PERCEPTIONS OF PARENTING STRESS AND FAMILY FUNCTIONING AMONG TAIWANESE MOTHERS WITH CHRONICALLY ILL CHILDREN

by

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ABSTRACT

A comparative research was designed to examine the difference of parenting stress and family functioning between Taiwanese families with chronically ill children (n = 20) and families with only healthy children (n = 20) from mothers' points of view. No significant difference was found in parenting stress between the two research groups. The two research groups were found significantly different (p < .05) in family active-recreation subscale of Family Environment Scale - Chinese (FES-C). Additional correlation research design was used to examine the relationship between parenting stress and family functioning in families with chronically ill children. The parent characteristics of Parenting Stress Index - Chinese (PSI-C) were found to be significant related (p < .05) to personal growth of FES-C. Life stress events were found to be related significantly (p < .05) to family maintenance. Discussion of the findings were provided. Implication for nursing were addressed and recommendation for further research were suggested.
Chapter I
INTRODUCTION

This chapter provides an overview of the problems experienced by the parents and families with children with chronic illnesses. The purpose of the research is presented, and the important terms used in this study are defined. The significance of the problem to nursing is also discussed.

While there has been progress in controlling a number of infectious disease in Taiwan, there has been an increase in the incidence of environmentally related health problems. Many diseases are related to the spread of chemicals and materials with recent urbanization and industrialization in Taiwan. For example, the percentage of childhood asthma in Taiwan attributable to pollutants has increased from 1.3% in the 1970's to 5% in the 1980's (Liu, 1991). Asthma is just one of the chronic childhood diseases that are common among children in Taiwan. Improved health care and advanced medical technology have resulted in a remarkable increase in the survival rate and the quality of life for chronically ill children over the past few decades (Hamlett, Pellegrini, & Katz, 1992). The change in the type of diseases, and the greater life expectancy of children with chronic illness presents a new challenge for health professionals, for both
physical and psychological care.

Chronic illness does not strike only an individual, it strikes the whole family. A number of studies have reported the psychosocial impact of chronic illness on entire families (Hamlett, et al. 1992; Riper, Ryff, & Pridham, 1992). Some studies suggest that parents of children with chronic illnesses have more negative psychosocial status than parents with healthy children (Engstrom, 1991; Trute & Hauch, 1988). On the other hand, Taiwanese mothers of chronically ill children reported the impact of chronically ill children on Taiwanese families (Pai & Wong, 1991).

Overview of the Problem

Among Taiwanese people, families assume most of the responsibility for health care (Chie, & Yaung, 1988). Taiwanese mothers play a significant role in the family. As a primary caregiver for children, mothers may experience more stress than other family members when a child has a chronic illness (Chie, Chang, Hu, Yen, & Yaung, 1992).

Few studies have investigated the impact of chronic childhood illnesses on parents in Taiwanese families. However, several studies have reported evidence of the impact of chronic childhood illnesses on parents in American families. The results indicated that 1) there is increased general parental stress among parents with children with
chronic illness (Kazak & Clark, 1986; Kazak & Marvin, 1984; Kazak, Reber, & Carter, 1988; Florian & Krulik, 1991); 2) the impact of childhood chronic illnesses on parent’s relationship (Kazak, & Clark, 1986; Waisbrenm, 1980; Williams & McKenry, 1981); 3) the chronically ill child is characterized as a stressor (Quittner, Glueckauf, & Jackson, 1990; McKinney & Peterson, 1987). On the reports of the impact of chronic illness on the parents’ relationship, one of the studies reported a decreased marital quality and increased divorce rates (Friedich, & Friedrich, 1981) while other studies reported no negative effects on the marriage of parents with retarded children (Waisbrenm, 1980; Williams, & McKenry, 1981).

Family Functioning among families with children with chronic illnesses has been investigated by several researchers. Most of the studies suggest that there is no relationship between the chronic illness and family functioning (Riper, Ryff, & Pridham, 1992; Hamlett, et al. 1992; Cadman, Rosenbaum, Boyle, & Offord, 1991). On the other hand, Beavers, Hampson, Hulgus, and Beavers (1986) demonstrated the evidence in a study of coping in families of retarded children where they found families could have positive outcomes if they deal with the problems they faced in spite of the family’s stress related to the child with the chronic illness/disability.
Previous studies have investigated the impact of chronic illness on the family regarding the various classifications of chronic illness; the severity of the chronic illness (McCubbin, 1988; & Doner, 1975), if it is a life-threatening chronic illness (Florian & Krulik, 1991) and the child's diagnosis (McKinney & Peterson, 1987). The studies indicated that chronic illness is a stressful life event for families with children with chronic illnesses regardless of the various classifications of chronic illnesses. All of the studies addressed above were conducted based on American families. Only one study regarding the effect of a child's chronic illness on parental stress and family functioning among Taiwanese parents was found (Pai & Wong, 1991). Thus, this study was conducted to understand Taiwanese mothers' perception of parenting stress and family functioning among families with children with chronic illnesses.

**Purpose of the Research**

The purpose of this study was to compare Taiwanese mothers' perception of parenting stress and family functioning between families with children with chronic illness and families with only healthy children. In addition, the study also investigated the relationship between parenting stress and family functioning among
Taiwanese mothers of chronically ill children.

Research Questions

The research questions for this study were:

1) What are the psychometric properties of Parenting Stress Index -Chinese (PSI-C) and Family Environment Scale - Chinese (FES-C)?

2) How do Taiwanese mothers of children with chronic illness perceive parenting stress?

3) How do Taiwanese mothers of children with chronic illness perceive family functioning?

4) Are there differences in perception of parenting stress and family functioning between mothers with chronically ill children and mothers with only healthy children?

5) What is the relationship between parenting stress and family functioning among mothers of children with chronic illness?

Definition of Terms

Chronic illness: Chronic illness has been defined by the National Commission on Chronic Illness in 1956 as (Stevens, 1989):

All impairment or deviations from normal which have one or more of following characteristics: are permanent,
leave residual disability, are caused by non-reversible pathological alteration, require special training for rehabilitation, and may be expected to require a long period of supervision, observation or care. (p. 737)

**Stress:** Stress was first described by Hans Selye in 1936 (Helman, 1990) and viewed as "the generalized response of the organism to environmental demands" (p. 249). The response is affected by the individual characteristics, the physical environment, the social support available to them, the economic status, and the cultural background (Helman, 1990b)

**Parenting stress:** In this study, parenting stress will be examined from the mother's point of view. Quitter, Glueckauf, & Jackson (1990) defined parenting stress as a mother's report of the extent of child behavior problems, difficulties in accomplishing daily parenting tasks, and the mother's perception of role exertion.

**Family functioning:** Family functioning refers to the quality of home environment which includes the personal growth of family members, the relationship among family members, and the maintenance of the family system (Moos & Moos, 1986).

**Significance of the Problem**

Ablon and Ames (1989) suggested "the culture patterns of the family play a significant role in determining how
families cope with crisis." (p.125) Family is a basic context where family members forming and sharing the health beliefs, and problem solving regard the challenges of illness, accidents and stressful situations (Ablon and Ames, 1989). Family is a basic context that provides physical and psychological health care for every family member.

Childhood chronic illness is a stressful event. Taking care of the individual with a chronic illness is time consuming. Taking care of the chronically ill person requires cooperation of the health professionals, the individual who has the chronic illness, and the family members of the chronically ill person. Because of the long-term care process, parents of chronically ill children have to cope with a variety of stressors related to the child's care and daily family life. The stress may also affect the health of the chronically ill child. In addition, women, especially the wives or the mothers, play a significant role in family health care among Taiwanese families (Chie, Chang, Hu, Yen, & Yaung, 1992). Mothers of chronically ill children may perceive more stress than other family members.

While nursing has focused the care on the family rather than only on the individual who needs the health care, nurses also increasingly are involved in the care of chronic illnesses. It is necessary for nurses to learn more about the reality of families with chronically ill children. It
is the nurse’s responsibility to understand the adaptation process and design effective interventions to promote psychosocial adaptation to chronic illnesses. Providing family nursing care for a family with a child with a chronic illness, nurses need to know the stress among these families.

However, the parenting stress and family functioning may be different among cultures (Helman, 1990b). The individual’s perception of stress is affected by the cultural background. Family stress among families from different cultural background may have different definitions. Many studies investigated the impact of chronic childhood illnesses on parents and family functioning on the American families.

Because of the cultural difference, the results of American studies can not be applied to Taiwanese families with chronically ill children. Thus, the purpose of this study was to compare Taiwanese mothers’ perception of parenting stress and family functioning between families with children with chronic illness and families with only healthy children. In addition, the study also investigated the relationship between parenting stress and family functioning among Taiwanese mothers of chronically ill children.
Summary

Chronic illness is a stressful life event that impacts physically or psychologically not only on the individual but the whole family. Parents of children with chronic illnesses may experience a higher degree of stress than parents of healthy children, which might cause psychological maladjustment or other health problems. However, the stress may or may not cause dysfunction in families with children with chronic illnesses. Previous studies have focused on American families with children with chronic illness. Only one study researched the Taiwanese families with chronically ill children. This study investigated the maternal perception of parenting stress and families functioning among Taiwanese families with children with chronic illnesses.
In Chapter two, three parts are included. Based on the Roy Adaptation Model (Roy, 1980), the conceptual framework describes the maternal perception of parenting stress and family functioning in families with children with chronic illnesses. Second, the Taiwanese cultural background that relates to the study are briefly introduced. Related literature is reviewed as the third part of this chapter.

**Conceptual Framework**

The Roy Adaptation Model is a systems model (Roy, 1978). Systems are assumed to be characterized by inputs, control and feedback processes, and output. In this model, the nursing care recipient is seen as an adaptive system. Person is defined as "an adaptive system with cognator and regulator acting to maintain adaptive modes; physiologic function, self-concept, role function, and interdependent" (Roy, 1984, p.12). Environment is described as "all conditions, circumstances, and influences surrounding and affecting the development and behavior of persons" (Roy, 1984, p.13). (Figure 1)
Figure 1. Conceptual Model of the Relationship Between Roy's Concepts. (Roy, 1978)
In the Roy Adaptation Model, adaptation is viewed as a process of coping with stressors, and also the product of the coping. The adaptation process includes two parts. One is the receiving of internal or external stimuli which may be focal, contextual, or residual stimuli. The second part is the coping mechanism that may result in adaptation or ineffective responses (Roy, 1984). Roy (1984) described the three stimuli: focal stimuli refer to the degrees of change that precipitate the behavior being observed; contextual stimuli are defined as those contributing to the behavior caused by focal stimuli; and residual stimuli are the past experiences that affect present behavior. When an adaptive system perceives a stimulus, cognator mechanism or regulator mechanism might be used as a coping mechanism. Regulator mechanism is viewed as a physiological mechanism, chemical, or neural, that acts as input to the central nervous system. The cognator mechanism includes perception-information processing, learning, judgement and emotion, and the outcome of the regulator mechanisms. After the coping mechanism process, the person responds in four adaptive modes: physiological, self-concept, role function, and interdependence. The person may respond effectively or maladaptively (Roy, 1984).

In this study, the focal stimuli is the chronically ill child, the contextual stimulus refers to the family
situation (demographic information of the family), and the residual stimulus is the cultural values of Taiwanese families. The mother whose child is chronically ill is the adaptive system. Her perceptions are represented in the cognator (measured by PSI-C) mechanism, and influencing four adaptive modes: physiological, self-concept, role function, and inter-dependent. The mother’s perception of family functioning as the result of adaptation is measured (Figure 2) by FES-C.

The researcher, as a native Taiwanese who was born and grew up in Taiwan, introduces the residual stimuli - Taiwanese cultural values based on personal experiences and literature about the Taiwanese culture.

**Taiwanese Cultural Background**

Taiwan is an island nation which is located in the southeastern sea of mainland China, with total land area of 14,000 square miles. There are about 20 million people living in Taiwan. The median age of the population was 26.11 in 1987. Among the total population, 37.91% were children and adolescents ages 19 or younger (Chen, Lee, Pigg, Huang, & Yen, 1990).

**Traditional Chinese Concepts**

Traditional Chinese concepts are based on the Confucians’ framework. Chinese people emphasize humanism,
Figure 2. Conceptual Framework for the Relationship of Demographic Factors, Parenting Stress and Family Functioning Among Taiwanese Mothers of a Chronically Ill Child.
familism, and cooperation. In Chinese familism, Chinese families emphasize the virtues of filial piety, respect for elders, mutual dependence, group identification, moderation and harmony, and self-discipline (Chiu, 1987). Children are taught to respect parents, ancestors, and authority. Children are trained to obey and learn satisfaction from conforming to parental or another authority’s expectations. Self-expression and self actualization are often inhibited (Li & Yang, 1989; Chiu, 1987).

The term of "self-concept" in Western culture has been used frequency in Chinese society and has been translated into Chinese as "tzu woo". However, the meaning of "self" (tzu woo) in Chinese culture is very different from it's meaning in Western culture. Most of the phrases which include the two words "tzu woo" tend to repress an individual’s self-expression. The principle of human relation, the individual’s responsibility to the society, and the sacrifice of little self for the big self are some concepts of the individual and the society in Chinese culture. When comparing public self-consciousness and private self-consciousness, the person who has more private self-consciousness had higher adaptability toward the society in western culture. However, in Chinese society, the more public self-consciousness the person has the higher
adaptability toward the society he/she processes (Yaung, 1991).

The other concept that is very important for Chinese people is "face". "Face" presents the meaning of "honor." In Chinese society, honor is the most important thing in one's life. Any event such as the loan of money, contracting disease, poverty, bad behavior or bad academic achievement of one's child, or the exposure of privacy will make people feel ashamed and have the result of "loosing face" (Ju, 1991).

Religions in Taiwan

The major religions in Taiwan are Buddhism and Taoism. Buddhism was introduced into Chinese culture in 65 A.D., during the Eastern Han Dynasty (25-220 A.D.). Buddhism exposes the belief that all living creatures are endowed with a Buddhist nature, and every one can become a Buddha through self-discipline and creation ("Religions in" 1990). Karma and the samsara are the major concept of Buddhism. Karma means the totality of a person's actions in any one of the successive states of that person's existence, thought of as determining the fate of the next stage. For example, a handicap or deformity could be the result of the person's action in his/her past life, this is karma (Cheng, 1990). Samsara means the continuing cycle in which the same soul is
repeatedly reborn. These two concepts have impressed most of the Chinese people whether or not she/he is a Buddhist.

Taoism is a fundamental religious and philosophical tradition that has helped to shape Chinese life for more than 2,000 years. "Tao" means the "way," and the extended meaning is "a code of behavior and a doctrine." (Religions in, 1990, p. 11) It is sometimes difficult to separate Taoism and Buddhism since Hui, an Emperor in the Sung Dynasty (960-1279 A.D.), combined the creeds and rituals of the Taoism and Buddhism into one. The tradition persists until today. ("Religions in," 1990)

The Chinese Family

The concept of time surrounding the existence of Taiwanese families is different from that of American families. American family is focused on the single nuclear family, which has a time limited life span. The traditional Chinese family does not have a limited time perspective. The concept of family extends both backward and forward. The individual is merely one generation of the whole family from the beginning of time. Ancestor worship and the family pedigree are two important symbols of this concept. Individual behaviors and one's personal life reflect not only on the individual and the existing members of family but also on all of the generations of the family since the beginning of time (Char, 1990).
In the Chinese culture, marriage does not signify the creation of a new family. A young couple usually lives with the man's family after marriage as the continuation of the man's family line. The woman has to leave her own family and become a member of the man's family. "To have a son" is important for the young generation because it is the continuation of a man's family line.

