PARENTING STYLES, MATERNAL EFFICACY, AND IMPACT OF A CHILDHOOD DISABILITY ON THE FAMILY IN MOTHERS OF CHILDREN WITH DISABILITIES

by

GWENDOLYN ANNE PUGH

(Under the Direction of Zolinda Stoneman)

ABSTRACT

The purpose of the study was to examine how maternal efficacy and the impact of a childhood disability on the family were related to the mother's parenting styles. Sixty-eight mothers of children with disabilities were recruited from intervention and educational programs for children with disabilities. Efficacy was positively related to positive parenting styles: induction and nurturance, but was not related to parenting style: power assertion. Efficacy was negatively related to negative cognitive appraisals of the impact of the childhood disability. Positive cognitive appraisals were positively related to parenting style: induction, but were not related to parenting style: nurturance and power assertion. Negative cognitive appraisals were not related to parenting. The results of the study allow professionals working with populations of children with disabilities and their mothers to better understand various contributors of parenting styles.

INDEX WORDS: Disabilities, parenting styles, efficacy, family, mother

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GWENDOLYN ANNE PUGH

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GWENDOLYN ANNE PUGH

Major Professor:	Zolinda Stoneman
Committee:	Charlotte Wallinga Jenny Manders

Electronic Version Approved:

Maureen Grasso
Dean of the Graduate School
The University of Georgia
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CHAPTER 1

INTRODUCTION

Between the 1960s and the present more children with disabilities began to live or remain at home with their families (DesJardin, 2003; Glidden, Kiphart, Willoughby, & Bush, 1993). With increasing numbers of children living at home there has been an increasing need for information about family dynamics and services. The initial studies on the family environment of young children with disabilities have given insight into family dynamics; however, the majority of these studies were written about the negative impact of a childhood disability on the family (Cummings, Bayley, & Rie, 1966; Farber, 1959; Friedrich & Friedrich, 1981). Most of the studies focused only on the difficult aspects of having a child with a disability. Parenting a child with a disability was considered a negative experience. Very few articles focused on the families' positive and negative cognitive appraisals of the impact of the childhood disability on their family. However, today researchers are beginning to find that having a child with a disability can lead to many positive feelings and outcomes for family members (Abbott & Meredith, 1986; Hodapp, Ly, Fidler, & Ricci, 2001).

Parents expect to be able to care for their child with the resources that they can provide. They expect to care for the child's physical, cognitive, and social-emotional needs as they develop through life. However, one aspect of parenting that many parents are unlikely to be prepared for is caring for a child with a disability. A child with a disability requires the same care that a child without a disability does, however, specialized

care is often required according to the severity of the specific disability (DesJardin, 2003). When a child is diagnosed with a disability a variety of emotions and reactions occur in the family system (Trute & Hiebert-Murphy, 2002). Different parents perceive the extra responsibility of caring for a child with a disability in different ways. Some parents react to the new responsibility with a positive sense of involvement and a feeling that they have the power to affect their child's future, while other parents react more negatively and do not feel as effective in this parenting role (DesJardin, 2003).

Parenting can be a very rewarding, yet difficult task. Disability services are responding to the needs of parents by becoming more family-centered. For example, early intervention is changing from merely providing services to children, to focusing on supporting families by enhancing parental competence in order to maximize the growth and development of their children (McWilliams & Scott, 2001). The philosophy behind this change in the early intervention service delivery system is to focus on families' strengths rather than deficits (Koren, DeChillo, & Friesen, 1992).

A family strength that is currently being researched is parenting self-efficacy (DesJardin, 2003). Parenting self-efficacy beliefs can be broadly defined as parents' confidence in their ability to parent their child effectively (Bandura, 1989). The parenting self-confidence literature highlights the importance of parenting self-efficacy beliefs as an important correlate of parenting styles (Bugental, Blue, & Cruzcosa, 1989; Raver & Leadbeater, 1999; Swick, 1988; Teti & Gelfand, 1991). Specifically, high maternal self-efficacy has been related to positive parenting practices, such as responsive, stimulating and nonpunitive caretaking (Unger & Wandersman, 1985); while low maternal self-efficacy has been related to negative parenting practices, such as coercive discipline (Bondy & Mash, 1999; Bugental et al., 1989). Research

that has found that self-efficacy is a significant correlate of parenting styles has been conducted on parents of typically developing children (Bugental et al.; Raver & Leadbeater, 1999; Swick & Hassell, 1990; Teti & Gelfand, 1991; Unger & Waudersman, 1985). Research has examined maternal efficacy in mothers of children with disabilities, but very little research has been conducted looking at the parenting styles of parents of children with developmental disabilities. There is a great need to research parenting styles and how maternal efficacy and the impact of the childhood disability on the family are related for mothers of children with developmental disabilities.

Efficacy has been found to be positively related to positive cognitive appraisals of the impact of the childhood disability on the family (Lazarus, Averill, & Opton, 1974). Parenting a child with a disability could be considered a family stressor or a positive impact on the family (Trute & Hiebert-Murphy, 2002). Negative cognitive appraisals of the impact of a child's disability on the family can be considered a form of stress. Parents who experience high levels of stress have been found to use less positive, more punitive parenting styles (Aunola, Nurmi, Onatsu-Arvilommi, & Pulkkinen, 1999). A similar link is anticipated to occur between negative cognitive appraisals (stress) and compromised parenting. Conversely, positive cognitive appraisals are predicted to be associated with more positive, nonpunitive parenting styles. In the current study, a mother's cognitive appraisal of the impact of the child's disability on her family is hypothesized to influence her parenting style.

This study examined how maternal efficacy and subjective interpretations of the impact of childhood disability on the family are related to the mother's parenting styles. This study hypothesized that maternal efficacy would be positively related to positive parenting styles, such as induction and nurturance, while negatively related to negative parenting styles, such as power

assertion. Maternal efficacy was also expected to be positively related to positive cognitive appraisals and negatively related to negative cognitive appraisals of the impact of the childhood disability on the family. Positive cognitive appraisals of the impact of the childhood disability on the family were hypothesized to be positively related to induction and nurturance, while negatively related to power assertion. Negative cognitive appraisals of the impact of the childhood disability on the family were expected to be positively related to power assertion, while negatively related to induction and nurturance.

CHAPTER 2

REVIEW OF LITERATURE

Parenting Styles

Most of the current research on parenting has been influenced by the research of Diana Baumrind in the early 1960s. In 1966, Baumrind proposed three parenting styles: permissive, authoritative, and authoritarian. She described permissive parents as tending to make few demands on their children. These parents do not see themselves in the role of shaping their child's behavior and future, but instead as a resource to their child. They try to provide their child with an open and accepting environment where the child can direct his or her own future and behaviors (Baumrind, 1966). Permissive parenting combines high parental support and nurturance, low control attempts (power assertion), and maturity demands (Baumrind, 1966, 1967, 1971, 1978).

Baumrind described authoritative parents as being firm, clear, and flexible, but not restrictive and rigid. They explain the reasoning behind decisions and regulations and are open to discussions. They recognize and reinforce their child's special qualities. They provide their child with encouragement, and they model appropriate behavior (Buri, 1989). Authoritative parenting combines high levels of maturity demands, parental support and nurturance, and inductive control attempts (power assertion) (Baumrind, 1966, 1967, 1971, 1978).

Baumrind described authoritarian parents as being more directive with their children. They attempt to control and shape their child's behaviors and future through restrictive methods,

keeping their child in a subordinate role. They are also not open to discussion and believe that a child should take a parent's words as absolute (Baumrind, 1966). Authoritarian parenting combines high coercive control attempt (power assertion), low support and nurturance, and inductive control attempts (Baumrind, 1966, 1967, 1971, 1978).

Research has found that when a child experiences an authoritative style of parenting, the child has a greater chance than their peers of being socially responsible, independent, and competent (Baumrind, 1991a, 1991b; Baumrind & Black, 1967). In a study where parents of gifted children used an authoritative style of parenting, the children had low levels of frustration and exhibited high levels of creativity (Christian & Snowden, 1999). Herman and Shantz (1983) found that mothers of children with a mental disability who gave their children more freedom to make decisions had children who were socially mature and were able to use problem-solving skills similar to children their own age without a mental disability; however, they found that when mothers were highly directive they had children with low problem-solving skills.

Hoffman and Saltzstein (1967) categorized parenting styles into three categories in order to examine the link between parenting and the moral development of children. The three categories were high power assertion, characterized by control and force through punishment or threat; love withdrawal or manipulation, characterized by avoidance and withdrawal of love or attention; and victim-centered discipline or induction, characterized by explanation of disciplinarian policy and consequences of actions. Hoffman and Saltzstein (1967) found that high power assertion was negatively associated with moral development. Love withdrawal or manipulation was unrelated to moral development; however, victim-centered discipline or induction was positively related to moral development.

