each participant in the survey, question number six was changed from:

“Would you like us to help you with any problems you are having?”

to: “Would you like help from your health-care provider with any problems you are having?”

The reading levels were obtained for each of the PPI instruments (Hymovich, 1988). The average grade reading level of the entire set of instruments was grade 6.4. Figure 1 lists the individual indexes measured as they relate to each of the four instruments. The Dale-Chall Index is a measurement of reading ease. The Flesch Index is an estimate of reading and grade level. The Fog Index is a measurement of reading ease. The Fry index is an estimate of reading grade level. The Smog Index reflects the grade level necessary to fully understand the material presented.

PPI SCALE	DALE-CHALL	FOG	FLESCH	FRY	SMOG
General information	6.5	5.9	6.8	3	5
Concerns	7.3	5.7	6.3	3	5
Coping	6.7	4.4	6.4	3	5

Figure 1. Reading Grade Levels of the three PPI Instruments used in this study

The initial reliability data for the PPI was obtained from twenty-two parents of children with cystic fibrosis (twelve mothers and ten fathers). Cronbach’s alpha was used to determine internal consistency reliability and t-tests were used to obtain test-retest reliability. Figure 2 is a listing of the current reliability data as obtained from research utilizing the Hymovich’s Parent Perception Inventory (PPI) over the last ten years.

SCALE	Items N	Mean	SD	Range	Theoretical range	Alpha	Test- Retest
(Concerns) Self concerns	18	61.64	24.6	27-101	0-136	.88	.82
(Needs) Child care-help	16	28.40	9.8	18-48	18-54	.92	.86
(Coping) Self-coping	21	50.00	6.8	29-57	21-84	.62	.78
(Coping) Cope-help	21	38.64	7.3	27-51	21-84	.80	.84

Figure 2. Means, Standard Deviations, Ranges, and Reliability Coefficients of the PPI

Data Analysis

The data were analyzed by descriptive statistics for key study variables. The process of frequency distribution and analysis was utilized on the data obtained from research questions one through four. This analysis established the numerical values from the lowest to the highest together with a count of the number of times each value was obtained. Research question number five was analyzed using frequency distributions, and was further assessed using the Kendal's tau and Spearman's rho to determine the magnitude of the relationships examined.

CHAPTER 4

DATA ANALYSIS AND RESULTS

This chapter reports statistical analysis derived from a compilation of the answers received from the Hymovich's Parent Perception Inventory (PPI) Questionnaire: General Information, Concerns, and Coping Questionnaires were utilized in this study.

Sample Description

The questionnaire was sent to three hundred fathers, and fifty-one questionnaires were return to the Candlelighters office. Two of the questionnaires were returned blank and one was completed by an individual who identified herself as the child's mother. Therefore, only forty-eight questionnaires were utilized. The following data were taken from the General Information Questionnaire.

The demographics of age and race can be found in Table 1. The age of the fathers ranged from 25 years of age to 45 years of age and over. Twenty-three fathers identified themselves as 35-44 years of age, with 45 years of age and over numbering fifteen and ten fathers reporting 25-34 years of age. The mean and modal age of the fathers was in the 35-44 years of age range. Thirty-seven fathers identified themselves as White, five as Spanish-American, three as Black, two as Other, and one as Asian. One of the subjects, who had checked the Other category, identified himself as a member of the "human race."

Most of the men were employed full-time (n=44) and were satisfied with their

current employment status (n=37). Only two men were not working and two men were working part-time. Eight of the fathers stated that they were not satisfied with their current employment status and three choose “not sure” in answer to the same question. The demographics of employment status and employment satisfaction can be found on Table 2.

One of the questions asked was “Who is the primary care-giver for the child with cancer?” Most of the fathers choose the child’s mother (n=26) with shared (n=12) as the next most frequently chosen answer. Five fathers stated that they were the primary care-giver and one chose other and identified the grandmother as the primary care-giver. In a related question, the fathers identified how often they had to miss work to care for the child with cancer. The majority of the men (n=24) missed work less than once a month, and one father chose “I do not work” as his answer. Four missed work 1-4 times a month and five missed work more than four times a month. Demographics of primary care-giver and missed work to care for the child with cancer can be found on Table 3.

Yearly income for this sample ranged from \$10,000 to more than \$40,000 with \$40,000 or more (n=38) as the most frequently cited income. The range of incomes included one subject as \$10,000-\$19,999, four as \$20,000-\$29,999 and five as \$30,000-\$39,999. A related question identified their educational status. These statistical results were bimodal with nineteen having attended some college and eighteen being a college graduate holding a bachelor, masters or doctoral degree. One respondent listed 7th grade or below as his educational status, six reported as a high school graduates, and four as a community college graduate. Demographics of economic status and educational status are located on Table 4.

Marital status results were quite homogeneous (See Table 5). Most of the men (n=43) were married, one was remarried, and four were divorced. Of those who were married, more than half (n=44) have been married for more than twelve years. One was married for less than two years, four have been married for 2-5 years, and fourteen have been married for 6-12 years. Thirty-seven of the fathers had only been married once, and eleven had been married twice.

Another interesting fact is that most of the men (n=42) answering the questionnaire were the fathers of the child with cancer. Four were stepfathers, one was a grandfather, and one listed himself as other. There was a wide range in the number of children each man reported (Table 6). Six men had one child, twenty-five had two children, seven had three children, three had four children, four had five children, one had six children and one has eleven children. The total number of children ranged from one to eleven with the mean being 2.63 and with the median and the mode being two.

Data identifying the health status of the men, their wives and their other children can be found on Table 7. Most of the men (n=43) stated that their health was good/excellent, only four stated that their health was poor/fair and one left that question blank. The health of their spouses (n=44) was also listed as good/excellent, with only one listed as poor/fair and three listed as not married. The health status of their other children (those children not in cancer treatment) was also good/excellent (n=43). One was identified as poor/fair and four stated that they had no other children.

Table 8 gives data regarding of religious preference and frequency of attendance at church. Protestant (n=13) was the most frequently identified religion. Eleven were Catholic, nine were LDS, eight listed Other, three were Jewish, and three listed No

religion as their preference (one person left the question blank). The question “How often have you attended religious services in the past three months?” had a bimodal response. Thirteen men stated that they never attended, while eighteen men said that they attended often. An equal number of men (n=8) choose “rarely” or “sometimes” as their answer.

Resources utilized by the fathers for information or help related to their child’s problems or needs were identified by the fathers. Doctors (n=43) were the most frequently identified as a source of information or help. Nurses (n=37) were next most frequently chosen followed closely by relative or spouse (n=30). Twenty-five listed friends, twenty-one utilized the library, and eighteen stated they used the support group. A complete list of informational resources can be found on Table 9.

Table 10 reports information regarding participation in parents’ associations related to the child’s illness. Even though the mailing list used was from the rolls of a parents organization, only twenty-one respondents said that they were members of an association. More fathers (n=27) said that they were not members. Of the members, only two “often attended meetings.” “Sometimes attends meetings” (n=6) and “rarely attends meetings” (n=7) were identified by a similar percentage of the fathers. However, most of the fathers (n=9) choose “never attends meetings” as their response. When asked about the helpfulness of the meetings, most of the fathers (n=5) said that the meetings were “somewhat helpful.” An even number of fathers (n=4) identified “very helpful” and “not at all helpful” as their answers. Only three fathers stated that the meetings were “not very helpful.”

Data Analysis for Research Question One

Research question number one asked “What are the concerns of fathers’ of children with cancer?” This question was addressed in the Concerns Questionnaire Part II: Concerns and Resources. The major portion of this questionnaire was a list of thirty-four concerns of all fathers, especially those who have children with chronic illnesses. For ease of comparison, the breakdown of five possible answers (0=Does not apply, 1=not sure, 2=little bit, 3=quite a bit, and 4=Great deal) was re-tabulated into three categories: does not apply, not sure/little bit, and quite a bit/great deal. The number one concern the fathers had was “Wondering what my child’s future is likely to be” (n=27), followed closely by “My child(ren)’s health,” and “Making my child comfortable or happy.” Money concerns were the next most frequent. These were “Having enough money to meet my family’s needs” and “The cost of my child’s medical care.” The list of the concerns identified by the fathers can be found in Table 11.