In many Chinese families the status and power of married members tend to depend upon whether they have had children, especially sons (Yang, 1976). Traditionally, a Chinese wife was considered an outsider to the family group until the birth of the first son. A wife who did not bear a son was viewed as worthless and had no status in the family.

From the beginning of pregnancy, the mother has more responsibility for rearing a healthy child. For example, a taboo about cleft palate for pregnant women is that pregnant women cannot use scissors in any situation, or the baby will get a rabbit lip (cleft palate).

Chinese parents think it is very important to provide a sense of security to an infant (Char, 1981; Li & Yang, 1989). Chinese people see a baby as weak, lovely, and in need of protection and nutrition. So, the first year for the infant is warm and secure. Chinese children have a very close relationship with their mothers in their early childhood. Chinese children receive a great deal of
attention and care from the adults around them from birth to preschool. The attitude of parents toward young children can be described as lenient or even indulgent - in sharp contrast to the attitude of strictness toward elder children (Ho, 1981). Children who are school-age are treated differently than they were treated before attaining school-age.

The parent has a sense of complete responsibility and belief that the child's behavior reflects his/her training (Char, 1981). A well-known proverb from "Three-Character Classic" (a chief primer for beginners) reads: rearing without education is the fault of the father; teaching without strictness is the negligence of the teacher, and represents the parents' responsibility.

Lin, and Fu, (1990) conducted a comparative study to investigate child-rearing practices among Chinese, immigrant Chinese, and Caucasian-American parents. A total number of 138 parents from Taiwan and the United States participated in the study. Four factors from Child-Rearing Practices Report (CRPR) were used in the study. Post-hoc Tukey tests were used to determine the ethnic group differences in child-rearing practices. The findings (p < .05) indicated that Chinese and immigrant-Chinese parents tend to have higher ratings than Caucasian-American parents on parental control and emphasis on achievement. Compared with American
parents, Chinese parents use more authoritarian-control in their relationships with young children, however, they also have closer relationship with their children (Chu, 1974).

Parents always expect their child to be a "good" child. A "good" child means the child should be well-behaved, obedient, and quiet. When the child has reached six or seven years of age, he/she will be asked to be "tung shih" (understanding things) (Ho, 1981). Boys are expected to be independent, courageous, and vivacious, girls are expected to be warm and tender, virtuous and intelligent, and gracefully quiet. "Everything is nothing, education is the best" (Chinese proverb). The Chinese proverb indicates the value of a scholar. In Chinese society, scholars receive more respect than other professions. Most parents expect their children to achieve as much education as possible. The most common words that children hear from their parents are "study hard".

**Concept About the Illness**

In many cultures, illness is thought of as negative, bad, or evil (Helman, 1990a). In Chinese culture, the concept of illness is related to karma. Because of samsara and karma, and familism, illness is viewed as a kind of punishment one receives from bad things one did in a past life, or from acts of an ancestor. Chinese people think "getting disease" is a painful and shameful event. Another
view of chronic illness is that parent don’t want others to know about the illness of their child especially of a son, because it might affect the continuation of a family line - nobody will marry him, and the family line will be cut off.

Because of the rapid change from an agricultural society to an industrial society, belief in folk taboos has decreased in the younger generation to belief in scientific evidence. Family members may have different perspectives regarding child-rearing practices and health care interventions (Char, 1981). More often, conflicts occur between generations.

In summary, the residual stimuli defined as Taiwanese cultural values was addressed, based on Confucian’ framework, and the effects of Buddhism and Taoism. Some concepts including "self" (tzu woo), "face" and familism contribute to the Chinese culture. Family line, women’s role in the family, and the practice of childrearing are specific characteristics in Chinese families. Also, the concept of illness as affected by Chinese cultural beliefs was addressed above.

Related Literature Review

Previous research that relates to this study was reviewed. Most of the relevant literature was American. The American literature was divided into four groups: 1) stress and family functioning; 2) parenting stress in
families with children with chronic illnesses; 3) family functioning in families with children with chronic illnesses; 4) parenting stress and family functioning. Two studies conducted in Taiwan discussing the impact of chronically ill children on Taiwanese families and family health care and women's roles in Taiwan were reviewed.

Stress and Family Functioning

Stress from negative life events is associated with family functioning - positive or negative. In order to understand parenting stress and family functioning in families with chronically ill children, the relationship between stress and family functioning was examined.

Stress is a pathological response to environmental demands, and mediated by several factors (Helman, 1990b). These factors that affect stress include individual characteristics, the physical environment of the stress recipient, the availability of social support, the economic status, and cultural background of the individual.

Hill developed the ABC model of family stress in 1949 (Gilliss, Rose, Hallburg, and Martison, 1989). The assumption of Hill's ABC model includes the idea that the environment where humans live is a complex symbolic environment and the family teaches the interpretation of these symbolic systems. Humans are actors and reactors, and their social behavior is influenced by ideas. Family is an
organization where human interact and transact. The family health and the individual health affect each other.

In 1983, McCubbin and Patterson developed the Double ABCX model to describe the family stress theory over time. In McCubbin and Patterson’s (1983) model, three variables (a=stressor, b=existing resources, and c=perception of "a") exist in the family before the crisis. When a family experience a crisis, at the period of post-crisis the variables of aA as the pile up of a (stressor), bB as the existing and new resources, cC as the perception of X+aA+bB result. After the coping process, the family adaptation may be bonadaptation or maladaptation (McCubbin, & McCubbin, 1987). Both the Double ABCX model and Roy’s Adaptation model include the adaptation process. When a stressor or stimuli occur, the adaptative system (family or person) might experience the stress (cognator mechanism), and the result of coping process might be positive or negative.

Parenting Stress in Families with Children with Chronic Illness

Studies that focused on the impact of chronic childhood illness on parents reported major findings that included: increased general parental stress among parents with children with chronic illness (Beckman, 1991; Dyson, 1991; Engstrom, 1991; Florian & Krulik, 1991; Thompson, Zeman, Fanurik, & Sirotkin-Roses, 1992); child’s characteristic as
a stressor (Quittner, Glueckauf, & Jackson, 1990; McKinney & Peterson, 1987).

Backman (1991) investigated mothers' and fathers' perception of the effect of young children with and without disabilities among 54 mothers and 54 fathers of young children, between 18 and 72 months age, with and without disabilities. Parenting Stress Index (PSI) was used to examined the parental stress. Carolina Parent Support Scale was used to measure parents' social support. The child's caregiving needs was examined by Caregiving Questionnaire. Finding indicated that parents of children with disabilities reported significantly (p < .0001) more stress than parents of children without disabilities.

In order to present the family and parent demographic characteristics and psychosocial adjustment in families of children with chronic illnesses, Cadman, Rosenbaum, Boyle, and Offord (1991) studied a large randomly selected group of families of children with chronic medical conditions (N=1896). In the study, family functioning was examined with a 12-item General Functioning scale of the Family Assessment Device. The general individual psychological well-being was measured by the Bradburn Affect Balance Scale. The findings revealed an increased rate of parental treatment for "nerves" among parents of children with chronic illnesses. An increase of maternal negative affect
scores (P < .001) indicates a more negative affective state.

In Dyson's (1991) study, parental stress and family functioning in families with children with handicaps was investigated. A total number of 110 families participated in the study. Half of the families had handicapped children and the other half did not. The Questionnaire of Resources and Stress-Short form and Family Environment Scale were used to measure the parental stress and family functioning. Parental stress was found in significant difference between the two groups (p < .001). The results suggested that parental stress is especially related to the child with a handicap.

Engstrom (1991) compared the parental distress and social interaction between 20 families with children with inflammatory Bowel Disease and 20 families with only healthy children. Three questionnaires were used as a measurement in this study. The instruments were (1) Symptom Check-List 90 (SCL-90) for parental distress, (2) Child Assessment Schedule (CAS) for psychiatric disorder in the children, and (3) Child Behavior Checklist (CBCL) for behavioral problems in the children. Results showed the significant difference (p < .001) of parental distress between two groups. The presence of chronically ill child in the family correlates with psychopathological symptoms in the mothers.
Florian and Krulik (1991) conducted a study to address the problem of loneliness and social support of mothers of chronically ill children. Thirty-three mothers of children with chronic life-threatening disease, 57 mothers of children with chronic illness and 92 mothers of healthy children participated in the study. The revised UCLA Loneliness Scale and the Norbeck Social Support Questionnaire were used to examine the loneliness and social support of mothers. Significant differences between healthy and chronic groups were found in the areas of loneliness (\( p < .001 \)), social network size (\( p < .01 \)), and social support (\( p < .001 \)).

Thompson, Zeman, Fanurik, and Sirotkin-Roses (1992) conducted a study to investigate the role of parental stress and coping and family functioning in parent and child adjustment to a specific chronic illness. The sample included 35 parents of children, aged 4 to 14 years, with Duchenne Muscular Dystrophy. Self-report measures and brief interviews were completed by the subjects. The self-report instruments included 1) the Way of Coping questionnaire to measure parent methods of coping, 2) the Family Environment Scale to examine the social support - family functioning, 3) the Symptom Checklist 90-Revised to investigate parent psychosocial adjustment, and 4) the Missouri Children’s Behavior Checklist to measure the child psychosocial
adjustment. The brief interviews were conducted by pediatric psychologist to assess stress appraisal and efficacy expectation in relation to four illness-related tasks 1) dealing with the child medical problems and symptoms; 2) maintaining the child's emotional well-being; 3) maintaining their own emotional well-being; and 4) preparing for an uncertain future. The findings suggested the rate of parent-report child behavior problems is relatively high (89%). Parents reported a rate of 57% of self-reported poor psychological adjustment. The investigators described the relatively high rate of parent-report child behavior problems as possible reflections of parental distress.

Family Functioning in Families with Children with Chronic Illness

Family functioning includes the relationship between family members, the personal growth within the family, and the maintenance of the family.

Comparing 34 families of children with Down Syndrome to 41 families with non-disabled children, Riper, Ryff, and Pridham (1992) conducted a study to examine the effects of the illness on general family functioning (N= 75). Family and marital functioning was assessed by the Family Assessment Measure (FAM III). Individual functioning was examined by structured self-report scales constructed by
Ryff in 1989 (Riper, Ryff, & Pridham, 1992). The Center for Epidemiological Studies Depression Scale (CES-D) was used to tap symptoms of depression. The findings suggested that there was no significant difference in family functioning between the two groups.

A comparison of thirty mothers of children with asthma (N=17) or diabetes (N=13) and thirty mothers of healthy children is included in the study on the impact of chronic childhood illnesses within the family context. Hamlett, et al. (1992) found mothers of asthmatic children reported a lower perceived adequacy of social support than mother’s of healthy children, t(45)=2.41, p < .03. The maternal perception of family functioning was assessed by the Family Environment Scale (FES). The results indicate no statistically significant group difference on any of the family function variables.

In the study conducted by Cadman, et al. (1991), the family and parent demographic characteristics and psychosocial adjustment in families of children with chronic illnesses, were examined from a large randomly selected group of families with children with chronic medical conditions (N=1896). In the study, family functioning was examined on a 12-item General Functioning Scale of the Family Assessment Device. The general individual psychological well-being was measured by the Bradburn Affect
Balance Scale. The findings related to parental stress have been addressed above. Family functioning is also examined between families with chronically ill children and families with healthy children. Results showed that no significant difference exists between the two groups.

Parenting Stress and Family Functioning

A common notion is that families of children with handicaps/ or chronic illness have a high degree of stress and a lower level of family functioning. Previous studies have shown inconsistence in the associating parental stress and family functioning. In order to find out the relationship, Dyson (1991) examined the relationship among the presence of parental stress and family dysfunctioning on fifty five families with young children with handicaps and a matched group of families of children without handicaps. The results indicated family relationship is a significant predictor of parental stress (F(2, 106) = 47.12, p < .0001).

The Impact of Chronically Ill Children on Taiwanese Families

The impact on families with chronically ill children has been studied in American families over decades. However, only one study regarding the impact of chronically ill children on Taiwanese families has been conducted in Taiwan.

Based on system theory, Pai, and Wong (1991) conducted an qualitative study - phenomenological research - to find
out the impact of a chronically ill child on the family. By interviewing eight mothers with a chronically ill child, with four open-ended questions regarding the impact of the chronically ill child, the results were 1) the initial response to the illness include shock, guilt, anger, denial and disability, sadness, and fear and anxiety; 2) the most significant impact on the family is the financial burden; 3) mothers of school aged chronically ill children are concerned about the education of the child; 4) the relationship between family members are not as close as before, 5) two of the mothers said they were more dependent on religions, 6) the most stressful period is related to the symptom and the treatment of the child’s chronic illness, 7) the coping strategies and supportive system include husband(3:8), religion(3:8), their mothers or sisters (2:8), searching for medical references. The researchers suggest that nurses need to be more aware of the needs of the family. Also, the study found that in the Chinese concept, it is shameful to get financial support and always results in a very difficult financial situation in the family.

Family Health Care and Women’s Role in Taiwan

In order to understand the pattern of health care in the family in Taiwan, a study was conducted by a group of community health professionals (Chie, Chang, Hu, Yen, & Yaung, 1992). The Proportional Probability Sampling to Size
with Chesters was used to obtained subjects. A total number of two thousand families were interviewed, and 1590 families completed the study. Among these families, 862 families had a family member with acute disease (14.7%), chronic disease (5%), severe disease (1.6%), disability (.9%), and a combination of two or more types (.6%). Chi-Square, and the Stepwise multiple logistic regression were used to analyze data. The findings presented showed that children with illness are more cared for by their mothers, the adjusted odd ratio is 20.17 (95%, 10.72-37.94). Chie and others (1992) also indicated that although mothers were the primary caretakers for their children, there was not much self-care occurring among mothers.

A study of psychological correlates of family size, preference for male children and birth control in Taiwan was done by Yang in 1976. The results show that Chinese husbands and wives who are more modern tended to have a lower ideal family size and display a weaker preference for sons than was previously the case (Yang, 1976).

Summary

Based on the Roy Adaptation Model, the conceptual framework was developed. The Taiwanese cultural background and literature related to the conceptual framework were presented in this chapter. Mothers of chronically ill
children in Taiwanese families were viewed as the adaptative system and the experience of cognator was examined by PSI-C. The adaptation outcome was measured by FES-C. Some important cultural background that related to self, the Chinese society, Taiwanese family, women's role and parenting in the Taiwanese family, were addressed. Most of the literature was American, and only a few studies have been conducted in Taiwanese families. Two studies that researched Taiwanese families and women’s roles were described in this chapter. Different outcomes have been found in previous studies. Parents of chronically ill children presented a higher degree of parental stress. Most of the previous studies reported no difference in family functioning between families with and without chronically ill children. The relationship between family functioning and parenting stress in previous studies showed an inconsistency in results.
Chapter III
METHODOLOGY

This chapter describes the methodology that was used to investigate Taiwanese mothers' perceptions of stress and family functioning when chronically ill children are involved. First, the research design is addressed. Next, the setting and sample, and the protection of Human Subjects are presented. The plan for data collection and data analysis is also described.