Both Baumrind and Hoffman's research in parenting styles and behavior constructs laid the foundation for the Parenting Style Survey (Saetermoe, Widaman, Borthwick-Duffy, 1990) that was used in this study. The Parenting Style Survey, which looks at seven parenting styles (i.e. power assertion, love withdrawal, control, maturity demands, nurturance, autonomy, and induction), was developed to assess parenting styles in families of children with disabilities. This study used only three of the parenting styles measured by the instrument: Nurturance, induction, and power assertion. Nurturance, induction, and power assertion were selected because they were the only parenting styles that exhibited both high reliability and construct validity scores in the Parenting Style Survey (Saetermoe et al., 1990). Nurturance, induction, and power assertion have found to be consistent parenting variables throughout the parenting literature (Baumrind, 1966, 1967, 1971, 1978; Hoffman and Saltzstein, 1967). The three parenting styles are briefly described in the following paragraphs.

Nurturance is defined as warmth and involvement in the child's personal life (Saetermoe et al., 1990). Nurturance, warmth, affection, and acceptance are considered parental support (Becker, 1964; Martin, 1975). Many studies have identified parental support and control as two components to the role of child socializer that predicts a child's behavioral outcome (Baumrind, 1966; Becker, 1964; Hoffman, 1970; Hoffman & Saltzstein, 1967; Maccoby, 1961). Parenting behaviors convey to children expectations and meaning during their socialization process (Peterson & Rollins, 1987). Nurturance was found to not directly promote changes in a child's behavior, but instead mediate the influence of other techniques allowing a child to increase his or her susceptibility to future compliance (Hoffman, 1970).

Parental induction is characterized by a parent explaining disciplinary policy, using reason to impel obedience, and an equalitarian philosophy (Saetermoe et al., 1990). It places

rational maturity demands on a child and makes a child aware of the fact that his or her actions have consequences that affect the child and others. Parental induction encourages a child to make his or her own decisions and it gives the child an opportunity to understand what is expected of him or her (Hoffman, 1970; Saetermoe et al.). Kuczynski (1984) found that induction was used to encourage long-term compliance. Induction has been identified as a positive subdimension of parental control (Hoffman, 1970; Saetermoe et al.).

Power assertion, also termed parental coercion is defined as deprivation of material objects or privileges, direct application of force, or threat of any of these (Hoffman, 1970; Saetermoe et al., 1990). Parental assertion does not involve the explanation of punishments or expectations leading a child to develop values and expectations that differ from their parent (Peterson & Rollins, 1987). Power assertion has been identified as a negative subdimension of parental control (Hoffman, 1970; Saetermoe et al.).

Parenting Styles and Maternal Efficacy

Coleman and Karraker (1998) found that in the parenting domain, self-efficacy has emerged as a key correlate of parenting behaviors. Bandura's social learning theory defines efficacy as the belief in one's ability and competence to successfully complete a task (Bandura, 1982, 1989). More specifically, maternal efficacy is defined as a mother's beliefs regarding her competence in the parental role; the mother's perceived ability to positively influence the development and behavior of her children (Bandura, 1989). According to Bandura's theory of self-efficacy, high perceived maternal self-efficacy should be valuable in parenting (Bandura, 1997). Parents develop a sense of themselves through multiple experiences in relation to being parents, individuals, and part of a community.

Parents who lack a strong sense of parental efficacy are usually unable to put their parenting knowledge into action and tend to feel overly burdened by their responsibilities as a parent (Coleman & Karraker, 2003). Bandura's efficacy theory suggests that a parent's sense of self-efficacy will enhance a child's sense of self-efficacy and other positive future outcomes by creating a sense of being in control of his or her future (Bandura, 1997). If a mother has high maternal efficacy, then she is more likely to engage in parenting behaviors that will have a positive effect on her child. In contrast, a mother who feels that she has little or no control over her child's behavior will be less likely to engage in those behaviors that would have a positive effect on her child (Eccles, Midgley, Wigfield, Buchanan, & Reuman, 1993; Furstenberg, 1993). High maternal self-efficacy enhances the parent's self confidence in undertaking parenting tasks, investing time and effort into their child's life, and persevering in challenging times.

High maternal self-efficacy has been related to the development of social competence in young children (Swick & Hassell, 1990), successful parent involvement (Swick & Broadway, 1997), positive parenting practices, such as responsive, stimulating and nonpunitive caretaking (Unger & Waudersman, 1985), active maternal coping orientations (Machida, Taylor, & Kim, 2002; Wells-Parker, Miller, & Topping, 1990), and fewer maternally perceived child behavior problems in children (Gibaud-Wallson & Wandersman, 1978). Conversely, low maternal self-efficacy has been related to behavior problems in children (Gibaud-Wallson & Wandersman, 1978), negative parenting practices, such as coercive discipline (Bondy & Mash, 1999; Bugental et al.,1989), maternal depression (Teti & Gelfand, 1991), passive maternal coping orientations (Wells-Parker et al., 1990), and high levels of stress (Wells-Parker et al., 1990). Dunst, Trivette, Boyd, and Brookfield (1994) also found that high levels of self-efficacy have been linked to positive parenting practices in parents of typically developing children.

Maternal Efficacy and Cognitive Appraisals of the Impact of Childhood Disability on the Family

All families are different; they interpret and react to situational events in different ways. Diagnosis of a disability can generate a range of emotional responses in the family system. Some families will look at the disability as unfortunate, but they also will look at the positive impact the child with a disability has had on their family. This event may generate psychological growth and family togetherness (Dohrenwend, 1978; Lazarus & Folkman, 1984). Other families will see the disability as a burden, crisis, and as added stress on the family physically, emotionally, and financially (Lazarus & Folkman, 1984; Trute & Hiebert-Murphy, 2002). Szymanski and Crocker (1985) found that a parent's initial reaction to the birth of a child with Down syndrome was characterized by anger, anxiety, sorrow, and guilt. However, these emotions are not applicable to all parents. Some of the emotions that parents feel about having a child with a disability are exhibited only at the time of diagnosis, and after caring for their child their emotions change (Byrne & Cunningham, 1985). With this wide range of emotions comes an array of subjective interpretations of the disability (Trute & Hiebert-Murphy, 2002).

Lazarus et al. (1974) stated that the subjective interpretation of the event or "cognitive appraisal" is the interaction of personality and situational events. A mother's cognitive appraisal of her child's disability as being positive or negative can influence whether this event will be a family stressor or a positive experience (Lazarus & Folkman, 1984). Lazarus et al. believe that these subjective interpretations are key in the coping process. The concept of cognitive appraisals is new to the stress theory research and has been linked to coping abilities. Coping can be an individual or community actively pursuing resources or services that enhance one's psychological and emotional, and physical well-being. Positive coping by one family member can be effective in helping another family member cope effectively (Lazarus & Folkman, 1984).

Lazarus and Folkman found that positive appraisals, coping, and high self-efficacy can lead to a stronger family unit (Lazarus & Folkman, 1984). Hastings and Brown state that, "Self-efficacy may be a particularly significant factor in understanding the effects of dimensions of childhood disability in parents" (Hastings & Brown, 2002, p. 222). Efficacy has been found to be related to positive cognitive appraisals (Lazarus & Folkman, 1984).

Parenting Styles and Cognitive Appraisals of the Impact of Childhood Disability on the Family

Cognitive appraisals or subjective interpretations of the impact of childhood disability on the family have been of interest to researchers for a long time, but the ability to reliably measure parent's cognitive appraisals is relatively new (Trute & Hiebert-Murphy, 2002). Family theorists posit that subjective interpretation of an event is a key element in determining whether the event is a family stressor i.e. the ABCX model of family stress (McCubbin & McCubbin, 1989). Lazarus and Folkman state that, "Psychological stress is a particular relationship between the person and the environment that is cognitively appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being." (Lazarus & Folkman, 1984, p. 19). Parenting stress refers to how parents feel about themselves in their parental roles, while parenting styles emphasize the ways in which parents interact with their children (Anuola et al., 1999; Snyder, 1991; Webster-Stratton & Hammond, 1988). Trute and Hiebert-Murphy (2002) found that parent cognitive appraisals, as measured by the Family Impact of the Childhood Disability Scale, predicted long-term parenting stress of parents of children with disabilities. Throughout the literature stress has had a history of relationships with negative parenting variables. Parental stress has been shown to lead to ineffective parenting, such as coercion and power assertion (Aunola et al.). Thus it follows that negative cognitive appraisals, which are closely linked to parental stress, would be related to negative parenting styles in families of

children with disabilities, while positive cognitive appraisals would be associated with more positive parenting styles.