Data Analysis for Research Question Two

Research question number two asked “What are the needs of fathers’ of children with cancer?” This question was addressed in the Concerns Questionnaire Part I: Child Care Needs. Fathers were asked to identify, for eighteen topics, if they #1 do not have questions now, #2 not sure, or #3 have questions. The two topics which the fathers identified as first and second most asked questions were intellectual development (n=15) and physical development (n=14). Three questions shared the third most frequently asked category. These questions (n=12) were school or learning experiences, emotional development, and child’s condition. The fourth most frequently asked question category was again shared by three answers. These questions (n=11) were physical care of the

child, care of minor illnesses, and dental needs. The fifth most frequently asked questions (n=10) were about the child's medicines, the child's treatments and the child's social development. The list of the questions most asked by the fathers can be found in Table 12.

Data Analysis for Research Question Three

“What are the coping strategies most utilized by the fathers’ of children with cancer?” is the third research question and was answered by the first part of the Coping Questionnaire. The most frequently utilized coping mechanism was bimodal which means that two strategies were chosen most frequently (n=21). “Pray” and “try to figure out what to do” was chosen by twenty-one out of forty-four men. The second method chosen as very often was “read about the problem” and was chosen by twenty out of forty-four men. Two other methods, “get information” and “look at options” are listed by seventeen out of forty-four of the fathers for being used very often. Other methods identified for being used very often were: Busy myself with other things, ask questions, ask for help, wish problems would go away, weigh choices, hide feelings, and try to relax.

The second part of this question was what coping mechanism almost always helps or always helps. The coping mechanism most often identified as almost always helps or always helps was ‘Pray’ (n=24). ‘Get information’ was most helpful for twenty-one out of thirty-four of the fathers while ‘Read about the problem’ was named as most helpful for twenty out of thirty-two men. The other coping mechanisms that almost always help or always helps were ‘Ask questions’ (n=20), ‘Try to figure out what to do’ (n=18), ‘Try to relax’ (n=16), ‘Busy myself with other things’ (n=16), ‘Look at options’ (n=16), and ‘Weigh choices’ (n=14). The list of coping strategies utilized most often and the list of the mechanisms identified as almost always helps/always helps can be found in Table 13.

Many coping strategies listed on the questionnaire were not used by the respondents. Table 14 lists the methods of coping that were not used or used very rarely. Forty of the forty-five fathers named blaming someone and thirty-seven of forty-four named blaming myself as strategies they do not utilize. Also included in this list are smoke (n=37), take alcohol or medication (n=36), yell, scream, and slam doors (n=33). Many do not ask for help (n=32) nor do they ignore or try to forget (n=32). Get away for a while (n=31) and try to laugh or joke about it (n=30) were also identified as strategies not used by the respondents.

In a related question, fathers were asked “How well are you coping with your feelings and concerns about your child?”. A parallel number of fathers identified “fairly well” (n=16) and “well” (n=17) as their answer with eleven choosing “extremely well.” Only three stated that they were “not coping well” with concerns about their child. Another similar question asked “How satisfied are you with the way you are able to cope with the stresses you have?”. Again, most of the fathers were satisfied (n=24) with their coping abilities. An equal number of fathers (n=9) were either very satisfied or dissatisfied with only four choosing very dissatisfied. The results showing the degree to which fathers are coping can be found on Table 15.

Data Analysis for Research Question Four

The last research question was “What is the relationship between demographic factors such as the age of the father, the educational status of father, and the economic status and the concerns, needs and coping strategies utilized by the fathers?” Each demographic factor was analyzed by Kendal’s tau, Spearman rho and by a regression analysis in relation to each individual concern, each individual need and each individual

coping strategy. All statistically significant results are reported.

Concerns

The subjects in this study demonstrated no statistically significant correlations between fathers' concerns and the demographic data.

Needs

Utilizing non-parametric testing, three relationships demonstrated a statistically significant correlation. The frequency of attendance at religious services was related to questions about school or learning experiences. Kendal's tau $\tau=0.409$ (0.002) and Spearman's rho $p=0.449$ (0.002) were two tests that show this relationship. Increased frequency of attendance at church was related to the likelihood of having questions about school or learning experiences. Likewise, type of religion was related to questions about dental needs; Kendal's tau $\tau=0.279$ (0.030) and Spearman's rho $p=0.309$ (0.037). Four who listed Other as religion, two listed as Catholic and two listed as Protestant had a question related to dental needs. Ten Catholics, ten LDS, and ten Protestants reported that they had no questions about dental needs. Regarding questions about school or learning experiences, four LDS, three Others, and two Catholics had questions; Kendal's tau $\tau=0.263$ (0.044) and Spearman's rho $p=0.293$ (0.048). Twelve Protestants and ten Catholics had no questions about school or learning experiences. For both dental and school/learning experiences questions, five out of eight fathers, that listed "Other" as their religion, were most likely to have questions. The results of these relationships can be found in Table 16.

Coping Strategies

There were three statistically significant correlations (See Table 17) between

demographic data and the coping strategies. The first relationship was associated with the frequency of attendance at religious services and how often fathers look at options as a way to cope; Kendal's tau $\tau = -0.264$ (0.040); Spearman's rho $p = -0.315$ (0.037). This shows that with an increased attendance at church, the fathers decreased how often they looked at their options as a way to cope. The families yearly income was related to how often the fathers would seek information as a way to cope. An increase in the families' yearly income was positively related to the increased frequency of the respondents seeking information about the disease; Kendal's tau $\tau = 0.336$ (0.015); Spearman's rho $p = 0.379$ (0.011). Also, the greater the family income, the more frequently the fathers choose to read about the problem as a coping strategy; Kendal's tau $\tau = 0.274$ (0.047); Spearman's rho $p = 0.305$ (0.044). Fathers in families with a higher income were more likely to get information and read about the problem than those fathers from lower income families.

CHAPTER 5

DISCUSSION

Sample

The sample of fathers who responded to the questionnaire was a quite homogenous group. The modal age range of 35-44 years of age ($n=23$) was to be expected as these were fathers of young children. The responses regarding race were incongruous with the target population. Even though the population of Caucasians in Clark County is less than 50%, more than 77% of the respondents in this research identified themselves as White (Table 1). This large response from one ethnic group accounts for the smaller percentages of the other respondents. Adjusting for the large White percentages, the proportion of the rest of the respondents is equivalent to the proportional population of Clark County; first White, next Spanish-American, followed by Black, Other and Asian (McKinnon, 1997).

The majority of the fathers were employed full-time, were satisfied with their employment status and missed few days of work in a year to care for their children (Tables 2 and 3). All of these facts can be related to the fact that most of the fathers did not identify themselves as care-givers for their child with cancer. Only five stated that they were the primary care-giver for their children. Most of the father's credited the child's mother ($n=26$) with this job. These facts point to a traditional family unit as the pattern

for most of the respondents' families. Much of the research defines the traditional family unit as a full-time employed father and a stay-at-home mother. The father's role in this type of family unit is as the breadwinner and financial caretaker while the mother's role is that of care-giver and nurturer (Barna, 1995; Cayse, 1994; Ferrell et al., 1994; Leventhal-Belfer et al., 1993; May, 1996; Meadow-Orlans, 1994; & Sterken, 1996). In keeping with the traditional family unit, most of the fathers were in their first marriage (n=37) and had been married for more than twelve years (n=25). Additionally, forty-two of the forty-eight fathers identified themselves as the father of the child with cancer (Tables 5 and 6). All of these statistics support the identification of the fathers in this study as involved in the traditional family unit.

Economic status and educational status were strongly related to each other (See table 4). Most of the fathers identified their family's yearly income as \$40,000 or more (n=38) and most of the fathers had attended some or graduated from college (n=41). Traditionally, people with more education have a greater earning capacity. The families in the research were in good to excellent health (Table 7). Fathers (n=43), mothers (n=44) and other children (n=43) were all healthy.

Most of the fathers had some type of religious affiliation (n=44). Only three said that they had no religion and only one left that answer blank. Interestingly, eighteen of them attend religious services often with eight attending sometimes. This shows that more than 50% of the fathers are active in their chosen churches (Table 8).

Some of the research demonstrates that the better educated consumer or those with a higher socioeconomic status were more likely to discuss problems or questions with their physician. These parents felt freer to challenge their "status peers" (Loxowski et al,

1993). The respondents in this study also followed this identified pattern (Table 9).

These fathers were well educated and were economically well off. They identified doctors (n=43) and nurses (n=37) as sources of information regarding their child's problems or needs.

