Parents of Children with Cancer: A Longitudinal Study of Emotional Distress, Coping Style, and Marital Adjustment Two and Twenty Months After Diagnosis

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Evaluated emotional distress, coping style, and marital adjustment in 84 parents (42 couples) of children with cancer 2 months after diagnosis and again about 20 months after diagnosis. As expected, mothers' mean state anxiety and trait anxiety scores decreased to near normal levels over time. Fathers' scores were lower initially and did not change. Neither mothers' nor fathers' mean marital adjustment scores changed over time. Marital adjustment at treatment follow-up was predicted by depression and the spouse's marital satisfaction in mothers, and depression, child health status, and spouse's marital satisfaction in fathers. In contrast to findings obtained 2 months after diagnosis, coping style was not related to marital adjustment at follow-up. Results are discussed in terms of possible gender differences in the role of social support in marital adjustment and the stability versus situational specificity of coping styles.

KEY WORDS: childhood cancer; marital distress; marital adjustment; parents; coping styles; anxiety; depression.

The marital relationship can serve as a powerful buffer against a variety of stressful life events (Schulz & Rau, 1985). Although having a child with cancer is indisputably stressful, this stressor is not homogeneous over time. After the initial crisis of the diagnostic phase, the family typically enters the treatment and
follow-up phases of the illness, which are more chronic stressors. This distinction is important, since both theory and empirical evidence suggest that predictors of responses to chronic versus acute conditions differ (Roth & Cohen, 1986; Suls & Fletcher, 1985). The present study longitudinally examines marital adjustment as it relates to two aspects of the coping process: parents’ affective distress and coping style. Two periods of the child’s illness are examined: the period 2 months after diagnosis and 20 months after diagnosis.

**Affective Distress**

Parental affective responses are likely to change from the acute diagnostic period to the chronic but less intense stress of the treatment and follow-up phase. Although extreme parental emotional distress in response to the child’s diagnosis is commonly observed (Dahlquist & Taub, 1991), there tends to be little evidence of psychological maladjustment in parents later in the child’s illness (e.g., Brown et al., 1992) or after treatment termination (Kupst & Schulman, 1988). However, the majority of studies have not employed standardized measures of parents’ emotional states.

Brown et al. (1992) utilized standardized measures to study mothers at diagnosis, 1 year after diagnosis, and off therapy. However, their cross-sectional design did not allow for assessment of changes over time. The only longitudinal study with repeated standardized measurement of parents’ affective states was conducted by Powazek, Payne, Goff, Paulson, and Stagner (1980). Although they reported decreases in mothers’ anxiety and depression 6 months after diagnosis, statistical analyses of these changes were not reported.

None of the studies reviewed above included fathers. Both Brown et al. (1992) and Powazek et al. (1980) reported that fathers generally did not come to clinic and therefore were difficult to evaluate. Brown et al. (1992) attempted to indirectly assess fathers’ emotional states by asking mothers to report their husband’s psychiatric symptomatology. However, past research suggests that spouses are remarkably inaccurate in their estimates of their partner’s response to stress (Pickersgill & Beasley, 1990).

The present study addresses the limitations in the literature by comparing standardized measures of the affective states of both mothers and fathers longitudinally at two points in time: 2 months and 20 months postdiagnosis. We predicted that parents’ emotional distress would be lower at follow-up than at 2 months after diagnosis, as long as the child’s condition had not worsened.

**Coping Style**

A number of theorists have argued that the utility of a coping strategy depends on the duration and the nature of the stressful situation (e.g., Lazarus &
Avoidant strategies may be most effective as an initial response to a stressor when emotional arousal is high and when the situation is uncontrollable. For chronic stressors, where vigilance or action are necessary, approach strategies may be more effective.

There is also some evidence that coping styles may be related to marital adjustment. In their early study of parents of children with cancer, Barbarin, Hughes, and Chesler (1985) found that similarity in emotion-focused coping and complimentarity in problem-focused coping were associated with better reported marital adjustment. However, generalization of their findings is limited by the fact that they did not use standardized measures of marital adjustment and did not standardize the time since the child’s diagnosis.

In our initial study of the coping strategies and marital adjustment of parents of children with cancer (Dahlquist et al., 1993) we addressed some of the limitations in the previous literature by standardizing the time of assessment and using objective, standardized measures of marital adjustment. In this study of the acute phase of the illness (approximately 2 months after diagnosis), we found an elevated incidence of marital distress (approximately 25% of mothers and 28% of fathers). Mothers’ and fathers’ state anxiety scores also were elevated above nonclinical norms.