Research Design

The comparative research was designed to compare Taiwanese mothers' perception of parenting stress and family functioning among families with children with chronic illness and families with only healthy children. This study also describes the relationship between parenting stress and family functioning among families with a chronically ill children from the mothers' points of view.

Setting and Sample

The study was conducted in urban areas in Taiwan. A convenience sample included mothers from 20 families with chronically ill children and a comparison group of 20 families with only healthy children. The criteria for the families were: 1) both parents were present in the family;
2) mother's education was at least high school level; 3) the mother was the primary caregiver for the children; 4) the ages of the children was between 7 and 12 years old; 5) the chronically ill school age children were diagnosed with the chronic illness at least six months ago; 6) the chronically ill children were not hospitalized at the time of the study.

Protection of Human Subjects

The study proposal was approved by the Human Subject Committee of the university of Arizona (Appendix A). A consent form (Appendix B) was completed by each subject. All of the subjects were informed of the purpose of the study. Subjects were encouraged to ask questions and were allowed to withdraw from the study at any time. Anonymity was assured to all of the subjects by the investigator.

Instruments

Three instruments were used and a short interview was conducted in the study. A demographic information sheet (Appendix C) solicited information about the chronically ill child, the structure of the family, and the mother. Parenting stress was measured by the Parenting Stress Index - Chinese (PSI-C) (Appendix G). Family functioning was measured by the Family Environment Scale - Chinese (FES-C)
(Appendix J). A short interview was designed to obtain the validity of PSI-C and FES-C by asking questions about the content and language statements in both instruments.

**Parenting Stress Index - Chinese (PSI-C):** The PSI-C is the Chinese vision of original English Parenting Stress Index (PSI) that was translated into Chinese by Yuk Chung Chan and Kovok Kwan Tam (Abidin, 1992). There was no information provided regarding the procedure of translation. The PSI-C is currently being normed in Hong Kong. However, the normative data of PSI was not completed at the time this study was conducted.

The PSI (Appendix F) was developed by Abidin (1990) to measure the effects of parenting stress in the parent-child system. The PSI covers three areas of stressors: 1) the Child Characteristics; 2) the Parent Characteristics; and 3) the Life Stress Event. In the Child Characteristics domain, subscales include child adaptability/plasticity, acceptability of child to parent, child demandingness, child mood, child distractibility/activity, and child reinforces parent. The subscales in the Parent Characteristics domain include parent depression, parent attachment, restrictions imposed by parental role, parent's sense of competence, social isolation, relationship with spouse, and parental health. The PSI (Abidin, 1990), is a 120-item, self-report questionnaire. Each item is responded to on a 5-point
Likert scale ranged from 1 (strongly agree) to 5 (strongly disagree).

Adequate reliability of original English Parenting Stress Index has been reported by Abidin (1990) in the PSI manual. The Pearson correlations between test-retest score in a three month interval were .63 for the Child domain, .91 for the Mother domain, and .96 for the Total Stress Score. Alpha reliability coefficients were also established and addressed in the manual. The alpha reliability for the subscales ranged from .62 to .70, in the Child domain, and .55 to .80 in the Parent domain. The reliability coefficients are .89 for total Child domain, .93 for total Parent domain, and .95 for Total Stress Score. The appropriate validity was also addressed in the manual by Abidin (1990). According to Abidin (1990, P.10), content validity of the PSI was established and described by Burke. After the process of general review of the research, they developed a comprehensive list of dimensions and items, pilot testing, rated by six professionals, and additional field tests resulted in 150 items. Among these 150 items, 95 percent were directly related to at least one study that provided the evidence of the item as a stressor for parents of young children (Abidin, 1990).

Family Environment Scale - Chinese (FES-C): The FES-C is a questionnaire translated from original English Family
Environment Scale (FES) - Form-R (Appendix I) (Moos & Moos, 1986) into Chinese by the researcher. The translation process will be described below.

The FES was designed by Moos & B. Moos (1986) to assess family structure, family functioning, and communication style. Three domains included in the FES are: 1) Relationship; 2) Personal Growth; and 3) System Maintenance. There are 10 subscales in the FES. The Relationship domain includes cohesion, expressiveness, and conflict. The Personal Growth domain includes independence, achievement orientation, intellectual-culture orientation, active-recreation orientation, and moral-religious emphasis. The Maintenance domain includes organization and control. The FES has three forms, the Real Form (Form-R), the Ideal Form (Form-I), and the Expectations Form (Form E). The FES is a 90-item, true-false, self-report questionnaire.

Moos and Moos (1986) present adequate reliability of the original English Family Environment Scale in the manual. Cronbach’s Alpha was used in computing the internal consistency for the 10 FES subscales and .61 to .78 demonstrated proper reliability. Test-retest reliability were .68 to .86 for a two months interval and .52 to .89 for a twelve months interval. Moos and Moos (1986) addressed in the manual that construct validity of the FES was established by several investigators. The cohesion is
positively related to Procidano-Heller, the Spainer Dyadic Adjustment Scale (DAS) and the Locke-Wallace Marital Adjustment Scale. The expressiveness and conflict of FES are predictably related to DAS. The subscales of FES are also significant, as predicted, in comparison to other conceptually similar aspects (Moos and Moos, 1986, p.20-22).

The first translation of original English FES into Chinese was done by the researcher. The first Chinese version of FES was read by two Taiwanese whose native language was Chinese. The Chinese version of FES was reviewed and revised based on the suggestion provided by the two Taiwanese; the Chinese version of FES was backtranslated by one native English speaking American who could also read Chinese. The translated English FES was compared to the original English FES by an American who spoke English only. Pilot testing was not feasible.

Data Collection Procedure

After obtaining the Human Subject Approval, data collection was conducted in two urban areas in Taiwan. The subjects in group 1 (families with chronically ill children) were selected by reviewing records after obtaining permission from the hospital administration department, and the pediatric clinic. The subjects in group 2 (families with only healthy children) were obtained from two
elementary schools. A total number of forty subjects who met the criteria described in this chapter were included. First, the subjects were contacted via telephone by the investigator. After a short introduction, the investigator briefly described the study and set an appointment with the subject to explain the purpose of the study to the subject and ask if they would participate. Once they agreed to participate, the data collection was conducted at the time of the appointment. The investigator gave each subject a packet including a written description of the study, a consent form, and three questionnaires (demographic information sheet, PSI-C, and FES-C). After the subject had completed all three questionnaires, the investigator then conducted a short interview. The subjects were asked if there was any other parenting stress or family functioning that was not included in the questionnaires. Questions include 1) Is there any inappropriate content of PSI-C? 2) Is the language statement of PSI-C appropriate? 3) Is there any inappropriate content of FES-C? 4) Is the language statement of FES-C appropriate? 5) What else concerns you about your child and about being a parent, not including the existing items in PSI-C? 6) Do you have any suggestions for both PSI-C and FES-C? The interviews were tape-recorded.
Data Analysis Plan

Descriptive statistics were used to describe the demographic characteristics of the sample. The psychometric properties of PSI-C and FES-C were evaluated before any further analysis of subjects scores on the PSI-C and the FES-C were done. Item analysis was conducted to assess the performance of individual items in the overall test. The validity will be assessed by comparing interview responses with responses on the questionnaires.

If the reliability was acceptable at the level of alpha=.65, then data analysis was conducted to answer the research questions. Descriptive statistics were used to answer research questions: 2) How do Taiwanese mothers of children with chronic illnesses perceive parenting stress? and 3) How do Taiwanese mothers of children with chronic illness perceive family functioning?

The fourth research question: 4) are there differences in mothers' perceptions of parenting stress and family functioning between mothers with chronically ill children and mothers with healthy children? were answered by the use of the two tailed t-test statistic. The Pearson (r) correlation coefficient was used to answer the fifth research question: 5) What is the relationship between parenting stress and family functioning among mothers of children with chronic illnesses? The rule of the decision
for determining statistical significance was set at $p < .05$. Only the statistically significant correlation coefficients were reported.
Chapter IV

FINDINGS

The purpose of this comparative research is to investigate Taiwanese mothers' perception of parenting stress and family functioning in families with a chronically ill child and families with only healthy children. The research was conducted in the urban areas of two cities (Tai-Chung and Hwa-Lian) in Taiwan. A convenience sample of 40 Taiwanese mothers participated in the study.

Description of the Sample

A total number of forty mothers agreed to participate in the study, half of them were from families with a chronically ill child aged from 7 to 12 years old, the other half were from families with only healthy children whose age range was also from 7 to 12 years old. The two groups were also matched in family structure (two parent families), and mothers' education level (at least junior high school). The chronic illnesses that the children had were showed in Table 1. The frequency distribution of selected demographic characteristics is presented in Table 2. A chi-square test was applied to the relationship between selected demographic characteristics and mothers with or without chronically ill children. The chi-square statistic results of the selected demographic characteristics: mothers' education level $x^2(4,$
Results by Research Questions

The statistic results of five research questions are presented. Additional findings are also reported following the research questions.

Research Question One

The research question one: What are the psychometric properties of Parenting Stress Index - Chinese (PSI-C) and Family Environment Scale - Chinese (FES-C)? examines the psychometric properties of PSI-C and FES-C. The Parenting Stress Index - Chinese (PSI-C) and Family Environment Scale - Chinese (FES-C) were used to investigate Taiwanese mother’s perception of parenting stress and family functioning in families with and without chronically ill children. The reliability testing of both PSI-C and FES-C were focused on homogeneity of the instruments. The internal consistency for both PSI-C and FES-C were calculated by Cronbach’s alpha coefficients. The content validity of both PSI-C and FES-C was established by face validity. Subjects were asked to evaluate the content after they have completed the questionnaires.
Table 1

The Frequency of the Children's Chronic Illness (n = 20)

<table>
<thead>
<tr>
<th>Chronic Illness</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Lymphocytic Leukemia</td>
<td>2</td>
<td>10.0</td>
</tr>
<tr>
<td>Idiopathic Thrombocytopenic Purpura</td>
<td>2</td>
<td>10.0</td>
</tr>
<tr>
<td>Asthma</td>
<td>11</td>
<td>55.0</td>
</tr>
<tr>
<td>Tumor</td>
<td>1</td>
<td>5.0</td>
</tr>
<tr>
<td>Diabetes</td>
<td>5</td>
<td>25.0</td>
</tr>
<tr>
<td>Renal Disease</td>
<td>2</td>
<td>10.0</td>
</tr>
<tr>
<td>Congenital Heart Disease</td>
<td>1</td>
<td>5.0</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Table 2

Frequency and Percentage of Selected Demographic Characteristics

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Chronically ill</th>
<th>Healthy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Average income (yearly, New Taiwanese Dollars)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;540,000</td>
<td>8</td>
<td>47.1</td>
</tr>
<tr>
<td>55-950,000</td>
<td>5</td>
<td>29.5</td>
</tr>
<tr>
<td>&gt;1,000,000</td>
<td>4</td>
<td>23.5</td>
</tr>
<tr>
<td>Total</td>
<td>17</td>
<td>100.0</td>
</tr>
<tr>
<td>Mother's age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30-34</td>
<td>7</td>
<td>36.8</td>
</tr>
<tr>
<td>35-39</td>
<td>10</td>
<td>52.6</td>
</tr>
<tr>
<td>40-43</td>
<td>2</td>
<td>10.5</td>
</tr>
<tr>
<td>Total</td>
<td>19</td>
<td>100.0</td>
</tr>
<tr>
<td>Mother's education level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Junior high school</td>
<td>8</td>
<td>44.4</td>
</tr>
<tr>
<td>Senior high school</td>
<td>7</td>
<td>38.9</td>
</tr>
<tr>
<td>Junior college</td>
<td>3</td>
<td>15.0</td>
</tr>
<tr>
<td>College</td>
<td>3</td>
<td>16.7</td>
</tr>
<tr>
<td>Graduate school</td>
<td>3</td>
<td>15.0</td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Table 2 (con’t)

Frequency and Percentage of Selected Demographic Characteristics

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Chronically ill</th>
<th>Healthy</th>
<th>Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Religious preference</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>4</td>
<td>25.0</td>
<td>3</td>
</tr>
<tr>
<td>Taoism</td>
<td>2</td>
<td>12.5</td>
<td>0</td>
</tr>
<tr>
<td>Buddhism</td>
<td>10</td>
<td>62.5</td>
<td>14</td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>100.0</td>
<td>17</td>
</tr>
<tr>
<td>Child’s health rated by mothers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor</td>
<td>2</td>
<td>10.0</td>
<td>0</td>
</tr>
<tr>
<td>Fair</td>
<td>8</td>
<td>40.0</td>
<td>4</td>
</tr>
<tr>
<td>Good</td>
<td>7</td>
<td>35.0</td>
<td>8</td>
</tr>
<tr>
<td>Excellent</td>
<td>3</td>
<td>15.0</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>100.0</td>
<td>20</td>
</tr>
<tr>
<td>Mother’s occupation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housewife</td>
<td>9</td>
<td>45.0</td>
<td>1</td>
</tr>
<tr>
<td>Business</td>
<td>8</td>
<td>40.0</td>
<td>6</td>
</tr>
<tr>
<td>Teacher</td>
<td>2</td>
<td>10.0</td>
<td>7</td>
</tr>
<tr>
<td>Government</td>
<td>1</td>
<td>5.0</td>
<td>4</td>
</tr>
<tr>
<td>Labor</td>
<td>0</td>
<td>0.0</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>100.0</td>
<td>19</td>
</tr>
</tbody>
</table>
The Reliability of PSI-C

The internal reliability of the Parenting Stress Index - Chinese (PSI-C) was calculated. The PSI-C was newly translated into Chinese, thus, an internal reliability of alpha coefficient was considered satisfactory when Cronbach’s $\alpha > .65$. The alpha coefficient of the total PSI-C in the study was $\alpha = .94$. The alpha coefficients for the subscales of PSI-C range from .09 to .83, and are illustrated in Table 3. However, among thirteen subscales of PSI-C score, four subscales which presented low reliability were child demandingness ($\alpha = .56$), child mood ($\alpha = .62$), parental health ($\alpha = .56$), and life stress ($\alpha = .59$), and one subscale presented an extremely low reliability (child distractibility/activity, $\alpha = .09$). Since the alpha coefficients of PSI-C total scales were $>.65$ and considered satisfactory, data analysis was conducted using the results from PSI-C. The researcher also recognizes the possible limitation of interpretation of the results because of some of the subscales in PSI-C with low alpha coefficients. Items that reduced the alpha coefficients to lower than $\alpha = .65$ for each subscales were presented in the Appendix K.

