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Nurses' Beliefs and Assessments Concerning Single-Parent Families

by

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ABSTRACT

The purpose of this thesis was to examine nurses' beliefs, experiences and assessment ratings of single-parent families. A study was conducted in two phases.

Phase I was an exploratory descriptive survey investigating, by means of audiotaped interviews, nurses' positive and negative beliefs and experiences of practice with single-parent families. The subjects, 58 pediatric and community health nurses, were interviewed individually for 30 minutes by the investigator using a structured interview schedule. Two female coders, graduate nursing students who received six hours of training, assisted in categorizing the interview data into categories. To estimate reliability, their percentage of agreement in grouping items into categories was calculated. It ranged from 85 to 94%.

The categories used most frequently to describe nurses' beliefs pertained to negative aspects of single-parent family life. About one-third of the nurses believe single-parent families have limited emotional support, financial difficulties, and need support from the nurse. Less than 10% of the nurses believe that children in single-parent families have increased independence or that the custodial parents are interested in self-improvement.

The categories used most frequently to describe nurses' experiences with single-parent families pertained to feelings of satisfaction when helping single-parent families and feelings of sympathy and frustration in dealing with these families.

Phase II was an experiment designed to examine nurses' ratings of

non-problem and problem boys living in various single-parent family conditions. The subjects, 25 pediatric nurses and 125 community health nurses, were randomly assigned to one of three experimental family conditions: father-headed, mother-headed and control. In each condition, subjects were required to view six videotapes of boys and rate their behaviour on the Personality Trait Rating Scale, the Predicted Behaviour Functioning Scale, the Nurses' Feelings Rating Scale and the Attribution Rating Scale. The latter two scales were devised by the investigator and pretested. Six videotaped vignettes were prepared by the investigator using 11-12 year old boys as confederates. Validity and reliability estimates were determined by four independent judges.

Results of a three-way analysis of variance with repeated measures indicated no significant differences among father-headed, mother-headed and control single-parent family conditions. Compared to pediatric nurses, community health nurses rated the boys as significantly less able to get along with others, more anxious/depressed, more delinquent and less able to relate effectively with peers. The community health nurses felt significantly more empathic toward the children than did the pediatric nurses. Non-problem boys were consistently rated more positively than problem boys.

Results of a Friedman two-way analysis of variance on ranks indicated that nurses significantly attributed the problem child's behaviour to his sex and family structure. Results of a multiple regression analysis with stepwise solution indicated that age, definition of self as a single-parent and length of full-time employment were significant background variables influencing the subjects' ratings.

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CHAPTER 1

INTRODUCTION

There has been a tremendous increase in the divorce rate in England (O'Brien, 1980), France (Lefaucheur, 1980), Denmark (Koch-Nielsen, 1980), Holland (Clason, 1980), the United States (Glick, 1979), Canada (Abernathy & Arcus, 1977) and particularly in Alberta and Calgary (Lupri, 1981) in the past decade. From 1969 to 1980 a five-fold increase in the crude divorce rate in Canada has been noted by Lupri (1984). The median duration of marriages in Canada before divorce was 9.9 years in 1980, a decline from 14.9 years in 1969 (Peters, 1983). The crude divorce rate in 1981 was 278 for Canada and 376.2 for Alberta (Statistics Canada, 1982) while for the United States it was 530 (Statistical Abstract, 1982-1983).

With the increase in the divorce rate has come transformations in family structure. The greatest transformation has been the rise of the single-parent family, also called lone-parent or one-parent family. Schlesinger (1979) defines a single-parent family as a family headed by only one parent because of separation, divorce, the death of a spouse or because the parent raising the children never married. An additional explanation for the single-parent family structure was proposed by researchers conducting early studies on father-absence (Hetherington, 1966). This explanation centered on the desertion of the father.

As Lupri (1984) notes, the number of single-parent families in

Canada has increased 28% between 1976 and 1981 while the number of husband-wife families has increased by only 22%. In 1981, in Canada, approximately 714,000 households or about one household out of nine (11.3%) was headed by one parent with 82.6% being mother-led and 17.4% being father-led. This is a rise from 1976 when Schlesinger (1983) indicated that 9.8% of Canada's families were lone-parent families.

Over 1.1 million children in 1981, in Canada, were estimated to be living in single-parent families, constituting about 11% of all children under 25 living at home (Lupri, 1984). The percent of families with one, two, three, four and five children was about 55, 28, 10, 4 and 2 respectively (Census of Canada, 1981). The number of children in each household did not differ significantly with mother-led or father-led households. It is estimated that 11% of children under 18 in the United States will be actually living with a divorced parent in 1990 and 32% of children will have lived with a divorced parent sometime during childhood (Glick, 1979). Despite the fact that approximately 75% of divorced persons in the United States remarry, the period of time a child lives in a single-parent family is significant (McGoldrick & Carter, 1980).

Because single-parent families are the fastest growing family form in Canada today, there is a need for reliable data about how these families are perceived by society in general and health professionals in particular. The specific type of single-parent families which will be the focus of this thesis are those resulting from separation or divorce. Brandwein, Brown and Fox (1974) have reported that

such one-parent families are often stereotyped and stigmatized. Santrock and Tracy's study (1978) of teachers' expectations of children from single-parent families confirms this notion of negative perceptions. That children from father-led as compared to mother-led single-parent families are more stigmatized by lay persons, teachers, and social workers has been confirmed by Fry and Addington (1984). These negative beliefs have developmental and clinical implications for health professionals who refer children for mental health services. How much of the emotional and social problems identified with single-parent families actually arise from family structure per se and how much arise from health professionals' expectations is unclear.

In the past decade, one group of health professionals most interested in the family has been the nursing group. They have increasingly demonstrated their interest and the evidence for this is contained in the nursing literature. Reference to family-focussed care, family-centered nursing and family nursing abound in both the community health and hospital nursing literature (Cunningham, 1978; Janosik & Miller, 1980; Friedman, 1981). What has been missing, however, is practical reference to the changing family structure (Hanson, 1981b). Single-parent families are acknowledged from a sociological perspective but not from a practical perspective. That is, there is little attention paid to nurses' actual pattern of practice with single-parent families. This is an important omission.

Nurses, perhaps more than other professionals, have opportunities to work with families in all stages of the divorce process and in a

variety of settings such as home, hospital, school and community health agency. In light of the increase in the number of single-parent families and of nursing's surging interest in the family, today's nurses must recognize how their theoretical framework and beliefs influence their diagnosis and intervention with families. For example, if a nurse believes in the pre-eminence of the maternal role in child-rearing, then she may likely offer a great deal of support to father-led households to make up for the lack of mother's presence. Alternatively, she may offer little support to father-led households because she does not understand their functioning. Katz's work (1979) confirms this latter notion. He pointed out that single-parent fathers often have their roles and needs misunderstood by professionals, especially teachers, social workers, medical personnel and the clergy. Thus, there exists the need to find out directly from nurses their beliefs about single-parent family functioning and the significant positive and negative aspects of family life.

A second need concerns the types of help which single-parent families seek from nurses. In a survey of 1201 mothers in the U.S. in 1978 conducted by the Task Force on Pediatric Education, it was found that 45% of divorced mothers were most likely to have had situations with their children where they would have liked to have had counselling for themselves. Furthermore, a significantly higher incidence of biosocial and developmental problems was reported by divorced mothers. For example, for children under age four, 28.2% of divorced mothers and 13.4% of married mothers reported growth and development

problems. Approximately 20% of divorced mothers reported learning difficulties as compared to 6.5% of married mothers. For children over age four, divorced mothers consistently reported more problems in behaviour and discipline, learning, relationships with schoolmates, teachers and parents, and emotional issues. These same issues seem to arise in the work of Calgary nurses with single-parent families. In a 1982 pilot study with 30 nurses, this writer found that single parents request the following types of help from the nurse: reassurance and support from the nurse as well as information about financial and community resources.

A third need which arose from the pilot study concerns the identification of difficulties which nurses themselves experience in providing health care to single-parent families. Twenty-six percent of the nurses stated they felt less than moderately competent in helping single-parent families.

In light of the above, it seemed research was necessary to identify nurses' specific beliefs and patterns of practice with single-parent families. A two-phased study was thus proposed:

> Phase I was an exploratory descriptive survey investigating by means of interviews, nurses' beliefs and professional experiences of practice with single-parent families. The objective of this survey was to identify major recurrent themes of positive and negative beliefs and experiences in dealing with single-parent families.

Phase II was an experiment designed to examine nurses' assessments of children living in different single-parent family conditions.

Each phase will be presented separately.

Statement of the Problem and Rationale

The problem that Phase I addresses is nurses' beliefs about single-parent families and their experience of practice with these families. The problem of nurses' concerns regarding the functioning of single-parent families might be clarified by asking a number of questions:

1. What do nurses believe are the major positive and negative aspects of single-parent family life?
2. What types of needs do nurses believe single-parent families present to them?
3. What do nurses identify as the major difficulties, satisfactions and feelings they experience in providing health care to single-parent families?

The problem that Phase I examines is important for a number of reasons. First, it is the first study to identify and isolate specific dimensions of positive and negative beliefs directly from the perspective of the practicing nurse. Second, the study may provide nurse educators with new points and directions for teaching students how to cope with the difficulties experienced by practicing nurses in providing health care to single-parent families. Finally, the study is

expected to have clinical implications for nurses devising both preventive and remedial educational and developmental services for single-parent families.

The problem that Phase II addresses is nurses' assessments of children living in single-parent families. The problem might be clarified by asking a number of questions:

1. What are nurses' assessments of the personality and behavioural functioning of children living in different types of single-parent family conditions?
2. What are nurses' feelings about children living in different types of single-parent family conditions?

The problem that Phase II examines is important for a number of reasons. First, the study will add to the sparse literature on professionals' assessments of children living in single-parent households. Second, the study will provide new information concerning nurses' feelings about such children. Finally, the study will have clinical and developmental implications for nurses referring children for mental health services.

Definition of Terms

Nurses refers to two groups of registered nurses:

1. Community Health Nurses (CHNs) employed by Calgary Health Services.
2. Pediatric Nurses (PNs) employed by Alberta Children's Hospital.

Single-Parent Family is a primary group of individuals consisting of a custodial parent (either male or female) and child(ren) living in a household in consistent proximity and intimate relationships. The parents are either divorced or separated. The widowed, the never-married, and the deserted single-parent families are excluded.

CHAPTER 2

REVIEW OF THE LITERATURE

This chapter presents a review of the literature dealing with single-parent families and health care professionals. More specifically, the literature is reviewed under two major headings:

1. Literature Related to Beliefs about Single-Parent Family Functioning.
2. Literature Related to Nurses' Experiences with Single-Parent Families.

Literature Related to Beliefs About Single-Parent Family Functioning

Little has been written regarding specific beliefs about single-parent families. What is written is frequently insufficiently explicit with respect to both the definition of the belief and the theoretical orientation from which it is derived. For the purposes of this thesis, a belief is defined as a cognitive structure comprising the perceived or assumed personal characteristics of a social group (Ashmore & Del Boca, 1981). Included in the definition are the basic notions of "generalization", "concept", "expectancy" and "impression" discussed by Brigham (1971) as well as the notion of "pictures in our heads" originally defined by Lippmann (1960).

Personal characteristics or attributes are not restricted to personality trait adjectives although they are an important part of how adults think about people and groups. Included also in the notion

of personal characteristics are the feelings aroused by the group and its members as well as the expected patterns of behaviour (Ashmore & Del Boca, 1979). A belief is a full set of attributes associated with a particular target, i.e., single-parent families.

The literature related to beliefs about single-parent family functioning will be reviewed under five sub-headings: deviant family structure, pre-eminence of mother's role, negative consequences of divorce, social isolation and transition in the family life cycle. Each will be discussed separately.

Deviant Family Structure

The first and most prevalent belief encountered in the literature about single-parent families is that these families are deviant. As Gongla (1982, p. 5) points out, "instead of viewing the single-parent family as simply an alternative family form, the public has usually viewed it as a deviant family, not living up to the ideal and norm of a two-parent family." This view holds not only for the lay public but also for professionals. Many different terms are used in the literature to describe one-parent families. They include phrases such as "broken", "disorganized" or "disintegrated" families. In the Dutch vocabulary, the term "one-parent family" is not accepted in common parlance. Far better known is the term "incomplete family" (Clason, 1980). All these terms imply a negative connotation and stigmatization. One-parent families are not contrasted with "two-parent families" but rather with "intact families". Brandwein, Brown and Fox

(1974) point out that any family without two parents is implied to be "abnormal" and its members "victims". This assumption of deviance has pervaded the literature and has prevented the growth of comprehensive knowledge about single-parent families.

Pre-eminence of Mother's Role

A second belief found in the literature follows the deviance perspective. Father absence is the major focus of the divorce literature. This has several implications. First, it is assumed that the custodial mother's role is pre-eminent. There is an overabundance of data concerning the importance of mothering and its beneficial effect on the psychosocial functioning of the child. In single-parent families, a two-fold deviance is often thus implied: The family type is deviant and the mother must assume a deviant role by becoming a father substitute.

Another implication of the focus on father-absence is that the father's role is assumed to be unimportant in contributing to the personality development of the child. This is an important area to assess because of the number of children living with custodial fathers. In 1981, 1.9% of children under 18 years old in the U.S. lived with their father only as compared to 1.7% in 1980 and 1.1% in 1970 (Statistical Abstract, 1982-1983). In 1982, approximately 10,200 children in Canada were put in the custody of their fathers, 65% of whom had petitioned for custody (Statistics Canada, 1982). With many children living with custodial fathers, it seems timely to consider

Hanson's (1981) position regarding the father's role in single-parenting. Hanson does not advocate "that we replace the supremacy of female parents with male parent supremacy, but we must finally acknowledge the fact that men are important members of the parenting team in two-parent families, and that single-father families are another acceptable and viable option in . . . society" (1981, p. 13). The current research of Hanson and Trilling (1983) on the characteristics of the healthy single-parent family (irrespective of the sex of the custodial parent) will contribute to an understanding of the healthy functioning associated with different custodial arrangements.

In addition to focussing attention on the custodial parent, whether male or female, consideration should be given to the non-custodial parent as a member of a one-parent family. Investigators have generally considered this parent to be absent and to have no effect on the family except by his or her absence. Trost (1980, p. 129) points out "that the life of the single parent without custody of a child is so closely influenced by the contacts and also by the lack of contacts between him/her and the child as well as the custodian that it is fully reasonable to look upon the non-custodian parent as a one-parent family". Even after divorce, one parent's existence has multiple social, emotional, and financial implications for the rest of the primary family group (Ahrons, 1983). Many researchers (Jacobson, 1978; Lowenstein & Koopman, 1978; Hetherington, Cox & Cox, 1980) have found that it is not reasonable to assume that marital separation creates a one-parent family. Often the non-custodial parent may

become more involved with parenting the children after the divorce than prior to the separation (Wallerstein & Kelly, 1980).

Negative Consequences of Divorce

A third belief found in the divorce literature also follows the deviance perspective: Single-parent families function instrumentally and emotionally different than two-parent families. This difference is generally considered to be a negative one. Instrumentally, these families have difficulty with what Weltner (1982) calls "time and motion" problems. There are enormous physical demands on the custodial parent who is often forced into a work setting that absorbs so much energy there is little time left for homemaking or parenting. Weltner (1982, p. 204) further suggests that "against this background there are meals to prepare, shopping to do, disciplining and providing support for children whose emotional condition has been weakened by the events leading to single-parenthood". The notion of the single-parent as stressed and overburdened pervades the literature. The interface of instrumental and emotional problems is well documented (Colletta, 1983). Kellam, Ensminger and Turner (1977, p. 1022) for example assert that "mother-alone families entail a higher risk of child social maladaptation to first grade, a risk that grows even stronger by third grade".

What is only beginning to be discussed in the literature however, is the relationship between marital turmoil in two-parent families versus one-parent families and behaviour problems in children (Emery,

1982). Whether children raised with one parent are at psychological risk has not been proven conclusively in four decades of research (Blechman, 1982). Yet the belief of predominantly negative functioning of one-parent families continues. A need for a balanced consideration of the positive and negative aspects of single-parent family functioning is thus evident.

An extensive review of the literature indicates some support for the positive effects of divorce on children. Weiss (1979) suggests that although children of divorce do grow up "a little faster" nevertheless as junior partners in household management, they become truly more responsible than children in intact families. Santrock and Warshak's work (1979) also points to some positive consequences. Their expectation that children growing up in one-parent families would show less competent social development than those raised in two-parent families was not totally met. Boys (aged 6-11 years) living with their single fathers "were observed to be warmer, have higher self-esteem, be less demanding, show more maturity, act more sociably, and behave more independently . . . than boys from intact families did with their fathers" (Santrock & Warshak, 1979, p. 120). Girls living with their fathers, on the other hand, did not show these positive effects. When children who resided with their mothers were contrasted however, with two-parent families, few significant differences were apparent. Thus, the family structure did not seem to be a "main effect". Rather, authoritative parenting and available adult social network support were associated with the child's positive social behaviour.

In contrast to those studies which indicated some positive effects are the many studies in which divorce is viewed as a negative experience. There are a number of methodological problems with these studies. First, there is the issue of biased sampling. For example, many (e.g., Jacobson, 1978) use clinical samples which by their nature are more likely to demonstrate difficulties. Second, the same observers rate both the parent and the child. That is, the observer is often not blind to the couple's marital status (e.g., Wallerstein & Kelly, 1980).

A third methodological problem is that many researchers fail to recognize how their theoretical framework influences their selection of questions and choice of instruments. For example, if a researcher believes in a strong echelon structure, then the absence of a hierarchy in a well-functioning single-parent household will not be viewed positively. Likewise, if the researcher has a psychodynamic orientation, then pathology and unresolved conflicts may appear in most couples experiencing divorce. Wallerstein and Kelly (1980), for example, acknowledge using a psychodynamic framework. It is not surprising to note therefore that many of their adults and 25% of their children were found to be "clinically depressed". Whether there is such an entity as childhood depression is not adequately discussed. Instead, a variety of presenting behavioural problems such as, stealing, enuresis and sexual promiscuity are labelled as depression. Thus, the theoretical orientation should be acknowledged for the methodology follows from it. For example, if the researcher views

divorce as deviant, then the subject's acknowledgement that it was a positive (although painful) experience will be seen as denial.

A final methodological problem is that children's perceptions of the divorce have been seldom noted although there are exceptions to this (Fry & Grover, 1983; Fry & Trifiletti, 1983; Fry & Leahey, 1983; Kavanaugh, 1979; Troyer, 1979). Rather, most times only parents have been interviewed and extrapolations have then been made to account for children's views. Congruence between parents' and childrens' perceptions has not always been demonstrated. Kurdek and Siesky (1980) found that children (5-19 years old, n = 132) did not view the divorce as an overly distressing event. Furthermore, Kurdek, Blisk, and Siesky (1981) found that "children's understanding of and feelings about the divorce were independent of each other" (p. 571). This is a particularly important issue because researchers have not always used multiple measures. Therefore, children's level of adaptation to divorce may have been assessed more on the basis of emotional than cognitive factors.

In conclusion, careful analysis of the literature does reveal that families who undergo marital dissolution do experience positive and adverse effects. Generally, the divorce process is a time of stress. Deciding to divorce, dealing with the loss of the non-custodial parent and adapting to a one-parent household are, however, all crisis experiences rather than chronic ones. A limited amount of research on one-parent families indicates that most children and adults report that they have not been adversely affected by the divorce.

Many people use it as a "marker event" and adults are more likely than children to discuss its benefits. What is required now is more research which would incorporate ratings of divorce - related changes along both positive and negative continua.

The assumptions underlying the position that divorce results in both positive and negative effects and that the type of family structure (father-headed vs. mother-headed) has little bearing on children's functioning are derived in part from Riegel's (1975) dialectic theory and Lerner and Spanier's interactionist approach (1978).