Purpose and Hypotheses

Most research on parenting styles and efficacy have been conducted on children and families without disabilities. The purpose of this study was to examine how maternal efficacy and the impact of childhood disability on the family system are related to the mother's parenting styles. As previously mentioned, this study hypothesized that:

1) Maternal efficacy would be positively related to positive parenting styles, such as induction and nurturance, while negatively related to the negative parenting style of power assertion.
2) Maternal efficacy was expected to be positively related to positive cognitive appraisals and negatively related to negative cognitive appraisals of the impact of the childhood disability on the family.
3) Positive cognitive appraisals of the impact of childhood disability on the family were hypothesized to be positively related to induction and nurturance, while negatively related to power assertion.
4) Negative cognitive appraisals of the impact of childhood disability on the family were expected to be positively related to power assertion, while negatively related to induction and nurturance.

CHAPTER 3

METHOD

Participants

Sixty-eight mothers of children with a developmental disability or delay took part in this study. Ninety-six percent of the mother's are the children's birth mothers and four percent are adoptive mothers. The sample met the following criteria: Mothers must have had a child, between two and seven years of age, with a physical or mental condition, which was known to result in a developmental delay, and/or have a diagnosed developmental disability. Mothers who had more than one child that met the above criteria were included, but they only completed the survey packet for one of the children.

The frequencies of the study demographic variables are presented in Table 1.1. The mothers' mean age was 35.1 years with a standard deviation of 5.22 (range 20 to 47 years), while the children's fathers' mean age was 37.41 years with a standard deviation of 6.25 (range 23 to 52 years). Their children (24 females and 44 males) with a disability or delay had a mean age of 4.39 years with a standard deviation of 1.34 (range 2.07 to 6.95 years). The children were divided into three diagnoses for this study: Down syndrome (26.5%), Autism (30.9%), and Other (42.6%), which includes language/speech delay, cerebral palsy, muscular dystrophy, visual impairment, spina bifida, hearing impairment, Fragile X syndrome, physical disability, and developmental delay. The children were diagnosed at a mean age of 16.47 months with a standard deviation of 16 (range 0 to 60 months). The number of children in the family household ranged from one to five (M = 2.19, SD = .91). The frequencies of the involvement in programs

of the child with a disability are presented in Table 1.2, while the frequencies of abilities, communication, and behaviors of the child with a disability are presented in Table 1.3.

Procedure

Disability-related organizations, programs, and schools in the southeast region of the United States that serve young children with developmental disabilities, such as family support groups and service organizations, were contacted to participate in this study. For organizations that allowed recruitment of their members, survey packets were sent to the organization to distribute to the mothers. Some organizations posted brief letters in their newsletters, enabling the mothers to directly contact the researchers. For mothers reached by newsletter, they were asked to contact the researchers by email or by phone if they were interested in participating in the study. These families were then mailed the survey packet. All packets included a stamped, return envelope to mail back to the researchers.

The packet included an introductory letter, an implied consent form, a demographic form, the Parenting Style Survey (Saetermoe et al., 1990), the Parenting Sense of Competence Scale (PSOC) (Gibaud-Wallson & Wandersman, 1978), the Parent Control of Child's Behavior subscale of the Parental Locus of Control Scale (PLOC) (Campis, Lyman, & Prentice-Dunn, 1986), and the Family Impact of Childhood Disability Scale (FICD) (Trute & Hiebert-Murphy, 2002). It was assumed that participants who returned the survey packet had the literacy and language skills to comprehend the implied consent and the surveys. The packets of surveys took approximately 45 minutes to complete. The incentive of participation was a raffle. Each mother who chose to participate was given the chance of winning one of two fifty-dollar checks. The last page in each of the packets was an unnumbered postcard requesting the mother's name and address. The mother was asked to fill out this postcard and send it to the researchers upon

completion of the questionnaires. At the end of the study each of the unnumbered postcards were put in a bowl, two of those forms were drawn out, and each of those mothers were mailed a fifty-dollar check.

Measures

Family Demographics. The participants completed three measures and some demographic information about their family. They were asked questions about family members' ages, number of children in the household, race, marital status, birth order of child with a disability, mother's employment, and parents' educational level, and the family's income . Questions were asked about the child with a disability such as: age of diagnosis, child's gender, and the child's abilities, communication skills, and behaviors. Mothers were also asked to describe their child's diagnosis as accurately as possible, and to indicate what activities their child with a disability was involved in (i.e. Public Early Intervention Services, Pre-K Special Education, Head Start, Daycare or Child Development Center).

Parenting Styles. The Parenting Style Survey (Saetermoe et al., 1991) assesses the perceptions of parents on seven parenting styles (1) *power assertion* (unipolar) – direct application of force, deprivation of material objects or privileges, or threat of any of these; (2) *love withdrawal* (unipolar) – punishment by withholding or withdrawing love; (3) *control* (bipolar: firm vs. lax) – enforces rules firmly, can resist child's demands, believes in directing the child; (4) *maturity demands* (bipolar) – makes and enforces demands for socially desirable behavior, personal neatness, orderliness about cleaning up, and sharing household responsibilities; (5) *nurturance* (bipolar) – warmth and involvement in the child's personal life; (6) *autonomy* (bipolar: restricts vs. permits) – low level of restrictions on child's behavior and lifestyle; and (7) *induction* (bipolar) – explains disciplinary policy, uses reason to impel

Table 1.1

Demographic Characteristics of Study Participants (N = 68)

	Frequency	Percent
Race		
White	56	82
Black or African American	9	13
Hispanic or Latino	2	
American Indian or Alaska Native	1	2
Marital Status		
Married	61	90
Single mothers	2	3
Divorced	1	2
Live-in partner	1	2
Separated	1	2
Widowed	1	2
Family Income		
Under $10,000	1	2
$10,000-$19,000	1	2
$20,000-$29,000	5	7
$30,000-$39,000	5	7
$40,000-$49,000	8	12

$50,000-$59,000	9	13
$60,000-$69,000	2	3
$70,000-$79,000	11	16
$80,000 and over	24	35
Employment of Mother		
Yes	26	38
No	41	60
Education		
Mothers		
High School diploma or GED	5	7
Some College or Technical School	18	27
College degree	32	47
Graduate degree	12	18
Fathers		
Less than 12th grade	4	6
High School diploma or GED	7	10
Some College or Technical School	20	29
College degree	24	35
Graduate degree	11	16
Birth Order of Child with Disability		
Only child	15	22
First born child	11	16
Middle born child	14	21

Last born child	27	40
Diagnosis of Disability		
Aware of the disability before their child's birth.	5	7
Diagnosed at birth	25	37
Diagnosed in infancy/childhood	38	56

Table 1.2

Types and Percentages of Involvement of Study Participants' Children with Disabilities (N = 68)

	Frequency	Percent
Early Head Start Program	3	4
Pre-K Program	16	24
Head Start Program	1	2
Speech Therapy	53	78
Occupational Therapy	50	74
Public Early Intervention	17	25
Private Early Intervention	20	29
Preschool Special Education	40	59
Physical Therapy	30	44
Daycare or Child Development Center	14	21

Table 1.3

Abilities, Communication, and Behaviors of Study Participants' Children with Disabilities (N = 68)

	Frequency	Percent
Sit	66	97
Stand	59	87
Walk	59	87
Communicate using words	51	75
Communicate using several words in a phrase or sentence	35	52
Toilet independently	28	41
Eat independently	55	81
Use a wheelchair	2	3
Difficult to manage behaviors	28	41

obedience, equalitarian philosophy. The instrument was developed to assess parenting styles in families of children with disabilities. The survey's response format consists of six scenarios and 12 to 15 parental responses for each scenario. Only three parenting styles were used from this measure: Power assertion, induction, and nurturance. Each scenario is responded to on a six-point likert scale, ranging from 0, never to 5, always. The power assertion subscale was comprised of 12 questions with a score range of zero to seventy-two. A higher score means a higher level of power assertion. An example of a question from the power assertion subscale is "Tell him/her if he/she doesn't do what you want you will punish him/her." The induction subscale was comprised of 13 questions with a score range of zero to seventy-eight. A higher score means a higher level of induction. An example of a question from the induction subscale is "Very carefully explain to the child why he/she must do what you have asked." The nurturance subscale was comprised of 12 questions with a score range of zero to seventy-two. A higher score means a higher level of nurturance. An example of a question from the nurturance subscale is "Hug him/her and tell him or her you wish he/she would not do it." The Cronbach's alpha reliability for power assertion was .72, for induction was .77, and for nurturance was .63. The Parenting Style Survey and the Family Environment Scale were found to be positively correlated as an indicator of study validity. (Saetermoe et al.).