The Validity of PSI-C

A total number of 30 mothers from both groups participated in the interviews and provided information
Table 3

**Reliability Standardized Alpha Coefficients for Parenting Stress Index - Chinese (PSI-C) (n=35)**

<table>
<thead>
<tr>
<th>Instruments</th>
<th>Standardized</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSI-C Total Scale</td>
<td>.94</td>
</tr>
<tr>
<td>Subscales:</td>
<td></td>
</tr>
<tr>
<td>Child Adaptability/Plasticity</td>
<td>.80</td>
</tr>
<tr>
<td>Acceptability of Child to Parent</td>
<td>.78</td>
</tr>
<tr>
<td>Child Demandingness</td>
<td>.56</td>
</tr>
<tr>
<td>Child Mood</td>
<td>.62</td>
</tr>
<tr>
<td>Child Distractibility/Activity</td>
<td>.09</td>
</tr>
<tr>
<td>Child Reinforces Parent</td>
<td>.69</td>
</tr>
<tr>
<td>Parent Depression</td>
<td>.82</td>
</tr>
<tr>
<td>Parent Attachment</td>
<td>.68</td>
</tr>
<tr>
<td>Restrictions Imposed by Parental Role</td>
<td>.81</td>
</tr>
<tr>
<td>Parent’s Sense of Competence</td>
<td>.72</td>
</tr>
<tr>
<td>Social Isolation</td>
<td>.74</td>
</tr>
<tr>
<td>Relationship with Spouse</td>
<td>.83</td>
</tr>
<tr>
<td>Parental Health</td>
<td>.56</td>
</tr>
<tr>
<td>Life Stress</td>
<td>.59</td>
</tr>
</tbody>
</table>
about the appropriateness of the content of the instruments and the language used in the statement of items in the instruments. Most of the mothers agreed with the content included in the PSI-C. While the researcher asked for suggestions other than the existing items, the inconsistency of parenting opinions between in-laws was suggested to be included. When the researcher asked about the language statement of items for PSI-C, most of the mother's suggested the statement of items in PSI-C should be restated, although they could understand the meaning.

The Reliability of FES-C

The internal reliability of the Family Environment scale - Chinese (FES-C) was calculated. The FES-C was newly translated into Chinese, thus, an internal reliability of alpha coefficient was considered satisfactory when Cronbach's $\alpha > .65$. The alpha coefficient of the total FES-C in the study was $\alpha = .68$. The alpha coefficients for the subscales of FES-C ranged from .24 to .69, were illustrated in Table 4. There was only one subscale, cohesion, in the relationship area of the FES-C which met the alpha coefficient at the level of $\alpha = .69$. Since the alpha coefficients of FES-C total scales were $>.65$ and considered satisfactory, data analysis was conducted using the results from FES-C. The researcher also recognized the possible limitation of interpretation while some of the subscales in
<table>
<thead>
<tr>
<th>Instruments</th>
<th>Standardized</th>
</tr>
</thead>
<tbody>
<tr>
<td>FES-C Total Scale</td>
<td>.68</td>
</tr>
<tr>
<td>Subscales:</td>
<td></td>
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<tr>
<td>Cohesion</td>
<td>.69</td>
</tr>
<tr>
<td>Expressiveness</td>
<td>.57</td>
</tr>
<tr>
<td>Conflict</td>
<td>.59</td>
</tr>
<tr>
<td>Independent</td>
<td>.28</td>
</tr>
<tr>
<td>Achievement Orientation</td>
<td>.24</td>
</tr>
<tr>
<td>Intellectual-Culture Orientation</td>
<td>.62</td>
</tr>
<tr>
<td>Active-Recreation Orientation</td>
<td>.28</td>
</tr>
<tr>
<td>Moral-Religion Emphasis</td>
<td>.42</td>
</tr>
<tr>
<td>Organization</td>
<td>.53</td>
</tr>
<tr>
<td>Control</td>
<td>.24</td>
</tr>
</tbody>
</table>
FES-C with low alpha coefficients. Items that reduced the alpha coefficients to lower than $\alpha = .65$ for each subscales were presented in Appendix L.

**The Validity of FES-C**

A total number of 30 mothers from both groups participated in the interview and provided information about the appropriate content of the instruments and the language used in the statement of items in the instruments. Only a few items regarding religion in FES-C had been suggested as inappropriate because the different religious preferences. While the researcher asked about the suggestions other than the existing items, some suggested that there should have been items about the relationship between in-laws and family life of a family where three or more generations lived together. When the researcher asked about the language statement of items for FES-C, all of the mothers agreed with the statement of items in FES-C.

**Research Question Two**

To answer the second research question, How do Taiwanese mothers of children with chronic illness perceive parenting stress? a descriptive statistic was used. The total score of PSI-C (n = 20) in the study ranged from 214 to 338, with the mean of 261.7 and s.d. of 34.71. In three areas of stressors: 1) the Child Characteristics; 2) the Parent Characteristics; and 3) the Life Stress Event, the
score of Child Characteristics domain ranged from 99 to 143 \( M = 120.4, \text{ sd } = 13.88 \). The score of Parent Characteristics domain ranged from 114 to 195 \( M = 140.4, \text{ sd } = 22.85 \). The score of life stress event ranged from 0 to 6 \( M = 1, \text{ sd } = 1.59 \). Table 5 illustrates the mean and s.d. of subscales including child adaptability/plasticity, acceptability of child to parent, child demandingness, child mood, child distractibility/activity, child reinforces parent, parent depression, parent attachment, restrictions imposed by parental roles, parent's sense of competence, social isolation, relationship with spouse, parental health, life stress event.

**Research Question Three**

The descriptive statistic was used to investigate the third research question of the perception of family functioning among Taiwanese mothers with children with chronic illnesses. The total score of FES-C \( n = 20 \) in the study ranged from 38 to 62 with the mean of 51.05 and standard deviation of 7.33. Three domains included in the FES are: 1) Relationship; 2) Personal Growth; and 3) System Maintenance. The range of the score of relationship domain was from 11 to 20 \( M = 15.4, \text{ s.d. } = 2.13 \). The score of Personal Growth domain ranged from 16 to 34 \( M = 24.55, \text{ s.d. } = 5.12 \). The score of Maintenance domain in the study ranged
Table 5

Mean and Standard Deviations of Parenting Stress Measures for the Two Research Groups

<table>
<thead>
<tr>
<th>Groups</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic ill (n = 20)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthy (n = 20)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (s.d.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (s.d.)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PSI-C**

**Subscales:**

<table>
<thead>
<tr>
<th></th>
<th>Chronic ill (s.d. = 4.70)</th>
<th>Healthy (s.d. = 6.75)</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Adaptability/Plasticity</td>
<td>28.25</td>
<td>26.25</td>
<td>1.09</td>
<td>.28</td>
</tr>
<tr>
<td>Acceptability of Child to Parent</td>
<td>17.3 (s.d. = 4.00)</td>
<td>16.55 (s.d. = 5.01)</td>
<td>.52</td>
<td>.60</td>
</tr>
<tr>
<td>Child Demandingness</td>
<td>23.25 (s.d. = 4.01)</td>
<td>22.35 (s.d. = 4.29)</td>
<td>.68</td>
<td>.49</td>
</tr>
<tr>
<td>Child Mood</td>
<td>12.8 (s.d. = 3.41)</td>
<td>12.2 (s.d. = 3.62)</td>
<td>.54</td>
<td>.59</td>
</tr>
<tr>
<td>Child Distractibility</td>
<td>25.35 (s.d. = 1.84)</td>
<td>26.75 (s.d. = 3.89)</td>
<td>-1.45</td>
<td>.15</td>
</tr>
<tr>
<td>Child Reinforces Parent</td>
<td>13.3 (s.d. = 2.25)</td>
<td>11.95 (s.d. = 3.3)</td>
<td>1.51</td>
<td>.14</td>
</tr>
<tr>
<td>Parent Depression</td>
<td>23.45 (s.d. = 4.79)</td>
<td>22.80 (s.d. = 6.37)</td>
<td>.36</td>
<td>.71</td>
</tr>
<tr>
<td>Parent Attachment</td>
<td>16.7 (s.d. = 3.64)</td>
<td>16.3 (s.d. = 3.64)</td>
<td>.35</td>
<td>.73</td>
</tr>
</tbody>
</table>
Table 5 (con’t)

Mean and Standard Deviations of Parenting Stress Measures for the Two Research Groups

<table>
<thead>
<tr>
<th></th>
<th>Groups</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic ill</td>
<td>Healthy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(n = 20)</td>
<td>(n = 20)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>Mean</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(s.d.)</td>
<td>(s.d.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PSI-C</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subscales:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Restrictions</td>
<td>18.00 (s.d. = 4.06)</td>
<td>19.00 (s.d. = 5.88)</td>
<td></td>
</tr>
<tr>
<td>Imposed by Parental Role</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent’s Sense of Competence</td>
<td>34.85 (s.d. = 7.00)</td>
<td>32.9 (s.d. = 6.12)</td>
<td></td>
</tr>
<tr>
<td>Social Isolation</td>
<td>15.15 (s.d. = 2.99)</td>
<td>15.40 (s.d. = 4.08)</td>
<td></td>
</tr>
<tr>
<td>Relationship with Spouse</td>
<td>18.95 (s.d. = 4.91)</td>
<td>20.55 (s.d. = 5.44)</td>
<td></td>
</tr>
<tr>
<td>Parental Health</td>
<td>14.45 (s.d. = 3.36)</td>
<td>15.10 (s.d. = 3.02)</td>
<td></td>
</tr>
<tr>
<td>Life Stress Event</td>
<td>1.00 (s.d. = 1.58)</td>
<td>1.00 (s.d. = 1.12)</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>262.80 (s.d. = 35.08)</td>
<td>259.20 (s.d. = 45.10)</td>
<td></td>
</tr>
</tbody>
</table>
from 6 to 15 (M = 11.05, s.d. = 2.65). Table 6 illustrates the mean and standard deviation of subscales in the FES-C including cohesion, expressiveness, conflict, independent, achievement orientation, intellectual-culture orientation, active-recreation orientation, moral-religious emphasis, organization and control.

**Research Question Four**

The forth research question examined the differences in parenting stress and family functioning between families with chronically ill children and families with only healthy children from the mothers' points of view. The t-test was used to answer the question, and the results are illustrated in Table 6 for the parenting stress and Table 7 for family functioning. No significant differences were found in parenting stress between mothers with chronically ill children and mothers with only healthy children. However, it was found that there was a statistically significant difference (p < .05) on the active-recreation orientation, a subscale of FES-C, between the two groups.

**Research Question Five**

The fifth research question: Is there a relationship between parenting stress and family functioning among families of children with chronic illnesses from the mother's points of view? was examined and answered by computing the Pearson correlation coefficient statistic.
### Table 6

**Mean and Standard Deviations of Family Functioning Measures for the Two Research Groups**

<table>
<thead>
<tr>
<th>Groups</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic ill (n = 20)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cohesion (s.d.)</td>
<td>7.40</td>
<td>7.50</td>
</tr>
<tr>
<td>(s.d. = 1.53)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expressiveness (s.d.)</td>
<td>5.75</td>
<td>5.70</td>
</tr>
<tr>
<td>(s.d. = 1.68)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conflict (s.d.)</td>
<td>2.30</td>
<td>2.75</td>
</tr>
<tr>
<td>(s.d. = 2.13)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Independent (s.d.)</td>
<td>5.35</td>
<td>5.60</td>
</tr>
<tr>
<td>(s.d. = 1.59)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Achievement Orientation (s.d.)</td>
<td>5.70</td>
<td>5.55</td>
</tr>
<tr>
<td>(s.d. = 1.34)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intellectual +Culture Orientation (s.d.)</td>
<td>4.70</td>
<td>5.10</td>
</tr>
<tr>
<td>(s.d. = 2.25)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Active +Recreation Orientation (s.d.)</td>
<td>4.45</td>
<td>5.45</td>
</tr>
<tr>
<td>(s.d. = 1.23)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Statistic Significance (p &lt; .05)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Statistic Significance (p < .05)
### Table 6 (con't)

Mean and Standard Deviations of Family Functioning Measures for the Two Research Groups

<table>
<thead>
<tr>
<th>Groups</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic ill</td>
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<td></td>
</tr>
<tr>
<td>(n = 20)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (s.d.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(n = 20)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (s.d.)</td>
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</tbody>
</table>

**FES-C**

**Subscales:**

<table>
<thead>
<tr>
<th>Subscale</th>
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</thead>
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<tr>
<td></td>
<td>(n = 20)</td>
<td>(n = 20)</td>
</tr>
<tr>
<td>Moral -Religion</td>
<td>4.35 (s.d. = 1.30)</td>
<td>4.55 (s.d. = 1.87)</td>
</tr>
<tr>
<td>Emphasis Organization</td>
<td>6.95 (s.d. = 1.76)</td>
<td>6.50 (s.d. = 1.76)</td>
</tr>
<tr>
<td>Control</td>
<td>4.10 (s.d. = 1.65)</td>
<td>4.10 (s.d. = 1.42)</td>
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</tbody>
</table>

* Statistic Significance (p < .05)
Table 7

Correlation Coefficient Between Parental Stress and Family Functioning of Families with Chronically Ill Children

<table>
<thead>
<tr>
<th>PSI-C</th>
<th>Child Characteristic</th>
<th>Parent Characteristic</th>
<th>Life Stress Event</th>
<th>Total PSI-C</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>FES-C</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship</td>
<td>r = .56</td>
<td>r = -.11</td>
<td>r = -.06</td>
<td>r = -.05</td>
</tr>
<tr>
<td></td>
<td>(p= .41)</td>
<td>(p= .32)</td>
<td>(p= .40)</td>
<td>(p= .41)</td>
</tr>
<tr>
<td>Personal Growth</td>
<td>r = -.31</td>
<td>*</td>
<td>r = .12</td>
<td>r = -.37</td>
</tr>
<tr>
<td></td>
<td>(p= .10)</td>
<td>(p= .05)</td>
<td>(p= .30)</td>
<td>(p= .06)</td>
</tr>
<tr>
<td>Maintenance</td>
<td>r = .06</td>
<td>r = -.19</td>
<td>*</td>
<td>r = -.08</td>
</tr>
<tr>
<td></td>
<td>(p= .40)</td>
<td>(p= .21)</td>
<td>(p= .04)</td>
<td>(p= .37)</td>
</tr>
<tr>
<td>Total</td>
<td>r = -.18</td>
<td>r = -.37</td>
<td>r = .21</td>
<td>r = -.30</td>
</tr>
<tr>
<td></td>
<td>(p= .23)</td>
<td>(p= .06)</td>
<td>(p= .18)</td>
<td>(p= .06)</td>
</tr>
</tbody>
</table>

* Statistic Significance (p < .05)
Results are illustrated in Table 8. Although the score of total PSI-C and total FES-C was not significantly related, scores of different domains in both instruments showed some significant relationship. Those included parental characteristics in PSI-C and personal growth in FES-C (p < .05), and life stress event in PSI-C and Maintenance in FES-C (p < .05).

**Additional Finding**

Additional statistical analysis was done to examine the relationship between parenting stress and family functioning among families with only healthy children. Table 9 illustrates the results and find statistically significance (p < .05) in the relationship between parenting stress and family functioning among families with only healthy children from the mothers' points of view.