An interesting fact was that, even though the mailing list came from the rolls of the Candlelighters Group of America in Las Vegas, less than half of the fathers (n=21) said that they were members of a parent's association (Table 10). This might be related to the low number of fathers that identified themselves as primary care-givers (n=5). The traditional family unit identified by the responses of the sample, has the mother as the person who interacts with those involved with cancer treatment (Cayse, 1994; Ferrell et al., 1994; Leventhal-Belfer et al., 1993; May, 1996; Meadow-Orlans, 1994; & Sterken, 1996). Barna (1995) suggests that many groups focus on the mother-child relationship and therefore on the needs of the mothers. The male-only group situations devised by his study provided many men with their first opportunity to ask and get answers to their questions. In other situations, the men's partners would take the lead when discussing their child while the fathers would remain in the background.

Concerns

The concerns of the fathers have followed a definable pattern (See Table 11). Wondering what my child's future is likely to be (n=27), my child(ren)'s health (n=25), and making my child comfortable or happy (n=25) are the top three needs that these fathers had identified. These concerns regarding the children's current and future well-being are much like the concerns identified by others (May, 1996; Lynam, 1987; Horn et al., 1995; & Heaman, 1995). Ferrel et al. (1994) described the father's need to 'fix-it and

make-it better.’ Not being able to provide physical comfort to their child is a concern of many fathers, including the respondents in this research. Financial concerns followed closely behind concerns about the child’s current and future well-being. Having enough money to meet my family’s needs (n=23) and the cost of my child’s medical care (n=21) were the next concerns identified. Much research has shown that the focus of the father’s role is to work and maintain insurance coverage and to provide income for the family. (Leventhal et al., 1993; Meadow-Orlans, 1994; & Patterson et al., 1994). These financial concerns can become a major force in the father’s orientation to their child’s illness. The majority of the fathers in this sample were employed full-time (n=44), satisfied with their work situation (n=37), and not the primary care givers for their children.

Even though the concerns expressed by this sample were similar to fathers in other studies, the concerns of sexual relationships (n=10), and time alone with their spouses (n=9) were not high priorities. Kachoyeanos and Selder (1993), in a study about sudden death of a child, found that fathers saw intimacy as the sharing of sexual relationships while mothers found the sexual act abhorrent. Other studies (Lynam, 1987; Leventhal-Belfer, et al., 1993; Heaman, 1995; and Ferrell, et al., 1994) supported this concern that many fathers have about sharing private, intimate time with their spouses. However, less than one-fourth of the respondents in this study identified sharing private, intimate time with their spouses as a concern.

Needs

The questions that the fathers most wanted answered were again about the current and future development of their child (Table 12). Questions about intellectual development (n=15), physical development (n=14), school or learning experiences (n=12),

and emotional development (n=12) were the most asked questions. A question about their child's condition (n=12) was also one of the most asked questions. All of these needs were typical of the findings of other studies. Cayse (1994) found that the most frequent stressors for the fathers were questions about their child's future and about their child's health. In a study of adaptation patterns of parents with chronically ill children, Clubb (1991) reported that the fathers of children with impaired cognitive abilities and therefore decreased intellectual development reported higher levels of stress. Sterken (1996) found that the degree of uncertainty experienced by fathers of children with cancer may have resulted for ambiguity, lack of clarity, and lack of information. He found that the fathers had a need for more factual knowledge about the course of the disease and that few support systems have taken the time to consider the unique needs of a father with a chronically ill child. Another interesting fact found was that even though six fathers identified that they had other questions, none of the fathers wrote in what those questions were.

Coping Strategies

With the need to solve problems, to secure the future, and to manage the money, what were the coping strategies utilized by the fathers? Prayer was the number one most often used (n=21) strategy identified as well as the most helpful (n=24). Other studies name spirituality as a source of strength and support (Cayse, 1994; Bearison et al., 1993). Nelson (1997) identified a knowledge of God's presence and pray as the number one spiritual needs of hospitalized patients. In another study, one father stated "I just know that I pray a lot and keep moving" (May, 1996, p. 243). Given the fact that more than 50% of the fathers are active in their chosen churches, this result is not surprising. The

next most often used coping strategies follow the same pattern most fathers have to solve the problem. These strategies were to try to figure out what to do (n=21), to read about the problem (n=20), to get information (n=17), and to look at options (n=17). All of these methods are congruent with the father's role of problem-solver and "Mr. Fix-it" that is evident in much of the current literature. (Evans, 1994; Ferrell et al., 1994; Heaman, 1995; Horn et al., 1995; & Sterken, 1996). These coping strategies mirror the needs and concerns regarding information gathering and future concerns (Table 13).

More than 80% of the respondents stated that the coping strategies they do not use or that they use very rarely were destructive behaviors (Table 14). Blame someone (n=40) and blame myself (n=37) were numbers one and two of the least used coping strategies. Smoke (n=37) and take alcohol or medicine (n=36) were named as the next two least used methods of coping. Also, these fathers do not yell, or scream, slam doors (n=33). Leventhal-Belfer, et al., (1993) found that with the father's desire to be strong for their partner, to be a supportive provider, and to be the leader in the family, they often neglect their own unspoken need to ask for help from others. The respondents in this study follow this same example. They do not ask for help (n=32) nor talk with someone about feelings (n=27) as methods of coping.

It is interesting to note that most of the fathers (n=44) were coping with feelings and concerns about their children fairly to extremely well (Table 15). These same fathers were either satisfied (n=24) or very satisfied (n=9) with the way that they were coping with their own stressors. This last question was not specific to the stressors of a child with cancer, but was a general question about overall ability to cope. Because the question was at the end of a questionnaire about their child with cancer, this challenge of

pediatric cancer factors deeply into the thought process as the fathers identified their overall level of coping. Even so, most of the fathers identified that they were coping well.

Relationships Between Demographics and Needs

There were three statistically significant relationships between demographics and needs (Table 16). All of these demographics were related to religion. The higher the frequency of attendance at religious services was related to more questions about school or learning experiences. Also, the type of religion was related to questions about dental needs and school or learning experiences. Even though all three of these relationships are statistically significant, none of them are clinically significant. With the massive amounts of correlational studies, the likelihoods of statistically significant relationships that happen just by chance increases. This fact may explain most if not all of the statistically significant relationships found in this study.

Relationships Between Demographics and Coping Strategies

Of the three statically significant relationships between demographic data and the coping strategies, one seemed most peculiar. Frequency of attendance at religious services was negatively correlated to the coping strategy of looking at options. This might be explained in the fact that those who attend church are often encouraged to develop faith and to accept the “will of God.” This may decrease the frequency of looking for other options, although no studies were found that support this theory (Table 17).

In the two other relationships, family’s yearly income is positively related to the coping strategies of getting information and reading about the problem. Family income is often related to educational status and the need to get information and to read about the problem. These consumers of medical services were more likely to be medically

sophisticated and well read (Lozowski et al., 1993). However, this correlation between family income and educational status may not be true in the Las Vegas, Nevada area and may not be clinically significant.

Support of the Model

Hymovich Contingency Model of Long-Term Care (Hymovich & Hagopian, 1992) is the model used in this study. The aim of this research was to explore the basic family unit with the focus on the father's role in the family. In her model, Hymovich stresses the need to explore the concerns, needs and coping strategies of the individual and the family to increase the understanding of the nurse. This increase in the knowledge base allows the nurse to work with the adults and children who have chronic conditions. This study adds to the knowledge base in general with the concerns, needs and coping strategies of the father being the specific target. Using this information, the nurse can better work with the families and the fathers to strengthen the family system. Nursing interventions can, over time, strengthen coping strategies and address concerns and needs of the family system thereby increasing the level of functioning.

Limitations of the Study

The limitations of this study need to be remembered as one integrates the data into the complete body of nursing knowledge. The small sample size, the small geographic area, and the homogeneousness of the group are all limitations.

Out of three hundred questionnaires mailed out, only forty-eight usable surveys were obtained. An attempt to increase the sample was made by distributing questionnaires at a Candlelighter's function. Attendance at this function resulted in twenty additional questionnaires being distributed to potential subjects, but none were returned. In addition,

questionnaires were taken to a local pediatric oncology clinic, but this action was of no use as none of the fathers accompanied their children. All of the children were with their mothers. Other research has shown that fathers are reluctant to share their feelings with strangers (Barna, 1995; Berland, 1987; Kachoyeanos and Selder, 1993) and are often unwilling to participate in research questionnaires (Heaman, 1995). Much of the research identifies the mother as the person who sees to the medical needs of her children, even when caretaking was being shared (Sterken, 1996; Barna, 1995; and Forsyth, 1992).