We then examined marital distress as it related to two aspects of the coping response: affective arousal and approach-avoidance coping style. Marital distress was predicted by general affective arousal (state anxiety and depression) and the degree of discrepancy in anxiety levels between the parents. We posited that this discrepancy may reflect differences in the appraisal phase of coping as defined by Lazarus and Folkman (1984). However, for coping styles, discrepancies between the parents were not related to marital distress. Rather, higher overall amounts of sensitizing coping activity in the marital relationship were related to greater marital distress.

In the present longitudinal study, we repeated the evaluation of emotional distress, coping style, and marital functioning approximately 20 months post-diagnosis. We wanted to determine whether the same pattern of affective arousal and coping style found to be related to marital distress postdiagnosis also was related to marital distress in this chronically (rather than acutely) stressful situation. We were also interested in changes in the parents’ marital functioning over the course of the child’s illness. This analysis was exploratory, since it was unclear whether distressed marriages would get worse by ineffectively coping with stress over a long period of time (Whiffen & Gotlib, 1989) or get better as parents pulled together to take care of the child (Patterson & McCubbin, 1983). The same bidirectional possibilities were considered in comparing the marital adjustment of those parents whose children’s health was improved versus not improved.
**METHOD**

**Participants**

Subjects were 42 mother–father dyads who completed study measures 2 months after diagnosis and again approximately 20 months into treatment. Participants were obtained in the following manner. Over a period of 4 years, 215 (roughly 75% of eligible families) participated in routine psychological screening evaluations approximately 2 months after their child was diagnosed with cancer. These evaluations were part of the standard clinical care offered to all English-speaking families of children diagnosed with cancer. The details of this screening process are reported in Dahlquist et al. (1993).

The 42 marital pairs in the present study were recruited from the pool of families of children who had participated in the psychological screening process 2 months after diagnosis. Four families were not contacted because their child was critically ill (i.e., in the ICU or terminally ill), and 23 children had died, and some families had moved, which left a potential pool of 188 children and their parents. Of the 188 families who were approached regarding participation in the study, 145 agreed to participate, 133 were two-parent families. Questionnaires subsequently were received from 69 mothers and 49 fathers. Questionnaires from both the mother and father in the same family were available for 42 marital pairs.

The children of these 42 couples had been diagnosed with cancer an average of 20 months prior to evaluation. Approximately 48% of the children had leukemia, 17% had lymphoma, 26% had solid tumors, and 9% had brain tumors. Children ranged in age from 22 months to 18 years, with a mean age of 7.92 years. Nineteen were girls. Approximately 88% of the children were Caucasian, 7% were African American, and 5% were Hispanic. Mean age of mothers was 34.10 (SD = 6.41, range = 20–49). Mean age of fathers was 37.05 years (SD = 7.55, range = 24–55). Mean length of marriage was 12.85 years (SD = 6.51, range = 2–27).

Based on parental descriptions of the child’s medical status, the child’s status was classified as improved or not improved since diagnosis, using the following criteria: For tumor patients, if the tumor currently was smaller than it was at the time of diagnosis, health status was coded as improved. No reduction in size, an increase in size, or metastases were considered not improved. For leukemia patients, if the child was in remission and had not relapsed, health status was considered improved. If the child had relapsed or had not achieved remission, health status was considered not improved. Based on these criteria, 7 children were classified as not improved. The children also were classified as currently receiving treatment (n = 30) or off treatment (n = 12), based on their medical records.

All of the mothers had at least a high school diploma, approximately 33%...
Parents of Children with Cancer had college degrees, and 7% had graduate training. Of the fathers, all but one had completed high school, 36% had college degrees, and 19% had graduate training. The families fell primarily in the middle range of socioeconomic status (SES). Mean Hollingshead (1975) household score was 47.19 (SD = 9.89).

**Representativeness of the Follow-Up Sample**

Because of the low response rate at follow-up, a series of t tests were conducted to determine whether the sample of parents who completed follow-up questionnaires differed from the sample of parents who did not return questionnaires. To accomplish this, the demographic and psychological screening data obtained from the parents who completed follow-up questionnaires were compared with the corresponding screening data of the parents who did not complete follow-up questionnaires. With respect to demographics, the parents who completed the follow-up measures were better educated than the parents who did not participate at follow-up (t > 3.04, p < .01). There were no significant differences in parents’ ages or length of marriage at screening.

The mothers who completed follow-up questionnaires did not differ from the mothers who elected not to return follow-up questionnaires with respect to postdiagnosis state anxiety, trait anxiety, depression, or marital adjustment. The sample of fathers who responded at follow-up also did not differ from the fathers who did not complete follow-up questionnaires with respect to depression or marital adjustment scores obtained at screening. However, the follow-up sample of fathers did report lower trait anxiety, r(80) = 2.45, p < .02, 2 months after diagnosis than did the fathers who did not return follow-up questionnaires.

