Impact of Severity of a Child’s Chronic Condition on the Functioning of Two-Parent Families

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Objective To examine the impact of the severity of a child’s chronic condition on family functioning from the perspectives of mothers and fathers and to compare their reports with the functioning of families with healthy children. Methods Mothers and fathers in two-parent families of 160 infants and 102 pre-adolescents with a wide range of chronic health conditions (noncategorical approach) completed standard self-report inventories. Results The families of children with chronic conditions functioned as well or better compared with normative data for families with healthy children. The only significant differences between mothers’ and fathers’ reports of family functioning were a greater negative impact on role performance reported by mothers of infants and pre-adolescents and a great negative impact on affective expression reported by fathers of pre-adolescents. Conclusions Overall, very little of the variance in family functioning was explained by severity of the child’s chronic condition in this sample of middle-class, two-parent families.

Key words chronic condition severity; family functioning; mother–father comparisons.

Meeting the needs of a child with a chronic health condition creates added challenges for most families. When coupled with the normative challenges faced by families in general, it is understandable that many families can be overwhelmed; the chronic demands and stress can compromise day-to-day family functioning. There is a widespread belief that these hardships have an adverse effect on family functioning, particularly among clinicians who often encounter families who are struggling to care for their child as they deal with the array of services and systems involved in meeting their child’s needs. However, it is also plausible that some of these families may not experience adverse effects in their style of functioning and may, in fact, manage quite well. Resilience theory has taught us that even in the face of adverse life conditions, some individuals and families not only do all right, but they actually become stronger (Masten, 2001; Patterson, 2002). A limited number of studies have focused on this potential for positive family functioning in the face of the chronic stress of caring for a child with a chronic health condition.

Family functioning refers to the “the patterns of relationship connecting members of a family system to each other” (Patterson & Garwick, 1994). Families develop patterns for managing basic, developmental, and crisis-related tasks (Skinner, Steinhauser, & Santa-Barbara, 1983). Accomplishing these tasks is associated with patterns of communication and role performance and the ability to control family member behavior within the range of the family’s shared norms and values. Families also develop patterns for how emotionally involved they wish to be with each other and how they express affection. With regard to all of these functioning patterns, there are generally agreed upon societal norms for what constitutes “healthy” family functioning. Hence, when “poor family functioning” is reported, it usually implies a deviation from these expected norms.

The birth or diagnosis of a child with a chronic condition may alter family functioning patterns in several ways. Extra caregiving tasks have to be learned and carried out, often for an extended period of time, affecting the accomplishment of tasks and the
performance of various roles. Family communication patterns may change, sometimes including less emotional expressiveness. Families may experience a depletion of their financial resources resulting in financial difficulties and an uncertain future for the family. Low family income (Canning, Harris, & Kelleher, 1996) has been found to be associated with psychological distress of parents of children with chronic conditions.

Many investigators have reported that family functioning is poorer in families with children who have chronic conditions (Evans, Cottrell, & Shiach, 2000; Spieth et al., 2001). On the other hand, there have been other studies reporting that family functioning may not be adversely affected when a child member has asthma (Brazil & Krueger, 2002), sickle cell disease (Ivers, Brown, Lambet, Hsu, & Eckman, 1998), cancer (Trask et al., 2003), or other chronic health conditions.

Nearly all of these studies have focused on specific diagnoses; however, the findings do not point to more family problems related to any specific diagnosis. It has been suggested by several national experts on childhood chronic conditions that variability in family impact may be more related to characteristics of the condition, such as age of onset, prognosis, course, or type of incapacitation rather than diagnosis per se (Perrin et al., 1993; Stein, Bauman, Westbrook, Coupley, & Ireys, 1993).

From this noncategorical perspective, one characteristic of chronic conditions that may have a differential impact on family functioning is the severity of the condition. One way of measuring chronic condition severity that can be applied across chronic conditions is functional severity. This has been described as the impact of the disorder on an individual’s ability to perform age-appropriate activities, irrespective of illness type, and under a broad range of circumstances (Stein et al., 1987). Several studies indicate that greater functional severity is associated with parental distress and poorer quality of life (Canning et al., 1996; Eker & Tuzun, 2004; Timko, Stovel, Moos, & Miller, 1992).