First, change is ubiquitous and results from contradiction. It does not imply "right" or "wrong" only "difference". Families tend to change their structures over time through the entrance or exodus of family members. The post-divorce family is therefore seen as an adaptive family unit having undergone the exit of a member. From a purely statistical perspective, there is support for the sheer numbers of this type of family (Beal, 1980). "Within the mental health field, it has been established that divorce does not automatically result in an unhealthy family environment" (Goldsmith, 1982, p. 298). From the sociological point of view, Aldous (1978) asserts that the one-parent family continues with similiar functions and responsibilities as the two-parent family. From the cross-cultural perspective, the ability of couples to maintain long-term relationships is not necessarily associated with "normality". Schwartzman (1982) cites the example of the Kanuri of northern Nigeria who have a divorce rate of almost 100%.

Second, the assumption is that the interrelations among the

nested systems in which children find themselves in the post-divorce period influence their adjustment positively or negatively (cf. Kurdek, 1981). These suprasystems may act as compensatory buffering mechanisms or as negative forces. For example, financial suppport by the outer system such as grandparents or Social Services Department, may be a compensatory force and alleviate strain within the family system.

With the increase in the number of children living with the custodial father, it seems timely to examine the social forces which may have a negative effect on children's functioning. Examples of such negative forces on the family system have been provided by the research of Santrock and Tracy (1978) and Fry and Addington (1984). Both of these studies explored the possibility that the assessment of children's personality and behavioural functioning indicated a stereotype involving more negative ratings of children from single-parent families as compared to two-parent families.

Santrock and Tracy (1978) asked 30 teachers to view a videotape of an eight year old boy and then to rate the child on a wide range of personality traits and to predict his behaviour in different social situations. Their findings indicated that teachers rated the child from a one-parent family significantly more negatively than a child from a two-parent family on happiness, emotional adjustment and ability to cope with stress.

There are a few methodological deficiencies, however, in the study conducted by Santrock and Tracy (1978) which may have influenced

their findings. First, no control group was used. Second, although the subjects were given a specific cognitive set about the nature of the study (that it dealt with divorce), no effort was made to verify if the subjects actually attributed their ratings to this cognitive set. Third, only one videotape of a child was used as stimulus material. Thus, it is difficult to determine if the ratings were based more on idiosyncratic features of the child or more on the teachers' stereotypes about single-parent families. Fourth, the subjects' feelings toward the child were not examined. This is an important omission as Ashmore and Del Boca (1979) point out that the feelings aroused by a specific target group as well as their expected pattern of behaviour form part of the subjects' belief or stereotype about the group.

Fry and Addington's study (1984) attempted to refine the experimental design used in Santrock and Tracy's work (1978). In addition to examining differences in stereotyped expectations about children from divorced versus intact families, focus was also placed on the father-headed versus the mother-headed divorced family structure. Four stimulus videotapes were shown rather than one. Fry and Addington's sample was considerably larger than that of Santrock and Tracy (1978) in that 300 lay persons, 150 elementary school teachers, and 150 social workers were the volunteer subjects. These social workers included pediatric nurses, community health workers, representatives from the child abuse prevention agencies and children's legal aid society. No attempt was made, however, to determine specifically the

stereotyped expectations of the nurses as distinct from the other "social workers". Also, there was no verification that subjects' ratings were attributed to their cognitive set or belief about divorce as opposed to the child's sex, age, or urban living environment. Subjects' feelings toward the child were also not examined.

Fry and Addington's findings (1984) are significant, however, in that both lay persons and professionals had more negative expectations of children living with the custodial father as compared to the custodial mother. There were no significant differences between the perceptions of lay persons and social workers but the teachers had significantly fewer stereotypic perceptions of children living with the custodial father than did the lay persons or the social workers. These findings have important implications not only for the welfare of the children in single-parent families, but also for the fathers who are assuming a more active role in child-rearing.

One of the areas that needs further exploration is an examination of nurses' expectations of children living in various family structures. One question which arises pertains to nurses' assessments of children living with their custodial father as compared to their custodial mother. Do nurses rate father-led households more negatively than mother-led ones? This has implications for nurses' patterns of practice. If nurses undermine the childrearing efforts of custodial fathers, then they may offer these families inappropriate health services. The fathers may find that their chidren are being referred more frequently for developmental and clinical services. These

referrals may stem not from the child's actual need but rather from the nurses' biased expectations.

Social Isolation

A fourth belief emerging from the literature about single-parent families concerns their social isolation. The literature has often viewed the one-parent family as divorced from the larger social system and existing in a social vacuum. Smith (1980) reports on the loneliness, decreased social support, lower level of community participation and feelings of powerlessness among heads of single-parent households. The findings generally hold for both lone fathers and lone mothers although some differences can be stated. Females usually score lower on alienation than do males. Single-parent fathers have been found to have their roles and needs often misunderstood by professionals. Katz (1979) notes that 48% of the fathers found that "school authorities had no understanding of what it meant to be a lone father" (p. 427). Social workers, medical personnel and the clergy did not rate much higher in providing useful assistance. It appears that although single parenthood is an emerging life style, both males and females with dependent children face many role adjustments which society does not acknowledge. Gasser and Taylor (1976) indicate that increased home management participation and curtailment of former social activities are common.

In contrast to the prevalent view that one-parent families are socially isolated, Saunders (1983) has described the social consequences of divorce for the divorcee's family of origin, former spouse,

family of the former spouse, friends and acquaintances. He found that outside the nuclear family are many suprasystems which are affected by divorce. The extended family can enhance or detract from the adjustment following separation. Beal (1979) reports that highly anxious grandparents can enhance family anxiety, impair parental functioning, and negatively influence adjustment. Extended family members who take sides may enhance polarization and conflict. On the other hand, they can often provide economic contributions which assist family stability (Brandwein, Brown & Fox, 1974).

Friends also provide support and emotional stability for the custodial parent. Kurdek and Blisk's study (1983) of 25 single divorced mothers found that these women rated friends as being most supportive in adjusting to the divorce. Other supportive people listed in rank order were children, relatives, counsellors/therapists, clergy, lawyer, and the ex-spouse. The high ranking assigned to children and the low ranking given to the ex-spouse vary from the findings of Chiriboga, Coho, Stein and Roberts (1979) who reported that "friends were most commonly turned to for help, followed by the spouse, counselors (a term which included social workers, psychiatrists and psychologists) relatives and parents" (p. 123). Self-help groups were the least sought out.

In addition to the extended family and friends, there are several other suprasystems that are affected by divorce. These social systems include schools, health care facilities and community agencies. Single-parent families may be referred to some of these facilities by

professionals or may seek out these services on their own. Krell's case reports (1972) suggest that divorced mothers often present children to the family doctor, pediatrician or child psychiatrist with specific symptom complaints which reflect the special problems of the single-parent family condition. Chiriboga et al (1979) found that 6% of men and 20% of women sought advice and assistance from doctors. The majority of these subjects turned to more than one category of helper and in fact, about 13% turned to six or more different categories of helper. Less than 20% sought no assistance.

In none of these studies is the nurse included as a "helping resource". Given the lack of emphasis in the literature on the single-parent family's relationship with nurses, little knowledge is available to adequately guide nursing educators and practitioners on how to deal with single-parent families. There is a need for such knowledge lest nurses themselves act in isolation with single-parent families.

Transition in the Family Life Cycle

A fifth belief evident in the literature is that single-parent families are in a state of transition in the family developmental life cycle. As Leahey (1984) notes, despite the rise in the rate of divorce, at any one time less than about 5% of women are divorced. In interpreting and applying the findings from research on divorce it is apparent that the overall population of divorced persons is quite small at any one time. The prevalent expectation is that adults in single-parent families will remarry and do so within a few years

(Beal, 1980). In 1980 in Canada 26.5% of all marriages involved at least one spouse who had been married previously (Statistics Canada, 1980). Of these remarriages, 89% involved at least one divorced person which is an increase since 1970 when 11% of all marriages were remarriages with 74% involving one divorced partner (Lupri, 1984). The United States has a higher divorce rate than Canada (5.3 vs. 2.8 in 1981) and among those who divorce approximately 75% of the women and 83% of the men in middle-age remarry (Glick, 1980).

Mitchell (1983) points out the implications of this trend toward remarriage. He notes, "A striking absence in the literature on divorce is the recognition of the strengths and opportunities of single-parenthood". Divorce is not seen as a progressive process for the individual but rather as a regressive one (Kantor & Vickers, 1983). The ability to maintain long-term relationships is viewed as "normal" (Schwartzman, 1982) and therefore by implication single-parent family life is "abnormal" and remarriage is desirable. The implications of these beliefs for nurses' work with single-parent families have not been addressed in the literature.

Literature Related To Nurses' Experiences With Single-Parent Families

Very little has been written about nurses' experiences or patterns of practice with single-parent families. What is written tends to be vague and non-specific. The literature related to this topic will be reviewed under two sub-headings: general literature and clinical practice.

General Literature

There is mention in the general nursing literature of military families where the father is absent (Johnson, 1974), single-mother families categorized according to the mother's marital status (Hoeffer, 1978) and family therapy for the single-parent family system (Collison & Futrell, 1982). Hanson (1981b) stresses the need for nursing educators to acknowledge the advent of the single-parent family structure. Friedman (1981) discusses the generic features of single-parent families including role conflicts/shifts and social stigma. She also explores, albeit minimally, the relationship between family structure and child development especially for pre-schoolers. Even in the most recent nursing texts (e.g., Clements, & Roberts, 1983) less than five pages are devoted to single-parent family functioning. The focus is again on role strain and the health care implications are few. Roberts (1983, p. 15), however, does suggest two implications. First, "there will be less money available for health care (including dental care) and less time to spend waiting in clinics or physician's offices". Second, it is postulated that single-parents and their children could be more susceptible to illness. This is a speculation also offered by Gongla (1982) who suggests the higher level of illness may be related to lack of social support. Roberts (1983) concludes that "when illness in a (single-parent) family member does occur, it is much harder to provide care, particularly if the care requires a lot of time" (p. 15).

Clinical Practice

Despite the preceding references in the general literature, the number of articles or chapters dealing with actual clinical practice is very few. One exception is Kaseman's article (1974). As a psychiatric mental health nurse clinician, Kaseman identifies several problems of single-parent divorced families referred to a community mental health centre. One problem for the mothers was melding the expressive and instrumental roles. Another issue was coping with their feelings of rejection by the ex-spouse. Problems experienced by the children included fantasies and feelings of guilt about their father's absence. Although Kaseman discusses her counselling approach to these families, she does not mention her own experiences in dealing with these clients. A number of gaps noted in the information derived from Kaseman's work (1974) concern nurses' affect and ideation. For example did Kaseman feel frustrated, empathic or sympathetic toward single-parent families? Did she find them compliant or not? Did she alter her pattern of practice to work with their special problems? Did she ever work with father-led families?

In contrast to Kaseman's work, Burke's (1983) article, "One-parent Families: Helping them Cope", deals with many of the issues that have been neglected in the other nursing literature. Burke offers case examples and nursing interventions for various types of one-parent families. She acknowledges the nurses' feelings in dealing with these families and offers concrete suggestions for care.

Another reference to single-parent family functioning and

clinical nursing practise is found in Wright and Leahey's (1984) Nurses and Families: A Guide To Family Assessment and Intervention. After reviewing the stages in the divorce process and the psychological outcomes for children of various developmental stages, the authors suggest four ways for nurses to assist one-parent families:

1. Provide information about normal growth and development and the possible effects of divorce on children.
2. Encourage single parents to talk directly with their children about the divorce in order to help their children cope effectively.
3. Provide information and counselling directly to the single parents about the expected stresses they may encounter.
4. Encourage single parents to mobilize a personal support system.

The authors offer further concrete suggestions for community health nurses working with one-parent families. There is no mention, however, of whether nurses employed in hospitals should assist single-parent families in the same ways as community health nurses should.

Unlike Wright and Leahey, Hoeffer (1978) addresses the pediatric hospital nurses and recommends them to be sensitive to their own biases about single-mother families. A re-examination of "preconceptions about family forms and life-styles" is urged (Hoeffer, 1978, p.81). There is no research data however to guide educators in instructing either community health nurses or pediatric nurses to examine their beliefs about single-parent families. Whether the two groups of

nurses have the same beliefs or different ones has not yet been investigated.

What is known however is that the pattern of health facility usage among single parents differs from that of traditional two parent families. Burke (1983) has "shown that single parents with a handicapped child are less likely to use out-patient clinics and more likely to use in-patient services for their children than two-parent families" (p. 33). This may have implications for how these families are perceived by pediatric nurses and consequently the type of care they receive.

Summary

A critical analysis of the literature pertaining to single-parent family functioning revealed the following:

1. Single-parent families are generally considered deviant rather than alternate family forms.
2. Father absence is the focus of the literature and the mother's role is pre-eminent.
3. Single-parent family functioning is instrumentally and emotionally different than two-parent family functioning. Single-parent families are assumed to function less adequately, partially due to researchers' biases.
4. Single-parent families are thought to be socially isolated.

5. Single-parent families are in a state of transition in the family development life cycle.

These findings all flow from a deviance perspective. The literature dealing with positive aspects of single-parent family functioning is just beginning to emerge.

There is little research specifically examining professionals' beliefs about single-parent families and none dealing with nurses' beliefs. The few studies that do exist have several problems. Samples are incompletely described so that generalizations from them to the population are not easily possible. No attempts are made to verify that subjects' ratings are attributed to their cognitive set about divorce and not to other variables. There is no examination of the affective component of the subjects' beliefs. A further problem is the inadequate description of the stimulus material.

This review also emphasized nurses' experiences with single-parent families. An extensive examination of the nursing literature revealed only minimal mention of single-parent families. Authors often urge examination of preconceptions about family forms and life styles. What is missing however, are any research studies dealing with nurses' beliefs about single-parent families or their pattern of practice with these families.

In conclusion, there is a need for research to explore more fully nurses' beliefs and experiences with single-parent families and their assessments of children living in these families.

CHAPTER 3

PHASE I

Phase I is an exploratory descriptive survey investigating, by means of interviews, nurses' beliefs about single-parent families and nurses' experiences in dealing with single-parent families. This chapter is divided into eight subsections: purpose and objectives, description of subjects, procedures, interview schedules, delimitations of the study, treatment of the data, results and summary. Each will be presented separately.

Purpose and Objectives

The purpose of Phase I was to examine nurses' beliefs about single-parent families and nurses' experiences in dealing with single-parent families. The specific objectives are listed below:

1. To identify and isolate from the nurses' perspective specific positive and negative beliefs about single-parent family functioning.
2. To identify and isolate from the nurses' perspective specific experiences in dealing with single-parent families.
3. To determine if there is a significant difference between pediatric nurses and community health nurses in their beliefs and experiences in dealing with single-parent families.

Description of Subjects

Subjects were 62 practicing nurses who volunteered for the study. They were female nurses employed either as community health nurses by Calgary Health Services or as pediatric nurses by Alberta Children's Hospital. Because nursing employs mainly females, it was thought the male subset would be too small for statistical evaluation. Males were thus excluded.

All subjects were assumed to be in the upper-middle socio-economic status as identified by the Blishen Socioeconomic Index (1967). The subjects were not a strictly homogeneous group but rather were a comparable group. No coercive influence was exerted in gathering the volunteer sample nor were subjects renumerated. Informed written consent was obtained from the subjects. Their anonymity was ensured.

The rationale for choosing community health nurses and pediatric nurses was based on the assumption that of all groups of nurses, these two have the most contact with single-parent families and young children. Community health nurses work in the Calgary elementary schools approximately seven to ten hours a week while pediatric nurses are continuously employed in a children's health care setting.

Attrition due to illness, scheduling problems and the use of data to train coders reduced the final sample to 58 subjects which included 19 pediatric nurses and 39 community health nurses. The mean age and years of full-time employment was 34.5 and 9.1 years respectively. The mean percent of nurses' contact with single-parent families was

23% of which approximately 21% was with mother-led families and 2% was with father-led families. Eleven of the pediatric nurses and 32 of the community health nurses participated both in Phases I and II.

The characteristics of the subjects are given in Table 1.

Procedures

Approval to conduct the research was secured from the Ethics Committee at the University of Calgary, the Research and Development Committees and the Directors of Nursing at Calgary Health Services and at Alberta Children's Hospital. Financial support for the research was received by grants from the Alberta Association for Registered Nurses Research Committee and the University of Calgary Research Policy and Grants Committee.

Arrangements for obtaining subjects differed at Calgary Health Services and at Alberta Children's Hospital. Each will be discussed separately.

Community Health Nurses

The investigator had a 20-minute meeting with the community health nurses at five branch offices in Calgary. The purpose of the study was explained to them and volunteers were requested to write their name and phone number on an index card. The investigator then telephoned the community health nurse and arranged a mutually convenient time during working hours for the interview.

Table 1

Characteristics of Nurses in Phase I

Characteristics	Frequency of Occurrence
Marital Status	
Single (never married)	13
Separated	3
Divorced	4
Married	36
Widowed	1
Defines Self as a Single-Parent	
Yes	6
No	51
Formal Education	
R.N. Diploma	4
Courses Toward Bachelors Degree	17
Bachelors Degree	34
Courses Toward Masters Degree	3

Pediatric Nurses

The investigator met with five senior nurses representing the out-patient and in-patient service divisions at Alberta Children's Hospital. The purpose of the study was explained to them. Because of logistic difficulties involved in making a personal request for volunteers, it was decided a letter would be sent to each pediatric nurse inviting her to participate in Phase I. The volunteer filled out a form indicating her name and telephone number and returned it either to the Education Coordinator (out-patients) or the Research and Development Coordinator (in-patients). The investigator then telephoned the pediatric nurse and arranged a mutually convenient time during working hours for the interview.

All subjects were assigned a code number by this writer at the time of the interview. Each subject signed a consent form agreeing to participate in the study. A sample of the consent form is included in Appendix A. A closed office in the subject's work setting was used and the subjects were interviewed individually for approximately 30 minutes. Each interview was audiotape-recorded and the only identifying data was the code number.

Interview Schedule

The choice of a structured interview schedule over a questionnaire was based on the results of a pilot study conducted by the investigator with 30 practicing nurses. These results indicated nurses

believed single-parent families had instrumental and emotional difficulties. Results also indicated single-parent families sought support from the nurse and information about child care facilities. What the results lacked however was sufficient detail about the specific nature of these issues. It was for this reason that a structured interview schedule was devised to explore the issues more fully.

An additional reason for choosing a structured interview schedule was to derive material to be incorporated in the instruments used in Phase II. In particular, answers to Question 6, concerning the feelings nurses have when working with single-parent families, were used in devising The Nurses' Feelings Rating Scale for Phase II.

The structured interview schedule comprised the following open-ended questions. Further probing was done whenever necessary or when specific information was not forthcoming. Subjects were asked to limit their discussion to single-parent families who had experienced divorce or separation. They were asked to compare these families with two-parent families.

1. What are the major stresses you see single-parent families experiencing?
2. What are the positive aspects of single-parent family life?
3. What kinds of needs do divorced families present to you as a nurse?
4. What kinds of difficulties do you experience in dealing with single-parent families?

5. What kinds of satisfactions do you experience in dealing with single-parent families?
6. What kinds of feelings would you say are aroused in you when working with single-parent families?
7. Do you think there are any long-term or short-term effects of divorce on children? If so, what are they?

Delimitations of the Study

The scope of this study was delimited by the writer in a number of ways. First, the study was restricted geographically to the Calgary area. Second, the study was confined to community health nurses and pediatric nurses only. Finally, the pediatric nurses were selected only from one hospital.

Treatment of the Data

The entire audiotaped interviews were transcribed on to paper and typescripts were prepared. The investigator did a content analysis and listed for each subject the main themes or items answered for each question (Krippendorff, 1980). Coders were then trained, categories were developed and statistical tests were chosen. Each will be discussed separately.

Training of Coders

To reduce investigator bias, two coders were hired to assist in the data analysis. The coders were two female registered nurses and

graduate students enrolled in the Masters of Nursing program at the University of Calgary. They were 44 and 38 years old and had 19 and 15 years nursing experience, respectively. They received four hours of training in itemizing responses for purposes of data reduction. Training continued until the coders reached a minimum of 85% agreement in itemizing responses. The coders then developed a master list of items based on each subject's response to Questions 1 to 7.