When the researcher asked mothers "What else concerns you about your child, not including the existing items?", the most frequent answer was the child's performance in academics. This is supported by Pai and Wong's (1991) study of the impact of a chronically ill child on Taiwanese families: mothers of school aged chronically ill children are concerned about the education of the child. This fully expresses the Chinese concept of "every thing is nothing,
Table 8

Correlation Coefficient Between Parental Stress and Family Functioning of Families with Only Healthy Children

<table>
<thead>
<tr>
<th>PSI-C</th>
<th>Child Characteristic</th>
<th>Parent Characteristic</th>
<th>Life Stress Event</th>
<th>Total PSI-C</th>
</tr>
</thead>
<tbody>
<tr>
<td>FES-C</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Relationship</td>
<td>r = .25</td>
<td>r = .34</td>
<td>r = .40</td>
</tr>
<tr>
<td></td>
<td>(p= .14)</td>
<td>(p= .07)</td>
<td>* (p= .04)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Personal Growth</td>
<td>r = -.58*</td>
<td>r = -.54*</td>
<td>r = .17</td>
</tr>
<tr>
<td></td>
<td>(p= .00)</td>
<td>* (p= .01)</td>
<td>(p= .24)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maintenance</td>
<td>r = -.24</td>
<td>r = -.55*</td>
<td>r = -.23</td>
</tr>
<tr>
<td></td>
<td>(p= .15)</td>
<td>* (p= .01)</td>
<td>(p= .17)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>r = -.40</td>
<td>r = -.45*</td>
<td>r = .16</td>
</tr>
<tr>
<td></td>
<td>(p= .04)</td>
<td>* (p= .02)</td>
<td>(p= .24)</td>
<td></td>
</tr>
</tbody>
</table>

* Statistic Significance (p < .05)
study is the best," and Chinese parents' expectations of their children.

Summary

The newly translated instruments, PSI-C and FES-C present well reliability ($\alpha > .65$) on the total scales, although the internal reliability of some subscales are low. There are no statistic significant difference between families with chronically ill children and families with only healthy children on parenting stress and family functioning. The statistically significant difference ($p < .05$) is only found in one subscale of FES-C - active-recreation - between families with and without chronically ill children from mothers' points of view. The significant relationship exists in the study between selected domain of parenting stress and family functioning among families with chronically ill children. It was also found that a significant relationship exist between most areas and the total score of parenting stress and family functioning among families with only healthy children.
Chapter V
DISCUSSION FINDINGS AND CONCLUSION

In this chapter, first, the findings of the study are discussed. Second, the limitation and strengths of this study are presented. Third, the implications on nursing practice and recommendation for further research are addressed.

Discussion of Findings

The purpose of this comparative research was to compare Taiwanese mothers' perception of parenting stress and family functioning among families with children with chronic illness and families with only healthy children. This study also examined Taiwanese mothers' perceptions of parenting stress and family functioning among families with chronically ill children.

Instrument Development

Both of the instruments - PSI-C and FES-C - were translated into Chinese from original English PSI and FES. No previous reliability and validity on normative data were available for either PSI-C or FES-C. In this study, the reliability for both total PSI-C and total FES-C met the required statistic level ( $\alpha > .65$ ). However, when the internal reliability of responses (n = 35) in the study
indicated such a high internal reliability (Cronbach's $\alpha = .94$), one factor should have been considered that there were a total number of 120 items in PSI-C and only 35 responses completely. On the other hand, some of the subscales in PSI-C and FES-C had low reliability. One of the cultural differences between American and Chinese is the inhibition of self-expression, and decreased the reliability of the self-reported instruments.

Since the reliability of total PSI-C and FES-C scores met the required statistic level, the subscales with low reliability and the individual items that reduced the reliability of subscales in both PSI-C and FES-C should be reconsidered in order to be included in the instruments. More study should be conducted for the instrument development in PSI-C and FES-C.

**Demographic Characteristics**

The comparative analysis on demographic characteristics of healthy and chronically ill study groups revealed that the educational level and occupations of mothers of chronically ill children and mothers of healthy children were different. In this study, mothers with only healthy children had higher educational level. Mothers who had different educational level might perceive and interpret parenting stress and family functioning differently.
Parenting Stress Among Taiwanese Mothers of Chronically Ill Children

There was no significant difference found between the two groups in relation to parenting stress. This result was inconsistent with previous studies that were conducted in the United States. For example, Dyson (1991) compared the difference between parents with handicapped children and parents with only healthy children and reported a significant difference in parental stress between the two groups. Results indicate that parental stress is specifically related to the child with the handicap (p < .001). One possible explanation is that most of the children's chronic illnesses included in this study had non-life threatening diseases. However, this study was designed to examine the parental stress in families with non-life threatening chronically ill children. The other possible reason for the lack of difference might be that the Chinese cultural issue of "face", because getting disease is sometimes thought as a shameful event.

Family Functioning Among Taiwanese Families with Chronically Ill Children from the Mothers' Points of View

There was no significant different found between the two groups in relation to most of the family functioning areas that were examined by FES-C. The lack of difference supported previous studies (Riper, Ryff, & Pridham, 1992;
Hamlett, et al, 1992; & Cadman, et al, 1991). Although one subscale - active-recreation - of FES-C was found significant difference between the two groups, the reliability of the subscale is rather low ($\alpha = .28$).

The Relationship Between Parenting Stress and Family Functioning Among Taiwanese Families

A relationship between parenting stress and family functioning was found in the personal growth of family functioning and parent characteristics of parenting stress. The greater the parenting stress on the parents domain, the lower the personal growth in the family. The other finding showed the greater the life stress events, the more maintenance in family functioning. The results disagreed with a previous study (Dyson, 1991) of parental stress. In Dyson’s (1991) study, the significant predictors of parental stress were the presence of handicap ($F(1, 107) = 74.15, p < .00001$) and the family relationship ($F(2, 106) = 47.12, p < .0001$).

Additional findings were the correlation between parenting stress and family functioning among Taiwanese families with only healthy children. It was interesting to find total parenting stress was negatively correlated to total family functioning in this group while there was no relationship to be found in the chronic illness group. Total parenting stress was also correlated to personal
growth and maintenance in family functioning in the healthy group. That is, the more parenting stress, the lower the personal growth and maintenance. Personal growth was also negatively related to child characteristic in parenting stress.

Since the correlation between parenting stress and family functioning were so different between the two groups, a possible explanation is the reliability of the score in both PSI-C and FES-C of the chronic illness group. The traditional Chinese concept of illness might explain this finding. Chinese concept of illness is viewed as a kind of punishment. According to karma, the result of illness reflect the individual or the family might have done something wrong in the past time. Thus, the possibility of hiding the reality explains no difference of parenting stress between the healthy group and chronically ill group.

**The Test of the Theoretical Framework**

The conceptual framework of this study was based on Roy Adaptation Model. Roy Adaptation Model was developed in western culture. Although the model has been broadly used in nursing science in Taiwan, no theoretical test of the model had been studied in the Taiwanese population. In this study, traditional Chinese concepts were reviewed. Two elements in Roy Adaptation Model, self-concept and interdependent, were found so different between western culture
and Taiwanese culture. On the other hand, the results of this study showed low reliability of the instruments, and few statistic significant difference were found between healthy and chronically ill groups. The use of Roy Adaptation Model in Taiwanese culture should be reconsidered.

**Strengths and Limitations**

The strengths of this study are as following: (1) The researcher is a native Taiwanese who was born and grew up in Taiwan. This fact decreased the cultural bias with the researcher conducting the study. (2) The matched demographic characteristics in mothers' ages, family structure, and children's ages controlled the variables between the two groups. (3) The methodology of data collecting included both questionnaires and interviews. According to Burns and Grove (1987), subjects have a higher response rate to interviews, and the questionnaires have less opportunity for bias because of the questions presented in a consistent manner. (4) All of the interviews were conducted by the researcher in Chinese. (5) Content validity of both PSI-C and FES-C were obtained for further development of the instruments (Burns, & Grove, 1987).

Limitations of this study are: (1) The non-random sample limited the generalization of the findings. (2) The sample size was small and might increase type II error. (3)
The mothers' educational level and the mothers' occupations were different between the two groups. (4) The newly translated instrument - FES-C was not pilot tested prior to use in this study. (5) The subjects were informed which group they were in. This might increase the Hawthorne effect that subjects changed their behavior because they were subjects in the study (Burns, & Grove, 1987). (6) The threats of self-reported measurement include the interpretation of the words by subjects, and the circumstances that affected the subjects such as the mood, and the health of the subjects. (7) There was low reliability in the subscales of both PSI-C and FES-C. (8) The Chinese culture of inhibited self-expression and self-actualization might have reduced the reliability of the results.

Recommendations for Further Research

Several recommendations are made for further research.
1) The development and testing of the instruments that are more appropriate for testing parenting stress and family functioning among Taiwanese families.
2) In considering the "face" issue and the non-life threatening disease, a qualitative study is recommended to find out the reality of parenting stress and family functioning among Taiwanese families with chronically ill
children.

3) During the data collecting period, the researcher found that many chronically ill children came from single parent families. Because of the comparative study design, the researcher had to exclude those families. However, the single parent families with chronically ill children might face different parenting stress and family functioning. Moreover, additional studies need to examine the causal relationship between chronically ill children and single parent families.

**Implication for Nursing**

The major findings in this study show that Taiwanese mothers of chronically ill children had no significant difference in parenting stress and family functioning from Taiwanese mothers of only healthy children. The findings were different from previous studies that were conducted in American families. Providing care to meet individual's needs is one of the goal of nursing care. In today's society, one of the challenges for nurses is to work with clients from different cultures, since the communities (not just in America) are becoming more multicultural. Thus, when working with families from different cultural background, it is very important for nurses to provide nursing care to meet the clients' needs. Nurses should
learn more about different cultural concepts regarding health and health care.

Because of the possible relationship between parenting stress and family functioning, nurses should be alert that mothers may experience stress. It is the nurses' responsibility to help mothers to find the stressors, observe the possible family dysfunction, and provide quality care for the whole family.

Summary

Regarding several limitations of the research nature, and the cultural bias, this final chapter discussed the possible explanation of the results of this comparative study. The conclusions about the findings were also stated. Strengths and limitations were addressed. Several recommendations for further study were provided based on the researcher's experience of the research process, data collection, and findings obtained from this study. The research findings' implication for nursing were addressed based on the significant findings in the study of Taiwanese mothers' perceptions of parenting stress and family functioning among families with a chronically ill children. Nurses should be aware of the multicultural society and provide cultural nursing care.
APPENDIX A

HUMAN SUBJECTS APPROVAL
MEMORANDUM

TO: Lui Chang, BS, RN
FROM: Leanna Crosby, D.N.Sc., R.N. Director of Intramural Research
DATE: February 10, 1993

SUBJECT: Human Subjects Review: "Perceptions of Parenting Stress and Family Functioning Among Taiwanese Mothers with Chronically Ill Children"

Your research project has been reviewed and approved by William Denny, M.D., Chairman of the University of Arizona Human Subjects Committee, and deemed to be exempt from review by their full committee. You will be receiving a confirmation letter from Dr. Denny. In addition, your project has been reviewed and approved by the College of Nursing Human Subjects Review Committee.

We wish you a valuable and stimulating experience with your research.

LC/ga
February 4, 1993

Lui Chang, B.S., R.N.
College of Nursing
Arizona Health Sciences Center

RE: PERCEPTIONS OF PARENTING STRESS AND FAMILY FUNCTIONING AMONG VIETNAMESE MOTHERS WITH CHRONICALLY ILL CHILDREN

Dear Ms. Chang:

We received documents concerning your above cited project. Regulations published by the U.S. Department of Health and Human Services [45 CFR Part 46.101(b)(2)] exempt this type of research from review by our Committee.

Thank you for informing us of your work. If you have any questions concerning the above, please contact this office.

Sincerely yours,

William F. Denny, M.D.
Chairman,
Human Subjects Committee

WFD:sj

cc: Departmental/College Review Committee
APPENDIX B

CONSENT FORM
Subject's Consent

Title of project: Taiwanese mothers' perceptions of parenting stress and family functioning among families with a child with chronic illness.

I AM BEING ASKED TO READ THE FOLLOWING MATERIAL TO ENSURE THAT I AM INFORMED THE NATURE OF THIS RESEARCH STUDY AND OF HOW I WILL PARTICIPATE IN IT, IF I CONSENT TO DO SO. SIGNING THIS FORM WILL INDICATE THAT I HAVE BEEN SO INFORMED AND THAT I GIVE MY CONSENT. FEDERAL REGULATIONS REQUIRE WRITTEN INFORMED CONSENT PRIOR TO PARTICIPATION IN THIS RESEARCH STUDY SO THAT I CAN KNOW THE NATURE AND THE RISKS OF MY PARTICIPATION AND CAN DECIDE TO PARTICIPATE OR NOT PARTICIPATE IN A FAIR AND INFORMED MANNER.

Purpose: I am being invited to voluntarily participate in the above-titled research project. The purpose of this project is to determine mothers' perception of parenting stress and family functioning among Taiwanese families with children with chronic illness.

Selection criteria: I am invited to participate because I am a mother of a child with chronic illness, who is at the age between 5 to 12-year-old.

Procedure: If I agree to participate, I will be asked to complete three questionnaires focusing on parenting stress and family functioning in the family with a child with chronic illness. I further understand that I will be asked to participate in a short interview in which I will be asked to a short interview and answer questions about my experience of parenting stress and family functioning.

Risks: I understand that there are no known risks to me or my child in this study. The information obtained from or about me will be kept confidential using the following procedures: 1) All information will be identified and recorded using a code number assigned to me, 2) All completed forms and audiotapes will be stored in a locked file, and 3) Reports of study findings will be reported as group data in a manner in which no individual can be identified.

Benefits: I understand that there are no direct benefits to me or my child as a result of participating in this study.

I understand that I can withdraw my permission and withdraw from the study at any time. My treatment by, and relations with the staff members in the China Medical College Hospital, now and in the future will not be affected in any way if I
refuse to participate, or if I enter the program and withdraw later.

I understand that I do not give up any of my legal rights by signing this form. If I have questions concerning my rights as a research subject, I may call the Human Subjects Committee at (602) 626-6721.

AUTHORIZATION

"BEFORE GIVING MY CONSENT BY SIGNING THIS FORM, THE METHODS, INCONVENIENCES, RISKS, AND BENEFITS HAVE BEEN EXPLAINED TO ME AND MY QUESTIONS HAVE BEEN ANSWERED. I UNDERSTAND THAT I MAY ASK QUESTIONS AT ANY TIME AND THAT I AM FREE TO WITHDRAW FROM THE PROJECT AT ANY TIME WITHOUT CAUSING BAD FEELING OR AFFECTING MY MEDICAL CARE. MY PARTICIPATION IN THIS PROJECT MAY BE ENDED BY THE INVESTIGATOR OR BY THE SPONSOR FOR REASONS THAT WOULD BE EXPLAINED. NEW INFORMATION DEVELOPED DURING THE COURSE OF THIS STUDY WHICH MAY AFFECT MY WILLINGNESS TO CONTINUE IN THIS RESEARCH PROJECT WILL BE GIVEN TO ME AS IT BECOMES AVAILABLE. I UNDERSTAND THAT THIS CONSENT FORM WILL BE FILED IN AN AREA DESIGNATED BY THE HUMAN SUBJECTS COMMITTEE WITH ACCESS RESTRICTED TO THE PRINCIPAL INVESTIGATOR, LU-I CHANG. I UNDERSTAND THAT I DO NOT GIVE UP ANY OF MY LEGAL RIGHTS BY SIGNING THIS FORM. A COPY OF THIS SIGNED CONSENT FORM WILL BE GIVEN TO ME.

----------------------------------
Subject’s Signature                Date

INVESTIGATOR

I have carefully explained to the subjects the nature of the above project. I hereby certify that to the best of my knowledge the person who is signing this consent form understands clearly the nature, demands, benefits, and risks involved in her participation and her signature is legally valid. A medical problem or language or educational barrier has not precluded this understanding.