In the 2003 national survey of Children with Special Health Care Needs (CSHCN) conducted by the National Center for Health Statistics and the Maternal and Child Health Bureau (MCHB), 12.8% of children, 18 years and younger, in the US were found to have a special health care need (van Dyck, Kogan, McPherson, Weissman, & Newacheck, 2004). CSHCN were defined as “having a chronic physical, developmental, behavioral, or emotional condition that requires health and related services of a type or amount beyond that required by children generally” (McPherson et al., 1998). Among this population of CSHCN, over 60% experienced some degree of functional limitation affecting their ability to perform daily activities—23.2% experienced functional limitations always or a great deal of the time and another 37.4% experienced limits in their activities some of the time (Newacheck et al., 1998). We are unaware of published studies that have taken a noncategorical approach using the MCHB definition of CSHCN to examine the impact of functional limitations associated with the condition on family functioning. We used this approach in our study.

Another indicator of condition severity is the number of different impairments a child has. Newacheck and Stoddard (1994) found that children with a greater number of impairments also have more functional limitations. Although the impact of multiple impairments on family functioning has not been widely researched, one study by Crowe (1993) found that mothers of children with multiple disabilities spent significantly more hours on child-related activities and less time on socializing than mothers of typically developing children.

Most of the research on the experience of parents of children with chronic conditions has relied on mothers’ reports because she is viewed as the most knowledgeable about her child and she is often more accessible as a research participant. Only a few studies have included the perspective of both parents. In some of those studies, mothers and fathers had similar views about the functioning of their families (Knall & Zoeller, 2000, Saddler, Hillman, & Benajamins, 1993); whereas in other studies, mothers and fathers held discrepant views, with mothers generally reporting more stress than fathers (Sawyer, Antoniou, Toogood, Rice, & Baghurst, 1993, Timko et al., 1992).

The present study examined mothers’ and fathers’ reports of family functioning when their child had a chronic condition. Specifically, we hypothesized that: (a) families with children with chronic conditions would report poorer family functioning than families who do not have children with chronic health conditions; (b) there would be no differences between mothers’ and fathers’ reports of family functioning; and (c) the greater the functional severity of the child’s chronic condition, the greater the negative impact on family functioning.

Methods
Sample
Secondary data from the first wave of a longitudinal study (called Project Resilience) conducted in 1991–1997 in Minnesota and Washington states were used to test
our hypotheses. The prospective cross-sequential cohort design of Project Resilience led to recruitment of families of children from two age groups: infants who were 6–24 months at enrollment and pre-adolescents who were 8–10 years at enrollment.

A noncategorical, non-disease-specific approach (Perrin et al., 1993) was used to identify study participants based on the following definition of a chronic health condition: a serious on-going physical health condition that: (a) has a biological, anatomical, or physiological basis; (b) has lasted or is expected to last at least one year; and (c) produces, or has the potential of producing, one or more long-term sequelae, such as limited functional ability, extra medical care, on-going treatment, or use of medical technology (Stein et al., 1993). Two physician investigators on the original study team identified ICD-9 codes that fit this definition of chronic health condition. Thirteen hospitals and health maintenance organizations in the seven counties in the Minneapolis–St. Paul area of Minnesota and three counties in the Seattle, Washington, area identified children from their medical records with these ICD-9 codes in our target age groups.

Following approval by Institutional Review Boards at all participating institutions, the identified children’s physicians first confirmed that the child met the above definition of chronic health condition and then sent letters to eligible families inviting study participation. Of the 454 families in the infant cohort identified by the above procedures, 186 (41%) agreed to participate in the study; of the 455 families in the pre-adolescent cohort similarly identified, 141 (31%) agreed to participate. Reasons for nonparticipation could not be determined because Institutional Review Board guidelines precluded investigator access to family names, addresses, and phone numbers for families who did not respond to the physicians’ invitation letters.

Data were collected in the families’ homes by trained interviewers. Parents completed self-report assessments about themselves and about their child’s and family’s functioning. The interviewer was present at all times to answer questions and assist participants in filling out the self-report measures.