Development of Categories

After the coders had itemized the data, the investigator developed 24 categories into which the items could be grouped. Categories 1 to 13 evolved after responses were itemized for Questions 1, 2, 3 and 7 pertaining to nurses' beliefs about single-parent family functioning. Specifically, the questions focussed on nurses' beliefs about negative and positive aspects of single-parent family life, the kinds of needs single-parent families present to nurses and the effects of divorce on children.

Categories 1 to 3 grouped items concerning nurses' beliefs about the negative aspects of single-parent family life:

1. Financial difficulties
2. Limited emotional support
3. Time-management difficulties

Categories 4 to 7 grouped items pertaining to nurses' beliefs about the positive aspects of single-parent family life:

4. Increased parent-child bond

5. Recovery following a tense marriage

6. Increased independence for children

7. Parental interest in self-improvement

Categories 8 and 9 grouped items reflecting the needs nurses believe single-parent families present to them:

8. Need information regarding resources

9. Need support from the nurses

Categories 10 to 13 grouped items pertaining to nurses' beliefs about the effects of divorce:

10. Children have emotional problems

11. Parent-child discipline problems

12. Children's emotional adjustment is dependent on parent's adjustment

13. No difference in functioning between single-parent families and two-parent families

Categories 14 to 24 evolved after responses were itemized for Questions 4, 5 and 6 pertaining to nurses' experiences in dealing with single-parent families. Specifically, the questions focussed on the difficulties, satisfactions and feelings nurses experience in working with single-parent families.

Categories 14 to 18 grouped items concerning difficulties nurses experience:

14. Instrumental difficulties

15 Lack of knowledge of community resources

16. Difficulties with assessment

17. Difficulties with making moral judgements

18. Difficulties with non-compliance

Categories 19 to 22 grouped items reflecting the satisfactions that nurses experience:

19. Single-parent families are challenging

20. Satisfied when they make changes

21. Feel needed

22. Satisfied when helping them

Categories 23 and 24 grouped items pertaining to feelings nurses experience in working with single-parent families:

23. Frustration

24. Sympathy

Coders received an additional two hours training in grouping items under the appropriate categories. To estimate interrater reliability, the percentage of agreement between coders in grouping items under the 24 categories was calculated. The percentage of agreement ranged from 85.4 to 94.4.

Statistical Tests

A frequency count was taken on the data by using Coder One's figures for the categories as input. The percentage of subjects using each category was tabulated. This method of data analysis was chosen because of the nominal level of the data. Consideration was given to analyzing the data by means of factor analysis. This approach was not

pursued because of insufficient and varying frequencies of the categories.

To determine if there were significant differences between pediatric nurses and community health nurses, and between those subjects who participated in Phase I and those who participated in both phases, cross-tabulations were done using Coder One's data for the categories as input. Separate cross-tabulations were done for nurses' beliefs about single-parent families (Questions 1, 2, 3 and 7) and nurses' experiences in dealing with single-parent families (Questions 4, 5 and 6). The computer program used for the cross-tabulations was SPSS: Statistical Package for the Social Sciences (Nie, Hull, Jenkins, Steinbrenner & Bent, 1975). A .05 level of probability was accepted for all analyses.

Results

Questions 1, 2, 3, and 7 were used to elicit nurses' beliefs about single-parent family functioning. A frequency count was taken of the number of subjects using the categories pertaining to nurses' beliefs. The percentage of subjects using each of the categories is given in Table 2. The categories used most frequently by the nurses pertain to negative aspects of single-parent family life.

Questions 4, 5, and 6 were used to isolate nurses' professional experiences in dealing with single-parent families. A frequency count was taken of the categories pertaining to nurses' experiences with single-parent families. The percentage of subjects using each of the

Table 2

Percentage of Subjects Using Categories Pertaining to Nurses' Beliefs About Single-Parent Families

Category	% of Subjects
Negative Aspects of Single-Parent Family Life	
Limited Emotional Support	38
Financial Difficulty	34
Time-Management Difficulties	17
Parent-Child Discipline Problems	12
Positive Aspects of Single-Parent Family Life	
Recovery Following Tense Marriage	26
Increased Parent-Child Bond	12
Interest in Self-Improvement	7
Increased Independence for Children	5
Needs Single-Parent Families Present	
Need Support from Nurse	29
Need Information about Resources	26
Effects of Divorce	
Children's Emotional Adjustment is Dependent on Parent's Adjustment	28
Children have Emotional Problems	19
No Difference in Functioning Between Single-Parent Families and Two-Parent Families	2

categories is given in Table 3. The categories used most frequently by the nurses pertain to feelings of satisfaction when helping single-parent families and feelings of sympathy and frustration in dealing with these families.

Cross-tabulations were done to determine if there were significant differences between pediatric nurses and community health nurses in their use of the categories. Separate analyses were done for their beliefs about single-parent families (Questions 1, 2, 3 and 7) and their experiences with single-parent families (Questions 4, 5 and 6). The hypotheses and statistical findings for each analysis will be reported separately.

Hypothesis 1A had predicted no significant differences between pediatric nurses and community health nurses on Questions 1, 2, 3 and 7 concerning positive and negative aspects of single-parent family life. Results indicating no significant chi-square differences between pediatric nurses and community health nurses in their use of the categories for these questions confirm that hypothesis 1a is accepted at the .05 level of probability.

Hypothesis 1B had predicted no significant differences between pediatric nurses and community health nurses on Questions 4, 5 and 6 concerning the difficulties, satisfactions and feelings nurses experience in working with single-parent families. Results indicating no significant differences between pediatric nurses and community health nurses in their use of the categories for these questions confirm that hypothesis 1B is accepted at the .05 level of probability.

Table 3

Percentage of Subjects Using Categories Pertaining to Nurses' Experiences with Single-Parent Families

Category	% of Subjects
Difficulties Nurses Experience	
Difficulties with Moral Judgement	17
Instrumental Difficulties	16
Difficulties with Non-compliance	14
Difficulties with Assessment	10
Difficulties with Knowing Resources	7
Satisfactions Nurses Experience	
Satisfied when Helping Families	29
Satisfied when Family Makes Changes	22
Feel Needed	16
Find Single-Parent Families a Challenge	14
Feelings Nurses Experience	
Sympathy	26
Frustration	26

Hypothesis 2 had predicted no significant differences between subjects who participated in Phase I only and those who participated in both phases. Results of a chi-square test indicate no significant differences between subjects who participated in Phase I only and subjects who participated in both Phases I and II in their use of the categories. Hypothesis 2 is thus accepted at the .05 level of probability.

Summary

Phase I was an exploratory descriptive survey investigating, by means of interviews, nurses' beliefs about single-parent families and nurses' experiences in dealing with single-parent families.

Results from the questions designed to elicit nurses' beliefs about single-parent families indicate the following beliefs are held. With respect to the negative aspects of single-parent family life, nurses believe single-parent families have limited emotional support, financial and time-management difficulties, and parent-child discipline problems. With respect to the positive aspects of single-parent family life, nurses believe single-parent families are in a transition or aftermath stage in the family life cycle. They believe there is an increased parent-child bond, interest in self-improvement, and increased independence for children in single-parent families. Nurses believe single-parent families need support from the nurse and need information about resources. Lastly, with respect to the effects of divorce on children, the nurses are divided in their beliefs. Some

believe the children have emotional problems while a few believe there is no difference in children's functioning in single-parent families as compared to two-parent families. Many stated their belief that the children's emotional adjustment is dependent on the parent's adjustment.

The categories used most frequently by the nurses to describe their beliefs pertain to negative aspects of single-parent family life. Approximately one third of the nurses believe single-parent families have limited emotional support, financial difficulties, and need support from the nurse. Less than 10% of the nurses believe that children in single-parent families have increased independence or that custodial parents are interested in self-improvement.

Results from the questions designed to elicit nurses' experiences with single-parent families indicate that nurses experience instrumental difficulties and difficulties with moral judgement, noncompliance, assessment and with knowing resources. Nurses experience satisfaction when helping families and when the family makes positive changes. Nurses feel needed by single-parent families and find them a challenge. Feelings of sympathy and frustration are reported by many of the nurses.

The categories used most frequently by the nurses to describe their experiences with single-parent families pertain to feelings of satisfaction. About 30% report being satisfied when helping single-parent families and 22% report satisfaction when single-parent families make changes. Approximately 25% of the nurses experience

sympathy and frustration in working with single-parent families. Fourteen percent report single-parent families are non-compliant. Less than 10% of the nurses have difficulty in assessing single-parent families or lack knowledge of resources for single-parent families.

Results from cross-tabulations indicated no significant differences between pediatric nurses and community health nurses concerning the major positive and negative aspects of single-parent family life. There were no significant chi-square differences between subjects who participated in Phase I only and subjects who participated in both Phases I and II.

These results affirm the importance of obtaining nurses' perspectives on single-parent family functioning. The results were used, in part, to form the base for Phase II. The nurses' feelings reported in Phase I were used in devising "The Nurses' Feelings Rating Scale" for Phase II. The results of Phase I are discussed in greater detail in Chapter 5.

CHAPTER 4

PHASE II

Phase II is an experiment designed to examine nurses' assessments of the characteristics and functioning of children living in father-headed versus mother-headed single-parent family conditions. This chapter dealing with Phase II is divided into nine subsections: purpose and objectives, selection and assignment of subjects, research design, description of stimulus material, instruments, procedures, treatment of the data, results and summary. Each will be presented separately.

Purpose and Objectives

The purpose of Phase II was to examine practising nurses' assessments of the characteristics and functioning of children living in single-parent households. The specific objectives are to examine:

1. whether nurses assess boys living in father-headed households less positively than boys living in mother-headed households.
2. whether there are differences in ratings of boys completed by pediatric nurses versus community health nurses.
3. whether videos depicting non-problem boys from single-parent families are rated more positively than videos depicting problem boys from single-parent families.
4. the influence of background variables on nurses' ratings of boys living in various single-parent family conditions.

5. differences in subjects' attributions of non-problem and problem boys.

Selection and Assignment of Subjects

A sample size of 154 practicing nurses was selected for Phase II: 128 community health nurses and 26 pediatric nurses. The community health nurses were all employed by Calgary Health Services and the pediatric nurses were employed by Alberta Children's Hospital. For the purposes of Phase II, they were considered as two distinct groups of nurses in order to examine if they differed because of their work settings. Community health nurses make home visits, have flexible working schedules and have more opportunity for intense contact with single-parent families than do pediatric nurses who are employed in an institution. All the subjects were members of a group collectively asked to take part in the study. No coercive influence was exerted nor were subjects remunerated.

Written consent was obtained from each subject. As far as possible, subjects were informed of the nature and purpose of the study. They were asked to give consent to participate in an experiment designed to examine social/psychological variables. They were told they would be shown videotapes of children interacting with other children in a play/group situation. The consent forms stated explicity that they could not be fully informed prior to the study about the true nature of the experiment. A sample of the consent form is included in Appendix B. Immediately following the data collection, subjects were

fully debriefed.

Anonymity of subjects was ensured as no names were required on the instruments. Each subject was given a code number and a Table of Random Numbers was used to designate the assignment to one of the following experimental groups: Group 1 Father-Headed Condition, Group 2 Mother-Headed Condition and Group 3 Control Condition. Because this was the first study of its kind, no attempt was made to match subjects in the three groups on preselected variables. All subjects were presumed to be in the upper-middle socio-economic status as identified by the Blishen Socioeconomic Index (1967).

Attrition due to failure to complete the instruments reduced the final sample to 150: 125 community health nurses and 25 pediatric nurses. The characteristics of the subjects are given in Table 4.

Research Design

Phase II was designed to evaluate nurses' assessments of boys from single-parent families. Subjects were randomly assigned to one of three experimental conditions:

Group 1 Father-headed family structure

Group 2 Mother-headed family structure

Group 3 Control family structure

In all experimental conditions, subjects were alerted to the fact that they would view six videotapes of boys and would be required to rate these boys on a number of variables.

The research plan for Phase II is depicted in Figure 1.

Table 4

Characteristics of Nurses in Phase II

Characteristics	Experiment Groups					
	Father Headed		Mother Headed		Control	
	PN	CHN	PN	CHN	PN	CHN
Frequency	6	42	10	42	9	41
Participation in Study II only	5	31	5	30	4	30
Mean Age	38.3	32.8	37.8	32.8	38.2	32.4
Marital Status						
Single (never married)	-	9	1	8	-	11
Separated	-	3	-	-	-	-
Divorced	1	1	-	-	2	-
Married	5	27	9	30	7	29
Widowed	-	1	-	2	-	-
Defines Self as Single-Parent						
Yes	1	4	-	2	2	-
No	5	34	10	37	7	39

Table 4 (continued)

Characteristics of Nurses in Phase II

Characteristics	Experiment Groups					
	Father Headed		Mother Headed		Control	
	PN	CHN	PN	CHN	PN	CHN
Mean Years of Full-Time Employment	11.5	8.8	11.9	9.2	6.1	7.6
Formal Education						
RN Diploma	3	2	1	3	2	1
Courses Toward Bachelors Degree	1	6	6	6	2	5
Bachelors Degree	2	30	3	32	2	32
Courses Toward Masters Degree	-	2	-	1	3	2
Masters Degree	-	1	-	-	-	-
Percent of Contact with						
Single-Parent Families	21.3	22.6	20.2	20.9	31.1	25.0
Mother-Led	18.1	20.7	18.4	19.4	29.0	23.2
Father-Led	3.2	1.9	1.8	1.5	2.1	1.8

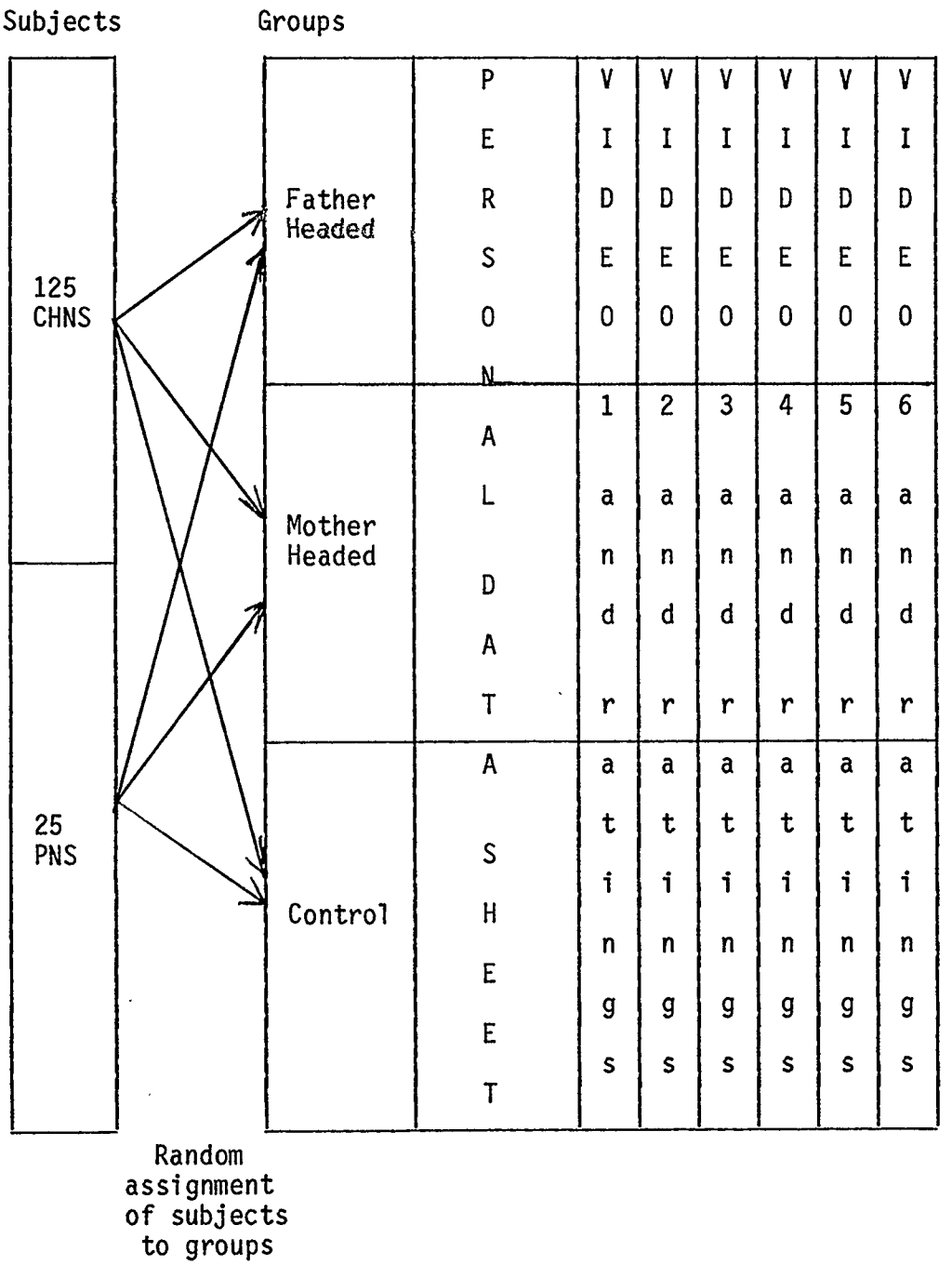

FIGURE 1

Research Plan of Phase II

Description of Stimulus Material

In preparing the videotape stimulus material for Phase II, several areas were considered: videotape medium, number of videotapes, length of videotapes, confederates, content of videotapes, validity and reliability of videotapes. Each will be dealt with separately.

Videotape Medium

The choice of a videotaped presentation mode was guided by a desire to neutralize and standardize the research situation as much as possible. Thurnblad, Muslin and Loesch (1973, p. 570) proposed that "watching a videotape equalizes the situation so that less advanced . . .[subjects] with clinical sophistication can better compete with advanced . . . [subjects]." Miller and Tupin (1972) substantiate this and comment on the advantages of relevant, representative and always available data. Videotape most approximates the child's activity that nurses observe. It allows for the representation of verbal and nonverbal communication as well as motion. The use of edited tapes directs subjects' attention to relevant material by eliminating distracting extraneous parts. A black and white picture produced on 1/2" Betamax was used.

Number of Videotapes

Six videotapes were required. The rationale for this was that the subjects' viewing of six different confederates provided more information about their characteristic pattern of assessments of

children from single-parent families than would viewing one target child who might have idiosyncratic qualities. Furthermore, because the first three videotapes depicted non-problem boys and the last three showed problem boys, the same confederate could not be used.

Length of Videotapes

Each videotape was eight minutes in length. This was to allow sufficient time for the subjects to observe the confederate in interaction. It has been shown in previous studies (Tomm & Leahey, 1980) that subjects are able to accurately assess interaction after they have viewed videotapes of three to seven minutes duration.

Confederates

The six boys selected to be confederates were all of comparable height, weight, hair color, ethnicity, age and had no conspicuous distinguishing facial characteristics. Considerable time was spent with each confederate and his friend to accustom them to the camera before actual taping. To avoid confounding, only boys were used as confederates. The rationale for using 11-12 year olds was predicated on the notion that prior to adolescence, boys are referred more often than girls for developmental and mental health services. The total number of boys involved as actors was 12. Six were the confederates and six were the peers. The informed consent of the actors and their parents was sought. Parents and children were fully informed as to the nature, aims and methods of the research.

Content of Videotapes

Each confederate was shown interacting with a peer, e.g., playing a board game, eating, etc. The videotaping was done in the child's home. There was the confederate and one of his friends depicted in each tape. For the first three videotapes, the interaction was positive in nature. That is, there was no obvious show of annoyance, depression or rejection. For the last three videotapes, the interaction was problematic in nature. The confederates showed obvious disagreement, sadness and difficulty in coping with stress. The rationale for depicting non-problem and problem behaviour was predicated on the notion that nurses' may have differential negative assessments of problem children from single-parent homes as opposed to non-problem children from single-parent homes. The rationale for having the problem confederates show sadness, aggression and difficulty in coping with stress was based on previous research indicating negative expectations of lay people and professionals about children from father-led versus mother-led homes. For example, in Fry and Addington's study (1984), children from father-led homes were rated as more aggressive, more sad and had more difficulty coping with stress than did children from mother-led homes.