The area served by the Las Vegas, Nevada Chapter of Candelighters Group of America is a small and isolated geographic area. Even though Las Vegas, Nevada is one of the fastest growing areas in the United States, there are still only approximately 1.2 million persons living in the area. Las Vegas is built in a “bowl” or a valley surrounded by mountain ranges on all sides. The nearest metropolitan areas, such as Los Angeles, California; Phoenix, Arizona; and Salt Lake City, Utah are at least two hundred fifty miles away from Las Vegas. This lack of exposure to the “outside world” may have decreased the variability of the childhood cancer experience.

This lack of variability is evident in the seeming homogeneity of the responses. One of the major factors influencing the results was the homogeneity of the study sample. Most of the respondents were white, married, educated, employed fathers of the children with cancer. These factors made for difficulty in finding any differences or relationships between demographics’ factors and the concerns, needs and coping strategies utilized by the fathers. Most of the men who returned the questionnaires were the biological fathers of the child with cancer and were married to the child’s mother. This leaves out the entire group of stepfathers and single fathers. Minority fathers and their unique prospects on life

were also under represented. The majority of the fathers were college educated, employed full time and financially stable. Underprivileged, uneducated, unemployed and poor families were not well represented in the responses received. None of the responses were from stay-at-home dads who were taking care of their children.

The mailing list came from the records of the Las Vegas, Nevada Chapter of Candelighters Group of America's membership records. Consequently, the men or their families have been associated with this group. Interestingly, only twenty out of forty-eight stated that they were members of a parent's association related to the child's illness. Twenty-seven of the men stated that they were not members. The question arises as to whether or not they recognize Candelighters as a parent's association or if the family uses the services of the group without the fathers becoming actively involved with the group.

A major influence on the outcome of these results is that historically fathers don't answer questionnaires. Many do not want to share their thoughts and feelings with outsiders (Heaman, 1995).

Implications of the Study for Nursing

These respondents in this study have identified a major concern, need and coping strategy. They need direct and complete information regarding their child's current and future needs. Over half (64%) of the respondents in this study identified their child's future as a concern. The nurse on the unit at the hospital, in the clinic, or in the home is in a unique position to help the fathers of the child experiencing cancer. The nurse is the teacher, the facilitator, and the advocate for the family.

As the teacher, the nurse is present when the fathers are there and they can help the fathers to understand the process of cancer treatment. The nurse can answer the

father's questions directly instead of having the questions relayed through the mothers. Twenty-five to 30% of the fathers in this study identified that they had questions regarding intellectual, physical, educational, and emotional development. Nurses can encourage the fathers to lead the discussion and ask their questions instead of, as many men do, relinquishing this role to their spouses (Barna, 1995). Literature, demonstrations, and other resources (ie the Internet) can be provided directly to the fathers.

As a facilitator, nurses can find other services to assist the families, especially during times of crisis. By giving the fathers information and resources, many will be able to better cope with the experience of childhood cancer. (Evans, 1994). Clergy (48% of the respondents in this study identified prayer as a frequently used coping mechanism) and financial planners (50+% of the men in this study identified financial concerns) are a few of the resources the nurse could provide.

As an advocate for the family, the nurse can present the families unique needs and wants to the entire medical team as the plan of care is created. Understanding the unique needs of fathers as identified in this study, ie, questions about the future, information gathering needs, and financial concerns will assist the nurse in this role. As the pediatric nurse functions as an advocate for the continuity of care, (Evans & Kelly, 1995) they may be able to improve the quality of life for the family experiencing pediatric cancer. Williams (1992), whose study examined the definition of support, found that the nurse's ability to listen well and to show compassion were highly valued by the families interviewed.

A sad fact was that while 91.5 % of the fathers named doctors as a major source of information, only 66% identified nursing in the same question (see table 13). Just as many of the fathers stated that they gained information from relatives and/or spouses as from the

nurses. This means that we as nurses need to work more diligently to insure that we speak to the fathers and attempt to encourage question-asking. Often the fathers visit their children at the hospital when the only persons they see are their wives and the nursing staff. Questions are often relayed from the father, through the mother, to the doctor, back through the mother and finally to the father (Aitken & Hathaway, 1993; May, 1996; Meadow-Orlans, 1994; and Barna, 1995). During those times, the nurse, at the bedside, can help to explain procedures and to correct misconceptions. In connection with this clarification, nursing could “save” the teaching session for a time when the fathers can be present. The nurse must address the questions and concerns of both parents and not suppose that the mother is alone in the care of the child. If both parents feel empowered by information, the child will have a broader base of support.

During these teaching sessions, the nurse should address the questions of intellectual, physical, emotional and educational development identified in this study as needs of the fathers. Also, many fathers need to understand not only their child’s current health status, but also what to expect in the future. These questions can be answered as the nurse interacts with the fathers. The nurse can also be a facilitator in helping the fathers to find ways to solve their financial concerns. Introducing them to social workers or to community agencies can, sometimes give the fathers the help that they need the most.

Another important aspect of nursing care is to support and foster healthy coping styles. In this study, prayer was the most used and the most effective coping strategy. Other studies have also shown that spirituality was an effective and frequently used strategy (Nelson, 1997; May, 1996). Finding ways in which to support the fathers and

their families in whatever way needed to foster their spirituality can be an important function of the nurse. Calling clergy, providing privacy, respecting religious practices, and even praying (when appropriate) with the families can be an integral part of nursing practice.

The other coping strategies that were identified in this study and that should be fostered by nursing was the need to intellectualize, to read, to get information and to try to figure out what to do. All of these coping strategies reflect the father's need to understand what is happening and then to solve the problems. Nurses can provide information through books, pamphlets, Internet addresses, and discussion. During the discussions, the nurse can also be a good listener as the fathers try to understand what they have read. In this manner, the nurse can support this coping method and help to clarify any misconceptions.

Recommendations for Further Research

This work was one of the beginning pieces of information needed to better understand fathers and their unique needs. Many more studies need to be done to add to the small, but growing body of knowledge. Research on teaching techniques, ways to relieve or mediate financial concerns, and ways to encourage adequate coping styles are just a few ideas for further study. Also, research which focuses on the needs of fathers at different stages of the disease process would be helpful

To add to the body of knowledge, research needs to focus on many types fathers in a variety of situations. The needs of stay-at-home fathers might be very different from the needs of full-time working fathers. The concerns of men, who have children with other chronic illnesses, need to be understood so that the support given to them will strengthen

them and their families.

How to educate fathers when they are confronted with medical technology is a subject for many researchers. How best to teach families during the onset of the disease process may be very different then how to teach for long-term medical care. Many of the fathers in this survey named the Internet as a source of information. Questions about how to teach through the use of the multimedia/mass media approach need to be explored. How can doctors, nurses, and medical personnel become more available to answer the fathers' questions when the fathers are available? Do we need more "after hours" educational opportunities? All of these questions might be answered with more research

Other topics which need to be explored are ways to relieve or mediate financial concerns. For many fathers, the role they assume during times of a child's illness is that of breadwinner and insurance holders. At times, money seems to take the place of the father's need to be with and comfort his child. Are there ways to allow financial concerns to be lessened thus allowing fathers to be with their children? Can social workers and financial planners be an integral part of the treatment of acute or chronic illness? Answers to these questions need to be explored.

Nursing research should also focus on ways to encourage adequate coping styles utilized by fathers. In this study prayer was the number one coping style followed by information-gathering activities. Some research related to both the spiritual needs of fathers and how to address those needs has been done. Exploring the nurse's role in encouraging and supporting spiritual coping strategies can be the focus of further research. Also, research in how to support the information-gathering activities of fathers could be topics of many different studies.

Studies which examine the needs, concerns and coping strategies of fathers experiencing different stages or diagnosis of the disease process are needed. For example, the teaching methods utilized when the child is first diagnosed might be quite different from those that would be effective when the child is finishing their bone-marrow transplant procedure.

Along with quantitative research, qualitative research needs to be done. Qualitative research can thoroughly examine a few individuals to understand the lived experience of pediatric cancer. An in depth exploration of the father's concerns, needs, and coping strategies would be of use as evidenced by the fact that many men chose the Other categories in the needs and the coping aspects of this research, but none of the fathers wrote in what other needs they had or what other coping strategies they utilized. Studying what those unidentified needs might be would be the goal of quantitative research.

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APPENDIX A

TABLES

Table 1.