For the analyses in this paper, a decision was made to use data only from families where children had two parental caregivers because our focus was on examining both mothers’ and fathers’ perspectives about family functioning. There were too few single-parent families in either cohort to stratify the sample by family structure and examine our study hypotheses. Thus, our analyses are based on 160 families in the infant cohort (35% of eligible families) and 102 families in the pre-adolescent cohort (22% of eligible families) for whom we had data from both mothers and fathers. Consistent with the noncategorical approach, a large variety of chronic health conditions was included in the sample. The conditions, categorized by organ system involvement, included (% of infant cohort,% of pre-adolescent cohort): gastroenterology (3.8, 4.0); neurology/neuromuscular (20.0, 23.8); developmental disability without mental retardation (10.6, 13.9); developmental disability with mental retardation (15.0, 0); cardiology (16.3, 5.0); maxillofacial (4.4, 5.0); pulmonary (11.9, 12.7); endocrine/metabolic (5.0, 13.7); ophthalmology (1.9, 6.9); urology (2.5, 1.0); orthopedics (4.4, 7.8); ear, nose, throat (1.9, 0); and hematology/oncology (2.5, 5.9).

Demographic characteristics of the parents and families in the study sample are reported in Table I. It is important to note that the sample was primarily White and middle class, and most of the parents were married only once. Hence, this self-selected sample is not representative of all children with chronic health conditions.

**Measures**

**Family Functioning**

The general scale of the Family Assessment Measure—FAM (Skinner et al., 1983) was used to assess family functioning. FAM consists of 50 items organized into seven subscales representing different family functioning domains: task accomplishment, role performance, communication, affective expression, affective involvement, control, and values/norms, plus an overall family functioning measure. Each parent completed the questionnaire independently. A standard score below 40 is an indicator of very healthy functioning, scores from 40 to 60 indicate an average range of family functioning, and scores above 60 indicate functioning problems (Skinner et al., 1983).

The normative sample (Skinner et al., 1983) on which preliminary analyses for FAM were conducted consisted of 475 families (adults and children) in various health and social service settings in the Toronto area. Ninety-three percent of the families were married and living together for an average of 13.5 years. About 70% of them owned their residences and the modal family income was in the range of $20,000–29,999 (1982–1983). The mean ages for the adults were 38 years. Thus the norm sample and our study sample were very similar demographically. The scores for FAM were
normalized such that each subscale has a mean of 50 and an $SD$ of 10 (Skinner et al., 1983).

For the present study sample, the total FAM functioning score had good internal consistency reliability ($\alpha = .94$), and the alpha reliabilities for the subscales were also good: task accomplishment (.73), role performance (.73), communication (.68), affective expression (.61), involvement (.76), control (.70), and values and norms (.70).

### Functional Severity

The Functional Status Questionnaire—FSQ (Stein & Jessop, 1990) is a 43-item scale designed to identify limits in the child’s ability to engage in age-appropriate activities and behavior (such as communicating, mobility, play, sleep, eating and toileting patterns) due to the presence of a chronic condition. Concurrent validity was established by correlating the FSQ total score with other measures of morbidity status and traditional health indicators. Internal consistency estimates were reported as being greater than 0.80 (Stein & Jessop, 1990). A single summative score is derived, with higher scores indicating better functional status. The parent(s) who knew the most about the child’s daily functioning was the respondent(s) for this questionnaire.

### Number of Impairments

As an additional indicator of condition severity, parent report of child impairment in more than one organ system (cognitive, visual, hearing, mobility, cardiac, pulmonary, gastrointestinal, genitourinary) was used. This was a dichotomous variable ($1 =$ two or more impairments, $0 =$ none or one impairment).