Validity

The videotapes were devised by the investigator because of the lack of any standardized stimulus material. Face and content validity were determined by four independent experts familiar with the

behaviour of 11-12 year old boys and with the work experiences of nurses. The experts were all nurse educators employed in the Department of Allied Health at Mount Royal College. Their mean age was 37.3 years and they had between 11 and 15 years of clinical and educational experience. There was 85% agreement among experts in judging the adequacy of behaviour of the children depicted on the videotapes in relation to the behaviour encountered by nurses in a school or hospital setting. The videotapes were judged valid.

Reliability

The same experts that were used to judge the validity of the videotapes were used to assess reliability. There was 100% agreement among experts that the boys were of the same size, same weight, same ethnicity and had no conspicuous disfigurements. One expert rated one boy as appearing slightly younger than the other boys who were depicted in the first three videotapes.

For the first three videotapes depicting non-problem boys, experts consistently reported high ratings of similarity among the confederates on the variables listed in the Personality Trait Rating Scale and the Predicted Behaviour Functioning Scale. The mean ratings on a nine point scale (1 = very dissimilar, 9 = very similar) ranged from 7.3 to 9.0 with an average of 8.6. There was 100% agreement among judges that there was no evidence of depression, annoyance or rejection in the first three videotapes.

For the last three videotapes depicting problem boys, experts

consistently reported high ratings of similarity among the confederates on the variables listed in the Personality Trait Rating Scale and the Predicted Behaviour Functioning Scale. The mean ratings on a nine point scale (1 = very dissimlar, 9 = very similar) ranged from 6.0 to 8.6 with an average of 7.6. There was 100% agreement among the judges that the confederates in the last three videotapes displayed more problem behaviour than the confederates in the first three videotapes.

Instruments

Two types of instruments, rating scales and a questionnaire, were used in Phase II. Each will be discussed separately.

Rating Scales

The Personality Trait Rating Scale and the Predicted Behaviour Functioning Scale were used to measure nurses' assessments of the confederates. These instruments were used in previous research by Santrock and Tracy (1978) who examined teachers' stereotypes of eight year old boys from single-parent and dual-parent families. Their findings indicated that subjects' ratings of a child from a single-parent family and a child from a two-parent family differed significantly on the variables included in the Personality Trait Rating Scale and the Predicted Behaviour Functioning Scale. Teachers rated the child from a one-parent family significantly more negatively than a child from a two-parent family on happiness, emotional adjustment and ability to cope with stress.

Fry and Addington (1984) also used these rating scales to evaluate lay persons', teachers' and social workers' perceptions of boys from father-led, mother-led and dual-parent families. Both the lay and professional subjects in Fry's study differentiated between children from mother-headed versus father-headed single-parent families on the variables in the Personality Trait Rating Scale and the Predicted Behaviour Functioning Scale. Children from mother-headed single-parent families were rated by subjects as better adjusted and children from father-headed single-parent families were rated as less happy, less achieving, less obedient to rules and less able to cope with stress.

The scales were administered in the following order:

1. Personality Trait Rating Scale

The subjects were asked to rate the confederate on a 1-9 scale (1 = very low, 9 = very high) on the following personality traits:

Happiness

Getting along with others

Achievement Needs

Emotional Adjustment

Morality Standards

Anxiety/Depression

Delinquency

Sex-role Adjustment

A sample rating scale is included in Appendix C. It is self-

administered and takes approximately 2-3 minutes to complete.

2. Predicted Behaviour Functioning Scale

Subjects were asked to predict how the confederate might be expected to act. The child was rated on a 1-9 scale (1 = very low, 9 = very high) on the following items:

Obedience to Rules

Coping with Stress

Cooperating with Adults

Assuming Responsibility

Leadership

Working Independently

Peer Interaction

Personal Initative and Creativity

A sample rating scale is included in Appendix D. It is self-administered and takes approximately 2-3 minutes to complete.

3. The Nurses' Feelings Rating Scale

Subjects were asked to rate on a 1-9 scale (1 = very low, 9 = very high) their feelings toward the confederate. The following items were listed:

Concerned

Pleased

Anxious/Fearful

Happy

Sympathetic

Frustrated

Sorry/Sad

Empathic

This scale was devised by the present investigator because no standard rating scales were available. Its objective was to explore the types of feelings aroused in nurses when assessing boys from single-parent families. Ashmore and Del Boca (1979) point out that feelings aroused by a specific target group form part of the subjects' beliefs about the group. The specific items were derived from subject's responses in Phase I. Four positive feelings (concerned, pleased, happy and empathic) were balanced with four negative feelings (anxious/fearful, sympathetic, frustrated, sorry/sad). The ordering of the items on the scale (i.e. which item was placed first, second and so forth) was randomly arranged.

A sample rating scale is included in Appendix E. It takes approximately two minutes to complete. Subjects were encouraged to be as spontaneous as possible in their reactions.

4. Attribution Rating Scale

Subjects were asked to rate on a 1-9 scale (1 = very low, 9 = very high) the contribution of the following items to their overall assessment of the confederate:

his sex

his family structure

his age

his urban living environment

other items (which the subject could specify)

This scale was devised by the present investigator as an initial attempt to verify the results of the three previously described scales. The objective was to verify if subjects attributed their ratings of the confederate to his family structure or to other variables. In similar studies of this type, no previous investigator has included such a scale. Rather, investigators assume their subjects' ratings are due to the "mind set" about single-parent families which they have created at the beginning of the study.

A sample of the Attribution Rating Scale is included in Appendix F. It takes less than one minute to complete because only first reactions are requested.

Pre-Testing of the Scales

The Nurses' Feelings Rating Scale and the Attribution Rating Scale were pre-tested by the investigator. Experts in the fields of educational psychology, family therapy and nursing were consulted. The experts included a professor in Educational Psychology at the University of Calgary, a nursing professor at Lehman College, New York City and Training Director of the Family Institute of Westchester, New York, and an internationally renowned nursing researcher who is former director of the Nursing Research Unit, Department of Nursing Studies at the University of Edinburgh, Scotland.

Each expert reviewed the entire research proposal and specifically was asked to comment on the Nurses' Feelings Rating Scale and the

Attribution Rating Scale. The scales were revised based on the respondents' comments. For example, one expert recommended that the specific items for the Nurses' Feelings Rating Scale be derived from the subjects' responses in Phase I.

Personal Data Questionnaire

A questionnaire was devised by the investigator to gather background data from the subjects. The first area which the questionnaire addressed pertained to sociodemographic information. The following background variables were addressed: age, marital status, number of years of full-time employment and educational level. Subjects were also asked to identify if they defined themselves as single-parents.

The second area which the questionnaire addressed pertained to the amount of contact between the subject and single-parent families. Subjects were asked to estimate how much of their total patient contact was with single-parent families. Information was also gathered on their amount of contact with mother-led versus father-led single-parent families.

The choice of the questionnaire method of data collection over other alternatives was based on the desire for reliable and easily quantifiable answers. Nurses' employment records were not available nor did they contain the background history data necessary for the study. Informal "depth" interviews were not chosen because of their time-consuming nature.

The questionnaire format is an eclectic one as is evidenced by

the presence of both direct and indirect questions. Each specific area to which the questionnaire is addressed has a set of structured questions. A few items have fixed probe or follow-up questions to gather specific differentiated information.

As several guides (Bureau of Applied Social Research, 1948; Van Dalen & Meyer, 1962) recommend, a pretest of the questionnaires was done in phases. During the first phase, five senior nurses representing the inpatient and outpatient service divisions at Alberta Children's Hospital reviewed the questionnaire. In particular, they were asked to critique the clarity of the questions pertaining specifically to the pediatric nurses in their hospital. During the second phase, the Director of Nursing at Calgary Health Services critiqued the questionnaire. Special attention was focussed on the clarity of the questions pertaining specifically to the community health nurses. In the third phase, twenty-five practicing nurses were administered the questionnaire. Although they were not all pediatric or community health nurses, they were all practicing nurses.

The questionnaire was revised based on the respondents' comments given during the three phases of pretesting. A sample of the Personal Data Questionnaire is included in Appendix G.

Procedures

Approval to conduct the research had already been secured as was discussed in Chapter 3. Procedural arrangements differed for the two groups of nurses: community health nurses and pediatric nurses. Each

will be discussed separately.

Community Health Nurses

Prior to conducting Phase II, the investigator met with the Chairperson of the Education Committee and explained in full the purpose of the study. A proposal was made to use 90 minutes of the community health nurses' inservice education time to gather the data. In addition, the investigator offered to give a one and a half hour inservice on related topics. The Education Committee met and agreed to the proposal.

At the inservice meeting, the Chairperson of the Education Committee gave a five-minute introduction and overview to the 128 community health nurses who were assembled in the lecture theatre. Subjects then answered a five-minute impersonally administered questionnaire designed to gather background data. Rating scales were randomly administered by the investigator to all the nurses who were only taking part in Phase II. Those who had participated in Phase I received rating scales with their code number on them.

Subjects were unaware of the fact that they had been assigned to conditions in which one group was told that the confederate came from a father-led single-parent family; a second group was told that the confederate came from a mother-led single-parent family; and a third group (control condition) was told that the confederate's family structure was unknown.

Each group of subjects was given different printed information

about the six videotapes that they were about to see. This information is as follows:

Group 1 Father-Headed Condition. The child you are about to see on videotape is from a divorced home. He is 12 years old and is in Grade 6. The child lives with his father in the city and his father, who works, has sole responsibility for caring for him. His father does not know the whereabouts of his mother.

Group 2 Mother-Headed Condition. The child you are about to see on videotape is from a divorced home. He is 12 years old and is in Grade 6. The child lives with his mother in the city and his mother, who works, has sole responsibility for caring for him. His mother does not know the whereabouts of his father.

Group 3 Control Condition. The child you are about to see is 12 years old and in Grade 6. The child lives in the city. There was some talk about his parents being separated but the nurse lost track of whether the parents are back together again or not.

One-hundred and twenty-five subjects completed the rating scales after viewing each of the six videotapes. Following this, subjects were debriefed about the true purpose of the study. The investigator then presented a lecture/discussion on the "Impact of Divorce on Children and Adolescents" and "Issues in Providing Health Care to Single-Parent Families".

Pediatric Nurses

Prior to conducting Phase II, the investigator met with five senior nurses representing the out-patient and in-patient service divisions. The study was explained to them in full and a similar proposal to the one previously stated was submitted. The nurses agreed and Phase II was conducted in a similar manner at an inservice education presentation. Because of the exigencies of running an acute pediatric hospital, the majority of the subjects present were from the outpatient rather than the inpatient area. Twenty-five subjects completed the rating scales.

Treatment of Data

Phase II is a 3 x 2 x 6 design with repeated measures on the third factor. The factors used in the analysis model were:

Factor A	Type of Family Condition:	3 levels:	father-headed
			mother-headed
			control
Factor B	Type of Nurse:	2 levels:	PN
			CHN
Factor C	Type of Child Behaviour:	6 levels:	non-problem
			(Videos 1,2,3)
			problem
			(Videos 4,5,6)

A three-way analysis of variance with repeated measures on the last factor was the statistical model used to determine if significant

mean differences existed for each variable on the following dependent measures:

Personality Trait Rating Scale

Predicted Behaviour Functioning Scale

Nurses' Feelings Rating Scale

The schematic representation of the treatment of the data is given in Figure 2. The equation for the linear model is given in Appendix H.

Where significant differences existed, a Newman-Keuls multiple range test was used to determine the source of the differences (Ferguson, 1971). The computer program used for the three-way analysis of variance with repeated measured was P2V from the BMDP Manual (Brown, Engelman, Frane, Hill, Jenrich & Toporek, 1981).

To determine the contribution of the background variables to the scores on the dependent measures, a multiple regression analysis with stepwise solution was done (Ahlgren & Walberg, 1975). The background variables consisted of the following: age, marital status, definition of self as a single-parent, number of years of full-time employment, educational level, contact with mother-led single-parent families and contact with father-led single-parent families. The dependent measures were the Personality Trait Rating Scale, Predicted Behaviour Functioning Scale, and the Nurses' Feelings Rating Scale.

To determine if there was a significant difference between subjects' rankings of non-problem and problem boys on the Attribution Rating Scale, a Friedman two-way analysis of variance was done. This

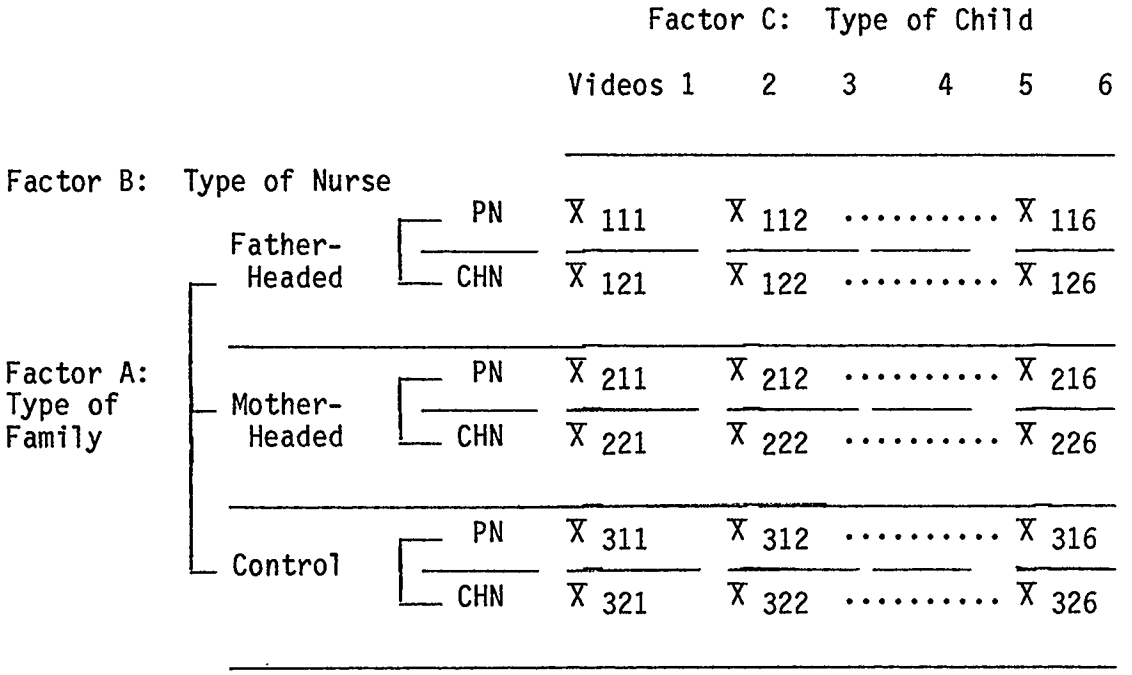

FIGURE 2

Schematic Representation of the Treatment of the Data

of whether the size of the scores depends on the conditions under which they were yielded". That is, it tests whether the related samples (non-problem boys and problem boys) could likely have come from the same population with respect to mean ranks. One advantage of the Friedman two-way analysis of variance is that it has tables of exact probabilities for very small samples.

For all statistical tests, a .05 level of significance was adopted.

Results

The hypotheses and statistical findings of Phase II are presented. The results of the three-way analysis of variance with repeated measures will first be discussed. Following this, the results of the Friedman two-way analysis of variance will be presented. Lastly, the results of the multiple regression analysis will be presented.

Three-way Analysis of Variance with Repeated Measures

Hypothesis 1 had predicted that the father-headed single-parent family condition would be rated significantly less positively than the mother-headed and control conditions as measured by mean scores on the Personality Trait Rating Scale, Predicted Behaviour Functioning Scale and the Nurses' Feelings Rating Scale. Table 5 presents mean scores for the three family conditions. Results of the three-way analysis of variance with repeated measures indicating no significant differences among father-headed, mother-headed and control conditions confirm that

Table 5

Mean Scores of Father-Headed, Mother-Headed and Control Conditions on Rating Scales

Rating Scales	Condition			
	Fa*	Mo*	Con*	F
Personality Trait Rating				
Happiness	5.1	5.3	5.1	.98
Getting Along with Others	5.3	5.3	5.2	.05
Achievement Needs	6.1	6.1	6.3	.24
Emotional Adjustment	5.2	5.2	5.0	.02
Morality Standards	5.5	5.4	5.5	.91
Anxiety/Depression	4.2	4.1	3.9	1.04
Delinquency	3.8	3.6	3.5	2.10
Sex-role Adjustment	5.6	5.2	5.5	1.50
Predicted Behaviour Functioning				
Obeying Rules	5.4	5.6	5.4	.02
Coping with Stress	4.8	5.0	4.8	.14
Cooperating with Adults	5.5	5.5	5.4	.05
Assuming Responsibility	5.6	5.6	5.5	.15
Assuming Leadership	5.5	5.5	5.4	.36
Working Independently	5.7	5.6	5.4	.55

Table 5 (continued)

Mean Scores of Father-Headed, Mother-Headed and Control Conditions on Rating Scales

	Condition			
Rating Scales	Fa*	Mo*	Con*	F
Predicted Behaviour Functioning				
Relating Effectively	5.3	5.2	5.2	.25
Personal Initiative/Creativity	5.4	5.3	5.2	.65
Nurses' Feelings Rating				
Concerned	4.7	4.7	4.9	.46
Pleased	4.8	4.9	4.7	2.05
Anxious/Fearful	4.1	4.1	3.7	2.26
Happy	4.6	4.7	4.5	1.76
Sympathetic	4.7	4.4	4.4	.00
Frustrated	3.8	3.6	3.5	.36
Sorry/Sad	4.0	3.8	3.7	.10
Empathic	5.2	4.8	5.0	.22

Note. Maximum Score = 9. The higher the score the higher the rating.

* Fa = Father-headed; Mo = Mother-headed; Con = Control

hypothesis 1 cannot be accepted at the .05 level of probability.

Hypothesis 2 had predicted no significant difference between pediatric nurses (PNs) and community health nurses (CHNs) as measured by mean scores on the Personality Trait Rating Scale, Predicted Behaviour Functioning Scale and the Nurses' Feelings Rating Scale. Table 6 presents mean scores for the two types of nurses on the rating scales. Results of the three-way analysis of variance with repeated measures indicate significant differences on five variables as shown in Table 7. Compared to pediatric nurses, the community health nurses rate the children as significantly less able to get along with others, more anxious/depressed, more delinquent and less able to relate effectively with peers. The community health nurses feel significantly more empathic toward the children than do the pediatric nurses. The results confirm that hypothesis 2 cannot be accepted for five variables at the .05 level of probability.

Hypothesis 3 had predicted no significant interaction effect between type of family condition and type of nurse as measured by mean scores on the Personality Trait Rating Scale, Predicted Behaviour Functioning Scale and the Nurses' Feelings Rating Scale. Results of the three-way analysis of variance with repeated measures indicate a significant difference on one variable in the Nurses' Feelings Rating Scale. There is a significant interaction effect between type of family condition and type of nurse statistic is recommended by Siegel (1956, p. 173) as an "overall test ($\underline{F}$ (2, 133) = 3.73, $\underline{p}$ < .03) as indicated in Figure 3. Results of a Newman-Keuls test indicate that

Table 6

Mean Scores of Pediatric Nurses and Community Health Nurses on Rating Scales

Rating Scales	Type of Nurse PN	CHN	F
Personality Trait Rating			
Happiness	5.4	5.1	.41
Getting Along with Others	5.8	5.2	6.31
Achievement Needs	6.2	6.2	.05
Emotional Adjustment	5.4	4.1	1.36
Morality Standards	5.7	4.2	1.83
Anxiety/Depression	3.5	4.2	4.10
Delinquency	3.0	3.8	5.88
Sex-role Adjustment	5.4	5.4	.02
Predicted Behaviour Functioning			
Obeying Rules	5.8	5.4	1.39
Coping with Stress	5.0	4.8	.18
Cooperating with Adults	5.7	5.4	1.18
Assuming Responsibility	5.8	5.5	.87
Assuming Leadership	5.6	5.5	.06
Working Independently	5.8	5.6	1.19

Table 6 (continued)

Mean Scores of Pediatric Nurses and Community Health Nurses on Rating Scales

Rating Scales	Type of Nurse PN	CHN	F
Predicted Behaviour Functioning			
Relating Effectively	5.6	5.1	3.90
Personal Initiative/Creativity	5.5	5.3	.82
Nurses' Feelings Rating			
Concerned	4.7	4.8	.04
Pleased	4.8	4.8	.18
Anxious/Fearful	3.6	4.0	1.40
Happy	4.7	4.6	.04
Sympathetic	4.1	4.6	2.00
Frustrated	3.2	3.7	2.25
Sorry/Sad	3.5	3.9	1.33
Empathic	4.4	5.1	4.93

Note. Maximum Score = 9. The higher the score the higher the rating.