Maternal Efficacy. The study used two measures of maternal efficacy. The first measure, the Parenting Sense of Competence Scale (PSOC) (Gibaud-Wallson & Wandersman, 1978) is a 17-item scale that assesses parenting self-esteem, through satisfaction and efficacy subscales. Each item on the PSOC is answered on a five-point likert scale, with responses ranging from 5-strongly disagree to 1-strongly agree. For this study only the efficacy items were used. The efficacy scale is comprised of seven questions with a score range of seven to thirty-

five. The efficacy scale is a reversed scale so a higher score means a higher level of efficacy. Previous studies with children with Down syndrome have used the PSOC (Belchic, 1996). The mothers were asked to fill out the questionnaire thinking only of their child with a disability. An example question from the efficacy subscale is "I meet my own personal expectations for expertise in caring for my child." In the original development and utility of the Parenting Sense of Competence Scale an alpha coefficient of .82 was found for the efficacy subscale. Based on a six-point likert scale means of mothers' scores were 31.56 with a standard deviation of 6.37 for the efficacy subscale. The authors reported adequate test-retest reliability scores over a six-week period for mothers of typically developing children. Johnston and Mash (1989) used 500 subjects to provide significant construct validation and a Cronbach's alpha reliability of .76 for the efficacy scale of the PSOC. The results of efficacy subscale of the Parenting Sense of Competence scale exhibited high reliability and validity scores (Gibaud-Wallson & Wandersman, 1978; Johnston and Mash (1989).

The second measure of parent efficacy was the Parent Control of Child's Behavior subscale of the Parental Locus of Control Scale (PLOC) (Campis et al., 1986). Each subscale item was assessed on a five-point likert scale, with answers ranging from 1-strongly disagree to 5-strongly agree. The Parental Control subscale was comprised of nine questions with a score range of five to forty-five. A lower score means a higher level of efficacy. An example of a question from the Parental Control of Child's Behavior subscale is "Sometimes I feel that my child's behavior is hopeless." The Parental Control subscale had an alpha coefficient of .71.

Cognitive Appraisals of Impact of Childhood Disability on the Family. The Family Impact of Childhood Disability Scale (FICD) (Trute & Hiebert-Murphy, 2002) is a 13-item scale that assesses subjective interpretation or cognitive appraisals of parents in relation to the impact

of the childhood disability on the family. Each item was assessed on a four-point likert scale, with answers ranging from 1-not at all to 4-to a substantial degree. When completing the FICD the mother was asked, "In your view, what consequences have resulted from having a child with a disability in your family." The scale is composed of two subscales: positive and negative. The positive subscale is comprised of five questions with a score range of five to twenty. A higher score means a higher level of positive cognitive appraisals. An example of a question from the positive subscale is "The child's disability has led to positive personal development in mother and/or father." The negative subscale is comprised of ten questions with a score range of ten to forty. A higher score means a higher level of negative cognitive appraisals. An example of a question from the negative subscale is "The situation has led to tension with spouse." Trute and Hiebert-Murphy (2002) sampled 88 households that had a child with a developmental disability. Adequate internal consistency, with alphas of .88 for the negative subscale and .71 for the positive subscale, was reported. Regression analyses confirmed long-term predictive validity in predicting long-term parenting stress in both mothers and fathers from the Family Impact of the Childhood Disability on the Family Scale.

CHAPTER 4

RESULTS

Descriptive Analyses

The means, standard deviations, and ranges of the study variables are presented in Table 2.1. One-way ANOVAs were conducted to examine whether efficacy (PSOC and PLOC), positive and negative cognitive appraisals of the impact of childhood disability on the family, and three parenting styles (induction, nurturance, and power assertion) differed by: type of disability (Down Syndrome, Autism, or other) and birth order (only child, middle born, first born, or last born child) of the child with a disability. Negative cognitive appraisals of the impact of childhood disability on the family differed depending on the child's disability $F(2,65) = 8.45$, $p = .001$. Post hoc Tukey HSD analyses indicated that mothers had higher levels of negative cognitive appraisals of the impact of the childhood disability on the family for children with autism ($M = 25.76$, $SD = 4.58$) then for children with Down syndrome ($M = 17.89$, $SD = 5.63$) and other disabilities ($M = 21.03$, $SD = 7.14$). Parenting nurturance was found to differ by children's birth order $F(3,60) = 3.65$, $p = .02$. Mothers had lower levels of parenting nurturance towards their first born children with a disability ($M = 34.93$, $SD = 6.76$) than toward only children ($M = 43.23$, $SD = 6.15$) and last born children ($M = 41.25$, $SD = 7.81$). Middle born children ($M = 39.18$, $SD = 7.79$) did not differ from any of the other birth order groups. No other significant differences were detected for type of disability or birth order.

T-tests were conducted to test whether the study variables differed by child gender (female versus male), mother's employment (employed ten or more hours versus not employed)

and difficult-to-manage behaviors (presence of versus absence of). Parenting nurturance was found to differ by mother's employment $t(62) = 2.11$, $p = .04$. Mothers who were not employed reported higher levels of parenting nurturance ($M = 38.48$, $SD = 7.70$) than mother who were employed ($M = 42.54$, $SD = 7.06$). Efficacy (PLOC) was found to differ by difficult-to-manage behaviors (PLOC), $t(65) = 4.24$, $p = .001$. Mothers who had a child with a disability without difficult-to-manage behaviors had higher efficacy ($M = 19.46$, $SD = 5.98$) than mothers who had a child with a disability with difficult-to-manage behaviors ($M = 25.68$, $SD = 5.83$) (note that the PLOC scale is reversed in that lower scores equal higher efficacy). Negative cognitive appraisals of the impact of childhood disability on the family also were found to differ by the presence or absence of difficult-to-manage behaviors $t(65) = 2.19$, $p = .03$. Mothers who had a child with a disability with difficult-to-manage behaviors had higher levels of negative cognitive appraisals of the impact of the childhood disability on the family ($M = 23.68$, $SD = 6.13$) than mothers who had a child with a disability without difficult-to-manage behaviors ($M = 20.13$, $SD = 6.84$).

Pearson correlations were conducted to explore the relationships between the demographic variables: family income, number of children, age of child with a disability, age of diagnosis, mother's education, and father's education and the study measures: efficacy (PSOC and PLOC), positive and negative cognitive appraisals of the impact of childhood disability on the family, and three parenting styles (induction, nurturance, and power assertion). Correlations and level of significance are presented in Table 2.2. Mothers who reported low levels of negative cognitive appraisals of the impact of childhood disability (FICD) on the family had a higher family income than mothers who reported high levels of negative cognitive appraisals of the impact of childhood disability (FICD). Mothers who reported high levels of parenting power

assertion (PSS) were found to have a child with a disability that was younger than mothers who reported low levels of parenting power assertion. Mothers reported higher levels of parenting nurturance when mothers and fathers had less education.

Tests of Study Hypotheses

Correlations were conducted to examine the study hypotheses (See Table 2.2). This study first hypothesized that maternal efficacy would be positively related to positive parenting styles, such as induction and nurturance, while negatively related to negative parenting styles, such as power assertion. This study found that mothers with high levels of efficacy (PLOC) (PSOC) reported higher levels of parenting induction than mothers with low levels of efficacy. Mothers who had high levels of efficacy (PLOC) also reported higher levels of parenting nurturance than mothers with low levels of efficacy. Neither measure of parenting efficacy was found to be correlated with power assertion.

The second hypothesis stated that maternal efficacy would be positively related to positive cognitive appraisals and negatively related to negative cognitive appraisals of the impact of the childhood disability on the family. This study found that mothers with high levels of efficacy (PSOC) reported higher levels of positive cognitive appraisals of the impact of childhood disability on the family than mothers with low levels of efficacy. Mothers with high levels of efficacy (PSOC) (PLOC) reported lower levels of negative cognitive appraisals of the impact of childhood disability on the family than mothers with low levels of efficacy.

The third hypothesis stated that positive cognitive appraisals of the impact of the childhood disability on the family would be positively related to induction and nurturance, while negatively related to power assertion. This study found that mothers with high levels of positive cognitive appraisals of the impact of childhood disability on the family reported higher levels of

parenting induction than mothers with low levels of positive cognitive appraisals of the impact of childhood disability on the family. No significant associations were found between positive cognitive appraisals and nurturance or power assertion.

The fourth hypothesis stated that negative cognitive appraisals of the impact of the childhood disability on the family would be positively related to power assertion, while negatively related to induction and nurturance. This hypothesis was not supported.