### Table I. Demographic Characteristics of Mothers and Fathers

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Infant cohort ($N = 160$)</th>
<th>Pre-adolescent cohort ($N = 102$)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mothers</td>
<td>Fathers</td>
</tr>
<tr>
<td></td>
<td>($n = 160$)</td>
<td>($n = 160$)</td>
</tr>
<tr>
<td>Race/ethnicity</td>
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<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>152 (95.0)</td>
<td>149 (93.7)</td>
</tr>
<tr>
<td>African American</td>
<td>2 (1.3)</td>
<td>6 (3.8)</td>
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<tr>
<td>Hispanic</td>
<td>1 (0.6)</td>
<td>1 (0.6)</td>
</tr>
<tr>
<td>Oriental, Asian, Pacific Islander</td>
<td>5 (3.1)</td>
<td>2 (1.3)</td>
</tr>
<tr>
<td>American Indian, Alaskan Native</td>
<td>0 (0)</td>
<td>1 (0.6)</td>
</tr>
<tr>
<td>Highest education level completed</td>
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<tr>
<td>Less than high school</td>
<td>3 (1.9)</td>
<td>6 (3.8)</td>
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<tr>
<td>High school diploma</td>
<td>32 (20.1)</td>
<td>25 (15.6)</td>
</tr>
<tr>
<td>Vocational—technical</td>
<td>62 (38.8)</td>
<td>68 (42.5)</td>
</tr>
<tr>
<td>College/University</td>
<td>50 (31.3)</td>
<td>45 (28.1)</td>
</tr>
<tr>
<td>Graduate/professional</td>
<td>13 (8.1)</td>
<td>16 (10.0)</td>
</tr>
<tr>
<td>Marital Status</td>
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<td></td>
</tr>
<tr>
<td>Never married</td>
<td>7 (4.4)</td>
<td>5 (3.1)</td>
</tr>
<tr>
<td>Married once</td>
<td>131 (81.9)</td>
<td>130 (81.3)</td>
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<tr>
<td>Remarried</td>
<td>17 (10.6)</td>
<td>20 (12.5)</td>
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<tr>
<td>Separated</td>
<td>1 (0.6)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Divorced</td>
<td>1 (0.6)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Living with partner</td>
<td>3 (1.9)</td>
<td>5 (3.1)</td>
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<tr>
<td>Age (mean)</td>
<td>31.40 (19–43)</td>
<td>34.15 (22–50)</td>
</tr>
<tr>
<td>$&lt;20,000</td>
<td>11 (6.9%)</td>
<td>2 (2.0%)</td>
</tr>
<tr>
<td>$20,000–39,999</td>
<td>57 (36.1)</td>
<td>27 (26.5)</td>
</tr>
<tr>
<td>$40,000–59,999</td>
<td>55 (34.8)</td>
<td>43 (42.1)</td>
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<td>$60,000–79,999</td>
<td>19 (12.0)</td>
<td>15 (14.7)</td>
</tr>
<tr>
<td>$&gt;80,000</td>
<td>15 (9.5)</td>
<td>14 (13.9)</td>
</tr>
<tr>
<td>Do not know</td>
<td>1 (0.6)</td>
<td>1 (1.0)</td>
</tr>
</tbody>
</table>
Demographic Variables
Age and gender of the child were available from the medical records and corroborated by parents in a conjoint interview. Parent education was reported by each parent on a demographic questionnaire. Father’s report of total family income was used in the analysis.

Data Analysis
One-sample t-tests were used to compare FAM scores as reported by mothers and fathers in this sample with the reported norms for FAM. Paired-sample t-tests were used to compare family functioning scores reported by mother–father dyads. To adjust for multiple comparisons, we set the significance level at .01, rather than .05. In separate hierarchical linear regression analyses, mothers’ and fathers’ overall family functioning scores were regressed in three steps on (a) child’s age and gender; (b) family income and level of education of the parent; and (c) chronic condition severity (functional status and multiple impairments).

Results
Mothers’ and Fathers’ FAM Score Compared with the Norms
The one-sample t-tests (see Table II) comparing mothers’ and fathers’ FAM scores in both cohorts with the norms revealed that the average scores for all domains of family functioning were in the normal range (between 40 and 60). In the infant cohort, 10 of the 16 comparisons revealed significantly better scores for mothers and fathers. In the pre-adolescent cohort, 2 of the 16 comparisons revealed significantly better scores in our sample, with only affective expression being significantly worse for both mothers and fathers, although still within the normal range. Except for poorer affective expression for parents of pre-adolescents, these results of average or better-than-average family functioning in our sample are contrary to our first hypothesis.

Comparisons of Mothers’ and Fathers’ FAM Scores
The results of the paired-sample t-tests for mothers and fathers indicated that only the role performance score was significantly different, with mothers reporting significantly poorer role performance compared to fathers in both the infant (mothers \( r = 0.29 \), fathers \( r = 0.32 \), \( p < .01 \)) and pre-adolescent (mothers \( r = 0.51 \), fathers \( r = 0.48 \), \( p < .01 \)) cohorts. On all other subscales and for overall family functioning, there were no significant differences between mothers’ and fathers’ reports. In other words, the null hypothesis was primarily supported with this sample. Correlations between mothers’ and fathers’ FAM subscale scores were between .20 and .40.

Associations between Family Functioning and Functional Severity of the Condition
Correlations between mothers’ and fathers’ reports of family functioning and functional severity of the chronic condition were all in the predicted direction: greater functional severity was associated with poorer family functioning. However, the only significant association in the infant cohort was between functional severity and role performance (for mothers, \( r = -0.29 \), \( p < .01 \) and for fathers, \( r = -0.32 \), \( p < .01 \)). For mothers of pre-adolescents, four aspects of family functioning were significantly associated with functional severity: affective expression (\( r = -0.26 \), \( p < .01 \)), affective involvement...
For fathers of pre-adolescents, functional severity was associated with affective involvement ($r = -.20$, $p < .01$) and the total FAM score ($r = -.22$, $p < .01$).