Table 7

Probability of Significant Difference Between PNs and CHNs on Rating Scale Variables

Rating Scales	F	df	Probability
Personality Trait Rating Scale			
Getting Along with Others	6.31	1,138	.01
Anxiety/Depression	4.10	1,133	.04
Delinquency	5.88	1,134	.02
Predicted Behaviour Functioning Scale			
Relating Effectively with Peers	3.9	1,128	.05
Nurses' Feelings Rating			
Empathic	4.93	1,130	.03

for pediatric nurses alone, father-headed is significantly lower than control whereas for community health nurses there is no significant difference among father-headed, mother-headed and control. These results confirm that hypothesis 3 cannot be accepted at the .05 level of probability.

Hypothesis 4 had predicted that Videos 1, 2 and 3 depicting non-problem boys would be rated significantly more positively than Videos 4, 5 and 6 which depict problem boys. The mean scores on the Personality Trait Rating Scale, the Predicted Behaviour Functioning Scale and the Nurses' Feelings Rating Scale are presented in Table 8. Results of the three-way analysis of variance with repeated measures indicate significant differences among the videos ($p < .001$) on all variables. Results of the Newman-Keuls test indicate that non-problem boys are consistently rated significantly more positively than problem boys on 23 out of 24 variables. Probabilities range from .01 to .05. There was no significant difference between non-problem and problem boys on the variable "empathy". Results of the Scheffe test indicate that non-problem boys are consistently rated significantly more positively than problem boys on 17 out of 24 variables. The Scheffe test is more conservative than the Newman-Keuls so fewer significant results would be expected.

Hypothesis 5 had predicted no significant differences between subjects who participated in Phase II only versus subjects who participated in both Phases I and II as measured by mean scores on the Personality Trait Rating Scale, Predicted Behaviour Rating Scale and

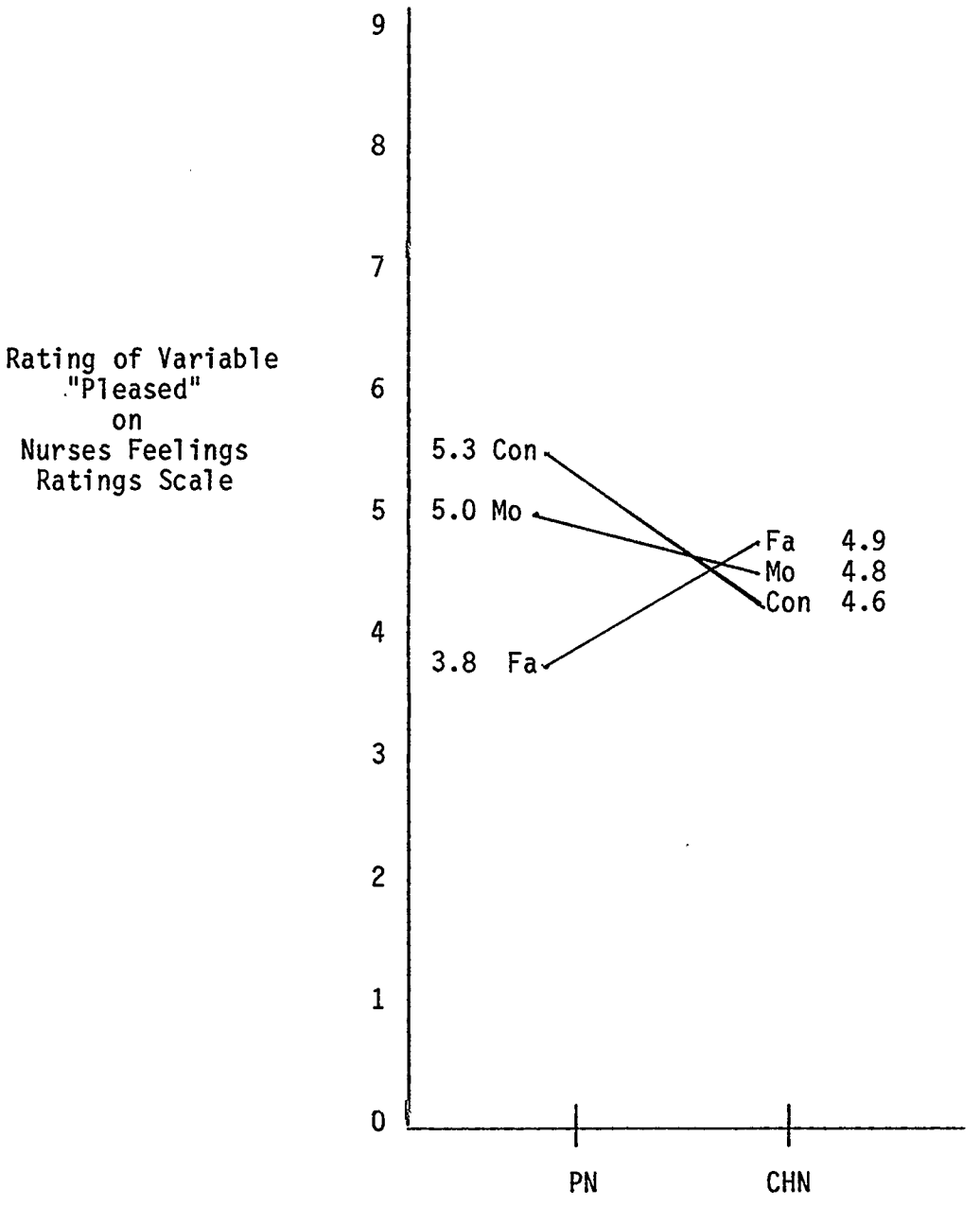

FIGURE 3

Interaction Effect Between Type of Family Condition and Type of Nurse

Table 8

Means Scores on Rating Scales for Videos 1, 2, 3: Non-Problem Boys and Videos 4, 5, 6: Problem Boys

	Videos						
Rating Scales	1	2	3	4	5	6	F*
Personality Trait Rating							
Happiness	6.6	4.9	6.9	3.1	4.5	5.0	82.32
Getting Along with Others	6.9	6.4	7.3	2.6	4.0	4.5	114.32
Achievement Needs	6.8	5.9	7.0	5.5	5.2	6.7	14.64
Emotional Adjustment	6.4	5.5	7.0	3.1	4.1	4.7	86.28
Morality Standards	6.3	6.7	6.8	3.8	4.3	5.0	28.58
Anxiety/Depression	3.9	4.3	3.1	4.7	4.2	4.1	5.68
Delinquency	3.3	3.0	2.7	4.6	4.5	3.8	10.07
Sex-role Adjustment	6.1	5.5	6.3	4.6	4.9	5.1	13.63
Predicted Behaviour Functioning							
Obeying Rules	6.3	6.8	7.0	3.8	4.1	4.9	36.89
Coping with Stress	5.8	5.4	6.7	3.0	3.8	4.4	56.34
Cooperating with Adults	6.3	6.6	6.9	3.8	4.1	5.1	42.44
Assuming Responsibility	6.4	6.2	7.2	4.2	4.4	5.1	32.83
Assuming Leadership	6.6	5.3	7.4	4.0	4.4	5.2	45.30
Working Independently	6.5	6.2	7.3	4.0	4.4	5.2	42.17

Table 8 (continued)

Means Scores on Rating Scales for Videos 1, 2, 3: Non-Problem Boys and Videos 4, 5, 6: Problem Boys

	Videos						
Rating Scales	1	2	3	4	5	6	F*
Predicted Behaviour Functioning							
Relating Effectively	6.6	6.2	7.2	2.8	3.9	4.5	73.72
Personal Initiative/ Creativity	6.3	5.7	7.3	3.5	4.1	4.9	51.30
Nurses' Feelings Rating							
Concerned	3.9	4.8	3.0	6.5	5.6	4.9	27.65
Pleased	6.1	5.4	6.7	2.8	3.6	4.2	58.19
Anxious/Fearful	3.2	3.8	2.5	5.5	4.6	4.0	20.43
Happy	5.9	4.9	6.6	2.7	3.4	4.2	57.73
Sympathetic	4.4	4.9	3.9	5.1	4.5	4.4	5.43
Frustrated	2.9	3.2	2.4	5.1	4.6	3.8	16.77
Sorry/Sad	3.2	4.0	2.5	5.0	4.5	3.9	17.93
Empathic	5.0	5.4	4.6	5.4	4.9	4.8	5.95

Note. Maximum Score = 9. The higher the score the higher the rating.

* All are significant at .001.

the Nurses' Feelings Rating Scale. Results of the three-way analysis of variance with repeated measures indicate significant differences between subjects who participated in Phase II only versus those who participated in both phases on the Nurses' Feelings Rating Scale. Nurses who participated in only Phase II rated significantly greater concern for the confederates than did nurses who participated in both phases (F (1, 32) = 5.85, $p < .02$). Mean ratings for subjects who participated in only Phase II were 4.94 and for those who participated in both phases were 4.44. These results confirm that hypothesis 4 cannot be accepted at the .05 level of probability.

Friedman Two-Way Analysis of Variance

Hypothesis 6 had predicted no significant difference between ranks for non-problem and problem boys on the Attribution Rating Scale variables: sex, family structure, age and urban living environment. Results of the Friedman two-way analysis of variance on the ranks indicate no significant difference between ranks for all four variables (sex, family structure, age and urban living environment) taken concurrently. The value for Friedman Xr^2 is 0 while the critical value is 7.87 for 1 df for .05 level of significance. There is a significant difference between non-problem and problem boys on the first two variables (sex and family structure) taken concurrently and the last two variables (age and urban living environment) taken concurrently. The value for the Friedman test Xr^2 observed equals 10 for 1 df while the critical value is 7.87 for .05 level of significance.

Problem boys rank higher than non-problem boys on sex and family structure. Problem boys rank lower than non-problem boys on age and urban living environment.

Sex and family structure made little contribution to nurses' overall ratings of non-problem boys but contributed significantly more to their ratings of problem boys. Age and urban living environment made little contribution to nurses' ratings of problem boys but were a significant contribution to their ratings of non-problem boys.

Multiple Regression Analysis

Hypothesis 7 had predicted no significant contribution of the subjects' background variables to their scores on the dependent measures. The background variables consisted of the following: age, marital status, definition of self as a single-parent, number of years of full-time employment, education level, contact with single-parent families, contact with mother-led single-parent families and contact with father-led single-parent families.

Results of a multiple regression analysis with stepwise solution indicate a significant relationship between three background variables (age, definition of self as a single-parent and length of full-time employment) and the subjects' scores on the Personality Trait Rating Scale, Predicted Behaviour Functioning Scale and the Nurses' Feelings Rating Scale. These results are presented in Table 9.

The younger the nurse the more positive she is in rating non-problem boys' achievement, obeying rules, assuming responsibility, and

Table 9

Probability of Significant Influence of Age, Definition of Self as a Single-Parent and Length of Full-Time Employment on Rating Scales

	Type of Boy					
	Non-Problem			Problem		
Rating Scales	β	F	R^2	β	F	R^2
Personality Trait Rating						
Achievement Needs	-.15	4.97*	.02			
Morality Standards	.15	4.41**	.03			
Sex-role Adjustment	.13	4.26**	.03			
Predicted Behaviour						
Functioning						
Obeying Rules	-.14	4.61*	.14			
Assuming Responsibility	-.15	5.01*	.02			
Personal Initiative/ Creativity	-.16	5.91*	.02			
Nurses' Feelings Rating						
Anxious/Fearful	-.16	4.69*	.02			
	.16	3.96***	.02	.18	4.87***	.03
Sympathetic	-.17	5.11*	.03			
Sorry/Sad	-.18	6.00*	.04			

* Age

** Definition of Self as Single-Parent

*** Years of Full-Time Employment

personal initiative/creativity. The younger the nurse the more anxious/fearful, sympathetic, and sorry/sad she is for non-problem boys. The longer the nurse is employed full-time the more anxious/fearful she is for non-problem boys and problem boys. If the nurse defines herself as a single-parent, she rates the non-problem boys lower on morality and sex-role adjustment than does the nurse who does not identify herself as a single-parent.

Summary

Phase II was an experiment designed to examine nurses' assessments of children living in father-headed, mother-headed and control single-parent family conditions.

The first objective of Phase II was to examine whether nurses assess boys living in father-headed households less positively than boys living in mother-headed households. Results of a three-way analysis of variance with repeated measures on the Personality Trait Rating Scale, the Predicted Behaviour Functioning Scale and the Nurses' Feelings Rating Scale indicate no significant differences among the family conditions.

The second objective was to examine whether there are differences in ratings done by pediatric nurses versus community health nurses. Results of a three-way analysis of variance with repeated measures indicate that compared to pediatric nurses, community health nurses rate the boys as significantly less able to get along with others,

more anxious/depressed, more delinquent and less able to relate effectively with peers. The community health nurses feel significantly more empathic toward the children than do the pediatric nurses.

The third objective was to examine whether videos depicting non-problem boys from single-parent families are rated more positively than videos depicting problem boys from single-parent families. Results of the three-way analysis of variance with repeated measures indicate significant differences among the videos on all variables. Results of the Newman-Keuls test indicate that non-problem boys are consistently rated more positively than problem boys.

The fourth objective was to examine the contribution of background variables to nurses' ratings of boys living in various single-parent family conditions. Results of a multiple regression analysis with stepwise solution indicate that age contributes significantly to the ratings of non-problem boys' achievement needs, obeying rules, assuming responsibility and personal initiative/creativity. The younger the nurse the more positive she is in her ratings on these variables. Age also influences significantly the ratings of anxiety/fear, sympathy and sorrow for non-problem boys. The younger the nurse, the higher are her ratings. Definition of self as a single-parent contributes significantly to ratings of morality standards and sex role adjustment for non-problem boys. If the nurse defines herself as a single-parent, she rates the non-problem boys lower on these variables. The subjects' number of years of full-time employment significantly influences their feelings of anxiety/fearfulness for

non-problem and problem boys. The longer the nurse is employed, the more anxious/fearful she is.

The fifth objective was to examine differences in subjects' attributions of non-problem and problem boys. Results of the Friedman two-way analysis of variance on ranks indicate sex and family structure made little contribution to nurses' overall ratings of non-problem boys, but contributed significantly more to their ratings of problem boys. Age and urban living environment made little contribution to nurses' ratings of problem boys but were a significant contribution to their ratings of non-problem boys.

CHAPTER 5

DISCUSSION

The first purpose of this chapter is to discuss the results of Phases I and II, relate them to the research reviewed in Chapter 2, present possible explanations for why certain results were obtained and state any implications stemming from the results. The second purpose of this chapter is to discuss the limitations that possibly affect interpretations of the results of this research.

Phase I

Phase I was an exploratory descriptive survey investigating, by means of interviews, nurses' beliefs and experiences of practice with single-parent families. The first objective of this phase was to identify positive and negative beliefs about single-parent families. The second objective was to identify nurses' experiences in dealing with single-parent families. The third objective was to determine if there is a significant difference between pediatric nurses and community health nurses in their beliefs and experiences in dealing with single-parent families. The results of Phase I will be discussed with particular reference to each of these objectives.

Nurses' Beliefs About Single-Parent Families

The questions designed to elicit nurses' beliefs about single-parent families focussed on beliefs about four areas:

negative aspects of single-parent family life, positive aspects of single-parent family life, the needs single-parent families present to nurses and lastly, the effects of divorce on children. Each area will be discussed separately.

Negative Aspects of Single-Parent Family Life

Limited Emotional Support

The first category which was used most frequently by the nurses (38%) pertained to their belief that single-parent families have limited emotional support. Nurses used statements such as the following to describe single-parent families:

"They need someone to love them."

"They have to be the givers of love."

"They lack a social life."

"They're lonely."

"If their support systems are good, they manage better."

"They're not able to brainstorm or have a backup."

"They don't have anyone to share the stress of parenthood."

"They lack support systems."

There is some support in the literature for this belief that single-parent families have limited emotional support (Smith, 1980; Gasser & Taylor, 1976) but it is also at variance with certain other findings. Chiriboga et al., (1979) found that single-parent families relied on several categories of helpers for support: friends, the ex-spouse, counsellors, and relatives. The majority turned to more than

one category of helper and 13% turned to six or more different categories of helper. Less than 20% sought no assistance. The extended family has also been found to enhance or detract from the adjustment following separation (Beal, 1980). Highly anxious grandparents can impair parental functioning and negatively influence adjustment. Extended family members who take sides either with the custodial parent or the ex-spouse may enhance polarization and conflict. On the other hand, relatives can often provide economic contributions which assist family stability (Brandwein, Brown, & Fox, 1974). They can provide frequent and high quality adult involvement at a time when the custodial parent's resources may be somewhat depleted (Santrock & Warshak, 1978).

One possible explanation for nurses' high ratings of the belief that single-parent families have limited emotional support is that nurses are unaware of the family's multiple support systems. Although nurses are beginning to be taught to assess whole family systems, many nurses lack the skills to adequately evaluate the family members' contact with their suprasystems. This is an important omission in nursing education and has implications for the needs which nurses believe single-parent families present to them. Although the nurses were asked to state their belefs about the needs which single-parent families present to them, many of the nurses answered the question by describing what they actually do with single-parent families. For example, 29% of the nurses' responses were grouped under the category that single-parent families need support from the nurse. Statements such

as the following were used to describe this need for support from the nurse:

"They need help with discipline. They need me for support."

"They need to confide in someone. They want a listener."

"They need a pat on the back from me."

There are several implications of these findings about the nurses' beliefs that single-parent families have limited emotional support and need support from the nurse. First, educators should teach nursing students to assess the current emotional functioning of the entire family.

Second, if the family has difficulty in the area of emotional functioning, then the nurse should be able to evaluate the family's connections with its natural support systems. The degree to which the ex-spouse can be involved in providing support to the children is an important area for assessment. Some nurses in this study expressed the belief that the "child doesn't have to share love with the other parent" and that the children "are not dichotomized between two parents". Such statements of belief could imply that the non-custodial parent and child relationship is unimportant. This belief is contrary to the findings of Lowenstein and Koopman (1978) who suggest that boys who saw their non-custodial parent once a month or more had greater self-esteem than boys who visited with their non-custodial parent less than once a month. Wallerstein and Kelly (1980) also report that the father-son relationship increases in importance to the boy's self-esteem as the child matures.

Thus, some nurses may need training in assessing the degree and

nature of the child's contact with the non-custodial parent so that at the time of either the child's admission to hospital or visit to the community health agency, this information can be secured. During the child's hospital stay, for example, nurses could then foster close parent-child relationships and improved inter-parental functioning, factors that have been associated with good post-divorce adjustment (Kurdek, Blisk, & Siesky, 1981).

A third implication pertains to the need for supervision and consultation. To date, nursing has not made full use of live supervision to guide and direct nurses doing family interviewing. Supervision is particularly important in nurses' work with single-parent families lest the nurse become overly involved in providing what Wright and Leahey (1984) have termed "paid friendship." Nurses have often chosen their profession because they have a strong desire to be helpful to individuals and families in obtaining optimal health and sometimes this interferes with their ability to accurately assess the degree of help families need. Supervisors could assist nurses in developing skills to mobilize single-parent families' personal support systems. Such non-professional support systems would assist the single-parent family in dealing with emotional and instrumental stress over the long term. Furthermore, these support systems lessen the likelihood of the nurse assuming the surrogate spouse role.