Signature of investigator          Date
同意書

研究題目：台語慢性病児童的母親對於親職壓力和家庭功能的認知。

聯邦條例規定在參與研究之前，要有書面同意報告書，這樣，我才可以了解參與這項研究的危險性，而在充分了解的情況下，決定是否參加這項研究。我將閱讀下面內容以確保我被告知 1. 這項研究的性質，
2. 如果我願意參與這項研究，參與的過程將是如何。簽下這份文件，表示我已經了解而且同意參與這項研究。

研究目的：我被邀請自願參與上述研究題目之研究，這項研究的目的是要了解在台語慢性病児童家庭中，母親對於親職壓力和家庭功能的認知。

選擇條件：因爲我是7〜12歲慢性病児童的母親，所以我被邀請參與這項研究。

過程：如果我同意參加這項研究，我將被要求填完三份問卷，這三份問卷著重於親職壓力和家庭功能。我同時了解，我將參與一個短暫的面談，這面談將會全程錄音，在其中，我將回答有關我的親職壓力及家庭功能的經驗。

危險性：我了解參與這項研究對我和我的小孩沒有任何危險性，所有有關我提的資料將以以下三種方式保存：
1) 所有資料將以編號確認和記錄。
2) 所有問卷和錄音帶將被鎖在資料櫃中。
3) 研究報告將以團體資料呈現，其中不會有獨立的個人被認出。

利益：我了解參與這項研究，對我或我的小孩沒有任何直接利益。

我知道，我可以在研究進行的任何時間退出這項研究，如果我拒絕參加這項研究或先參加後退出，在現在或未來都不會影響到我所接受的治療，和我們與中國醫藥學院附設醫院的醫護人員之間的關係。
我了解我不会因签了这份文件而代表我放棄了任何法律權利，如果我有任何有關身為一個研究對象的權利問題，我可以聯絡美國亞利桑那大學研究審核委員會，電話號碼 (602) 626-6721。

授權：

在簽同意書之前，研究者已經對我解釋了所有有關研究方法、不適之處、危險性及利益，而且也回答了我的疑問。我了解我可以在任何時間提出我的疑問，而且我可以在任何時間退出研究而不會帶來不好的感覺或影響我小孩的治療，研究者可能因某些可解釋的原因而終止我參與這項研究。

在研究過程中如果有任何會影響我參與這項研究意願的新發展訊息，研究者將會提供給我知道，我了解這份同意書將被置於由研究審核委員會所設計的檔案中，而只有研究者張綠怡能看到。

我了解我不会因签了这份同意書而放棄所有法律權利，同時我會擁有此份已簽名同意書的副本。

_________________________  __________________________
立同意書人 簽名  日期

研究者：

我已經仔細地解釋上述研究的性質，在此，我確認在我所知的範圍內，立同意書人已清楚的了解他所參與的研究性質、需求、利益、危險性及她的簽名之法律意義。醫學問題或語言及教育上的障礙不妨礙她的了解。

_________________________  __________________________
研究者 簽名  日期
Subject Consent

Title of project: Taiwanese mothers' perceptions of parenting stress and family functioning among families with a child with chronic illness.

I AM BEING ASKED TO READ THE FOLLOWING MATERIAL TO ENSURE THAT I AM INFORMED THE NATURE OF THIS RESEARCH STUDY AND OF HOW I WILL PARTICIPATE IN IT, IF I CONSENT TO DO SO. SIGNING THIS FORM WILL INDICATE THAT I HAVE BEEN SO INFORMED AND THAT I GIVE MY CONSENT. FEDERAL REGULATIONS REQUIRE WRITTEN INFORMED CONSENT PRIOR TO PARTICIPATION IN THIS RESEARCH STUDY SO THAT I CAN KNOW THE NATURE AND THE RISKS OF MY PARTICIPATION AND CAN DECIDE TO PARTICIPATE OR NOT PARTICIPATE IN A FAIR AND INFORMED MANNER.

Purpose: I am being invited to voluntarily participate in the above-titled research project. The purpose of this project is to determine mothers' perception of parenting stress and family functioning among Taiwanese families with children with chronic illness.

Selection criteria: I am invited to participate because I am a mother of a healthy child who is at the age between 7 to 12-year-old. The researcher needs to have a comparison group of the subject that matches for family structure, age of child (7-12), and maternal education of the subjects with a child with chronic illness.

Procedure: If I agree to participate, I will be asked to complete three questionnaires focusing on parenting stress and family functioning in the family with a child with chronic illness. I further understand that I will be asked to participate in an short interview in which I will be asked to answered questions about my experience of parenting stress and family functioning.

Risks: I understand that there are no known risks to me or my child in this study. The information obtained from or about me will be kept confidential using the following procedures: 1) All information will be identified and recorded using a code number assigned to me, 2) All completed forms and audiotapes will be stored in a locked file, and 3) Reports of study findings will be reported as group data in a manner in which no individual can be identified.

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Signature of investigator Date
同意書

研究題目：台灣慢性病兒童的母親對於親職壓力和家庭功能的認知。

聯邦條列規定在參與研究之前，要有書面同意報告書，這樣，我才可以了解參與這項研究的危險性，而在充分了解的情況下，決定是否參加這項研究。我將閱讀下面的內容以確保我被告知 1. 這項研究的性質，
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研究目的：我被邀請自願參與上述研究題目之研究，這項研究的目的是要了解在台灣慢性病兒童家庭中，母親對於親職壓力和家庭功能的認知。

選擇條件：因爲我是 7～12 歲健康兒童的母親，而研究者需要有一個在家庭結構、兒童年齡（7-12 歲）和母親教育程度三方面都與研究對象相同的對照組，所以我被邀請參與這項研究。

過程：如果我同意參加這項研究，我將被要求填完三份問卷，這三份問卷著重於親職壓力和家庭功能。我同時了解，我將參與一個短暫的面談，這面談將會全程錄音，在其中，我將回答有關我的親職壓力及家庭功能的經驗。

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我了解我不會因爲簽了這份文件而代表我放棄了任何法律權利，如果我有任何有關身為一個研究對象的權利問題，我可以聯絡美國亞利桑那大學研究審核委員會，電話號碼 (602) 626-6721。

授權：

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在研究過程中如果有任何會影響我參與這項研究意願的新發展訊息，研究者將會提供給我知道，我了解這份同意書將被置於由研究審核委員會所設計的檔案中，而只有研究者張錄怡能看到。

我了解我不會因簽了這份同意書而放棄所有法律權利，同時我會擁有此份已簽名同意書的副本。

| 立同意書人 | 簽名 | 日 期 |

研究者：

我已經仔細地解釋上述研究的性質，在此，我確認在我所知的範圍內，立同意書人已清楚的了解她所參與的研究性質、需求、利益、危險性及她的簽名之法律意義。醫學問題或語言及教育上的障礙不妨礙她的了解。

| 研究者 | 簽名 | 日 期 |
APPENDIX C

DEMOGRAPHIC INFORMATION SHEET
Demographic Information Sheet

Subject No. ________________

1. The chronically ill child
   Age of the child: ________________
   Sex of the child: ________________
   Grade in the school: ________________
   Child’s Dx.:____________________
   How long has the diagnosis been made? ________________
   Type of treatment: ____________________

2. The family
   Average income (yearly): ________________
   Type of the family living together: (check one below)
   Nuclear family _________
   Extended family _________
   Other children in the family? Yes ____ No ___
   If yes, please list ages and sex: ____________________
   Careprovider of the chronic illness child in the family:

3. The mother:
   Age of the mother: ________________
   Highest education: (check one below)
   Junior high school _________
   Senior high school _________
   Junior college _________
   College _________
   Graduate school _________
   Occupation: ____________________
   Religious preference: ____________________
   Involvement in religion: ____________________

4. How do you rate your child’s health: (please check one)
   Excellent _____
   Good _____
   Fair _____
   Poor _____
APPENDIX D

CHINESE VERSION OF DEMOGRAPHIC INFORMATION SHEET
基本資料

個案編號： ____________________

1. 有關慢性病兒童
   年齡： ______________
   性別： ______________
   年級： ______________
   診斷： ______________
   診斷時間： ______________
   所接受的治療： ______________

2. 有關家庭
   年平均收入： ______________
   家庭型態（請選一項）
   小家庭 ______________
   折衷家庭或大家庭 ______________
   家中有無其他小孩？ 有 ______________，無 ______________
   如果有，請列出其年齡與性別： ____________________
   家中慢性病兒童的主要照顧者： ______________

3. 母親
   年齡： ______________
   教育程度：
   高中或高職 ______________
   專科 ______________
   大學 ______________
   研究所 ______________
   職業： ______________
   宗教： ______________
   參與宗教的程度： ______________

4. 您認為您孩子的健康狀況（請選一項）
   很好 ______________
   好 ______________
   還可以 ______________
   不好 ______________
APPENDIX E

PERMISSION FOR THE USE OF PSI-C
APPLICATION FOR PERMISSION TO REPRODUCE, ADAPT, MODIFY, AND/OR TRANSLATE
PPP MATERIALS OR EXCERPTS THEREFROM

PPP will be pleased to consider your request to reproduce, adapt, modify, and/or translate test materials to be used in your work. Kindly complete this form in duplicate, and return both copies to PPP. If your request is approved, you will be sent a statement of the handling and/or royalty fee to be paid. Upon receipt of payment, we will return to you a copy of this agreement, signed by a PPP official, your possession of which will be your protection against possible charges of copyright violation. Completion of this form is a prior condition to permission, but does not guarantee that such permission will be granted.

Name of applicant:
LU-I, CHANG

Position or title:
GRADUATE STUDENT

Organization or organization and address:
The University of Arizona College of Nursing
1401 N. Martin
Tucson, AZ. 85721

Phone:
(602) 626-6151

Signature:
( )

Degree:
Bachelor Nursing

Institution:
China Medical College

Year
1987

Membership in professional organizations:
Sigma Theta Tau Internatl., Honor Society of Nursing; Nurse's Assoc. ROC

Specify the particular PPP materials you wish to reproduce, adapt, modify, and/or translate, e.g., name of test, test booklet, including form and edition: answer sheet, etc. If selected test items, list item number, if excerpts from Handbook, etc., give pages). State how many copies would be made, and exactly how they would be used. If a translation is being requested, please include language(s) and/or dialect(s). (Use separate sheet if more space is needed.)

<table>
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<th>Test materials</th>
<th>Quantity</th>
<th>Describe use</th>
</tr>
</thead>
<tbody>
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<td>30</td>
<td>Chinese Version</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If statement, please give full and brief description of Project. Use separate sheet if more space is needed.

See Attachment

IMPORTANT NOTE

If you are a student, or if you are not a member of the American Psychological Association or similar professional organization, please have supervising professor of psychology, or committee or staff psychologist sign below your signature on page 2.
If permission requested is granted, I agree that:

1. FTP will receive for approval, two (2) copies of any test material reproduced, adapted, modified, and/or translated by permission, as soon as it is produced or reproduced, not later than six (6) months after the later date of the signing of this permission, and before the project is undertaken.

2. FTP will receive one (1) copy of all reports, or articles describing the project. If no formal report is prepared, I agree to prepare a special report for FTP, covering at least those aspects of the work related to FTP materials.

3. FTP has my full permission to quote from or otherwise use the reports or data in (2) above, in any FTP publications, providing due acknowledgement is given to the researchers and/or report authors.

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(804) 296-8211

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11. Other:
Title:

The title of my thesis is "the perception of patenting stress and family functioning among Taiwanese mothers of chronically ill child".

Description:

The purpose of the descriptive research is to describe Taiwanese mothers' perception of parenting stress and family functioning among families with children with chronic illness. In addition, the study also compares the Taiwanese mother's perception of parenting stress and family functioning with the established normative data on American family.

The study will be conducted in an urban area in Taiwan. Thirty Taiwanese mother with a chronically ill school aged child will be included in the study.
APPENDIX F

PARENTING STRESS INDEX (PSI)
PARENTING STRESS INDEX (PSI)

Administration Booklet

Richard R. Abidin
Institute of Clinical Psychology
University of Virginia

Directions:

In answering the following questions, please think about the child you are most concerned about.

The questions on the following pages ask you to mark an answer which best describes your feelings. While you may not find an answer which exactly states your feelings, please mark the answer which comes closest to describing how you feel. YOUR FIRST REACTION TO EACH QUESTION SHOULD BE YOUR ANSWER.

Please mark the degree to which you agree or disagree with the following statements by filling in the number which best matches how you feel. If you are not sure, please fill in #3.

1 2 3 4 5
Strongly Agree  Agree  Not Sure  Disagree  Strongly Disagree

Example: 1 2 3 4 5 I enjoy going to the movies. (If you sometimes enjoy going to the movies, you would fill in #2.)

Form 6 — Copyrighted 1983
1. Strongly Agree
2. Agree
3. Not Sure
4. Disagree
5. Strongly Disagree

23. My child doesn't seem to learn as quickly as most children.
24. My child doesn't seem to smile as much as most children.
25. My child does a few things which bother me a great deal.
26. My child is not able to do as much as I expected.
27. My child does not like to be cuddled or touched very much.
28. When my child came home from the hospital, I had doubtful feelings about my ability to handle being a parent.
29. Being a parent is harder than I thought it would be.
30. I feel capable and on top of things when I am caring for my child.
31. Compared to the average child, my child has a great deal of difficulty in getting used to changes in schedules or changes around the house.
32. My child reacts very strongly when something happens that my child doesn't like.
33. Leaving my child with a babysitter is usually a problem.
34. My child gets upset easily over the smallest thing.
35. My child easily notices and overreacts to loud sounds and bright lights.
36. My child's sleeping or eating schedule was much harder to establish than I expected.
37. My child usually avoids a new toy for a while before beginning to play with it.
38. It takes a long time and it is very hard for my child to get used to new things.
39. My child doesn't seem comfortable when meeting strangers.
40. When upset, my child is:
   1. easy to calm down,
   2. harder to calm down than I expected,
   4. very difficult to calm down,
   5. nothing I do helps to calm my child.
41. I have found that getting my child to do something or stop doing something is:
   1. much harder than I expected,
   2. somewhat harder than I expected,
   3. about as hard as I expected,
   4. somewhat easier than I expected,
   5. much easier than I expected.
103

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

42. Think carefully and count the number of things which your child does that bothers you. For example: dawdles, refuses to listen, overactive, cries, interrupts, fights, whines, etc. Please fill in the number which includes the number of things you counted.
   1. 1-3
   2. 4-5
   3. 6-7
   4. 8-9
   5. 10+

43. When my child cries it usually lasts:
   1. less than 2 minutes,
   2. 2-5 minutes,
   3. 5-10 minutes,
   4. 10-15 minutes,
   5. more than 15 minutes.

44. There are some things my child does that really bother me a lot.

45. My child has had more health problems than I expected.

46. As my child has grown older and become more independent, I find myself more worried that my child will get hurt or into trouble.

47. My child turned out to be more of a problem than I had expected.

48. My child seems to be much harder to care for than most.

49. My child is always hanging on me.

50. My child makes more demands on me than most children.

51. I can't make decisions without help.

52. I have had many more problems raising children than I expected.

53. I enjoy being a parent.

54. I feel that I am successful most of the time when I try to get my child to do or not do something.

55. Since I brought my last child home from the hospital, I find that I am not able to take care of this child as well as I thought I could. I need help.