Demographic Data Summarizing Age and Race:

Characteristic	Frequency	Percentage
Age:		
25-34	10	20.8%
35-44	23	48.0%
45 years of age and over	15	31.3%
Race:		
White	37	77.1%
Spanish-American	5	10.4%
Black	3	6.3%
Other	2	4.2%
Asian	1	2.1%

Table 2.

Demographic Data Summarizing Employment Status and Employment Satisfaction:

Characteristic	Frequency	Percent
Employment Status:		
Full time	44	91.7%
Part time	2	4.2%
Unemployed	2	4.2%
Employment Satisfaction:		
Satisfied	37	77.1%
Not sure	3	6.3%
Unsatisfied	8	16.7%

Table 3.

Demographic Data Summarizing Who is Primary Care-giver for Child and How OftenFathers Missed Work to Take Care of Their Child:

Characteristic	Frequency	Percent
Primary Care-giver:		
You	5	11.4%
Child's Mother	26	59.1%
Shared	12	27.3%
Other	1	2.3%

How Often Fathers Missed Work to Take Care of Their Child

I do not work	1	2.1%
Less than once a month	24	50.0%
1-4 times a month	4	8.3%
over 4 times a month	5	10.4%

Table 4.

Demographic Data Summarizing Economic Status and Educational Status:

Characteristic	Frequency	Percent
Economic Status:		
\$10,000-\$19,999	1	2.1%
\$20,000-\$29,999	4	8.3%
\$30,000-\$39,999	5	10.4%
\$40,000 or more	38	79.2%
Education:		
7th grade or below	1	2.1%
8th through 11th grade	0	0.0%
High school graduate	6	12.5%
Attended some college	19	39.6%
Community college graduate	4	8.3%
College graduate-bachelor, masters or doctoral degree	18	37.5%

Table 5.

Demographic Data Summarizing Marital Status, Years of Marriage, and Number of TimesMarried:

Characteristic	Frequency	Percent
Marital status:		
Married	43	89.6%
Remarried	1	2.1%
Divorced	4	8.3%
Years of Marriage:		
Under 2	1	2.1%
2-5	4	8.3%
6-12	14	29.2%
Over 12	25	52.1%
Number of Times Married:		
Once	37	77.1%
Twice	11	22.9%

Table 6.

Demographic Data Summarizing Relationship of Respondent to Child with Cancer andTotal Numbers of Children:

Characteristic	Frequency	Percent
Relationship to Child with Cancer:		
Father	42	87.5%
Stepfather	4	8.3%
Grandfather	1	2.1%
Other	1	2.1%
Total Number of Children:		
One	6	12.5%
Two	25	52.1%
Three	7	14.6%
Four	3	6.3%
Five	5	8.3%
Six	1	2.1%
Eleven	1	2.1%

Table 7.

Demographic Data Summarizing Health Status of the Father, Mother, and OtherChildren:

Characteristic	Frequency	Percent
Father's Health:		
Good/excellent	43	89.7%
Poor/fair	4	8.3%
Mother's Health:		
Good/excellent	44	91.7%
Poor/fair	1	2.1%
Other Children:		
Good/excellent	43	89.6%
Poor/fair	1	2.0%
No other children	4	8.3%

Table 8.

Demographic Data Summarizing Religious Affiliation and Frequency of Attendance at Religious Services in the Past Three Months:

Characteristic	Frequency	Percent
Religious Affiliation:		
Protestant	13	27.1%
Catholic	11	22.9%
Latter-Day Saint (LDS)	9	18.8%
Other	8	16.7%
Jewish	3	6.3%
No Religion	3	6.3%
Blank	1	2.1%
Frequency of Attendance at Religious Services in the Past 3 Months:		
Often	18	37.5%
Sometimes	8	16.7%
Rarely	8	16.7%
Never	13	27.1%

Table 9.

Percentages of Fathers Utilizing Different Sources for Information or Help related to
Their Child's Problems or Needs:

Sources	Frequency	Percentages
Doctor	n=43	91.5%
Nurse	n=37	66.0%
Relative or Spouse	n=30	63.8%
Friend	n=25	53.2%
Library	n=21	44.7%
Support Group	n=18	38.3%
Clergy	n=14	29.8%
Other Parent	n=14	29.8%
Nutritionist	n=13	27.7%
Community agency	n=12	25.5%
Therapist	n=12	25.5%
Newspaper	n=9	19.1%
Social Worker	n=8	17.0%
Pharmacist	n=7	14.9%
Teachers	n=6	12.8%

Table 10.

Percentages of Fathers Participation in Parent's Association Related to the Child's Illness:

Topic	Frequency	Percentages
Are you a member?		
Yes	21	43.8%
No	27	56.3%
If a member, attendance at meetings		
never	9	37.5%
rarely	7	29.2%
sometimes	6	25.0%
often	2	8.3%
How helpful are the meetings?		
not at all	4	25.0%
not very	3	18.8%
somewhat	5	31.3%
very	4	25.0%

Table 11.

Concerns: Topics Identified as Quite a Bit or a Great Deal of Concern:

Rank	Topic	Frequency	Percent
1	Wondering what my child's future is likely to be	27	61.4%
2	My child(ren)'s health	25	59.5%
3	Making my child comfortable or happy	25	56.8%
4	Having enough money to meet my family's needs	23	52.3%
5	The cost of my child's medical care	21	50.0%
6	Wondering if I will recognize important changes in my child's condition	20	46.5%
7	Wondering about how my child feels about him/herself	20	45.5%
8	Wondering whether my other children will develop the same condition	19	44.2%
9	Whether I am taking care of my child in the best way	19	43.2%
10	Worrying about the responsibility of caring for my child	18	40.9%
11	Getting enough information about my child's condition	17	39.6%
12	Feeling worn out	16	37.2%
13	Getting to do activities together as a family	16	36.4%
13	Having enough insurance to meet expenses of child care	16	36.4%
13	Having money for extra pleasures	16	36.4%
14	Extra demands on my time	16	36.3%
15	My spouse or partner's health	15	35.7%

Table 11.

Concerns: Topics Identified as Quite a Bit or a Great Deal of Concern (continued):

Rank	Topic	Frequency	Percent
16	Having enough time or attention from my spouse/partner	13	30.3%
16	Talking to my child about his or her condition	13	30.3%
17	Having the right agencies in the communities to provide the care my child needs	12	27.3%
18	Getting enough sleep for myself	11	25.0%
19	My own health	10	23.8%
19	Sexual relationship with my spouse/partner	10	23.8%
20	Getting out of house with spouse/partner without children	9	21.4%
20	Helping my child cooperate with taking medicines or doing treatments	9	21.4%
21	Talking with or understanding my spouse or partner	9	21.0%
22	Having enough time alone with my spouse or partner	8	19.1%

Table 12.

Needs of Fathers: Topics Fathers Have Questions About:

Rank	Topic	Frequency	Percent
1	Intellectual development	15	32.6%
2	Physical development	14	30.4%
3	School or learning experiences	12	26.1%
3	Emotional development	12	26.1%
3	Child's condition	12	26.1%
4	Physical care of child	11	23.9%
4	Care of minor illnesses	11	23.9%
4	Dental needs	11	23.9%
5	Child's medicines	10	21.7%
5	Child's treatments	10	21.7%
5	Social development	10	21.7%
6	Genetic counseling	9	19.6%
6	Play or recreation activities	9	19.6%
6	Knowing when my child needs to see the doctor	9	19.6%
7	Diet or nutrition	7	15.2%
7	Talking to my child about the condition	7	15.2%
8	Other questions	6	13.3%
9	Managing child's behavior	5	10.9%
10	Sleep habits	4	8.7%

Table 13.

Coping Strategies Used Very Often and Almost Always/Always Helpful:

Mechanism	Used very often Frequency Percent	Almost always/ Always helps Frequency Percent
Pray	(21/44) 47.7%	(24/37) 64.9%
Try to figure out what to do	(21/44) 47.7%	(18/38) 47.4%
Read about the problem	(20/44) 45.5%	(20/32) 62.6%
Get information	(17/44) 38.6%	(21/34) 64.7%
Look at options	(17/44) 38.6%	(16/35) 45.8%
Busy myself with other things	(15/42) 35.7%	(16/34) 47.0%
Ask questions	(15/44) 34.1%	(20/34) 55.9%
Ask for help	(12/44) 27.3%	(10/32) 21.3%
Wish problems would go away	(12/44) 27.3%	(2/33) 6.1%
Weigh choices	(12/44) 27.3%	(14/31) 45.2%
Hide feelings	(11/43) 24.4%	(1/33) 3.0%
Try to relax	(9/44) 20.5%	(16/34) 47.1%

Table 14.