Financial Difficulties

The second category which was used most frequently by the nurses (34%) pertained to their belief that single-parent families have financial difficulties. Nurses used statements such as the following to

describe this category.

"The women are in lower-income earning occupations."

"They are stressed to pay for babysitting, house, health and dental care."

"Many live on social assistance."

"Money is a big factor unless there's been a good settlement."

There is ample support in the literature for this belief that single-parent families have financial difficulties (Brandwein, Brown, & Fox, 1974). The largest proportion of single-parents are women, many of whom are in the labour force. They tend to receive lower wages than men and are concentrated in low income positions with limited mobility. Child support payments are frequently erratic and the courts are generally apathetic to legal action against the father.

What is perhaps less acknowledged but important for nurses to know are the direct economic implications of divorce on family functioning. Colletta (1983) suggests that income is a key factor in that child rearing practices tend to be more restrictive and demanding at lower income levels as compared to higher income levels. Desimone-Luis, O'Mahoney, and Hunt (1979) further imply a connection between a 50% drop in income following divorce and maladjustment in children.

Time-Management Difficulties

The third category pertaining to nurses' beliefs about the negative aspects of single-parent family life focussed on time management difficulties. Seventeen percent of the nurses reported the belief that single-parent families have difficulties with time management. They stated single-parents had such problems as:

"arranging babysitting and Day Care",

"getting to the doctor for a rash",

"finding someone to be there when the kids are ill",

"getting to school interviews",

"reorganizing working from part to full-time",

"having time to be alone and away from the children".

The belief that single-parent families have difficulties with time management is consistent with findings from clinical practice (Weltner, 1982). The emergence of this belief reflects the fact that nurses are involved with the day-to-day care of single-parent families. Because they make home visits on newborn babies, do preschool screening assessments and work in elementary schools, community health nurses are well aware of the time constraints under which these families struggle. Likewise, pediatric nurses who see single-parent families in a hospital setting are cognizant of their difficulties.

This belief of the nurses that single-parent families have time-management difficulties has implications for social policies. The suggestion is that health care agencies and hospitals should adapt to the needs of single-parent families. Such institutions should consider having flexible working hours for their staff. It is unrealistic to expect working single-parent adults to bring their children for immunizations to a clinic where the hours conflict with most employment schedules. It is worth noting that Calgary Health Services has already adjusted its clinic schedule to be open one evening every week to accommodate the special needs of single-parent and other types of families.

Parent-Child Discipline Problems

The fourth category pertaining to nurses' beliefs about the negative aspects of single-parent family life focussed on parent-child discipline problems. Twelve percent of the nurses reported the belief that single-parent *families* have parent-child discipline problems. Nurses noted such difficulties as child behaviour problems, sibling rivalry and parents being stressed by discipline issues. There is some evidence to support the emergence of this belief (Beal, 1980) but the overwhelming research evidence suggests that family structure per se does not influence parent-child discipline issues (Blechman, 1982; Santrock & Warshak, 1979).

One possible explanation for the emergence of this belief relates to the nurses' work context. Community health nurses reported that their contact with single-parent families was most often in the home with the community health clinic being the second most frequently mentioned place. The school was reported as the least frequent place for contact. The home was listed twice as often as the other two settings. F. Herz (personal communication, March, 1983) has postulated that nurses working with single-parent families often do one of the following:

1. Allow the parent to talk about the discipline problem even while the problem is enacted in the here and now (e.g., child has a temper tantrum).
2. Conceptualize the discipline problem as a "power gap" in the single-parent family and actively try to fill that gap by

directly disciplining the child themselves (e.g., nurse tells child to stop the tantrum).

The likelihood of the nurse choosing the first alternative is increased if the nurse is in the family's home territory. The chances of choosing the second alternative are maximized if the nurse is working in the community health clinic or school. By choosing either approach, the nurse misses opportunities to assist the single-parent family. If the first approach is used, the parent has no opportunity to practice an intervention and receive immediate feedback from the nurse. By using the second approach, the nurse takes over from the parent and thus undermines the parent's ability.

A practical implication related to this belief is that nurses, especially community health nurses, can learn to assist the single-parent to effectively deal with discipline problems. The nurse can actively intervene to have the parent deal with the situation in an effective manner.

Positive Aspects of Single-Parent Family Life

Recovery Following a Tense Marriage

The first category pertaining to nurses' beliefs about the positive aspects of single-parent family life focussed on the belief that single-parent families are in a stage of recovery following a tense marriage. Twenty-six percent of the nurses reported that single-parent families are recovering from a difficult marital situation and are in an aftermath or transition stage. Nurses focussed on the present positive functioning of single-parent families as compared to the

past negative functioning. Subjects often made such statements as:

"It's a relief to get out of a rocky marriage."

"It's the lesser of two evils - better a one-parent household than living in a tense two-parent household."

"Things are more settled than prior to the divorce."

This belief in the present status as being positive versus the past as being negative is not altogether complimentary to single-parent families. No clear recognition is given to the one-parent family as a family form in its own right. Rather, the family's strengths are always noted against a background history of turmoil and by implication a future of remarriage and happiness.

The belief that single-parent families are in a transition stage in the family developmental life cycle is somewhat supported by demographic data. One-half of the divorced who remarry do so within three years (Beal, 1980). What is not noted by the nurses, however, is that many adults in single-parent families who do remarry get divorced again. Other adults never remarry. Thus, many single-parent families are not in transition. One-parent families in 1981 accounted for 21% of the 31.6 million families in the U.S. and out of 61 million children, almost 12 million were living with their single-parents (U.S. Census Bureau, 1981). In 1981 in Canada 11.3% of the households were headed by one parent and over 1.1 million children were estimated to be living in single-parent families (Lupri, 1984).

One possible explanation for the emergence of the belief that single-parent families are in a transition stage is that nurses may

tend to elicit information in their family interviews about present functioning only in relation to poor past performance. Thus, they tend to think of the family as being in a stage of "relief after the turbulence".

A practical implication of this belief is that nurses must assist single-parent families to develop a positive identity about their current life-style. As Mitchell (1983) suggests, intervention might "best focus on single-parenthood as a training ground - a rite of passage with self-improvement (competence) and not remarriage as a . . . desirable goal" (p. 42).

Increased Parent-Child Bond, Interest in Self-Improvement and Independence for Children

Three categories, namely, increased parent-child bond, interest in self-improvement and independence for children in single-parent families were used by 12, 7 and 5% of the nurses respectively to describe the positive aspects of single-parent family life.

To describe the emotional closeness in single-parent families, nurses used such phrases as:

"really strong bond with parent",

"kids devote more attention and time to one person",

"mother and child work together in a comrade-type relationship".

To describe the parent's interest in self-improvement, subjects made statements such as the following:

"The parent is motivated to 'do well' for the family's sake".

"There is a little extra ambition toward career".

"Divorce leads to increased self-esteem".

"The woman has more time to think about herself. It's positive".

To describe the children's increased independence in single-parent families, subjects stated:

"Children tend to be given more responsibility".

"They're more mature".

"These children grow up a little faster".

The positive aspects of single-parent family life that were identified by the subjects are similar to those positive dimensions of single-parent family life noted by Santrock and Warshak (1979) and Weiss (1979). These authors have found that a change in the echelon structure of the family does not necessarily result in poor functioning. The finding that nurses believe single-parent families can function in an emotionally positive manner is, however, at odds with much of the literature reflecting the prevalent belief that single-parent families are a deviant group.

One possible explanation for the emergence of these beliefs pertaining to positive aspects of single-parent family life may be found in the nature of the questions asked the subjects. That is, subjects were specifically asked to comment on any positive aspects of single-parent family life. Perhaps if the subjects' attention were not directed specifically to the positive, it is conceivable that they would have responded differently. There is some nonstatistical evidence to suggest that this premise may have some basis. A few subjects, when interviewed, were unable to identify specific positive

aspects and stated that they could think of "nothing positive" about single-parent family life.

Needs Single-Parent Families Present to Nurses

Two categories clustered items relating to the beliefs nurses hold about the needs single-parent families present to them. The first category pertained to the nurses' belief that single-parent families need support from them. This category was used by 29% of the nurses and was discussed earlier along with the belief that single-parent families have limited emotional support.

The second category pertained to the nurses' belief that single-parent families need information about resources. Twenty-six percent of the nurses expressed the belief that single-parent families have insufficient information about resources. In describing this belief, the nurses made such statements as the following:

"These families need help with Day Care."

"They need information about parenting groups."

"They need to know resources to be able to make decisions."

"They need places to stay when the child is sick or in hospital."

Evidence to support the prevalence of this belief is found in the literature pertaining to the social isolation of single-parent families (Brandwein, Brown &, Fox, 1974), especially those that are mother-led. One possible explanation for the emergence of this belief pertains to the widely held notion that single-parent families move frequently (and often to poorer neighbourhoods) because of their decreased economic status (Gongla, 1982). Thus, they are unfamiliar

with the resources in the new neighbourhood. Another possible explanation can be derived from the work of Mitchell (1983) who found that divorced women felt less competent than remarried women about feeling in control of their lives and managing their time. Perhaps the lack of sufficient information about resources is based partly on instrumental and economic difficulties and partly on single-parents' decreased sense of power and ability to seek relevant information.

One implication arising from this belief is that nurses must be flexible in providing information about resources to single-parent families. Less emphasis should be placed on providing information to individual single-parent families and more emphasis should be given to working with either groups of single-parent families or single-parent families with their extended family. There would be two benefits to this change in approach. First, it would promote social integration rather than isolation. Second, it would foster self-help as opposed to dependence on the nurse for new and continuous information.

Effects of Divorce on Children

Three categories grouped items relating to the nurses' beliefs about the effects of divorce on children. The first category used by 28% of the nurses pertained to their belief that children's emotional adjustment is dependent on the custodial parent's adjustment. Nurses often made statements such as the following:

"The long-term effects of divorce are very individual. Each child's coping varies with the parent's coping",

"The effects on the children depend on the kind of breakup,

whether bitter or civilized".

The second category used by 19% of the nurses pertained to their belief that children have emotional problems following divorce. Statements such as the following were frequently made:

"The kids have a terrible time. There's a lot of hurt",

"The children are resentful, bitter, and anxious".

The third category which was used by only 2% of the nurses pertained to their belief that there was no difference in how children functioned after divorce than before divorce.

There is some support in the literature for each of these widely varying beliefs about the effects of divorce on children. The work of Kurdek and Blisk (1983) lends some support to the notion that children's emotional adjustment is dependent on the parent's adjustment. They reported that mothers' post-separation stress, parental conflict in the post-separation period, and a high degree of environmental change brought about by the divorce were correlated with poor social and psychological adjustment for the children. Santrock's findings (1972) strengthen the contention that cognitive changes in children following divorce are mediated by social influence. The availability of the non-custodial parent to the child as well as the quality of their relationship needs to be examined.

Evidence concerning the effect of divorce on children's emotional well-being is inconclusive. Approximately one third of Wallerstein and Kelly's subjects (1980) coped fairly well with the divorce.

McDermott's findings (1968) indicate about 19% of the preschool children used play and fantasy to master and work out the problem of separation. They did not passively or helplessly experience it.

The belief that there is no difference between children reared by one or two parents has yet to be soundly disproved. Blechman (1982), in her methodological review of research concerning single-parent families, asserts that "conceptual blind spots include equation of conventional with healthy behaviour" (p. 179). She concludes her review by stating "should findings of no difference attributable to number of parents. . . continue to result from well-controlled studies, the hypothesis of risk among children with one parent will have to be judged without empirical support" (p. 179).

While further longitudinal research is needed to examine more closely the bidirectional and reciprocal relationship between children of divorce and their parents, there is one implication from the research findings which may be useful for nurses. Current evidence suggests that "interparental conflict, not separation, may be the principal explanation for the association found between divorce and continuing childhood problems" (Emery, 1982, p. 313). There is thus a sound premise for nurses to educate <u>both</u> divorced parents about the negative consequences of exposing children to continued interparental hostility. Nurses must not consciously or unconsciously undermine or overvalue the non-custodial parent's relationship with the child and with the ex-spouse or they may hinder the family's satisfactory post-

divorce adjustment. Nurses need to foster healthy post-divorce relationships among all family members.

Nurses' Experiences with Single-Parent Families

The questions designed to elicit nurses' experiences with single-parent families focussed on three areas: difficulties, satisfactions and feelings which nurses experience. Each area will be discussed separately. Implications arising from the results will be discussed with the conclusions from Phase I.

Difficulties Nurses Experience

Five categories grouped items pertaining to the difficulties nurses experience in working with single-parent families. The first category pertained to nurses' difficulties with moral judgement and was used by 17% of the nurses. In describing these difficulties, nurses made such statements as the following:

"Society has a negative perception of divorced people. I have to watch my perceptions".

"I have to avoid judging these families by my standards for my own life".

"I must suspend my own moral stance".

The second category used by 16% of the nurses pertained to the instrumental difficulties they experience in working with single-parent families. In describing these difficulties, nurses made such statements as the following:

"I often have to cancel booked assessments for these families."

"The working mothers have trouble getting time off to bring the child in so I have to juggle my time."

"They don't show up for clinic appointments because they can't leave the job."

"I have difficulty getting in touch with them - no phone numbers, hard to reach."

"We don't work evenings and so most contact is by telephone."

The third category mentioned by 14% of the nurses referred to the difficulties they experience with single-parent families being non-compliant. Such statements as the following reflect the perceptions of the nurses about the non-compliance of families:

"They are not receptive".

"They question but don't use the information given."

"Their problems persist and they don't do anything."

"They don't expect to get out of the cycle and they don't try."

"They don't put the effort in and you have to put pressure on them."

Approximately 10% of the nurses used the fourth category, difficulties with assessment. In describing the difficulties, nurses made such statements as the following.

"I don't want to pry, but I need to know their situation. It's hard to know how to ask them questions."

"I'm not sure what they think I'm there to assess."

The last category, difficulties with knowing resources, emerged from only 7% of the nurses. Phrases such as the following were used

to describe this lack of knowledge:

"not sure where to send people,"

"not sure which resource agencies are good."

Satisfactions Nurses Experience

Four categories grouped items pertaining to the satisfactions nurses experience in working with single-parent families. The first category used by 29% of the nurses related to the satisfaction they feel when helping single-parent families. The second category pertained to nurses' satisfaction when families make positive changes. This category was used by 22% of the nurses. The third category grouped items pertaining to nurses' satisfaction in being needed by single-parent families. Sixteen percent stated they experience satisfaction in feeling needed by the families, in "being a listening ear", "helping the family's peace of mind", "developing a strong rapport" and "giving the family socialization". The last category related to nurses' experiences of challenge and satisfaction. Fourteen percent found single-parent families a challenge despite the difficulties noted previously.

Feelings Nurses Experience

Two categories emerged to reflect the feelings nurses experience most frequently in working with single-parent families. Twenty-six percent of the nurses reported feelings of sympathy and 26% reported feelings of frustration.

In conclusion, nurses' beliefs about single-parent families and their experiences in working with single-parent families have been

identified. It can be extrapolated from the data that nurses seem to experience the following pattern of practice with single-parent families. Nurses recognize single-parents have such difficulties as limited emotional support and financial as well as time management problems. They extend themselves personally for these families. Nurses feel sympathy for the family's situation and desire a better life for the members. Consequently, nurses invest heavily in the family and provide much emotional support and advice. They feel satisfied when helping, especially if the family makes a positive change. If the family does not comply with advice, however, then the nurse feels frustrated. Whether this frustration is with her own lack of skills or with the family is unknown. The single-parent family is sometimes seen as non-compliant to the nurse's wishes.

There is minimal support in the nursing literature for this pattern of practice. No one has delineated this pattern of practice. Burke (1983) does allude to it when she comments on the nurse's involvement with a particular single-parent family. "This family is frustrating for the community health nurse and workers, who have essentially taken over many of the child-rearing functions that are ordinarily done by a parent" (p. 36) (underlining added). It is this overinvolvement and "taking over" that seem to trigger the frustration. Burke does not comment however on the problematic nature of this pattern of practice.

Although the nursing literature has not described this phenomenon, the family therapy literature has termed it "suction" (Lynch,

1975). The therapist is triangulated into the family's emotional system and then has difficulty being an effective intervener (Bowen, 1978).

There are two implications of this position about nurses' pattern of practice with single-parent families. First, educators should teach nursing students about the influence of their feelings on their pattern of practice. For example, Wright and Leahey (1984) "recommend that nurses acknowledge their feelings and immediate reactions to family members. Having done so, they can then either discard these feelings or use them appropriately" (p. 152). Allmond, Buckman and Gofman (1979) suggest that a combination of sympathy and frustration be used to enable patients to resolve an impasse. "With sympathy alone the physician becomes as trapped as the patient, manipulated by that individual's helplessness. With frustration alone, the physician will soon be viewed as just another part of the hostile environment . . ." (pp. 96-97).

A second implication pertains to the need for supervision and consultation. To date, nursing has not made full use of live supervision to guide and direct nurses doing family interviewing. Supervision is particularly important in nurses' work with single-parent families lest the nurse become overly involved in providing support which could be given by the family's natural support network.

Comparison of Pediatric Nurses' and Community Health Nurses' Beliefs and Experiences

An analysis of the category data revealed no significant difference between pediatric nurses and community health nurses either in their beliefs about single-parent families or in their experiences with these families. Because there has been no previous investigation, this finding is neither supported by the literature or at variance with it. A possible explanation for the finding may relate to the small sample of pediatric nurses. There were 19 pediatric nurses and 39 community health nurses in Phase I. Another possible explanation is that nurses as a total group are similar to other professionals in their beliefs about single-parent families.

Comparison Between Subjects Participating in Phase I Only and Phases I and II

An analysis of the category data revealed no significant difference between subjects who participated in Phase I only and those who participated in both phases. This finding offers some small indication that the subjects who volunteered for Phase I only are representative of the population.

Phase II

Comparison of Groups Using Rating Scale Scores

An analysis of the rating scale data revealed no significant differences among subjects assigned to the father-headed, mother-headed and control family conditions. These results are not supported by the

research literature which indicate father-headed are rated less positively than mother-headed and control family conditions (Fry and Addington, 1984) on the Personality Trait Rating Scale and the Predicted Behaviour Functioning Scale. Children from mother-headed single-parent families are rated by subjects as better adjusted and children from father-headed single-parent families are rated as less happy, less achieving, less obedient to rules and less able to cope with stress.

One possible explanation for the non-significant results may be found in the nature of the stimulus material. Fry and Addington (1984) used videotape vignettes that depicted only non-verbal behaviour whereas in this study, the videotapes depicted verbal and non-verbal behaviour. It is postulated that the additional channel of communication directed the subject's attention to the confederates' actual behaviour. Subjects had to attend to both the auditory and visual channels. Thus, it is conceivable that they were less able to be preoccupied with the fact that the children came from various single-parent family conditions.

Another possible explanation for the results is that subjects who participated in both Phases I and II were influenced in a number of specific directions by the investigator during Phase I. Their attention was directed during Phase I to the positive aspects of single-parent family life. Furthermore, they were questioned about the long-term effects of divorce on children.

To determine if the fact that some subjects participated in Phase

I only and some participated in both Phases I and II was a possible explanation for the non-significant findings, additional data analysis was undertaken. A three-way analysis of variance with repeated measures was conducted using as data the mean scores on the Personality Trait Rating Scale, Predicted Behaviour Rating Scale and the Nurses' Feelings Rating Scale. Results indicated a significant difference between subjects who participated in Phase II only versus those who participated in both phases on just one variable out of a possible 24. Nurses who participated in Phase II only rated significantly greater concern for the confederates on the Nurses' Feelings Rating Scale than did nurses who participated in both studies. Thus, it does not seem as if participation in both studies confounded the results.