56. I often have the feeling that I cannot handle things very well.

57. When I think about myself as a parent I believe:
   1. I can handle anything that happens,
   2. I can handle most things pretty well,
   3. sometimes I have doubts, but find that I handle most things without any problems,
   4. I have some doubts about being able to handle things,
   5. I don’t think I handle things very well at all.
58. I feel that I am:

1. a very good parent,
2. a better than average parent,
3. an average parent,
4. a person who has some trouble being a parent,
5. not very good at being a parent.

59. What were the highest levels in school or college you and the child's father/mother have completed? 
   Mother:
   1. 1-8th grade
   2. 9-12th grade
   3. Vocational or some college
   4. College graduate
   5. Graduate or professional school

60. Father:
   1. 1-8th grade
   2. 9-12th grade
   3. Vocational or some college
   4. College graduate
   5. Graduate or professional school

61. How easy is it for you to understand what your child wants or needs?
   1. very easy,
   2. easy,
   3. somewhat difficult,
   4. it is very hard,
   5. I usually can't figure out what the problem is.

62. It takes a long time for parents to develop close, warm feelings for their children.

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

64. Sometimes my child does things that bother me just to be mean.

65. When I was young, I never felt comfortable holding or taking care of children.

66. My child knows I am his or her parent and wants me more than other people.

67. The number of children that I have now is too many.

68. Most of my life is spent doing things for my child.

69. I find myself giving up more of my life to meet my children's needs than I ever expected.

70. I feel trapped by my responsibilities as a parent.

71. I often feel that my child's needs control my life.

72. Since having this child I have been unable to do new and different things.
73. Since having a child I feel that I am almost never able to do things that I like to do.
74. It is hard to find a place in our home where I can go to be by myself.
75. When I think about the kind of parent I am, I often feel guilty or bad about myself.
76. I am unhappy with the last purchase of clothing I made for myself.
77. When my child misbehaves or fusses too much I feel responsible, as if I didn't do something right.
78. I feel everytime my child does something wrong it is really my fault.
79. I often feel guilty about the way I feel towards my child.
80. There are quite a few things that bother me about my life.
81. I felt sadder and more depressed than I expected after leaving the hospital with my baby.
82. I wind up feeling guilty when I get angry at my child and this bothers me.
83. After my child had been home from the hospital for about a month, I noticed that I was feeling more sad and depressed than I had expected.
84. Since having my child, my spouse (male/female friend) has not given me as much help and support as I expected.
85. Having a child has caused more problems than I expected in my relationship with my spouse (male/female friend).
86. Since having a child my spouse (or male/female friend) and I don't do as many things together.
87. Since having my child, my spouse (or male/female friend) and I don't spend as much time together as a family as I had expected.
88. Since having my last child, I have had less interest in sex.
89. Having a child seems to have increased the number of problems we have with in-laws and relatives.
90. Having children has been much more expensive than I had expected.
91. I feel alone and without friends.
92. When I go to a party I usually expect not to enjoy myself.
93. I am not as interested in people as I used to be.
94. I often have the feeling that other people my own age don't particularly like my company.
95. When I run into a problem taking care of my children I have a lot of people to whom I can talk to get help or advice.
Since having children I have a lot fewer chances to see my friends and to make new friends.

During the past six months I have been sicker than usual or have had more aches and pains than I normally do.

Physically, I feel good most of the time.

Having a child has caused changes in the way I sleep.

I don't enjoy things as I used to.

Since I've had my child:
1. I have been sick a great deal,
2. I haven't felt as good,
4. I haven't noticed any change in my health,
5. I have been healthier.

STOP HERE — unless asked to do items below
During the last 12 months, have any of the following events occurred in your immediate family? Please check on the answer sheet any that have happened.

102. Divorce
103. Marital reconciliation
104. Marriage
105. Separation
106. Pregnancy
107. Other relative moved into household
108. Income increased substantially (20% or more)
109. Went deeply into debt
110. Moved to new location
111. Promotion at work
112. Income decreased substantially
113. Alcohol or drug problem
114. Death of close family friend
115. Began new job
116. Entered new school
117. Trouble with superiors at work
118. Trouble with teachers at school
119. Legal problems
120. Death of immediate family member
APPENDIX G

PARENTING STRESS INDEX - CHINESE (PSI-C)
親職壓力指標（PSI）

Richard R. Abidin
Institute of Clinical Psychology
University of Virginia

請注意:

在答以下問題時，請想及你最關注的孩子。

以下問題要求你就著最能描述你感受的答案作出選擇。若在所提供的答案中未有直接描述你的感受時，請選擇一個最近似的答案。請記著：你對問題的第一個反應應當就是你的答案。

請根據你的感受，選出你對問題1至101的同意程度。如果你不肯定的話，請選擇答案3。

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>極同意</td>
<td>同意</td>
<td>不肯定</td>
<td>不同意</td>
<td>極不同意</td>
</tr>
</tbody>
</table>

例如：1 2 3 4 5 我喜歡觀賞電影（如果你只不過是有時喜歡觀賞電影，你便選擇答案2）

此問卷版權屬下列機構：

Pediatric Psychology Press
320 Terrell Road West,
Charlottesville, VA 22901
請表示你對下列句子的同意程度：

<table>
<thead>
<tr>
<th>句子</th>
<th>同意程度</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 我的孩子想要東西時，我總會設法得到為止。</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>2. 我的孩子活躍得教我吃不消。</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>3. 我的孩子做事沒有條理而且容易分散注意力。</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>4. 比起一般小孩，我的孩子較難於集中精神和注意力。</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>5. 我的孩子常拿著同一玩具玩十分鐘以上。</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>6. 我的孩子閒逛的時間比我想像中多。</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>7. 我的孩子比我想像中要活躍得多。</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>8. 當我爲孩子穿衣或洗澡時，他常會扭動不安或亂踢。</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>9. 我的孩子很容易分散精神而忘記想要的東西。</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>10. 我的孩子很少做一些令我開心的事。</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>11. 很多時我都感到孩子喜歡我和希望接近我。</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>12. 有時候，我感到孩子不大喜歡我和不想接近我。</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>13. 我的孩子對我笑的時候比我期望中少得多。</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>14. 我覺得孩子不大欣賞我為他做的事情。</td>
<td>1 2 3 4 5</td>
</tr>
</tbody>
</table>
15. 下列那一項最正確描述你的孩子：

1. 他幾乎常常都喜歡和我玩
2. 他有時候喜歡和我玩
3. 他不大喜歡和我玩
4. 他幾乎從不喜歡和我玩

□

16. 我的孩子哭或吵鬧的次數：

1. 比想像很少
2. 比想像很少
3. 和想像中差不多
4. 比想像中多
5. 十分穩定

□

17. 我的孩子哭或吵鬧的次數比一般小孩多
18. 我的孩子玩的時候不大發笑或大笑.
19. 我的孩子起床時太多很不愉快.
20. 我覺得我的孩子很情緒化和容易間情緒．
21. 我孩子相貌和我想中有些不同，而這很多時令我不安．

□

22. 在某些方面，我的孩子似乎會忘記以往學過的東西，並且做回一些年紀較小的孩子才做的東西．

□

23. 我的孩子學習的速度不如一般小孩快．
24. 我的孩子不如一般小孩笑得多．
25. 我的孩子會做一些令我十分困擾的事．
26. 我的孩子不大能夠做到我對他的期望．
27. 我的孩子不大喜歡被人抱或撫．

□

28. 自從孩子出世以後，我曾經懷疑我是否
有足夠能力為人父母．

□

29. 為人父母比想像中的難．
30. 照顧孩子時，我覺得自己很能幹和勝任有餘．

□

31. 比起其他小孩，我的孩子很難適應日常生活
程序或家中的變動．

□
32. 我的孩子遇到不喜歡的事物時，反應十分激烈。 1 2 3 4 5 □
33. 將我的孩子交給人托管會是件難題。 1 2 3 4 5 □
34. 我的孩子很容易為極小的事而鬱鬱。 1 2 3 4 5 □
35. 我的孩子對於噪音和強光十分敏感而且反應過於強烈。 1 2 3 4 5 □
36. 我的孩子養成睡覺和飲食的習慣比我想像中難。 1 2 3 4 5 □
37. 開始玩一件新玩具時，我的孩子通常初時會對它抗拒。 1 2 3 4 5 □
38. 我的孩子需要一段時間去適應新事物，而且十分吃力。 1 2 3 4 5 □
39. 我的孩子遇到陌生人時會表現不安。 1 2 3 4 5 □
40. 鬱鬱時，我的孩子：
   1. 很容易平服過來
   2. 比想像中難平服
   4. 很難平服
   5. 怎樣做也不平服
   41. 我發覺要我的孩子做或者不做某些東西是：
   1. 比想像中困難得多
   2. 比想像中困難些
   3. 大約和想像中般難
   4. 比想像中易
   5. 比想像中容易得多
42. 細想並計算一下有多少件你的孩子叫你困擾的事。例如：四處亂碰、不聽話、過份活躍、哭泣、打擾、打架、發牢騷等。請於各個數列中選擇一個包括你的答案的數列：
   1. 1 - 3 件
   2. 4 - 5 件
   3. 6 - 7 件
   4. 8 - 9 件
   5. 10 件或以上
   43. 我的孩子哭的時候，通常維持：
   1. 少過二分鐘
   2. 二至五分鐘
   3. 五至十分鐘
   4. 十至十五分鐘
   5. 十五分鐘以上
44. 有時候我的孩子做一些事情在令我困擾。 1 2 3 4 5 □
45. 我的孩子的健康問題比想像中多。 1 2 3 4 5 □
46. 我的孩子長大並且比較獨立後，我發覺自己擔心他會受傷或有麻煩。 1 2 3 4 5 □
47. 我的孩子是個比想像中更難處理的問題。 1 2 3 4 5 □
48. 我的孩子比一般小孩子難照顧。 1 2 3 4 5 □
49. 我的孩子常常靠在我身邊。 1 2 3 4 5 □
50. 我的孩子比其他一般小孩子要求多。 1 2 3 4 5 □
51. 我不能在沒有人幫助的情況下作決定。 1 2 3 4 5 □
52. 我在照顧小孩方面的問題比想像中多。 1 2 3 4 5 □
53. 我很享受為人父母的生活。 1 2 3 4 5 □
54. 我很多時都叫能夠叫我的孩子做或不要做某些事。 1 2 3 4 5 □
55. 自從我的孩子出世後，我總覺得我未能如我想像般照顧他。我需要別人幫助。 1 2 3 4 5 □
56. 我常有不能辦好事情的感覺。 1 2 3 4 5 □
57. 想起我自己作為人父母的時候，我想信:
   1. 我能應付任何事情
   2. 我能辦好大部份事情
   3. 雖然有些時候我有些疑惑，但我發現我能辦大部份事情，不會有問題。
      □
   4. 對自己能否辦好事情，有些疑惑
   5. 自己把事情處理得不大好
58. 我覺得自己：
   1. 是好的父母
   2. 比一般父母好
   3. 和一般父母一樣
   4. 為人父母方面有些困難
   5. 不是太適合當父母
59. 我最高的學歷是:

1. 小學程度或以下
2. 中一至中三
3. 中四至中五
4. 預科或工業學院
5. 大專或以上

60. 我丈夫的最高學歷是:

1. 小學程度或以下
2. 中一至中三
3. 中四至中五
4. 預科或工業學院
5. 大專或以上

61. 我容易明白孩子的欲望和需要嗎?

1. 非常容易
2. 容易
3. 有些困難
4. 非常困難
5. 你常常都不知道困難出在哪裡

62. 父母需要一段長時間才能和孩子建立密切而溫馨的關係。

1 2 3 4 5

63. 我希望和我的孩子能有密切而溫馨的關係，
可是卻做不到，這使你十分困煩。

1 2 3 4 5

64. 有時候，你的孩子做的事情實在叫你惱怒發脾氣。

1 2 3 4 5

65. 年紀小的時候，抱小孩子和照顧他們總是我不自然。

1 2 3 4 5

66. 我的孩子知道我是他的父母，並且需要我
甚於其他人。

1 2 3 4 5

67. 我有太多孩子。

1 2 3 4 5

68. 我一生大部份時間都花在照顧孩子上。

1 2 3 4 5

69. 我發覺這一生裏，花在滿足我的孩子需要
的時間比想像中多。

1 2 3 4 5

70. 我感到自己被為人父母的責任所牽累。

1 2 3 4 5

71. 我常感到孩子的一切所需控制了我的一生。

1 2 3 4 5
72. 有了這個孩子以後，我已經不再可做其他
新鮮不同的事了。  1 2 3 4 5 □

73. 自有了孩子以後，我差不多不能再做喜歡
的事了。  1 2 3 4 5 □

74. 家裡很難有一處地方給我獨處片刻。  1 2 3 4 5 □

75. 想起自己是個怎樣的父母時，你總會感到
內疚和不安。  1 2 3 4 5 □

76. 我不滿自己上一次為自己買的衣服。  1 2 3 4 5 □

77. 我覺得自己對孩子的劣行和煩惱應該負責，
好像沒有把事情處理好。  1 2 3 4 5 □

78. 我覺得每次孩子做錯事其實都是我自己的錯。  1 2 3 4 5 □

79. 我常為自己對孩子的感覺感到內疚。  1 2 3 4 5 □

80. 生命中頗有一些事困擾我。  1 2 3 4 5 □

81. 孩子剛出世不久，我發覺自己比想像中
更不快樂和憂鬱。  1 2 3 4 5 □

82. 每當我的孩子發怒時，內疚的感覺就會消失，
這使我十分困擾。  1 2 3 4 5 □

83. 我的孩子出世大約一個月後，我發覺自己比想像中
不快樂和沮喪。  1 2 3 4 5 □

84. 有了孩子後，我的配偶（男性／女性朋友）
的幫助沒你想像中多。  1 2 3 4 5 □

85. 有了孩子後，我和配偶（男性／女性朋友）
之間的問題比想像中更多。  1 2 3 4 5 □

86. 有了孩子以後，我和配偶（男性／女性朋
友）一起做的事情少了。  1 2 3 4 5 □

87. 有了孩子後，我和配偶（或男性／女性朋
友）一起相處的時間比我想像一個家庭應該
有的少。  1 2 3 4 5 □

88. 有了你最年幼的孩子後，我對性的興趣減少了。  1 2 3 4 5 □

89. 有了孩子後，我們和親戚的問題多了。  1 2 3 4 5 □

90. 供孩子的支出比想像中多許多。  1 2 3 4 5 □

91. 我感到孤單和缺少朋友。  1 2 3 4 5 □
92. 和朋友聚會時，我總有不能盡情投入的感覺。 1 2 3 4 5 □
93. 我對別人沒有以往那樣注意。 1 2 3 4 5 □
94. 我總覺得同年紀的不會喜歡與我為伴。 1 2 3 4 5 □
5. 照顧孩子有問題時，我可向許多人傾訴，求助和求教。 1 2 3 4 5 □
96. 有了孩子以後，見朋友和結識新朋友的機會少了許多。 1 2 3 4 5 □
97. 最近這六個月以來，我比以往虛弱和多病。 1 2 3 4 5 □
98. 身體方面，我常感到很精神。 1 2 3 4 5 □
99. 我的孩子改變了你的睡眠習慣。 1 2 3 4 5 □
100. 我不像以往般享受事物。 1 2 3 4 5 □
101. 有了孩子後：
   1. 我病了許多次。
   2. 我不似以往精神。
   3. 身體方面，沒有異樣。
   4. 我比前更健康。 □

過去十二個月來，你的直系家庭成員是否發生過以下事情：

<table>
<thead>
<tr>
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<tr>
<td>102. 離婚</td>
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<td>103. 復合</td>
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<td>104. 結婚</td>
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<td>105. 分居</td>
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<td>106. 姻孕</td>
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<td>107. 其他親友搬進與你家庭同住</td>
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<td>108. 人數大大增加（兩成以上）</td>
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<tr>
<td>No.</td>
<td>Scenario</td>
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<td>109</td>
<td>負重傷。</td>
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<td>升職</td>
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<td>112</td>
<td>人患大大減少</td>
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<tr>
<td>113</td>
<td>酗酒或吸毒問題</td>
<td></td>
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<tr>
<td>114</td>
<td>親密的朋友死亡</td>
<td></td>
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<tr>
<td>115</td>
<td>開始新工作</td>
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<td>116</td>
<td>入新學校就讀</td>
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<td>117</td>
<td>和上司發生問題</td>
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<td>118</td>
<td>和老師發生問題</td>
<td></td>
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<tr>
<td>119</td>
<td>法律問題</td>
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<tr>
<td>120</td>
<td>直系親屬死亡</td>
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</tr>
</tbody>
</table>
APPENDIX H

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appropriate test use lies with the test user. The user should become knowledgeable about the test and its appropriate use and also communicate this information, as appropriate, to others.