Table 2.1

Means and Standard Deviations of the Study Measures

Measure	M	Range	SD
PSOC	25.38	16 – 35	3.50
PLOC	22.16	9 – 37	6.64
PSSN	39.75	23 – 60	7.87
PSSI	34.22	7 – 57	12.58
PSSPA	18.51	1 – 43	9.85
FICDP	14.38	6 – 20	3.58
FICDN	21.66	10 – 34	6.70

Note: PSOC – Efficacy subscale of the Parent Sense of Competence Scale, PLOC - Parent Control of Child's Behavior subscale of the Parental Locus of Control Scale, PSSN - The Parenting Style Survey / Nurturance, PSSI - The Parenting Style Survey / Induction, PSSPA - The Parenting Style Survey / Power Assertion, FICDP – Positive subscale of the Family Impact of Childhood Disability Scale, FICDN – Negative subscale of the Family Impact of Childhood Disability Scale

Table 2.2

Correlations Among Study Measures and Demographic Variables

Measure	PLOC	PSS	PSSI	PSSPA	FICDP	FICDN	Income	# of Children	Child Age	Age of Diagnosis	M Edu.	F Edu.
PSOC	-.44**	.24	.31*	.20	.28*	-.25*	-.07	.21	-.04	-.20	-.17	-.19
PLOC	.---	.27*	.31*	-.17	.21	-.38**	.04	.15	-.10	-.22	-.12	.02
PSSN	.---	.---	.34**	-.12	.17	-.02	-.19	-.01	-.01	-.05	-.35**	-.25*
PSSI	.---	.---	.---	.21	.35**	-.13	-.21	-.08	.24	-.04	-.13	-.13
PSSPA	.---	.---	.---	.---	.22	-.05	-.18	-.01	.32**	.07	-.10	-.09
FICDP	.---	.---	.---	.---	.---	-.08	-.06	-.13	-.07	-.22	-.12	-.15
FICDN	.---	.---	.---	.---	.---	.---	-.26*	-.12	.13	.12	.15	-.20
Income	.---	.---	.---	.---	.---	.---	.---	.25*	-.01	-.06	.42**	.54**
# of Children	.---	.---	.---	.---	.---	.---	.---	.---	.16	-.02	.04	.32*
Child Age	.---	.---	.---	.---	.---	.---	.---	.---	.---	.51**	-.14	-.06
Age of Diag.	.---	.---	.---	.---	.---	.---	.---	.---	.---	.---	-.11	-.11

TABLE 2.2 (Con't)

Measure	PLOC	PSSN	PSSI	PSSPA	FICDP	FICDN	Income	# of Children	Child Age	Age of Diagnosis	M Edu.	F Edu.
Mother's Edu.	.---	.---	.---	.---	.---	.---	.---	.---	.---	.---	.---	.45**

*p< .05 (2-tailed), **p<.01 (2-tailed).

Note: PSOC – Efficacy subscale of the Parent Sense of Competence Scale, PLOC - Parent Control of Child's Behavior subscale of the Parental Locus of Control Scale, PSSN - The Parenting Style Survey / Nurturance, PSSI - The Parenting Style Survey / Induction, PSSPA - The Parenting Style Survey / Power Assertion, FICDP – Positive subscale of the Family Impact of Childhood Disability Scale, FICDN – Negative subscale of the Family Impact of Childhood Disability Scale

CHAPTER 5

DISCUSSION

The purpose of this study was to examine how maternal efficacy and the impact of a childhood disability on the family are related to the mother's parenting styles. In the first hypothesis maternal efficacy (PLOC and PSOC) was found to be positively correlated with induction, while one measure of maternal efficacy (PLOC) was found to be correlated with nurturance. These results support findings that mothers with high self-efficacy are more likely to engage in parenting behaviors that will have a positive impact on their child (Eccles, Midgley, Wigfield, Buchanan, & Reuman, 1993; Furstenberg, 1993). Unger and Wandersman (1985) found that high maternal efficacy has been related to positive parenting practices, such as responsive, stimulating and nonpunitive caretaking. Dunst, Trivette, Boyd, and Brookfield (1994) also found that high levels of self-efficacy have been linked to positive parenting practices in parents of typically developing children. Overall the findings in this study show that mothers who reported high levels of self-efficacy also reported high levels of positive parenting practices: induction and nurturance. Similar results were found between mothers of children with disabilities in this study and research relating to mothers of typically developing children.

Kuczynski (1984) characterized parents that used high levels of induction and nurturance as having an effortful parenting style. Efficacious mothers perceive themselves as having the ability to positively influence the development and behavior of their children, so mothers with high self-efficacy are more likely to use an effortful parenting style (Bandura, 1989). One of the explanations for these results is that parents may be more likely to choose the

parenting style that promotes their socialization goals for their child in some situations, while react less consciously in other situations. The parents in this study had their children involved in many educational, recreational, and disability related organizations that attribute to their socialization goals. Research has also shown that parents have used reasoning and nurturance when trying to establish internalized or long-term control over a child's behavior (Kaczynski, 1984). Even though the Efficacy subscale of the Parenting Sense of Competence Scale (PSOC) (Gibaud-Wallson & Wandersman, 1978) was not found to be correlated with nurturance the r values of the Efficacy subscale of the Parenting Sense of Competence Scale and the Parent Control of Child's Behavior subscale of the Parental Locus of Control Scale (Campis, Lyman, Prentice-Dunn, 1986) were so close that the limited power of the small sample probably caused the difference in significance.

Neither measure of parenting efficacy was correlated with power assertion. Research studies have found that low maternal self-efficacy has been related to negative parenting practices, such as coercive discipline in typically developing children (Bondy & Mash, 1999; Bugental, Blue, & Cruzcosa, 1989). In this population of mothers of children with disabilities, efficacy was found to be associated with positive parenting styles, but not negative parenting styles. Future research should be explored to understand this difference in studies of mothers of typically developing children and mothers of children with disabilities.

In the second hypothesis maternal efficacy (PSOC and PLOC) was found to be negatively correlated with negative cognitive appraisals, while one measure of maternal efficacy (PSOC) was found to be positively correlated with positive cognitive appraisals of the impact of the childhood disability on the family. Negative cognitive appraisals of the impact of the childhood disability on the family can be considered a form of stress. High levels of stress have

been found to be related to low maternal self-efficacy in mothers of typically developing children (Wells-Parker et al., 1990). Lazarus, Averill, and Opton (1974) found that efficacy has been positively related to positive cognitive appraisals of the impact of a childhood disability on the family. Lazarus and Folkman's research found that positive appraisals, coping, and high self-efficacy can lead to a stronger family unit (Lazarus & Folkman, 1984). Efficacy (PLOC) and the positive cognitive appraisals of the impact of the childhood disability on the family had an r value that was so close in value to the r value of efficacy (PSOC) and positive cognitive appraisals of the impact of the childhood disability on the family. This suggests that the power of the study may not have been high enough to cause efficacy (PLOC) and the positive cognitive appraisals of the impact of a childhood disability on the family relationship to be significant. Similar results were found between mothers of children with disabilities and research relating to mothers of typically developing children.

In the third hypothesis positive cognitive appraisals of the impact of the childhood disability on the family were positively correlated with parenting induction. Parental induction encourages a child to make his or her decisions and gives the child an opportunity to understand what is expected of him or her (Hoffman, 1970; Saetermoe et al., 1990). Kuczynski (1984) found that mothers' positive perceptions of their child's compliance influenced them to use induction and reasoning more frequently to promote long-term compliance. Induction encourages long term compliance (Kuczynski, 1984). It is plausible that mothers' positive perceptions of their child's compliance would be associated with their positive appraisals on the family. Therefore a mother's cognitive appraisal of the impact of a childhood disability on the family would be positively correlated with induction, which was found in this study. Positive cognitive appraisals of the impact of childhood disability on the family were found to not be

correlated with nurturance or power assertion. More research needs to be conducted using the Family Impact of Childhood Disability Scale and the Parenting Style Survey to help us to understand these results.

In the fourth hypothesis negative cognitive appraisals of the impact of the childhood disability on the family were not correlated with power assertion, induction, or nurturance. High levels of negative cognitive appraisals of the impact of the childhood disability on the family were expected to be positively related to negative parenting practices: power assertion, while negatively related to positive parenting practices: induction and nurturance. Negative cognitive appraisals of the impact of the childhood disability on the family have been considered a form of stress. Aunola et al. (1999) found in a study with parents of typically developing children that parents who experience high levels of stress have been found to use negative parenting styles. In this study negative cognitive appraisals and parenting styles were not found to be correlated. Stress can be measured in many forms. Aunola et al. used the Gerris Parental Stress Inventory (Gerris, Vermulst, van Boxtel, Janssens, van Zutphen, & Relling, 1993) to measure stress, while this study used the Negative Cognitive Appraisal subscales of the Family Impact of Childhood Disability Scale (Aunola et al.; Trute, & Hiebert-Murphy, 2002). Differences in measures of stress could account for the differences in the results of these two studies. Future research also needs to be conducted to understand the differences in research of mothers of typically developing children and mothers of children with disabilities.