An implication of this result of no significant difference among father, mother, and control family conditions is that nursing educators should continue to focus on the development of students' perceptual skills and increase their focus on the development of conceptual skills. Janzen (1980) has emphasized that the student entering nursing has intuitive perceptual/conceptual skills but needs to develop an overt awareness of the perceptual/conceptual process. The findings in Phases I and II support Janzen's recommendation. Nurses are not biased when they are asked to observe and rate specific boys supposedly from single-parent family conditions. Yet, nurses do exhibit biases against single-parent families when they openly discuss these families in a general way.

This finding about nurses' biases has implications for their work

in interdisciplinary settings. Nurses may be more accurate in their observation of children than social workers or teachers (cf. Fry and Addington, 1984). Yet during the multidisciplinary conference, nurses may disparage single-parent families and increase other professionals' biases.

Comparison of Nurses Using Rating Scale Scores

The first result comparing pediatric nurses with community health nurses revealed community health nurses rated the boys as significantly less able to get along with others, more anxious/depressed, more delinquent and less able to relate effectively with peers. The community health nurses feel significantly more empathic toward the children than do the pediatric nurses.

Establishing the validity of this finding that there is a difference between pediatric nurses and community health nurses is difficult in view of the dearth of previous research in this area. A possible explanation for this finding is that pediatric nurses have more continuous contact with children than do community health nurses who work with children for short periods of time. Thus, pediatric nurses are more aware of 12-year-old boys' behaviour and are less likely to judge it negatively. An implication of this finding is that community health nurses need to increase their observational skills and have opportunities for live supervision so that their perceptions can be validated.

The second result comparing type of nurse (pediatric nurse, community health nurse) and type of family condition (father, mother,

control) revealed a significant interaction effect for the variable "pleased" on the Nurses' Feelings Rating Scale. Pediatric nurses in the father-headed condition were significantly less pleased with the confederates than pediatric nurses in the mother-headed and control conditions. For community health nurses there was no significant difference among father-headed, mother-headed and control conditions.

It is difficult to offer an interpretation for this finding and it may be a chance occurrence. There were six pediatric nurses in the father-headed family condition. They tended to report more contact with father-headed families (3.2%) versus the other pediatric nurses in the mother-headed condition (1.8%) and the control condition (2.1%). Why this group of pediatic nurses were less pleased with the confederates would require further investigation by means of individual interviews with the nurses.

Comparison of Non-Problem and Problem Boys Using Rating Scale Scores

An analysis of the scores on the Personality Trait Rating Scale, Predicted Behaviour Functioning Scale and the Nurses' Feelings Rating Scale revealed non-problem boys are consistently rated significantly more positively than problem boys on all variables except "empathy". There was no significant difference between non-problem and problem boys on this variable. These results were expected and are consistent with the literature pertaining to accurate empathy which is understanding of another's situation. Empathy is a neutral feeling and thus, can be aroused by both non-problem and problem behaviour.

Possible explanations for non-problem boys being rated more positively than problem boys relates to the nature of the stimulus materials. The first three videotapes were designed to depict non-problem behaviour and the last three were designed to illustrate problem behaviour. Also, the written instruments cued the subjects to the confederate's problem behaviour in that it was stated he "has been brought to the nurse's attention because of his problems".

An analysis of the Attribution Rating Scale data indicated no significant difference between ranks for the four variables (sex, family structure, age and urban living environment) taken concurrently. The results differed, however, when the first two variables (sex and family structure) were taken concurrently and the last two variables (age and urban living environment) were taken concurrently. Sex and family structure made little contribution to subjects' overall ratings of non-problem boys but contributed significantly more to their ratings of problem boys. Age and urban living environment made little contribution to nurses' ratings of problem boys but were a significant contributor to their ratings of non-problem boys. Thus, there seems to be a suggestion that if problem behaviour is noted, then it is attributed to the family structure. Caution should be exercised however in overinterpreting this finding because of the small amount of data.

Nevertheless, these findings have implications for the propagation of negative stereotypes about single-parent families. Nurses must learn to notice positive functioning and relate normal behaviour

with single-parent family structure.

Relationship of Background Variables and Rating Scale Scores

Results of a multiple regression analysis with stepwise solution indicated a significant relationship between background variables and scores on the rating scales. First, age contributes significantly to the subjects' ratings of non-problem boys' achievement needs, obeying rules, assuming responsibilty and personal initiative/creativity. The younger the nurse, the more positive she is in her ratings of these variables. Age also contributes significantly to nurses' feelings of anxiety/fear, sympathy and sorrow for non-problem boys. The younger the nurse, the higher are her ratings. One possible explanation for these findings is that there is a cognitive/emotional split within the younger nurses. That is, younger nurses perceive the non-problem boys as functioning well and rate them accordingly. Yet these nurses feel sympathetic and sorry for the boys. The cognition and emotion may be independent of each other.

These findings have implications for education and supervision of nurses in their work with single-parent families. Emphasis should be placed on live or videotape supervision and not on verbal process recordings. With live or videotape supervision, the supervisor observes the nurse's work with the family and provides direction for perceptual/conceptual, executive and affective skill development. If process recordings are used, it seems likely that the nurse's feelings of anxiety/fear, sympathy and sorrow might predominate the supervision

sessions. Inadvertently, the supervisor would then be focussing only on one part of the nurse's cognitive/emotional split.

The second result from the multiple regression analysis pertains to the influence of the subject's definition of self as a single-parent. If the nurse defines herself as a single-parent, she rates the non-problem boy as lower on morality standards and sex-role adjustment. One possible explanation for this finding is that the small number of nurses (9) who designated themselves as single-parents has produced misleading results. Another possible explanation is that the nurses who defined themselves as single-parents are heavily influenced by the early literature on poor sex-role adjustment of boys from single-parent families (Biller & Bahm, 1971) or have stereotyped views of masculinity and femininity versus androgyny (Kurdek & Siesky, 1980b).

The third result from the multiple regression analysis pertains to the background variable, length of full-time employment. The longer the nurse is employed, the more anxious/fearful she is for non-problem and problem boys. One possible explanation for this finding is that the longer the nurse is employed full-time, the more aware she is of the possibility of future problems for these children. Hence, she may be more fearful for their future.

A possible explanation for the lack of findings relating background variables and problem boys is that the problem behaviour itself superseded all other influences. That is, subjects were so influenced by the provoking stimulus that their own background factors receded in

importance. The basic problem in dealing with subjects' ratings is one of determining which factors are more relevant to the rating process and which are less relevant. This is a particularly difficult task in the field of ratings of children from single-parent families where the literature is sparse.

Limitations

The following limitations are acknowledged as possibly influencing the results of Phases I and II. They will be discussed under the sub-headings of limitations related to the research problem definition, design, methodology, and data analysis. Each will be discussed separately.

Limitations Related to Research Problem Definition

Conclusions regarding nurses' beliefs about single-parent families and their experiences with such families must be made with caution. One reason for this is that the operational definition of beliefs and experiences contains several variables that are difficult to quantify or accurately measure. For example, subjects were asked to discuss the major stressful aspects of single-parent family life as well as the major positive aspects. To define stressful and positive aspects operationally is very difficult. Another example pertains to the definition of difficulties and satisfactions subjects experience in working with single-parent families. One nurse's great satisfaction may not be equivalent to that of another nurse.

Limitations Related to Design

There are several limitations inherent in the use of the research designs for Phases I and II. First, the interviews in Phase I differed in amount of investigator-subject contact time, a fact that may confound the results. Attempts were made to reduce this possibility by scheduling 45 minutes for each interview and thus allowing each subject equal time. The fact that some subjects chose to take less time than others was beyond the investigator's control. Second, contamination or discussion among subjects about the nature of the research may be a limiting factor in interpreting the results. Personal discussion by the investigator with the subjects following the studies, however, does not support the contamination issue. Third, only boys were used as the confederates in Phase II. Results might have been less positive if subjects were asked to rate girls living in father-led households.

Limitations Related to Methodology

There are three limitations related to methodology. First, the subjects for both studies were volunteers. It is possible that those persons not choosing to participate in the research may differ significantly from those persons who volunteered to participate. Second, the sample for both studies was not particularly large. There were 19 pediatric nurses and 39 community health nurses in Phase I and 25 pediatric nurses and 125 community health nurses in Phase II. The small

number of pediatric nurses may be due to the manner in which the subjects were approached to participate in the studies. Personal appeal by the investigator was not possible because of logistic constraints inherent in an acute care hospital. For example, staff work shifts and are geographically spread out in a large hospital complex consisting of out-patient and in-patient units. Furthermore, it was stated to the pediatric nurses working in the in-patient area that they would be participating on their own time. Other subjects who were invited were told they could participate during working hours.

A third limitation was that the videotapes depicting non-problem and problem boys were not shown in random order. Rather, emphasis was placed on having as many subjects as possible view the videotapes at one time.

Limitations Related to Data Analysis

There are two limitations related to data analysis that may influence conclusions about nurses' beliefs and experiences with single-parent families. First, all the interview data were not used because coders were unable to classify the data into categories. Second, to determine the extent to which subjects attributed their ratings to different variables, a Friedman two-way analysis of variance was used. Because of the small amount of data, only possible trends can be stated. To verify these trends, the dichotomy between non-problem and problem boys needs to be expanded and more cells included. A parametric statistical test could then be done.

CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

The purposes of this chapter are to present the conclusions from Phase I and Phase II and to discuss recommendations for future research. Each will be addressed separately.

Conclusions

After considering the results of these studies, three conclusions emerge.

First, from the questions designed to elicit nurses' beliefs about single-parent families, the following beliefs emerged. With respect to the negative aspects of single-parent family life, nurses believe single-parent families have limited emotional support, financial and time management difficulties, and parent-child discipline problems. With respect to the positive aspects of single-parent family life, nurses believe single-parent families are in a transition or aftermath stage in the family life cycle. They believe there is an increased parent-child bond, interest in self-improvement, and increased independence for children in single-parent families. Nurses believe single-parent families need support from the nurse and need information about resources. Lastly, with respect to the effects of divorce on children, the nurses are divided in their beliefs. Some believe the children have emotional problems while a few believe there is no difference in children's functioning in single-parent families.

Many stated their belief that the children's emotional adjustment is dependent on the parent's adjustment.

The categories used most frequently by the nurses to describe their beliefs pertain to negative aspects of single-parent family life. Approximately one third of the nurses believe single-parent families have limited emotional support, financial difficulties, and need support from the nurse. Less than 10% of the nurses believe that children in single-parent families have increased independence or that custodial parents are interested in self-improvement.

Second, results from the questions designed to elicit nurses' experiences with single-parent families indicate that nurses experience instrumental difficulties and difficulties with moral judgement, non-compliance, assessment, and with knowing resources. Nurses experience satisfaction when helping families and when the family makes positive changes. Nurses feel needed by single-parent families and find them a challenge. Feelings of sympathy and frustration are reported by many nurses.

The categories used most frequently by the nurses to describe their experiences with single-parent families pertain to feelings of satisfaction. About 30% report being satisfied when helping single-parent families and 22% report satisfaction when single-parent families make changes. Approximately 25% of the nurses experience sympathy and frustration in working with single-parent families. Fourteen percent report single-parent families are non-compliant. Less than 10% of the nurses have difficulty in assessing single-parent families

or lack knowledge of resources for single-parent families.

Third, there is no significant difference among nurses in father-headed, mother-headed and control family conditions in their ratings of 11-12 year old boys on the Personality Trait Rating Scale, Predicted Behaviour Functioning Scale and the Nurses' Feelings Rating Scale. Community health nurses rate the boys as significantly less able to get along with others, more anxious/depressed, more delinquent and less able to relate effectively with peers. The community health nurses feel significantly more empathic toward the children than do the pediatric nurses. There is a significant interaction effect between type of nurse (pediatric nurse, community health nurse) and type of family condition (father, mother, control) on only one variable out of a possible 24 variables. Pediatric nurses in the father-headed condition are significantly less pleased with the confederates than pediatric nurses in the control condition. Subjects rate non-problem boys significantly more positive than problem boys on all variables except the feeling of "empathy" for which there is no significant difference. Nurses' attributions of their ratings of non-problem and problem boys differ significantly. The boys' sex and family structure make little contribution to subjects' overall ratings of non-problem boys but contribute significantly more to subjects' rating of problem boys. Nurses' background variables of age, definition of self as a single parent, and years of full-time employment contribute significantly to their ratings on nine variables for non-problem boys and one

variable for problem boys. The younger the nurse, the higher are her ratings of anxiety/fear, sympathy and sorrow for non-problem boys. If the nurse defined herself as a single-parent, she rates the non-problems boys lower on morality standards and sex-role adjustment. The longer the nure is employed, the more anxious/fearful she is for non-problem and problem boys.

Recommendations

Recommendations for future direction can be considered in three areas: specific studies based on Phases I and II, general suggestions for work on research pertaining to nurses and single-parent families and practical recommendations based on the results of Phases I and II. Each will be considered separately.

Specific Studies Based on Phases I and II

Based on this research, several suggestions can be given for further work in the area of delineating nurses' beliefs and experience with single-parent families. These recommendations can be made for work on design, methodology and instruments.

Design

A study could be designed in three phases. During the first phase, nurses could be asked to complete a questionnaire documenting their beliefs and expectations about single-parent families. The items on the questionnaire could be developed from the categories used in the present research. During the second phase, all subjects could

be shown a videotape of a problem child from a single-parent family. They could be asked to devise interventions for this child. During the third phase, a random sample of subjects could be selected from the initial pool of subjects who have completed the first two phases. These randomly selected subjects could then be asked to interact with the same child actor seen on the videotape. Comparisons could then be made between the nature of the nurse's beliefs and the interventions that are stimulated by videotape versus those that are actually practised in a live setting. Such a study would address the question of validity of beliefs and have implications for various types of training.

Other studies which could be designed are ones that compare the beliefs of the nurses about single-parent families with the beliefs of family members themselves. For example, a sample of mothers, fathers and children from single-parent families could be administered questionnaires or interviewed to elicit their beliefs. These beliefs could then be contrasted with those of the nurses and also, ideally, with those of a sample of mothers, fathers and children from two-parent families. Research could also be done to compare nurses' beliefs about single-parent divorced families with nurses' beliefs about other types of single-parent families, e.g., widowed, or never-married.

An experiment could also be designed in a similar manner to the experiment conducted in Phase II of the present research. In the

proposed study, girls instead of boys would be used as the confederates. Although Canadian data (1969-1979) showed that custody is awarded most often to a parent when all the children are of the same gender as that parent, nevertheless, McKie, Prentice and Reed (1983) observed that when the children were all girls, fathers received custody in 11.9% of the cases. When there were both boys and girls, the figures rose to 14.6%. Hanson (1983) reports that in the United States men won 10% of the cases of contested custody in 1976 but six years later were winning 22% to 50% of the cases. Nurses may be increasingly called upon to assist these girls in father-led families with such issues as sex education. Thus, nurses' assessments of girls living with their fathers requires examination.

Methodology

The sample of in-patient pediatric nurses might be increased if research were conducted in an area closer to the in-patient unit. Nurses for Phases I and II had to leave their units and travel to a completely different and sometimes distant part of the hospital complex.

Instruments

Test validity and equivalence of videotapes should be examined more closely. Several, instead of four judges, should be used. In addition, some items need to be reworded to ensure more accurate understanding by subjects. Further, more items need to be included in the Attribution Rating Scale. In Phase II, only four items (sex, family structure, age and urban living environment) were included.

General Suggestions

The area of examining nurses' beliefs about single-parent families and their experiences with such families is a complex one. Perhaps in the future, more time should be spent in grappling with specific issues regarding nurses' practice with single-parent families rather than in examining their beliefs.

As a result of this study, some general recommendations can be given for further work in the area of nurses' experiences and pattern of practice with single-parent families:

1. Document the amount of time nurses actually spend with single-parent families. Because many nurses find satisfaction in helping these families, it would be useful to know if they tend to visit them more often and stay longer.
2. Examine nurses' problem-oriented records to note the actual type and number of problems documented as well as the referrals for other types of service.
3. Conduct an observational study on nurses' interviews with single-parent families to actually ascertain the content of their interaction.
4. Conduct outcome research to evaluate nurses' effective ways of helping single-parent families.

Practical Recommendations

Based upon the findings of this research, a number of suggestions

can be made for educators and for administrators of health care agencies and hospitals.

Educators should teach nurses:

1. to work with single-parent families (including the extended family) instead of just individuals. Even though community health nurses provide the leadership within the nursing field in recognizing the family as the unit of health care, most nurses in clinical practice still concentrate on individual family members within the home. Cunningham (1978) cited some inhibiting factors to more family-centered care as time (inflexible working hours), patient motivation (difficulty in engaging parents) and nurse-centered problems (lacking confidence and/or competence).
2. to value the importance of the non-custodial parent in the child's post-divorce adjustment. Nurses should be able to assess the degree and nature of the child's contact so as to foster closer relationships and improved interparental functioning.
3. to help single-parents develop a positive identity about their current life-style.
4. to help single-parent families with discipline issues in the here and now so that they can provide specific feedback to the single-parent.
5. to acknowledge their feelings and immediate reactions to family members so that they will be able to either discard these

feelings or use them appropriately.

6. about how biased beliefs regarding families can be propagated during interdisciplinary conferences. Imber-Coppersmith (1982) calls this sharing of biased information "gossiping" and warns of its interference in effective treatment planning.

Health care agencies and hospitals should

1. have flexible (e.g., evening) hours for their staff to meet with clients.
2. provide supervision and consultation opportunities for nurses working with single-parent families. This is especially important for community health nurses who have opportunities to plan their caseloads and home visits.

In conclusion, the single-parent family is the fastest growing family form in Canada today. It is apparent that nurses have opportunities to work with single-parent families in a variety of health care settings. It is hoped that nurses will continue to recognize the challenges these families face and will be sensitive to their stresses and accomplishments.

REFERENCES

Abernathy, T., & Arcus, M. (1977). The law and divorce in Canada. The Family Coordinator, 26, 409-413.

Ahlgren, A., & Walberg, H. (1975). Generalized regression analysis. In D. Amick & H. Walberg (Eds.), Introductory multivariate analysis (pp. 8-52). Berkeley: McCutchan Publishing.

Ahrons, C. (1983). Predictors of paternal involvement postdivorce: Mothers' and fathers' perceptions. Journal of Divorce, 6(3), 55-69.

Aldous, J. (1978). Family careers: Developmental change in families. New York: John Wiley.

Allmond, B., Buckman, W., & Gofman, H. (1979). The family is the patient: An approach to behavioral pediatrics for the clinician. St. Louis: C. V. Mosby.

Ashmore, R., & Del Boca, F. (1979). Sex stereotypes and implicit personality theory: Toward a cognitive-social psychological conceptualization. Sex Roles, 5, 219-248.

Ashmore, R. & Del Boca, F. (1981). Conceptual approaches to stereotypes and stereotyping. In D. Hamilton (Ed.), Cognitive processes in stereotyping and intergroup behavior (pp. 1-35). New Jersey: Lawrence Erlbaum.

Beal, E. (1979). Children of divorce: A family systems perspective. Journal of Social Issues, 35, 140-154.

Beal, E. (1980). Separation, divorce and single-parent families. In E. Carter & M. McGoldrick (Eds.), The family life cycle: A developmental framework for family therapy (pp. 241-264). New York: Guilford.

Biller, H., & Bahm, R. (1971). Father absence, perceived maternal behaviour, and masculinity of self-concept among junior high school boys. Developmental Psychology, 4, 178-181.

Blechman, E. (1982). Are children with one parent at psychological risk? A methodological review. Journal of Marriage and the Family, 44, 179-196.

Blishen, B. (1967). A socioeconomic index for occupations in Canada. Canadian Review of Sociology and Anthropology, 4, 41-53.

Bowen, M. (1978). Family therapy in clinical practice. New York: Jason Aronson.

Brandwein, R., Brown, C., & Fox, E. (1974). Women and children last: The social situation of divorced mothers and their families. Journal of Marriage and the Family, 37, 498-514.

Brigham, J. (1971). Ethnic stereotypes. Psychological Bulletin, 76, 15-38.