6.1 Test users should evaluate the available written documentation on the validity and reliability of tests for the specific use intended.

6.2 When a test is to be used for a purpose for which it has not been validated, or for which there is no supported claim for validity, the user is responsible for providing evidence of validity.

6.5 Test users should be alert to probable unintended consequences of test use and should attempt to avoid actions that have unintended negative consequences."

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By: Lisa Smereso - Permission Specialist
Date: 3-23-13

I AGREE TO THE ABOVE CONDITIONS

By: Lu-I Chang
Date: 2-9-13
APPENDIX I

FAMILY ENVIRONMENT SCALE (FES)
There are 90 statements in this booklet. They are statements about families. You are to decide which of these statements are true of your family and which are false. Make all your marks on the separate answer sheet. If you think the statement is True or mostly True of your family, make an X in the box labeled T (true). If you think the statement is False or mostly False of your family, make an X in the box labeled F (false).

You may feel that some of the statements are true for some family members and false for others. Mark T if the statement is true for most members. Mark F if the statement is false for most members. If the members are evenly divided, decide what is the stronger overall impression and answer accordingly.

Remember, we would like to know what your family seems like to you. So do not try to figure out how other members see your family, but do give us your general impression of your family for each statement.
1. Family members really help and support one another.
2. Family members often keep their feelings to themselves.
3. We fight a lot in our family.
4. We don’t do things on our own very often in our family.
5. We feel it is important to be the best at whatever you do.
6. We often talk about political and social problems.
7. We spend most weekends and evenings at home.
8. Family members attend church, synagogue, or Sunday School fairly often.
9. Activities in our family are pretty carefully planned.
10. Family members are rarely ordered around.
11. We often seem to be killing time at home.
12. We say anything we want to around home.
13. Family members rarely become openly angry.
14. In our family, we are strongly encouraged to be independent.
15. Getting ahead in life is very important in our family.
16. We rarely go to lectures, plays or concerts.
17. Friends often come over for dinner or to visit.
18. We don’t say prayers in our family.
19. We are generally very neat and orderly.
20. There are very few rules to follow in our family.
21. We put a lot of energy into what we do at home.
22. It’s hard to “blow off steam” at home without upsetting somebody.
23. Family members sometimes get so angry they throw things.
24. We think things out for ourselves in our family.
25. How much money a person makes is not very important to us.
26. Learning about new and different things is very important in our family.
27. Nobody in our family is active in sports, Little League, bowling, etc.
28. We often talk about the religious meaning of Christmas, Passover, or other holidays.
29. It’s often hard to find things when you need them in our household.
30. There is one family member who makes most of the decisions.
31. There is a feeling of togetherness in our family.
32. We tell each other about our personal problems.
33. Family members hardly ever lose their tempers.
34. We come and go as we want to in our family.
35. We believe in competition and “may the best man win.”
36. We are not that interested in cultural activities.
37. We often go to movies, sports events, camping, etc.
38. We don't believe in heaven or hell.
39. Being on time is very important in our family.
40. There are set ways of doing things at home.
41. We rarely volunteer when something has to be done at home.
42. If we feel like doing something on the spur of the moment we often just pick up and go.
43. Family members often criticize each other.
44. There is very little privacy in our family.
45. We always strive to do things just a little better the next time.
46. We rarely have intellectual discussions.
47. Everyone in our family has a hobby or two.
48. Family members have strict ideas about what is right and wrong.
49. People change their minds often in our family.
50. There is a strong emphasis on following rules in our family.
51. Family members really back each other up.
52. Someone usually gets upset if you complain in our family.
53. Family members sometimes hit each other.
54. Family members almost always rely on themselves when a problem comes up.
55. Family members rarely worry about job promotions, school grades, etc.
56. Someone in our family plays a musical instrument.
57. Family members are not very involved in recreational activities outside work or school.
58. We believe there are some things you just have to take on faith.
59. Family members make sure their rooms are neat.
60. Everyone has an equal say in family decisions.
61. There is very little group spirit in our family.
62. Money and paying bills is openly talked about in our family.
63. If there's a disagreement in our family, we try hard to smooth things over and keep the peace.
64. Family members strongly encourage each other to stand up for their rights.
65. In our family, we don't try that hard to succeed.
66. Family members often go to the library.
67. Family members sometimes attend courses or take lessons for some hobby or interest (outside of school).
68. In our family each person has different ideas about what is right and wrong.
69. Each person's duties are clearly defined in our family.
70. We can do whatever we want to in our family.
71. We really get along well with each other.
72. We are usually careful about what we say to each other.
73. Family members often try to one-up or out-do each other.
74. It's hard to be by yourself without hurting someone's feelings in our household.
75. "Work before play" is the rule in our family.
76. Watching T.V. is more important than reading in our family.
77. Family members go out a lot.
78. The Bible is a very important book in our home.
79. Money is not handled very carefully in our family.
80. Rules are pretty inflexible in our household.
81. There is plenty of time and attention for everyone in our family.
82. There are a lot of spontaneous discussions in our family.
83. In our family, we believe you don't ever get anywhere by raising your voice.
84. We are not really encouraged to speak up for ourselves in our family.
85. Family members are often compared with others as to how well they are doing at work or school.
86. Family members really like music, art and literature.
87. Our main form of entertainment is watching T.V. or listening to the radio.
88. Family members believe that if you sin you will be punished.
89. Dishes are usually done immediately after eating.
90. You can't get away with much in our family.
APPENDIX J

FAMILY ENVIRONMENT SCALE - CHINESE (FES-C)
家庭環境評估 (FES)

Rudolf H. Moos

指引

這份問卷包含 90 題有關家庭情況的描述，在您的家庭中，那些描述是真的，那些是不真的，請將您的答案寫在答案紙上，如果您認為某項描述是真的或大致是真的，請在標示著 “T” 的格子中打勾，如果是不真的或大致是不真的，請在標示著 “F” 的格子中打勾。

您也許會認爲有些陳述對於家中某些成員來說是真的，而對於其他成員是不真的，如果對大部份成員來說是真的，請答 “T” ，如果對大部份成員來說是不真的，請答 “F” ，如果是一半一半的情況，則請憑您較強烈印象的一方來作答。

請注意：我們希望了解您對您家庭的看法，所以請不要以家中其他人對家庭的看法來做答，對於每個情況的描述，請給我們您對您家庭的看法。

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1. 家人真的相互支持與協助。
2. 家人總是保留自己的感受。
3. 我們家常有爭吵。
4. 在家裡，我們不常獨自處理事情。
5. 我們覺得不管做任何事情，做到最好是很重要的。
6. 我們經常談論政治上的和社會上的一些問題。
7. 大部份的週末和夜晚我們都待在家裡。
8. 家人常參加宗教性的活動。
9. 我們細心的計劃家裡的一些活動。
10. 家人很少被指使來指使去的。
11. 我們似乎常在家中打發時間。
12. 在家裡，我們可以想說什麼就說什麼。
13. 家裡人很少公然地發怒。
14. 在家裡，我們被強烈鼓勵著要獨立。
15. 在我們家，努力往前過日子是很重要的。
16. 我們很少去聽演講、看戲劇表演或聽音樂會。
17. 我們家常有朋友來訪或用餐。
18. 我們家不禮告。
19. 大致上，我們家很整潔而且有條理。
20. 在我們家，必須遵守的規則不多。
21. 我們花很多心力在家庭生活上。
22. 在家裡發洩情緒而不傷害到別人是很難的。
23. 有時候家人會因爲非常生氣而摔東西。
24. 我們會為了自己而對事情深思熟慮。
25. 對我們來說，賺多少錢並不是很重要的事。
26. 在我們家，學習新奇的事物被認爲是很重要的。
27. 我們家沒有人愛好運動。
28. 我們常談論宗教節日的意義。
29. 在我們家，當你需要某些用品時，常常是不容易找到。
30. 家裡大部份的事，都由家裡某一個人作主。
31. 我們家人對家庭都很有歸屬感。
32. 我們會相互告知自己的困擾。
33. 家人很少發脾氣。
34. 在家裡，行動是不受限制的。
35. 我們相信競賽而且相信在競賽中輸的一定是最好的。
36. 我們對文化活動不是很有興趣。
37. 我們經常去看電影，或運動比賽等等。
38. 我們不相信有天堂或地獄。
39. 在我們家，守時是非常重要的。
40. 在家裡，做任何事都有一定的方法或規矩。
41. 當家裡有事或工作必須完成時，我們很少主動去做。
42. 當我們有衝動要去做某件事時，我們經常就著手去做。
43. 家人經常互相批評。
44. 在家裡幾乎沒有什麼隱私。
45. 做任何事情，我們總是努力做得一次比一次好。
46. 我們家很少有知識性的討論。
47. 在我們家裡每個人都有一種或兩種嗜好。
48. 家人對於是非都有明確的認同。
49. 家人經常會改變主意。
50. 我們家很注重遵守規則。
51. 家人真的互相支持。
52. 在我們家裡，如果你抱怨，總會有人感到不高興。
53. 家人有時候會打自己家人。
54. 當遇到問題時，家人通常都靠自己解決。
55. 家人很少擔心工作發展、學校成績……等等。
56. 家裡有人會彈奏樂器。
57. 家人很少參與工作或學校之外的休閒活動。
58. 我們相信有些事情就是不容置疑。
59. 家人負責維持自己房間的整潔。
60. 在家庭決策上，每個人都有表達意見的權利。
61. 我們家不太團結。
62. 在家裡，家中的經濟和開銷是公開談論的。
63. 當家人有不同的意見時，我們努力使事情和平順利的解決。
64. 家人相互強烈鼓勵著去爭取自己的權利。
65. 在我們家，我們不會很努力去爭取成功。
66. 家人常上圖書館。
67. 家人有時會為了嚐好或興趣而參加進修的課程。
68. 在我們家，每個人對於對與錯都有不同的看法。
69. 我們家很清楚地規劃著每個人的職責。
70. 在家裡，我們可以想做什麼就做什麼。
71. 我們相互之間都相處得很好。
72. 我們相互之間經常小心翼翼的說話。
73. 家人相互之間經常試著要勝人一籌或優於他人。
74. 在家庭中，很難做到自己處理事情而不會讓別人感覺不好。
75. 我們家的規矩是 "工作做完了，才可以遊玩"。
76. 在我們家，看電視要比看書重要多了。
77. 家人常常出去。
78. 在我們家，經書是很重要的書籍。
79. 在我們家，理財方面不是做得很好。
80. 家裡的規定是非常有彈性的。
81. 在我們家每個人都獲得充分的關注。
82. 在我們家常會有很多即席的討論。
83. 我們相信你不會因提高音量而可以爲所欲爲。
84. 在家裡，我們並不是真的被鼓勵著爲自己說話。
85. 在我們家，工作或學校的表現，常常被拿來和其他人做比較。
86. 家人間的喜歡音樂、藝術或文學。
87. 看電視或聽音機是我們最主要的娛樂。
88. 家人相信做錯事將會被處罰。
89. 碗盤通常在餐後立刻洗乾淨。
90. 在我們家，避開責罰是行不通的。
APPENDIX K

ITEMS THAT REDUCED THE ALPHA IN EACH SUBSCALE OF PSI-C
Table K

Items That Reduced the Alpha in PSI-C Subscales That Might Meet the Criterion of $\alpha = .65$

<table>
<thead>
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<th>Subscales</th>
<th>Alpha of Subscale</th>
<th>Alpha of subscales If Item Deleted</th>
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<tr>
<td>Child Adaptability/Plasticity</td>
<td>.80</td>
<td></td>
</tr>
<tr>
<td>Acceptability of Child to Parent</td>
<td>.78</td>
<td></td>
</tr>
<tr>
<td>Child Demandingness</td>
<td>.55</td>
<td>.66</td>
</tr>
<tr>
<td>49. My child is always hanging on me.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Mood</td>
<td>.62</td>
<td>.69</td>
</tr>
</tbody>
</table>
| 16. My child cries and fusses:  
   1. much less than I had expected,  
   2. less than I expected,  
   3. about as much as I expected,  
   4. much more than I expected,  
   5. it seems almost constant. |
| Child Distractibility/Activity| .09               |                                  |
| Child Reinforces Parent       | .69               |                                  |
| Parent Depression             | .81               |                                  |
| Parent Attachment             | .68               |                                  |
| Restrictions Imposed by Parental Role | .81            |                                  |
| Parent’s Sense of Competence  | .72               |                                  |
| Social Isolation              | .74               |                                  |
| Relationship with Spouse      | .83               |                                  |
| Parental Health               | .56               |                                  |
| Life Stress                   | .59               |                                  |
APPENDIX L

ITEMS THAT REDUCED THE ALPHA IN EACH SUBSCALE OF FES-C
Table L

**Items That Reduced the Alpha in FES-C Subscales That Might Meet the Criterion of $\alpha = .65$**

<table>
<thead>
<tr>
<th>Subscales</th>
<th>Alpha of Subscale</th>
<th>Alpha of Subscale If Item Deleted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cohesion</td>
<td>.69</td>
<td></td>
</tr>
<tr>
<td>Expressiveness</td>
<td>.57</td>
<td></td>
</tr>
<tr>
<td>Conflict</td>
<td>.59</td>
<td>.66</td>
</tr>
<tr>
<td>83. In our family, we believe you don't get anywhere by raising your voice.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Independent</td>
<td>.28</td>
<td></td>
</tr>
<tr>
<td>Achievement Orientation</td>
<td>.24</td>
<td></td>
</tr>
<tr>
<td>Intellectual-Culture Orientation</td>
<td>.62</td>
<td>.66</td>
</tr>
<tr>
<td>46. We rarely have intellectual discussions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Active-Recreation Orientation</td>
<td>.28</td>
<td></td>
</tr>
<tr>
<td>Moral-Religion Emphasis</td>
<td>.42</td>
<td></td>
</tr>
<tr>
<td>Organization</td>
<td>.53</td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>.24</td>
<td></td>
</tr>
</tbody>
</table>