Differences Between Study Samples

It is informative to look at the differences in the samples of studies using the same scales. In a study conducted by Coleman and Karraker (2003) the participants had a higher Efficacy subscale of the Parenting Sense of Competence Scale (Gibaud-Wallson & Wandersman,

1978) mean than the participants in this study (M = 32.6, SD = 5.46 and M = 25.38, SD = 3.50, respectively). Both studies were composed of predominately white, married, middle-class women with similar family incomes. Coleman and Karraker's study researched mothers of typically developing toddlers, while this study researched mothers of young children with disabilities (Coleman & Karraker, 2003). It is plausible that either the child's age or disability may have accounted for the difference in efficacy (PSOC) means.

In a study conducted by Campis et al. (1986) the participants had higher parenting locus of control means for two samples than the participants in this study (Group A: M = 26.63, Group B: M = 31.44; Current study: M = 22.16, SD = 6.64, note that lower scores indicate higher levels of efficacy). This sample of mothers were found to have higher levels of efficacy than the parents in Campis, Lyman, and Prentice-Dunn's study. The parents in Campis, Lyman, and Prentice-Dunn's study reported lower family incomes and educational level than the parents in this study. This sample difference could account for the lower levels of efficacy in Campis, Lyman, and Prentice-Dunn's study than in this study.

In a study conducted by Trute and Hiebert-Murphy (2002) lower means for positive cognitive appraisals of the impact of childhood disability on the family were reported than the participants in the current study. This study's participants had a higher percentage of two-parent families and their incomes than Trute and Hiebert-Murphy's sample. The sample difference could be the reason for higher positive cognitive appraisals in this study. Trute and Hiebert-Murphy reported very similar means for negative cognitive appraisals of the impact of childhood disability on the family as those reported in the current study, despite differences in the samples (Trute & Hiebert-Murphy, 2002). The parenting means for Saetermoe et al.'s study using the Parenting Style Survey (Saetermoe et al.) were not available.

Demographic Characteristics

Several associations were found between the demographic characteristics of the sample and study variables. Mothers had higher levels of negative cognitive appraisals of the impact of the childhood disability on the family for children with autism then for children with Down syndrome and other disabilities. One explanation for this result may be that autism is related to negative behavior characteristics and extensive therapy which could cause a mother to be stressed and view her child's disability as a negative impact on the family (Trepagnier, 1999). Mothers who were not employed reported higher levels of parenting nurturance. This result could be that mothers then have more time to spend with their children. Mothers who had a child with a disability without difficult-to-manage behaviors had higher efficacy and lower levels of negative cognitive appraisals than mothers who had a child with a disability with difficult-to-manage behaviors. An explanation for these results may be that mothers who had a child with a disability with difficult-to-manage behaviors may feel less competent in their role to parent their child and in turn may view these difficult-to-manage behaviors associated with the disability as having a negative impact on the family. Mothers who reported low levels of negative cognitive appraisals of the impact of childhood disability on the family had a higher family income than mothers who reported high levels of negative cognitive appraisals of the impact of childhood disability. High family income usually means access to more resources and/or less stress. Mother who reported high levels of parenting power assertion were found to have a child with a disability that was younger than mothers who reported low levels of parenting power assertion. One explanation for this result may be that because the children were younger the mothers used more power assertion because the children were less able to understand reasoning. Mothers reported higher levels of parenting nurturance when mothers and fathers had less education and

when children were either only children or last born. More research needs to be conducted to understand the correlation between parenting nurturance, birth order, and parents' education.

Limitations and Future Research

This study had many limitations. The study sample was a conveniently gathered sample in the southeast region of the United States. All of the participants' children were involved in disability related organizations, programs, schools, and many of the mother's were involved in support groups in their community. Participants were asked to volunteer to participate in this study, and were not randomly sampled. The majority of the women in this study were white, well educated, and married. This study only looked at mothers subjective interpretations of their efficacy, parenting, and impact of the disability on their family and did not take into account the father's perceptions. The Parenting Style Survey and the Family Impact of Childhood Disability Scale are relatively new scales that have been only used for development purposes in published studies. Future research needs to be conducted using both scales to differentiate from measurement error.

This study found that parenting, efficacy, and cognitive appraisals of the impact of the childhood disability have strong relationships with one another. This study is a starting point. More research needs to be conducted with families of children with disabilities to understand the causality of these relationships. This study should also be continued and tested on a larger sample so as to not have difficultly with the power levels of the sample. It would also be interesting to conduct this study with fathers of children with a disability or delay. Longitudinal data could enable us to examine the relationship with parental efficacy, parenting, and the impact of the disability on the family, with child behavior outcomes for all of the children in the family.

Implications for Practice

This study bridges the gap in the literature between maternal self-efficacy, parenting styles, and the impact of a childhood disability on the family system. The results of the study allow professionals working with populations of children with disabilities and their mothers to better understand various contributors of parenting styles such as: self-efficacy and stress for these mothers. Self-efficacy has emerged in this study as a strong correlate of parenting. It is important for early interventionists to empower the family by enhancing their competence and confidence in their parenting role. Teaching them strategies and techniques to parent their child will hopefully provide mothers with a sense of self-efficacy that will effect their parenting practices. Increasing a mother's self-efficacy may also enable her to perceive her child's disability as a positive experience rather than a family stressor. It is important as professionals providing intervention services to not discount the risks of mothers who have low self-efficacy. Mothers need to be adequately informed of effortful and effective parenting strategies.
The family system theory states that, one part of the family system affects each other part of the family system (Boss, Doherty, LaRossa, Schumm, & Steinmentz, 1993).

A child's disability has the ability to affect every member of the family, as does a mother's reaction to her child's disability. To provide effective holistic intervention services to children, we must look at the characteristics of each family system and provide individual plans of care based on these assessments.

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APPENDIX A

INTRODUCTORY LETTER

Dear Participant,

We are conducting this study in order to gain a better understanding of parenting children with developmental delays and disabilities between the ages of two to six years. We are particularly interested in learning more about what styles of parenting mothers use, how mothers feel about their ability to parent, how social support influences parenting, and about perceptions of stress related to parenting a child with a disability. The study is being conducted by the Department of Child and Family Development of the University of Georgia under the direction Dr. Zolinda Stoneman.

We would like our research to increase current knowledge of how mothers of children with developmental delays and disabilities parent their children and what factors influence this process. If you consent to participate in this research project, please fill out the following questionnaires. To participate in this study you must meet the following criteria: be a mother between the age of 18 and 50 and have a child between the age of two and six with a developmental disability or delay. If you have more than one child that meets the criteria, then fill out questionnaires for only one of your children. The questionnaires will be completely anonymous. The packet of questionnaires will take approximately 30 minutes to complete. Upon completion please return the questionnaires using the provided envelope.

In thanking you for your participation you will be given a chance of winning one of two fifty-dollar checks. Please fill out the postcard requesting your name and address. Mail the postcard separately from the packet of questionnaires. The postcard does not have any codes or numbers on it, the researchers will be unable to match your postcard with your questionnaire. At the end of the study each of these postcards will be put into a bowl. Two of the postcards will be drawn out and each of those two mothers will be mailed a fifty-dollar check.
If you have any questions please contact Gwendolyn Pugh at 205-356-7111, email: gap1@uga.edu or Caroline Almand at 404-861-2067, email: csalmand@uga.edu. We greatly appreciate your help and your time.

Sincerely,

Gwendolyn A. Pugh and Caroline S. Almand
Graduate Students

APPENDIX B

LETTER OF INFORMED CONSENT

February 14, 2004

Dear Participant,

The research entitled **The Relationship between Daily Hassles, Social Support, Sense of Competence, Impact of Childhood Disability on the Family, and Parenting Styles for Mothers of Children with Disabilities** is being conducted by Gwendolyn Pugh (phone 706-543-1880) and Caroline Almand (phone 404-861-2067), through the Department of Child and Family Development at the University of Georgia. This research is being conducted under the direction of Dr. Zolinda Stoneman, Ph.D, the Institute on Human Development and Disability, The University of Georgia, 850 College Station Road, Athens, Georgia 30602, Telephone (706) 542-4827, Email address: zo@uga.edu. If you choose to participate in this study the questionnaires that will be completed will be used for research that may be published.

The reason for this research is to gain information relating to the relationships between parenting styles, parent's sense of competence, social support, daily hassles, and impact of childhood disability on the family for a mother, who has a young child with a developmental disability. The benefits that will be obtained will allow professionals working with populations of children and their mothers to better understand various contributors to parenting satisfaction, efficacy, and parenting styles. The results will allow professionals to develop and implement beneficial educational and support programs for mothers of children with disabilities.