Brown, M., Engelman, L., Frane, J., Hill, M., Jenrich, R., & Toporek, J. (1981). BMDP statistical software. Berkeley: University of California.

Bureau of Applied Social Research (1948). Training guide on constructing questionnaires and interview schedules. New York: Columbia University.

Burke, S. (1983). One-parent families: Helping them cope. Canadian Nurse, 79 (10), 33-37.

Census of Canada (1981). Census families in private households. Selected characteristics.

Chiriboga, D., Coho, A., Stein, J., & Roberts, J. (1979). Divorce, stress and social supports: A study in helpseeking behavior. Journal of Divorce, 3 (2), 121-135.

Clason, C. (1980). The one-parent family: The Dutch situation. Journal of Comparative Family Studies, 11, 3-15.

Clements, I. W., & Roberts, F. B. (Eds.). (1983). Family health: A theoretical approach to nursing care. New York: John Wiley.

Colletta, N.D. (1983). Stressful lives: The situation of divorced mothers and their children. Journal of Divorce, 6 (3), 19-31.

Collison, C., & Futrell, J. (1982). Family therapy for the single-parent family system. Journal of Psychosocial Nursing and Mental Health Services, 20 (7), 16-20.

Cunningham, R. (1978). Family-centered care. Canadian Nurse, 2, 34-37.

Desimone-Luis, J., O'Mahoney, K., & Hunt, D. (1979). Children of separation and divorce: factors influencing adjustment. Journal of Divorce, 3, 37-42.

Emery, R. (1982). Interparental conflict and the children of discord and divorce. Psychological Bulletin, 92, 310-330.

Fagin, C., & Diers, D. (1984). Nursing as metaphor. International Nursing Review, 16-17.

Ferguson, G. (1971). Statistical analysis in psychology and education. New York: McGraw-Hill.

Friedman, M. (1981). Family nursing - Theory and assessment. New York: Appleton-Century Crofts.

Fry, P.S., & Addington, J. (1984). Professionals' negative expectations of children from father-headed single-parent families: Implications for the training of child-care professionals. British Journal of Developmental Psychology, 2, 67-76.

Fry, P.S., & Grover, S. (1983). An exploration of the child's perspective: Children's perceptions of parental treatment and attributions of blame in the single-parent family. Journal of Psychiatric Treatment and Evaluation, 5, 353-362.

Fry, P.S., & Leahey, M. (1983). Positive and negative events in single-parent families. Journal of Applied Developmental Psychology, 4, 377-394.

Fry, P.S., & Trifiletti, R. (1983). An exploration of the adolescent's perspective: Perceptions of major stress dimensions in single-parent families. Journal of Psychiatric Treatment and Evaluation, 5, 101-111.

Gasser, R., & Taylor, C. (1976). Role adjustment of single-parent fathers with dependent children. The Family Coordinator, 25, 397-401.

Glick, P. (1979). Children of divorced parents in demographic perspective. Journal of Social Issues, 35, 170-181.

Glick, P. (1980). Remarriage: Some recent changes and variations. Journal of Family Issues, 1, 455-478.

Goldsmith, J. (1982). The postdivorce family system. In F. Walsh (Ed.), Normal family processes (pp. 297-330). New York: Guilford.

Gongla, P.A. (1982). Single-parent families: A look at families of mothers and children. Marriage and Family Review, 5 (2), 5-27.

Hanson, S. (1981, October). Single custodial fathers. Paper presented at the National Council on Family Relations Annual Meeting, Milwaukee, Wisconsin.

Hanson, S. (1981b). Single custodial fathers and the parent-child relationship. Nursing Research, 30, 202-204.

Hanson, S. (1983, October). Linkages: The father-child relationship in non-traditional family forms. Paper presented at the National Council on Family Relations Annual Meeting, St. Paul, Minnesota.

Hanson, S., & Trilling (1983). A proposed study of the characteristics of the healthy single-parent family. Family Perspective, 17 (2), 79-88.

Hetherington, E.M. (1966). Effects of paternal absence on sex-typed behaviours in Negro and White preadolescent males. Journal of Personality and Social Psychology, 4, 87-91.

Hetherington, E.M., Cox, M., & Cox, R. (1980). The aftermath of divorce: In P. Mussen, J. Conger & J. Kagan (Eds.), Readings in child and adolescent psychology (pp. 163-177). New York: Harper and Row.

Hoeffer, B. (1978). Single mothers and their children: Challenging traditional concepts of the American family. In P. Brandt, P. Chinn, V. Hunt & M.E. Smith (Eds.), Current practice in pediatric nursing (pp. 175-184). Saint Louis: C.V. Mosby.

Imber-Coppersmith, E. (1982). The place of family therapy in the homeostasis of larger systems. In L. Wolberg & M. Aronson (Eds.), Group and family therapy (pp. 216-227). New York: Brunner/Mazel.

Jacobson, D. (1978). The impact of marital separation/divorce on children: I. Parent-child adjustment. Journal of Divorce, 1, 341-359.

Janosik, E., & Miller, J. (1979). Theories of family development. In D. Hymovich & M. Barnard (Eds.), Family health care - General perspective, Volume 1, 2nd Edition (pp. 3-16). New York: McGraw-Hill.

Janzen, S. (1980). Taxonomy for development of perceptual skills. Journal of Nursing Education, 19, 33-40.

Johnson, P. (1974). Crisis intervention in two military families: The absent father and the family of one. In J.E. Hall & B.R. Weaver (Eds.), Nursing of families in crisis (pp. 84-95). Philadelphia: J. B. Lippincott.

Kantor, D., & Vickers, M. (1983). Divorce along the family life cycle. In H. Liddle (Ed.), Clinical implications of the family life cycle (pp. 78-98). Rockville, Maryland: Aspen Systems.

Kaseman, C. (1974). The single-parent family. Perspectives in Psychiatric Care, 12, 113-118.

Katz, A. (1979). Lone fathers: Perspective and implications for family policy. The Family Coordinator, 28, 521-528.

Kavanaugh, D. (1978). Listen to us. New York: Workman Publishing.

Kellam, S., Ensminger, M., & Turner, J. (1977). Family structure and the mental health of children. Archives of General Psychiatry, 34, 1012-1022.

Koch-Nielsen, I. (1980). One-parent families in Denmark. Journal of Comparative Family Studies, 11, 17-29.

Krell, R. (1972). Problems of the single-parent family unit. Canadian Medical Association Journal, 107, 867-872.

Krippendorff, K. (1980). Content analysis: An introduction to its methodology. Beverly Hills: Sage.

Kurdek, L. (1981). An integrative perspective on children's divorce adjustment. American Psychologist, 36, 856-866.

Kurdek, L., & Blisk, D. (1983). Dimensions and correlates of mothers' divorce experiences. Journal of Divorce, 6 (4), 1-24.

Kurdek, L., Blisk, D., & Siesky, A. (1981). Correlates of children's long-term adjustment to their parents' divorce. Developmental Psychology, 17, 565-579.

Kurdek, L. & Siesky, A. (1980a). Children's perceptions of their parents' divorce. Journal of Divorce, 3, 339-378.

Kurdek, L., & Siesky, A. (1980b). Sex role self-concepts of single divorced parents and their children. Journal of Divorce, 3, 249-261.

Leahey, M. (1984). Findings from research on divorce: Implications for professionals' skill development. American Journal of Orthopsychiatry, 54, 298-317.

Lefaucheur, N. (1980). Single-parenthood and illegitimacy in France. Journal of Comparative Family Studies, 11, 31-48.

Lerner, R., & Spanier, G. (1978). A dynamic interaction view of child and family development. In R. Lerner & G. Spanier (Eds.), Child influences on marital and family interaction: A lifespan perspective. New York: Academic Press.

Lippman, W. (1960). Public opinion. New York: Macmillan.

Lowenstein, J., & Koopman, E. (1978). A comparison of the self-esteem between boys living with single-parent mothers and single-parent fathers. Journal of Divorce, 2, 195-207.

Lupri, E. (1981). Family life in boomtown Calgary. Unpublished manuscript, Universiity of Calgary, Calgary, Alberta.

Lupri, E. (1984). The family. In K. Ishwaran (Ed.), Sociology. Don Mills: Addison-Wesley.

Lynch, C. (1975). On not getting caught up in the family's system. Family Process, 14, 163-170.

Lynn, D. (1969). Parental and sex role identification: A theoretical formulation. Berkeley: McCutcheon.

McDermott, J. (1968). Parental divorce in early childhood. American Journal of Psychiatry, 124, 118-126.

McGoldrick, M., & Carter, E. (1980). Forming a remarried family. In E. Carter and M. McGoldrick (Ed.), The family life cycle: A framework for family therapy (pp. 265-294). New York: Guilford.

McKie, D., Prentice, B., & Reed, P. (1983). Divorce: Law and the family in Canada. Ottawa: Minister of Supply and Services.

Miller, P., & Tupin, J. (1972). Multimedia teaching of introductory psychiatry. American Journal of Psychiatry, 128, 39-43.

Mitchell, K. (1983). The price tag of responsibility: A comparison of divorced and remarried mothers. Journal of Divorce, 6 (3), 33-42.

Nie, N., Hull, C., Jenkins, J., Steinbrenner, K., & Bent, D. (1975). SPSS: Statistical package for the social sciences. New York: McGraw-Hill.

O'Brien, M. (1980). Lone fathers: Transition from married to separated state. Journal of Comparative Family Studies, 11, 115-127.

Peters, J. (1983). Divorce: The disengaging, disengaged, and re-engaging process. In K. Ishwaran (Ed.), The Canadian family (pp. 277-288). Toronto: Gage.

Riegel, K. (1975). Toward a dialectical theory of development. Human Development, 18, 50-64.

Roberts, F.B. (1983). The American family. In I. Clements & F. Roberts (Eds.), Family health: A theoretical approach to nursing care (pp. 5-20). New York: John Wiley.

Santrock, J. (1972). Relation of type and onset of father absence to cognitive development. Child Development, 43, 455-469.

Santrock, J., & Tracy, R. (1978). Effects of children's family structure status in the development of stereotypes by teachers. Journal of Educational Psychology, 70, 754-757.

Santrock, J., & Warshak, R. (1979). Father custody and social development in boys and girls. Journal of Social Issues, 35, 112-125.

Saunders, B. (1983). The social consequences of divorce: Implications for family policy. Journal of Divorce, 6 (3), 1-17.

Schlesinger, B. (1979). One in ten: The single parent in Canada. Toronto: University of Toronto.

Schlesinger, B. (1983). Living in one-parent families: The children's viewpoint. In K. Ishwaran (Ed.), The Canadian family (pp. 331-339). Toronto: Gage.

Schwartzman, J. (1982). Normality from a cross-cultural perspective. In F. Walsh (Ed.), Normal family processes (pp. 383-398). New York: Guilford.

Siegel, S. (1956). Nonparametric statistics for the behavioral sciences. New York: McGraw-Hill.

Smith, M. (1980). The social consequences of single parenthood: A longitudinal perspective. Family Relations, 29, 75-81.

Statistical Abstract of the U.S. (1982-1983). National Data Book & Guide to Sources. U.S. Department of Commerce, Bureau of the Census.

Statistics Canada (1982). Marriages and Divorces, Vital Statistics, Volume II.

Task Force on Pediatric Education (1978). The future of pediatric education.

Thurnblad, R., Muslin, H., & Loesch, J. (1973). A test of clinical learning by medical students. American Journal of Psychiatry, 130, 568-570.

Tomm, K., & Leahey, M. (1980). Training in family assessment: A comparison of three teaching methods. Journal of Marital and Family Therapy, 6, 453-458.

Trost, J. (1980). The concept of one-parent family. Journal of Comparative Family Studies, 11, 129-138.

Troyer, W. (1979). Divorced kids. Toronto: Clarke, Irwin.

Van Dalen, D., & Meyer, W. (1962). Understanding educational research: An introduction. New York: McGraw Hill.

Wallerstein, J., & Kelly, J. (1980). Surviving the breakup: How children and parents cope with divorce. New York: Basic Books.

Weiss, R. (1979). Growing up a little faster: The experience of growing up in a single-parent household. Journal of Social Issues, 35, 97-111.

Weltner, J.S. (1982). A structural approach to the single-parent family. Family Process, 21, 203-210.

Wright, L., & Leahey, M. (1984). Nurses and families: A guide to family assessment and intervention. Philadelphia: F.A. Davis.

Code # _____

APPENDIX A

Phase I

Subject Consent Form

I hereby give my consent to be interviewed by Maureen Leahey (University of Calgary) or her representative.

The nature of the interview and the objectives of Mrs. Leahey's study have been explained to me and I have had a chance to raise questions about the study.

I reserve the right:

(a) to refuse to answer any questions which I regard to be an invasion of my right to privacy of information;

(b) to break off an interview at any time should I feel that I am being put under undue stress or not being treated with appropriate respect by the interviewer; and

(c) at any time, to terminate my participation in the study without being required to state a reason.

I understand that the interview with me will be audio taperecorded and that the recording will be completely erased after the information has been transcribed on paper. The information will be coded and no names will be on the paper.

I understand that all information will be kept strictly confidential and that my name or address will not be mentioned in any written or oral report that is developed as part of the study.

I voluntarily consent to participate in the interview.

_____ _____

DATE SIGNATURE

_____

NAME

_____

ADDRESS

Code # _____

APPENDIX B

Phase II

Subject Consent Form

I hereby give my consent to participate in an experimental study designed to examine social/psychological variables. I understand that I will be shown videotapes of children interacting with other children in a play-group situation. I will be asked to rate the children's personality and answer questionnaires based on seeing these videotapes.

I understand that I cannot be fully informed prior to the study about the true nature of the experiment. I understand that I will be fully debriefed and will be told the full purpose of the experiment immediately after the study is over.

I understand that all information will be kept strictly confidential and that my name or address will not be mentioned in any written or oral report that is developed as part of the study. I understand that the questionnaires, rating sheets and key linking my name to the code number will be shredded upon completion of the study.

I reserve the right to withdraw my participation in the study at any time without being requested to state a reason.

I voluntarily consent to participate.

_____ _____

DATE SIGNATURE

_____

NAME

_____

ADDRESS

APPENDIX C

Personality Trait Rating Scale

Rate (child's name) on a 1 - 9 scale (1 = very low; 9 = very high) on the following personality traits.

		Very Low								Very High
		1	2	3	4	5	6	7	8	9
1.	Happiness									
2.	Getting Along with Others									
3.	Achievement Needs									
4.	Emotional Adjustment									
5.	Morality Standards									
6.	Anxiety/Depression									
7.	Delinquency									
8.	Sex-Role Adjustment									

APPENDIX D

Predicted Behaviour Functioning Scale

Predict how (child's name) might be expected to behave. Rate (child's name) on a 1 - 9 scale (1 = very low; 9 = very high) on the following items:

		Very Low								Very High
		1	2	3	4	5	6	7	8	9
1.	Obeying Rules									
2.	Coping with Stress									
3.	Cooperating with Adults									
4.	Assuming Responsibility									
5.	Assuming a Leadership Role									
6.	Working Independently									
7.	Relating Effectively with Peers									
8.	Personal Initiative/ Creativity									

APPENDIX E

Nurses' Feelings Rating Scale

Rate on a 1 - 9 scale (1 = very low; 9 = very high) how you feel toward (child's name)

		Very Low								Very High
		1	2	3	4	5	6	7	8	9
1.	Concerned									
2.	Pleased									
3.	Anxious/Fearful									
4.	Happy									
5.	Sympathetic									
6.	Frustrated									
7.	Sorry/Sad									
8.	Empathic									

APPENDIX F

Attribution Rating Scale

To what do you attribute your ratings of (child's name) personality, your predictions abut his behaviour and your feelings about him? Rate on a 1 - 9 scale (1 = very little; 9 = very big) how much the following items contribute to your overall rating of (child's name):

		Very little contribution								Very Big Contribution
		1	2	3	4	5	6	7	8	9
1.	His Sex									
2.	His Family Structure									
3.	His Age									
4.	His Urban Living Environment									
5.	Other Items									
	Please Specify: _____									
	_____									
	_____									

APPENDIX G

Code # _____

Personal Data Questionnaire

I. Demographic

1. Age: _____years.

2. Current Status:

Single (never married) _____

Separated _____ How long? _____

Divorced _____ How long? _____

Married _____ How long? _____

Widowed _____ How long? _____

3. Past Status:

If your current status differs from your past status, please describe (e.g. currently married but was married first time for seven years, separated for one year and divorced for two years.)

_____

_____

_____

4. How many of your children (biological or adopted) are living with you currently?

_____ Have no children	_____ 13-15 yrs. old
_____ None	_____ 16-18 yrs. old
_____ 0-2 yrs. old	_____ 19-21 yrs. old
_____ 3-5 yrs. old	_____ 21+ yrs. old
_____ 6-12 yrs. old	

5. How many children (not biological and not adopted) are living with you currently?

_____ Not Applicable	_____ 13-15 yrs. old
_____ 0-2 yrs. old	_____ 16-18 yrs. old
_____ 3-5 yrs. old	_____ 19-21 yrs. old
_____ 6-12 yrs. old	_____ 21+ yrs. old

6. Do you consider yourself to be a single-parent?

   Yes _____ No _____

7. How would you define the term "single-parent family"?

_____

_____

_____

_____

8. How many years have you been working full-time? _____years

9. How much formal education have you completed?

R.N. Diploma Program _____

Some courses toward a Bachelor's Degree _____

Bachelor's Degree _____

Some courses toward a Master's Degree _____

Master's Degree _____

10. Any other comments? Please feel free to provide additional information which you think might be useful.

_____

_____

_____

_____

_____

_____

_____

Personal Data Questionnaire: CHN

II. Contact

1. What percentage of your patient contact is with single-parent families? _____%

2. What percentage would be single-parent families:
   led by mothers? _____%
   led by fathers? _____%

3. In what type of clinical setting would you have most of your contact?

   _____

4. Do you sometimes work in an elementary school? Yes ____
   No ____

5. Approximately how many hours per week do you work in an elementary school?

1-3	_____	21-25	_____
4-6	_____	26-30	_____
7-10	_____	31-35	_____
11-15	_____	36+	_____
16-20	_____		

Personal Data Questionnaire: PN

II. Contact

1. What percentage of your patient contact is with single-parent families? _____%
2. What percentage would be single-parent families:
   led by mothers? _____%
   led by fathers? _____%
3. In what type of clinical setting would you have most of your contact e.g. DAT, cluster, ICN, emergency, etc.?

   _____

4. What age range of children do you most often work with?

   Ages: Less than 12 mos. _____ 6 - 12 yrs. _____
   1 - 5 yrs. _____ 13 - 18 yrs. _____

5. Approximately how many hours per week do you work with children in the age range you have designated? Hrs. per week?

1-3	_____	21-25	_____
4-6	_____	26-30	_____
7-10	_____	31-35	_____
11-15	_____	36+	_____
16-20	_____		

6. Answer a or b:
   a) How many years have you been working full time in pediatrics? _____yrs.
   b) How many years have you been working part-time in pediatrics? _____yrs.

APPENDIX H

The equation for the linear model for the three-way analysis of variance with repeated measures used in Phase II is as follows:

$$X_{ijkm} = \mu + \alpha_i + \beta_j + \gamma_k + \pi_{m(ij)} + \alpha\beta_{ij} + \alpha\gamma_{ik} + \beta\gamma_{jk} + \alpha\beta\gamma_{ijk} + \gamma\pi_{km(ij)}$$

μ = grand mean

α_i = effect of ith level of A

β_j = effect of jth level of B

γ_k = effect of kth level of C

$\pi_{m(ij)}$* = effect of mth subject nested within ith level of A and jth level of B

$\alpha\beta_{ij}$ = interaction of A and B

$\alpha\gamma_{ik}$ = interaction of A and C

$\beta\gamma_{jk}$ = interaction of B and C

$\alpha\beta\gamma_{ijk}$ = interaction of A, B and C

$\gamma\pi_{km(ij)}$** = interaction of C and π

*$\pi_{m(ij)}$ is the error (between) term

**$\gamma\pi_{km(ij)}$ is the error (within) term