Coping Strategies Listed as Do Not Do This or Very Rarely Do This:

Mechanism	Frequency	Percent
Blame someone	40/45	88.9%
Blame myself	37/44	84.1%
Smoke	37/45	82.2%
Take alcohol or medicine	36/44	81.8%
Yell/scream/slam doors, etc.	33/45	73.3%
Ask for help	32/44	72.7%
Ignore/Try to Forget	32/44	72.7%
Get away for a while	31/44	70.5%
Try to laugh or joke about it	30/45	66.7%
Talk with someone about feelings	27/44	61.4%
Cry	26/45	57.8%
Eat	26/45	57.8%

Table 15.

Coping: Degree to Which Fathers are Coping:

Topic	Frequency	Percent
1. How well are you coping with your feelings and concerns about your child?		
Not well	3	6.4%
Fairly well	16	34.0%
Well	17	36.2%
Extremely well	11	23.4%
2. How satisfied are you with the way you are able to cope with the stresses you have?		
Very dissatisfied	4	8.5%
Dissatisfied	9	19.1%
Satisfied	24	53.2%
Very satisfied	9	19.1%

Table 16.

Relationship Between Demographic Data and the Needs of the Fathers:

Demographic Data	Questions	Kendal's tau	Spearman's rho
Frequency of attendance at religious services	Questions about school or learning experiences	$\tau=0.409$ (0.002)	$p=0.449$ (0.002)
Type of religion	Questions about dental needs	$\tau=0.279$ (0.030)	$p=0.309$ (0.037)
Catholic	2=yes	10=no	
Jewish	1=yes	2=no	
Protestant	2=yes	11=no	
LDS	0=yes	10=no	
Other	4=yes	3=no	
No religion	1=yes	2=no	
Type of religion	Questions about school or learning experiences	$\tau=0.263$ (0.044)	$p=0.293$ (0.048)
Catholic	2=yes	10=no	
Jewish	1=yes	2=no	
Protestant	1=yes	12=no	
LDS	4=yes	5=no	
Other	3=yes	4=no	
No religion	0=yes	3=no	

Table 17.

Relationship Between Demographic Data and the Coping Strategies Used by the Fathers:

Demographic Data	Coping strategies	Kendal's tau	Spearman's rho
Frequency of attendance at religious services	Look at options	$\tau = -0.264 (0.040)$	$p = -0.315 (0.037)$
Family's yearly income	Get information	$\tau = 0.336 (0.015)$	$p = 0.379 (0.011)$
Family's yearly income	Read about the problem	$\tau = 0.274 (0.047)$	$p = 0.305 (0.044)$

APPENDIX B
LETTERS TO THE PARTICIPANT



Dear Candlelighter Dad,

My name is Judy A. Scott, RN, BSN. I am a graduate student from the Nursing Department at the University of Nevada at Las Vegas. I am conducting this study to investigate the concerns, needs and coping strategies of fathers when their children have cancer. You have been chosen by Candlelighters to share with us your thoughts and feelings by completing the enclosed survey. It will take approximately 15-20 minutes and your answers will be completely confidential. Your address stays in the possession of Candlelighters and no identifying marks are on the survey. Also, be assured that your interaction with this study will in no way influence your relationship with the Candlelighters organization. When you return the survey in the enclosed envelope, it will be considered your consent for me to use the data provided. This information will be compiled and compared to find trends regarding fathers and their needs. The benefits of this study will be to increase the knowledge base for all healthcare providers regarding fathers and their unique needs. You may contact the Office of Sponsored Programs at UNLV (895-1357) if you have any questions about the rights of research subjects.

Thank-you in advance for your help. Your information from a father's perspective will assist the Candlelighters organization and nurses to better understand family's needs in responding to a child that has been diagnosed with cancer. If you experience any anxiety due to your participation in this study, please contact your health care provider or the Candlelighters organization. If you have any questions, please feel free to contact me at the UNLV Nursing Department (895-3360).

Sincerely,

A handwritten signature in black ink that reads "Judy". The signature is fluid and cursive, with a horizontal line extending from the end of the name.

Judy A. Scott, RN, BSN

Department of Nursing
4505 Maryland Parkway • Box 453018 • Las Vegas, Nevada 89154-3018
(702) 895-3360 • FAX (702) 895-4807



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March 26, 1998

Dear Dads,

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Jacnie Johns

Helen Krouse*

Neal Leshner*

Mark McKinley*

We have been asked by Judy Scott, an Oncology nurse to assist her in completing a study for her graduate thesis. We have enclosed a survey for you to complete and return. This survey will help nurses and others in the medical profession to better serve the families of ill children.

We thank you in advance for your assistance in this matter. If you have any questions please let us know.

EXECUTIVE DIRECTOR

Eleyna Olivas

Sincerely

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:ly

*Parent of child
with cancer

**Adult survivor of
childhood cancer

3201 S. Maryland Parkway - Suite 512 - Las Vegas, Nevada 89109
Office No. 702-737-1919 Fax No. 702-792-2780

APPENDIX C
HYMOVICH'S PARENT PERCEPTION INVENTORY (PPI)

GENERAL INFORMATION

1. My child involved in cancer treatment has been admitted to the hospital?

(0) never	(2) 2-4 times	(4) 8- or more times
(1) 1 time	(3) 5-7 times	
- 1b. How long ago was this child's last admission to the hospital?

(1) under 1 month	(3) 6-12 months
(2) 1-5 months	(4) over a year
2. How many (total number) children do you have? _____
3. How many of your children are under 5 years of age? _____
4. How many of your children are between 6 & 12 years of age? _____
5. How many of your children are 13 years of age or older? _____
6. In general, how has the health of your other children (those not involved in cancer treatment) been during the past 3 months?

(1) Poor/fair	(3) Very Good
(2) Good	(4) Excellent
7. How has your health been during the past 3 months?

(1) Poor/fair	(3) Very Good
(2) Good	(4) Excellent
- 7a. How has your spouse's health been during the past 3 months?

(1) Poor/fair	(3) Very Good
(2) Good	(4) Excellent
8. What is your religion?

(1) Catholic	(3) Protestant	(5) Other _____
(2) Jewish	(4) LDS	(6) No religion
9. How often have you attended religious services in the past 3 months?

(1) Never	(3) Sometimes
(2) Rarely	(4) Often
10. Are you employed now?

(1) no	(2) yes
--------	---------
- 10a. If yes, what do you do? (Please put the type of work you do not where you work).

- 10b. Do you work... (1) full-time (2) part-time
11. Are you satisfied with your current employment status?
(1) No (2) Not sure (3) Yes
12. What is your age?
(1) Under 18 years (4) 30-34 years (7) 45-49 years
(2) 19-24 years (5) 35-39 years (8) 50 years or over
(3) 25-29 years (6) 40-44 years
13. How much school have you completed?
(1) 7th grade or below (5) some college
(2) 8th or 9th grade (6) community college graduate
(3) 10th or 11th grade (7) college graduate
(4) high school graduate (8) masters or doctoral degree
14. How would you describe yourself?
(1) White (3) Black (5) Native American Indian
(2) Asian (4) Spanish-American (6) Other (specify)
15. What is your family's yearly income?
(1) under \$5,000 (3) \$10,000-\$19,000 (5) \$30,000-\$39,999
(2) \$5,000-\$9,999 (4) \$20,000-\$29,999 (6) \$40,000 or more
16. What is your current marital status?
(1) Married (3) Widowed (5) Divorced
(2) Remarried (4) Separated (6) Single (never married)
- 16a. If married, for how many years have you been married?
(1) under 2 years (3) 6-12 years
(2) 2-5 years (4) over 12 years
- 16b. How many times have you been married?
(1) (2) (3) or more times
17. If you are separated or divorced, please answer the following questions.
- 17a. For how many years have you been separated or divorced?
(1) under 2 years (3) 7-12 years
(2) 2-6 years (4) over 12 years
- 17b. Were you separated or divorced before or after you child's condition was diagnosed?
(1) before (2) after

18. In the past year, how often have you had to miss work to take care of your child?
- | | | | |
|-----|------------------------|-----|----------------------|
| (0) | I do not work | (2) | 1-4 times a month |
| (1) | Less than once a month | (3) | Over 4 times a month |

CONCERNS

PART I. CHILD CARE NEEDS

Please answer these questions regarding your child experiencing cancer treatment.