Participation in this study is entirely voluntary and you can withdraw your consent at any time without penalty, or skip any questions you may feel uncomfortable answering. By participating in this study you will complete the packet of questionnaires that is provided by the researchers. If you have more than one child between the age of two and six that has a developmental disability or delay, please fill out questionnaires for only one of your children. Completing the questionnaires should take approximately 30 minutes. The answers you give in this study will be completely anonymous. Please do not place your name on any of the questionnaires. This is to insure your anonymity. After completing the questionnaires you will mail or give the packets back to the researchers using the envelope and stamps that are provided. In thanking you for your participation you will be given a chance of winning one of two fifty-dollar checks. Please fill out the postcard requesting your name and address. These postcards will be stamped and addressed to the researchers. They will be mailed back separately from the packets of questionnaires. The researchers will be unable to match the postcards with the questionnaires. At the end of the study each of these postcards will be put into a bowl. Two of the postcards will

be drawn out and each of those two mothers will be mailed a fifty-dollar check. The postcards will then be destroyed.

The researchers will answer any further questions about the research. Information about the research can be answered by calling Gwendolyn Pugh (phone 205-356-7111) or Caroline Almand (phone 404-861-2067). We greatly appreciate your help and your time.

Sincerely,

Gwendolyn A. Pugh and Caroline S. Almand
Graduate Students
Institute on Human Development and Disability
Department of Child and Family Development
College of Family and Consumer Sciences
University of Georgia Athens, Georgia 30602
gap1@uga.edu and csalmand@uga.edu

Additional questions or problems concerning your rights as a research participant should be addressed to Chris A. Joseph, Ph.D, Subjects Research Office, The University of Georgia, 606A Graduate Studies Research Center, Athens, Georgia 30602-7411, Telephone (706) 542-3199, Email address: IRB@uga.edu.

APPENDIX C

SAMPLE NEWSLETTER ARTICLE

Research Opportunity for Mothers of Young Children with a Developmental Delay or Disability

Dear Families,
We are graduate students of the Department of Child and Family Development at the University of Georgia, and we are conducting a study on parenting children with disabilities. The study is being carried out under the supervision of Dr. Zolinda Stoneman at the Institute on Human Development and Disability. For participating in this study you will be given the chance of winning one of two $50.00 checks. We are looking for mothers between the ages of 18 and 50 that have a child between the ages of two and six with a developmental delay or disability. This study will involve answering some simple questionnaires, which can be mailed to you. Return, stamped envelopes are provided. If you would be interested in participating or have further questions, please contact us.

Gwendolyn Pugh
(205) 356-7111
gap1@uga.edu

Caroline Almand
(404) 861-2067
csalmand@uga.edu

APPENDIX D

RAFFLE WINNER LETTER

Dear

I am writing to inform you that you won one of two fifty dollar checks through your participation in the research study entitled, *The Relationship between Daily Hassles, Social Support, Sense of Competence, Impact of Childhood Disability on the Family, and Parenting Styles for Mothers of Children with Disabilities*. This study was conducted by Gwendolyn Pugh and Caroline Almand, through the Department of Child and Family Development at the University of Georgia. This research was conducted under the direction of Dr. Zolinda Stoneman, Ph.D., the Institute on Human Development and Disability, The University of Georgia, 850 College Station Road, Athens, Georgia 30602. Thank you so much for your help and participation in this study. The insight provided by each participant is invaluable. We look forward to continuing to learn more about families of children with disabilities. Please feel free to contact Gwendolyn Pugh (205-356-7111) or Caroline Almand (404-861-2067) if you have any questions.

Sincerely,

Caroline S. Almand and Gwendolyn A. Pugh
Graduate Students
Institute on Human Development and Disability
Department of Child and Family Development
College of Family and Consumer Sciences
University of Georgia Athens, Georgia 30602
csalmand@uga.edu and gap1@uga.edu

APPENDIX E

MEASURES

DEMOGRAPHIC SURVEY

We would like some information about you. Please fill in the section below by either filling in the blank space or circling your choice.

Today's date ___/___/___

Age of Mother _____ **Age of Father _____**

Are you the child's biological mother? Yes No

If no, please indicate your relation to the child_____

Birth date of child with a disability ___/___/___

Gender of child with disability (please circle) female male

Number of children in the household _____

Ages of other siblings _____

How do you describe yourself? (Check all that apply)

____American Indian or Alaska Native
____Asian
____Black or African American
____Hispanic or Latino
____Native Hawaiian or Other Pacific Islander
____White

Marital Status:

____Single ____Divorced ____Separated
____Married ____Live-in Partner ____Widowed

My child that has a disability/disabilities is the:

____Only child ____Middle born ____First born ____Last born.

My Family's Total Income is between:

____Under $10,000 ____$30,000-$39,000 ____$60,000-$69,000
____$10,000-$19,000 ____$40,000-$49,000 ____$70,000-$79,000
____$20,000-$29,000 ____$50,000-$59,000 ____$80,000 and over

How adequate do you feel your income is in meeting your needs? (Place a check next to the statement that best describes your situation.)

____More than adequate to meet all of our needs and wants
____More than adequate to meet our needs and some of our wants
____Adequate to meet our needs, but no wants
____Not adequate to meet all of our needs
____Much less than adequate to meet even our basic needs

Are you currently employed outside your home? Yes No

If yes, how many hours per week do you typically work? _____ hours/week
Can you easily take time off during the day or rearrange you work schedule to attend to the needs of your child with a disability? Yes No

Mother's Educational Level:

____Less than 8th grade
____Less than 12th grade
____High School diploma or GED
____Some College or Technical school
____College degree
____Graduate degree

Father's Educational Level:

____Less than 8th grade
____Less than 12th grade
____High School diploma or GED
____Some College or Technical school
____College degree
____Graduate degree

Were you aware of your child's diagnosis with a disability prior to his/her birth?

____Yes ____No

Was your child's diagnosis made at birth?

____Yes ____No

If no, how old was your child when he/she was diagnosed with a disability?
Child's age_____

Please CHECK the item(s) that most accurately describes your child's diagnosis

____Down syndrome ____Language/Speech delay ____Autism
____Fragile X ____Cerebral Palsy ____Visual Impairment
____Hearing Impairment ____Physical Disability ____Developmental delay
____Cognitive/Mental delay ____Muscular Dystrophy ____Spina Bifida
____Pervasive Developmental Delay (PDD)
____Other (please describe)_____

Which of the following is your child involved in? (Please check all that apply)

____Early Head Start
____Pre-K
____Head Start
____Speech Therapy
____Occupational Therapy
____Babies Can't Wait/Public Early Intervention Services
____Private Early Intervention Services
____Preschool Special Education
____Physical Therapy
____Day Care or Child Development Center

Does your child with a disability:

Sit without support	____YES	____NO	Toilet independently	____YES	____NO
Stand without support	____YES	____NO	Eat independently	____YES	____NO
Walk independently	____YES	____NO	Use a wheelchair	____YES	____NO
Communicate using words	____YES	____NO			

Communicate using several words in a phrase or sentence ____YES ____NO

Does your child have any difficult-to-manage behaviors (strong tantrums, biting, etc.)?

____Yes ____No

If yes, describe the behavior(s):

If a young child came up to you and asked you to explain your child's disability (Why does he/she act like that? Why does he/she look like that? etc.), what would you say to the child?

How would you explain your child's disability to an adult? What would you say to them?

PARENTING SENSE OF COMPETENCE SCALE (PSOC)

Please *circle* how much you agree with each of the following statements related to parenting. Focus on your child with a disability or delay.

1. The problems of taking care of an infant are easy to solve once you know how your actions affect your child, an understanding I have acquired.

strongly agree agree neutral disagree strongly disagree

2. Even though being a parent could be rewarding, I am frustrated now while my child is at his/her present age.

strongly agree agree neutral disagree strongly disagree

3. I go to bed the same way I wake up in the morning, feeling I have not accomplished a whole lot.

strongly agree agree neutral disagree strongly disagree

4. I do not know why it is, but sometimes when I'm supposed to be in control, I feel more like the one being manipulated.

strongly agree agree neutral disagree strongly disagree

5. My mother/father was better prepared to be a good mother/father than I am.

strongly agree agree neutral disagree strongly disagree

6. I would make a fine model for a new mother/father to follow in order to learn what he/she would need to know in order to be a good parent.

strongly agree agree neutral disagree strongly disagree

7. Being a parent is manageable, and any problems are easily solved.

strongly agree agree neutral disagree strongly disagree

8. A difficult problem in being a parent is not knowing whether you're doing a good job or a bad one.

strongly agree agree neutral disagree strongly disagree

9. Sometimes I feel like I'm not getting anything done.

strongly agree agree neutral disagree strongly disagree

10. I meet my own personal expectations for expertise in caring for my child.

    strongly agree agree neutral disagree strongly disagree

11. If anyone can find the answer to what is troubling my child, I am the one.

    strongly agree agree neutral disagree strongly disagree

12. My talent and interests are in other areas, not in being a parent.

    strongly agree agree neutral disagree strongly disagree

13. Considering how long I've been a mother/father, I feel thoroughly familiar with this role.

    strongly agree agree neutral disagree strongly disagree

14. If being a mother/father of an infant were only more interesting, I would be motivated to do a better job as a parent.

    strongly agree agree neutral disagree strongly disagree

15. I honestly believe I have all the skills necessary to be a good mother/father to my child.

    strongly agree agree neutral disagree strongly disagree

16. Being a parent makes me tense and anxious.

    strongly agree agree neutral disagree strongly disagree

17. Being a good mother/father is a reward in itself.

    strongly agree agree neutral disagree strongly disagree

FAMILY IMPACT OF CHILDHOOD DISABILITY SCALE (FICD)

Please circle, in your view, what consequences have resulted from having a child with a disability in your family.