### Associations between Family Functioning and Child’s Chronic Condition

In an effort to explain how much influence the child’s chronic condition had on mothers’ and fathers’ reports of overall family functioning, we examined the relationship between severity of the child’s chronic condition (using functional severity and multiple impairments) and family functioning, after controlling for child age and gender, family income, and parent education. For mothers in the infant cohort, the regression analyses indicated significant findings when parameters for severity were entered ($R^2$ change = .08, $F$ change = 6.85), but in the pre-adolescent cohort, those severity parameters only approached significance (Table III). The overall $R^2$ for mothers in the infant cohort was .118 and in the pre-adolescent cohort was .149.

For fathers of infants, significant findings were obtained when parents’ education and family income were included in the analysis ($R^2$ change = .059, $F$ change = 4.58) and also when severity parameters were added in Step 3 ($R^2$ change = .038, $F$ change = 3.13; Table IV). For fathers of pre-adolescents, parent education and family income were significant predictors ($R^2$ change = .06, $F$ change = 3.13) but severity parameters were not significant. The overall $R^2$ for fathers in the infant cohort was .102 and in the pre-adolescent cohort, it was .098.

### Discussion

Contrary to our hypothesis, 80–90% of the families in this sample demonstrated normal family functioning; that is, mothers’ and fathers’ standard FAM scores were in the normal range or better. In the infant cohort, only 5.4% of mothers and 4.3% of fathers had scores in the family problem range (>60); among pre-adolescent parents, only 2% of mothers and 8% of fathers had scores >60. There are several possible explanations for these findings. Due to the manner of sample recruitment, it is quite likely that there was a self-selection bias, wherein higher functioning families were more likely to agree to participate in a longitudinal study of this kind. Furthermore, our analyses were limited to two-parent families because 90% of the families in the original data had two parents.
set had both parents, with too few single-parent families for any meaningful sub-analyses. Two-parent families may be able to share responsibilities in caring for their child, and for addressing other normative tasks and responsibilities of family life, in contrast to single-parent families where the responsibility is more likely shouldered by one parent. In addition, the parents in our sample were relatively well-educated and primarily had middle-class family incomes. As a result, they may have had both knowledge and access to more and better health, education, and social services for their children. Having adequate resources to meet family demands is likely to contribute to better family functioning. Fourth, these families were recruited from two states, namely Washington and Minnesota that, by and large, have fairly good health care service systems. Based on MCHB national performance measures (MCHB, 2004), 73.5% of families in Minnesota and 74.1% in Washington reported that community-based service systems are organized so that families can use them easily.

Another possible explanation for the finding of good family functioning could be that the presence of a stressor like having a child with a chronic condition challenged these families to develop internal strengths for managing their situation, perhaps leading to stronger family functioning. More families in this sample were in the optimal range for family functioning (FAM <40: 14% in the infant cohort and 9% in the pre-adolescent cohort) than were in the problem range. We do not, of course, know how these families would have reported their functioning before they had a child with a chronic condition, but becoming stronger in the face of stress is consistent with the inoculation mechanism associated with resilience theory (Patterson, 2002).

Although it is encouraging to find that a majority of the families in our sample exhibited normal family functioning, it is important to mention that this finding cannot be generalized to all families who have children with chronic conditions. Clearly, the demographics of our sample are nonrepresentative of the overall population of CSHCN, since children from families with lower socioeconomic status (SES) are more likely to have a chronic condition (Case, Lubotsky, & Paxson, 2004), and lower SES and minority families are more likely to have unmet service needs (Honberg, McPherson, Strickland, Gage, & Newacheck, 2005).

Consistent with our hypothesis, our findings revealed almost no differences between mothers and fathers on their situation, perhaps leading to stronger family functioning. More families in this sample were in the optimal range for family functioning (FAM <40: 14% in the infant cohort and 9% in the pre-adolescent cohort) than were in the problem range. We do not, of course, know how these families would have reported their functioning before they had a child with a chronic condition, but becoming stronger in the face of stress is consistent with the inoculation mechanism associated with resilience theory (Patterson, 2002).