1. Child's Age: _____ / _____
(years) (months)
2. Child's sex: (1) Male (2) Female
3. What's is your child's illness, condition or disability?
4. How severe is your child's condition?
(1) not severe (slight) (2) moderately severe (3) very severe
5. How old was your child when the condition was diagnosed?
(1) under 6 mos (3) 1-3 yrs 11mos (5) 6-12yrs 11mos
(2) 6-11 mos (4) 4-5 yrs 11 mos (6) 13 yrs or older
6. How are you related to this child?
(1) father (3) guardian (5) grandfather
(2) stepfather (4) foster father (6) other _____
7. Does anyone else in your family have the same illness or disability as your child?
(1) no (2) yes
- 7a. If YES, is it your child's
(1) mother (3) brother or sister (5) cousins, aunts, uncles
(2) father (4) grandparent (6) other _____

8. Parents have many questions about their child's development and care, including those listed below (especially when the child is involved in cancer treatment). Do you have questions regarding any of the following topics? (You may want to discuss these questions with your physician or health-care provider.)

TOPIC	(1) Do not have questions now	(2) Not sure	(3) Have questions
Physical care of child	1	2	3
Diet or nutrition	1	2	3
Sleep habits	1	2	3
Genetic counseling	1	2	3
Care of minor illnesses	1	2	3
Dental needs	1	2	3
Play or recreation activities	1	2	3
Managing child's behavior	1	2	3
School or learning experiences	1	2	3
Talking to my child about the condition	1	2	3
Physical development	1	2	3
Social development	1	2	3
Emotional development	1	2	3
Intellectual development	1	2	3
Child's condition	1	2	3
Child's medicines	1	2	3
Child's treatments	1	2	3
Knowing when my child needs to see the doctor	1	2	3
Other questions? What?	1	2	3
	1	2	3

PART II. CONCERNS AND RESOURCES

All parents have some concerns. During the past 3 months, how much have you been concerned with the following? Circle the number in the column that best explains your concern. (Remember "child" means your child involved in cancer treatment)

CONCERNS	(0) Does not apply	(1) Not sure	(2) Little bit	(3) Quite a bit	(4) Great deal
Extra demands on my time	0	1	2	3	4
Feeling worn out	0	1	2	3	4
Having enough fun and relaxation as I would like	0	1	2	3	4
Having enough time alone with my spouse or partner	0	1	2	3	4
Talking with or understanding my spouse or partner	0	1	2	3	4
Sexual relationship with my spouse or partner	0	1	2	3	4
Making my child comfortable or happy	0	1	2	3	4
Having enough time or attention from my spouse or partner	0	1	2	3	4
Getting out of house with spouse or partner but without children	0	1	2	3	4
Getting out of house by myself	0	1	2	3	4
Getting to do activities together as a family	0	1	2	3	4
Whether I am taking care of my child in the best way	0	1	2	3	4
Having to travel too far for medical help or child care	0	1	2	3	4
The weather affecting what my child can do	0	1	2	3	4
Having enough insurance to meet expenses of child care	0	1	2	3	4

CONCERNS	(0) Does not apply	(1) Not sure	(2) Little bit	(3) Quite a bit	(4) Great deal
Having the right agencies in the community to provide the care my child needs	0	1	2	3	4
Wondering what my child's future is likely to be	0	1	2	3	4
Worrying about the responsibility of caring for my child	0	1	2	3	4
Having enough money to meet my family's needs	0	1	2	3	4
Having money for extra pleasures	0	1	2	3	4
Having someone to talk with about my worries	0	1	2	3	4
Finding someone to stay with my child	0	1	2	3	4
Wondering about how my child feels about himself or herself	0	1	2	3	4
Getting enough sleep for myself	0	1	2	3	4
Talking to my child about his/her condition	0	1	2	3	4
Talking with neighbors or friends about my child's condition	0	1	2	3	4
Wondering whether my other children will develop the same condition	0	1	2	3	4
The cost of my child's medical care	0	1	2	3	4
Wondering whether I will recognize important changes in my child's condition	0	1	2	3	4
Getting enough information about my child's condition	0	1	2	3	4
Helping my child cooperate with taking medicines or doing treatments	0	1	2	3	4
My spouse or partner's health	0	1	2	3	4

CONCERNS	(0) Does not apply	(1) Not sure	(2) Little bit	(3) Quite a bit	(4) Great deal
My own health	0	1	2	3	4
My child(ren)'s health	0	1	2	3	4

2. Are you a member of a parents' association related to your child's illness or disability?
(1) no (2) yes
- 2a. If YES, how often do you do to meetings?
(1) never (2) rarely (3) sometimes (4) often
- 2b. If you go to meetings, how helpful have they been?
(1) not at all (2) not very (3) somewhat (4) very
3. Does your family have someone to take care of your child involved in cancer treatment for a day in case of an emergency (such as if your family cannot take care of this child)?
(1) no (2) not sure (3) yes
4. Does your family have someone to take your child involved in cancer treatment for a week or more in case of an emergency?
(1) no (2) not sure (3) yes
5. Does your family have a regular baby sitter for your child involved in cancer treatment?
(1) Do not need (2) no (3) yes
6. Are you responsible for the care of any other ill family members?
(1) no (2) yes, WHO? _____
7. How much time do you usually spend taking care of your child involved in cancer treatment's health needs each day?
(1) Less than 1 hour (3) 3-5 hours (5) over 8 hours
(2) 1-2 hours (4) 6-8 hours
8. Who primarily provides direct care for your child involved in cancer treatment?
(1) you (2) child's mother (3) shared
(4) other (please name relationship to child) _____

COPING

1. Parents cope with their concerns in many different ways. There are times when you may have more problems or concerns because of your child's special needs as they are involved in cancer treatment. The first column has a list of some ways people cope. Coping means what a person does in order to make the situation better or to try to make oneself feel better.
 - A. If you do not use a coping method in the list, circle the 0 in the first column; and leave the center columns blank.
 - B. Circle the number that shows how often you used the coping method in the past 3 months when you had a problem related to your child's needs. (Remember "child" refers to your child involved in cancer treatment)

COPING	HOW OFTEN				HOW HELPFUL			
	(0) DO NOT DO THIS	(1) Very rarely	(2) Some- times	(3) Very often	(0) Never helps	(1) Some- times helps	(2) Almost always helps	(3) Always helps
Cry	0	1	2	3	0	1	2	3
Busy myself with other things	0	1	2	3	0	1	2	3
Talk with someone about feelings	0	1	2	3	0	1	2	3
Ignore/try to forget	0	1	2	3	0	1	2	3
Look at options	0	1	2	3	0	1	2	3
Get away for a while	0	1	2	3	0	1	2	3
Hide feelings	0	1	2	3	0	1	2	3
Change my expectations	0	1	2	3	0	1	2	3
Blame someone	0	1	2	3	0	1	2	3
Yell/scream/slam doors, etc.	0	1	2	3	0	1	2	3
Exercise	0	1	2	3	0	1	2	3
Ask for help	0	1	2	3	0	1	2	3

	HOW	OFT	EN		HOW	HELP	FUL	
COPING	(0) DO NOT DO THIS	(1) Very rarely	(2) Some- times	(3) Very often	(0) Never helps	(1) Some- times helps	(2) Almost always helps	(3) Always helps
Take alcohol or medicine	0	1	2	3	0	1	2	3
Pray	0	1	2	3	0	1	2	3
Blame myself	0	1	2	3	0	1	2	3
Ask questions	0	1	2	3	0	1	2	3
Use advice of others	0	1	2	3	0	1	2	3
Try to figure out what to do	0	1	2	3	0	1	2	3
Sleep	0	1	2	3	0	1	2	3
Find help	0	1	2	3	0	1	2	3
Smoke	0	1	2	3	0	1	2	3
Try to laugh or joke about it	0	1	2	3	0	1	2	3
Sleep	0	1	2	3	0	1	2	3
Find help	0	1	2	3	0	1	2	3
Smoke	0	1	2	3	0	1	2	3
Try to laugh or joke about it	0	1	2	3	0	1	2	3
Eat	0	1	2	3	0	1	2	3
Try to relax	0	1	2	3	0	1	2	3
Read about the problem	0	1	2	3	0	1	2	3
Wish problems would go away	0	1	2	3	0	1	2	3
Weigh choices	0	1	2	3	0	1	2	3
Get information	0	1	2	3	0	1	2	3

	HOW	OFT	EN		HOW	HELP	FUL	
COPING	(0) DO NOT DO THIS	(1) Very rarely	(2) Some- times	(3) Very often	(0) Never helps	(1) Some- times helps	(2) Almost always helps	(3) Always helps
Try to change things	0	1	2	3	0	1	2	3
Other?	0	1	2	3	0	1	2	3

With the following question, "child" refers to your child involved in cancer treatment.