1. There have been extraordinary time demands created in looking after the needs of the child with a disability.

Not at all To a mild degree To a moderate degree To a substantial degree

2. There has been unwelcome disruption to "normal" family routines.

Not at all To a mild degree To a moderate degree To a substantial degree

3. The experience has brought us closer to God.

Not at all To a mild degree To a moderate degree To a substantial degree

4. It has led to additional financial costs.

Not at all To a mild degree To a moderate degree To a substantial degree

5. Having a child with a disability has led to an improved relationship with spouse.

Not at all To a mild degree To a moderate degree To a substantial degree

6. It has led to limitations in social contacts outside the home.

Not at all To a mild degree To a moderate degree To a substantial degree

7. The experience has made us come to terms with what should be valued in life.

Not at all To a mild degree To a moderate degree To a substantial degree

8. Chronic stress in the family has been a consequence.

Not at all To a mild degree To a moderate degree To a substantial degree

9. We have had to postpone or cancel major holidays.

Not at all To a mild degree To a moderate degree To a substantial degree

10. It has led to a reduction in time parents could spend with their friends.

Not at all To a mild degree To a moderate degree To a substantial degree

11. The child's disability has led to positive personal development in mother and/or father.

Not at all To a mild degree To a moderate degree To a substantial degree

12. Because of the situation, parents have hesitated to phone friends and acquaintances.

Not at all To a mild degree To a moderate degree To a substantial degree

13. The situation has led to tension with spouse.

Not at all To a mild degree To a moderate degree To a substantial degree

14. Because of the circumstances of the child's disability, there has been a postponement of major purchases.

Not at all To a mild degree To a moderate degree To a substantial degree

15. Raising a child with a disability has made life more meaningful for family members.

Not at all To a mild degree To a moderate degree To a substantial degree

PARENTING STYLE SURVEY (PSS)

On each of the next few pages, a situation is described that involves an interaction between an adult and a child. Below them are examples of possible specific situations. Please think about your interactions with your child in this study and imagine what your reaction would be if you were in these situations with him or her. It is important that you keep your interactions with this particular individual in mind while you answer.

Below the situation, you will find a number of possible responses listed. On the left you will find six columns that describe the likelihood of your responding in this manner with the person we are asking you about. You should check how often you would respond for each possible response.

Remember, if the situation as described does not fit in with what has happened to you and this person in the past, try to imagine a similar situation and what you did at that time.

Thank you very much for your cooperation.

Example: While running through your house, the child stumbles and breaks a valuable lamp.

	Always	Often	Half of the time	Some-times	Rarely	Never	
1							Remind him/her to be more careful
2							Restrict his/her privileges since he/she has been warned not to run.
3							Explain to him/her how difficult it will be to replace the lamp.
4							Speak angrily to him/her so he/she will realize the seriousness of what he/she has done.

1. You have had a bad day and are feeling irritable. You ask your child to do something that you think he or she is capable of doing and he or she refused to try.

Some examples might be that your child refused to try to clear the table or refuses to try to brush his or her teeth. Remember, think of something that you think he or she is capable of doing and what you would do if he or she refused to even try do it when you are feeling irritable.

	Always	Often	Half of the time	Some-times	Rarely	Never	
1							Tell him/her if he/she doesn't do what you want you will punish him/her.
3							Very carefully explain to the child why he/she must do what you have asked.
6							Spank or hit him/her lightly to let him/her know you are angry
9							Immediately ask him/her why he/she is refusing.
10							Try to understand his/her reasons for refusing.
12							Tell him/her that he/she must do it because you told him/her to do it.
13							Force him/her to do it for his/her own good.

2. You are playing with your child and having a good time. You tell your child not to do something that you know he or she understands not to do but he or she does it anyway.

Some examples might be if you told your child not to rock back and forth and he or she did so anyway or if you told your child not to play with a certain toy and he or she continued. It is not important if your child has not done these particular things in the past but what your reaction is when your child does something that he or she has been told not to do when you are having a good time with him or her.

	Always	Often	Half of the time	Some-times	Rarely	Never	
17							Hug him/her and tell him or her you wish he/she would not do it.
18							Discuss with him/her why what he/she is doing is wrong.
20							Laugh warmly and redirect his/her attention.
22							Try to find out exactly why he/she is disobeying you.
24							Smile and start another activity.
25							Take away a privilege.
26							Do not let him/her manipulate you. Physically stop him/her from doing it.
27							Explain why he/she must never do what he/she did.
28							Threaten to send him/her to his/her room for disobeying.
29							Tell him/her he/she has to stop because you told him/her to stop.

3. You are getting ready to take your child somewhere and he or she is making you late by getting ready too slow. You are late for a very important appointment and will get in a great deal of trouble because you are late.

Some examples might be if your child is taking a long time to get shoes tied or money together. If your child is not able to do these things, think of something he or she can do to independently get ready to go somewhere and what you would do in this case if you were late for an appointment.

	Always	Often	Half of the time	Some-times	Rarely	Never	
32							Praise and hug him/her for what he/she has done so far; very calmly ask him/her to hurry.
33							Punish him/her by making him/her go with you without being completely ready.
34							Spank the child to get him/her to hurry.
38							Tel the child that if he/she doesn't hurry, you might take away a privilege.
41							It is your reputation at stake. Make him/her hurry.
42							Ask him/her if there is a reason why he/she is taking so long.
44							Hug the child to let him/her know he/she is cared for and help him/her get ready.

4. You are in a public place with your child and he or she unknowingly does something that is socially unacceptable.

Some examples would be that you are in a restaurant with your child and he or she spoke extremely loudly or your child undresses outside by the street. If these situations or one similar to them have not happened, try to remember a time when your child did something that was inappropriate for the place and what you did about it.

	Always	Often	Half of the time	Some-times	Rarely	Never	
48							Quietly explain why he/she shouldn't do what he/she did.
50							Give him/her examples of why he/she shouldn't do what he/she did.
51							Ask him/her if he/she knows why his/her behavior is unacceptable.

5. Your child has just performed a task that he or she has not been able to do before. You have worked very hard to teach your child this task.

For example, you child has bathed independently for the first time or successfully went shopping alone and you assisted him or her in gaining this skill. Remember, if your child is unable to do these things or is capable of much more than these examples think of how you reacted when he or she gained a skill that you helped him or her with.

	Always	Often	Half of the time	Some-times	Rarely	Never	
60							Cheerfully ask him/her to describe how he/she did it.
62							Hug your child and give him/her a reward.
70							Smile warmly and tell him/her you are proud.

6. Your child is playing in a situation in which he or she could be hurt if he or she is not careful and has been in this situation several times before.

For example, your child has run out into the street or is in danger of falling off a high platform. If your child has not been in one of these situations, think of a time when he or she could have been hurt and what you did in that situation.

	Always	Often	Half of the time	Some-times	Rarely	Never	
76							Later describe your own experiences in similar situations and explain how you've learned from them.
77							Strongly encourage your child away from the situation and ask if he/she is alright.
78							Let him/her do it over if he/she might not be careful.
79							Tell your child you're glad he/she's alright after making sure he/she is out of danger.
83							Very thoroughly explain to your child why the situation is so dangerous.
84							Ask him/her if he/she has a reason for what he/she did.
86							Yell at him/her because he/she shouldn't be doing what he/she was doing.

PARENTAL CONTROL SUBSCALE OF THE PARENTING LOCUS OF CONTROL SCALE

Please indicate your belief about each of the following:

	Strongly Disagree				**Strongly Agree**
1. I always feel in control when it comes to my child.	1	2	3	4	5
2. My child's behavior is sometimes more than I can handle	1	2	3	4	5
3. Sometimes I feel that my child's behavior is hopeless.	1	2	3	4	5
4. It is often easier to let my child have his/her way to avoid a tantrum.	1	2	3	4	5
5. My child can get me to do things I really did not want to do.	1	2	3	4	5
6. My child often behaves very differently from what I would like.	1	2	3	4	5
7. Sometimes when I'm tired I let my child do things I normally wouldn't.	1	2	3	4	5
8. Sometimes I feel that I do not have enough control over the direction my child's life is taking.	1	2	3	4	5
9. I allow my child to get away with things.	1	2	3	4	5