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Consistent with our hypothesis, our findings revealed almost no differences between mothers and fathers on
most aspects of family functioning. It was only for role performance that mothers in both cohorts reported significantly poorer scores than fathers, which may be related to mothers’ having greater responsibility for providing daily care for their children.

The other mother–father difference was that fathers reported worse scores for affective expression than mothers, but only in the pre-adolescent cohort. Given mothers’ greater involvement with the child with the chronic condition, mothers may have been less available to show expressiveness to their husbands, and perhaps this becomes more apparent to fathers over time—since this difference only occurred in the pre-adolescent cohort. The stress of handling a child who is entering the stage of adolescence, a time of confusion where there is a need for the child to have his or her own privacy and a need to develop his or her own identity, may also be a factor. However, this singular difference for fathers reporting worse scores may be due to chance and clearly requires additional study to understand if there is a real difference, particularly over time.

Our findings also revealed several significant associations between the severity of the chronic condition and family functioning as reported by mothers and fathers, particularly for the infant cohort where all of the associations were significant for mothers, and all, but affective expression were significant for fathers. As hypothesized, greater functional limitations were associated with a greater negative impact on family functioning. For the pre-adolescent cohort, poorer role performance was associated with greater functional severity as reported by both parents. In addition, mothers’ reports of poorer task accomplishment were associated with functional severity, and fathers’ scores for affective expression and total family functioning were worse when the child had more functional limitations. The fact that more domains of family functioning were significantly associated with functional severity in the infant cohort compared to the pre-adolescent group may reflect the stage of adjustment for these families. Those with young children are in the earlier stages of adjustment where their family interaction patterns are undergoing changes needed to accommodate the special needs. In contrast, for families in the older cohort, adjustment to the chronic condition is more likely to have stabilized because the child and family adapt over time to managing the condition (Kovacs et al., 1990; Timko et al., 1992). Furthermore, our sample may not have included those families for whom the disruption was so great that the parents were no longer together. In other words, these cohort differences may reflect time since diagnosis relative to family functioning adjustment.

Although severity of the child’s condition was associated with family functioning, it explained very little of the overall variance in family functioning. The addition of demographic variables also added little explanation to the variance in family functioning. The total variance explained for mothers (12% in the infant cohort, 15% in the pre-adolescent cohort) was greater than that for fathers (10% for both the cohorts). One unexpected finding was that having a girl with a chronic condition was a significant predictor of family functioning for mothers of pre-adolescents. Perhaps this is related to the normative strain in mother–daughter relationships, which often increases at adolescence (Gilani, 1999).

**Limitations**

There were several limitations to this study. First, this study used cross-sectional data to examine the relationship between functional severity and family functioning. Although we hypothesized that greater functional limitations would negatively affect family functioning, it is possible that better family functioning could reduce functional limitations if mediated by better treatment adherence, access to and utilization of health services, etc. With cross-sectional data, it is not possible to determine the direction of effects. Second, the results of this study can only be generalized to a limited population, given the homogeneity of our sample with regard to race, family structure, and SES. The findings also revealed that a majority of the families were in the normal range of functioning, indicating that our self-selected sample was most likely biased towards more well-functioning families. Third, data were collected at the level of individual members of a family rather than the family as a unit. Fourth, using self-report measures to gather information from the families also has its limitations in the form of response bias such as response set, response pattern anxiety, and social desirability.

**Implications**

The results of this study highlight the need for future research about family functioning with a more diverse sample of participants, particularly SES and racial diversity as well as family structure diversity.
Families with chronic conditions are found in all cultures and at all levels of the social strata. By understanding families in these different contexts, policy makers and health care professionals can become aware of the differing needs of these families and tailor necessary services according to those needs.

Although we found little difference between mothers and fathers in their reports of family functioning, we believe it is important for future studies with more heterogeneous samples to assess both mothers’ and fathers’ perspectives of the impact of a chronic condition on the family. Other factors (such as mother’s level of education, which was associated with her reports of family functioning in this study) should be included in follow-up studies to increase our understanding of the variability of chronic conditions’ impact on family functioning.

An important result of this study was the finding that families functioned well despite the stress of living with a child’s chronic health conditions. Further research needs to be conducted to gain greater insight into how and why these families managed to stay resilient. Future research may need to augment the quantitative measures of family functioning with a qualitative approach. Clearly, chronic conditions are long-term in nature; therefore, data needs to be collected at different points in time over a longer period to better understand the impact on the family.

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