- In the past, what sources have you used for information or help related to your child's problems or needs? Circle all that apply.

(1) Clergy	(6) Relatives or spouse	(11) Therapist
(2) Doctor	(7) Pharmacist	(12) Library
(3) Friend	(8) Other parent	(13) Newspaper
(4) Nurse	(9) Social worker	(14) Support group
(5) Teacher	(10) Nutritionist	(15) Community agency
	(16) Other (please name) _____	
- How often have there been times when you did not know what to do to get information of help related to your child?

(0) Never	(1) Sometimes	(2) Often	(3) Always
-----------	---------------	-----------	------------
- In general, how well do you believe you are coping with (managing) problems related to your child's care?

(1) Not well	(2) Well
--------------	----------
- In general, when you have problems related to your child's needs, how often are they things you can change or have some control over?

(1) Always	(2) Almost
(3) Not very often	(4) Never
- In general, how well do you believe you are coping with (managing) your feelings and concerns about your child?

(0) Not well	(1) Fairly well	(2) Well	(3) Extremely well
--------------	-----------------	----------	--------------------
- Would you like help from your health-care provider with any problems you are having?

(1) No	(2) Not sure	(3) Yes
--------	--------------	---------

7. How satisfied are you with the way you are able to cope with the stresses you have?
- | | | | |
|-----|-------------------|-----|----------------|
| (1) | Very dissatisfied | (3) | Satisfied |
| (2) | Dissatisfied | (4) | Very Satisfied |

APPENDIX D
PERMISSION TO USE THE INSTRUMENT



The University of North Carolina at Charlotte
 9201 University City Boulevard
 Charlotte, N.C. 28223-4001

College of Nursing and Health Professions
 Office of Nursing and Health Research
 704-347-4658

March 17, 1998

Judy A. Scott
 201 Courtney Circle
 Las Vegas, NV 89107

Dear Ms. Scott:

I have received your payment for the use of the PPI instrument. Please allow this letter to serve as your written permission to use the instrument. In regards to the changes that you need to make, I have approved the changes listed below.

Changing question 8 on the Concerns instrument to read:

"Parents have many questions about their child's development and care, including those listed below. Do you have questions regarding any of the following topics? (You may want to discuss these questions with your physician or health-care provider)"

Changing question 6 on the Coping instrument to read:

"Would you like help from your health-care provider with any problems you are having?"

Although, the instrument is not available in Spanish, you have my permission create a translated version. Please send me a copy of the translated version for my records. You also have my permission to reproduce the tool and change the font size and style as long as there are no changes in the wording.

Thank you for your interest in the PPI instrument. Please remember to return the contract, and feel free to contact me with any other questions or concerns.

Sincerely,

Debra P. Hymovich, RN, PhD, FAAN
 Associate Dean for Research

The University of North Carolina at Charlotte is an equal opportunity institution.
 The University of North Carolina at Charlotte is an equal opportunity institution.

APPENDIX E

HUMAN SUBJECTS RIGHTS APPROVAL

PROTOCOL FORM APPROVAL SHEET
FOR RESEARCH INVOLVING HUMAN SUBJECTS

Log Number: 9-1998

Title of Project:

The concerns, needs and coping strategies of fathers with a child who has cancer

Investigator: Judy Scott
Susan R. Michael

After reviewing this proposal, the members of the Department of Nursing, Human Subjects Rights Review Committee have indicated below their approval/disapproval of this proposal.

Signature of Committee Members	Approve	Disapprove
<u>Susan Kowalski</u>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<u>Carol Kayfied</u>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<u>Margaret Lee</u>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>

The above named project is hereby approved/disapproved (circle one):

Date: 20 Apr 1998

Margaret Lee
Committee Chairperson's Signature



DATE: May 7, 1998

TO: Judy A. Scott
M/S 3018 (NUR)

FROM: Dr. William E. Schulze, Director
Office of Sponsored Programs (X1357)

RE: Status of Human Subject Protocol Entitled:
"The Concerns, Needs, and Coping Strategies of
Fathers When Their children Have Cancer"

OSP #501s0598-026e

The protocol for the project referenced above has been reviewed by the Office of Sponsored Programs and it has been determined that it meets the criteria for exemption from full review by the UNLV human subjects Institutional Review Board. This protocol is approved for a period of one year from the date of this notification and work on the project may proceed.

Should the use of human subjects described in this protocol continue beyond a year from the date of this notification, it will be necessary to request an extension.

If you have any questions regarding this information, please contact Marsha Green in the Office of Sponsored Programs at 895-1357.

cc: S. Michael (NUR-3018)
OSP File

Office of Sponsored Programs
4505 Maryland Parkway • Box 451037 • Las Vegas, Nevada 89154-1037
(702) 895-1357 • FAX (702) 895-4242

VITA

Graduate College
University of Nevada, Las Vegas

Judy Anne Christensen Scott

Home Address:

201 Courtney Circle
Las Vegas, NV 89107

Degrees:

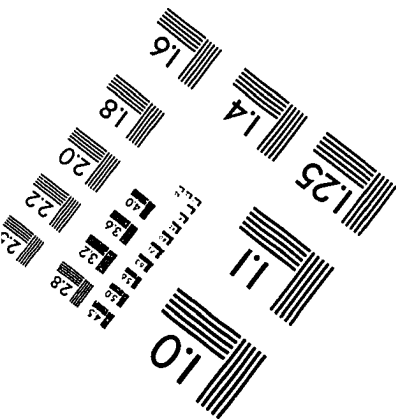
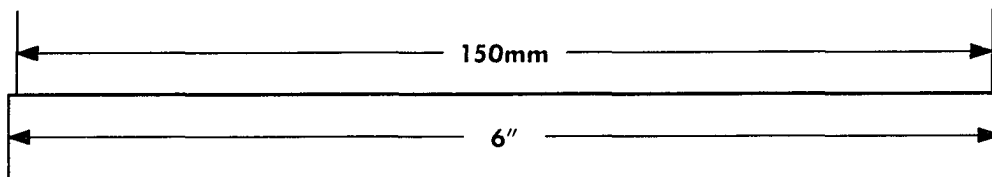
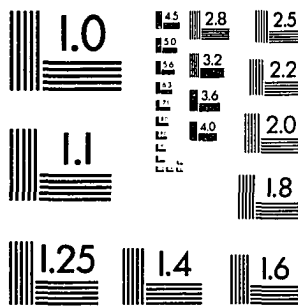
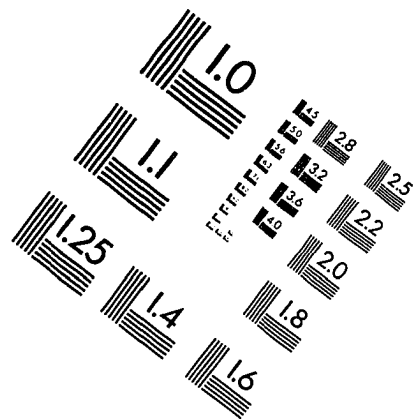
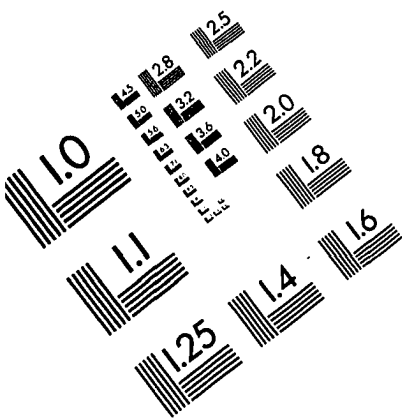
Bachelor of Science, Nursing, 1991
University of Nevada, Las Vegas

Thesis Title: The Concerns, Needs, and Coping Strategies of Fathers When Their
Children Have Cancer

Thesis Examination Committee:

Chairperson, Dr. Susan Michael, R.N., D.N.Sc.
Committee Member, Dr. Rosemary Witt, R.N., Ph.D.
Committee Member, Dr. Margaret Louis, R.N., Ph.D.
Graduate Faculty Representative, Dr. Robert Parker, Ph.D.

IMAGE EVALUATION TEST TARGET (QA-3)



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