**Procedure**

Parents who had participated in postdiagnosis psychological screening were contacted for the present study approximately 20 months after diagnosis. Advanced clinical psychology graduate students explained the study and obtained informed consent from both parents during a clinic visit or by telephone. Parents consented to completing the questionnaires and to allowing the investigators access to the psychological data obtained 2 months after diagnosis.

Information regarding the child’s health status and family demographics was obtained from the parent after consent was obtained. Questionnaires were distributed in person or by mail and were accompanied by postage paid return envelopes. Parents were paid $10 apiece for completing the questionnaires. Parents who did not return questionnaires within 2 weeks were contacted by phone as a reminder. A second set of questionnaires with a reminder letter was mailed approximately 2 weeks later if questionnaires still had not been returned.
Questionnaires

Spielberger State-Trait Anxiety Inventory (STAI; Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1970). The STAI assesses the transitory condition of perceived tension with 20 items indicating "how you feel right now" and the relatively stable trait of anxiety proneness with 20 items indicating "how you generally feel." As would be expected, test–retest reliabilities are higher for trait (.73–.86) than for state (.16–.33) anxiety. Trait scores are correlated with other measures of trait anxiety. Nonclinical age-referenced norms were used (Spielberger et al., 1970). Higher scores denote greater anxiety. The STAI was administered at screening and at follow-up. The degree of discrepancy between partners' anxiety levels was measured in the same manner as in Dahlquist et al. (1993). For each marital pair, the absolute value of the difference between the mother's and father's state anxiety scores was calculated (state anxiety differ- ence score). A trait anxiety difference score was calculated in an analogous manner.

Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). The BDI is a 21-item scale which measures the presence and intensity of various somatic, emotional, and cognitive features of depression. Internal consistency and concurrent validation are well documented for the scale (Beck et al., 1961; Harrell & Ryon, 1983). Higher total scores denote greater depression. Scores above 16 are considered indicative of clinical depression (Harrell & Ryon, 1983). The BDI was administered at screening and at follow-up.

Modified Repression–Sensitization Scale (R-S; Epstein & Fenz, 1967). The Modified R-S is a 30-item true/false scale used to assess a person's characteristic style of responding to stress along the dimension of repression–sensitization. Repression is defined as the tendency to avoid or not think about stressful stimuli, whereas sensitization refers to the tendency to focus on or approach these stimuli. The scale is scored in a unidimensional fashion; higher scores denote greater sensitization. The R-S was administered at screening only.

Dyadic Adjustment Scale (DAS; Spanier, 1989). The DAS is a 32-item multidimensional self-report measure which yields four marital adjustment factor scores (satisfaction, cohesion, consensus, and affectional expression). The four factors of the DAS have been shown to form one higher order factor: marital adjustment (Eddy, Heyman, & Weiss, 1991; Sabourin, Lussier, Laplante, & Wright, 1990). Test–retest reliability above .90 has been demonstrated for the total score. Total scores have been shown to successfully discriminate between distressed and nondistressed spouses in general and clinical samples (Eddy et al., 1991) and to correlate highly with other measures of marital adjustment for married as well as unmarried couples (Spanier, 1989). DAS total scores and DAS satisfaction subscale scores were obtained for each parent. Lower total scores denote greater marital distress and lower marital satisfaction, respectively (Eddy
et al., 1991). The Satisfaction subscale score measures "the amount of tension in the relationship as well as the extent to which the individual has considered ending the relationship" (Spanier, 1989). It appears to measure affective reaction toward the relationship, rather than consensus on more objective marital activities, which are reflected in the other subscales (i.e., the Cohesion or Consensus subscales). The DAS was administered at screening and at follow-up.

RESULTS

To control for experimentwise error, alpha was set at .01.

Characteristics of the Follow-Up Sample

Descriptive Statistics. Means, standard deviations, and ranges of the follow-up parent self-report variables are presented in Table I. For comparison, the corresponding scores obtained at diagnosis also are presented. At diagnosis, mothers scored significantly higher than fathers on state anxiety, \( t(34) = 2.72, p = .01 \). Mothers' and fathers' mean scores at follow-up did not differ significantly (all \( ts < 1.0 \), all \( ps > .40 \)).

Clinical Elevations. Overall, neither mothers' nor fathers' mean follow-up

| Table I. Parent Self-Report Measures Two Months After Diagnosis and at Follow-Up |
|-------------------------------|-------------------|-------------------|
| **Variable**                  | **Diagnosis**     | **Follow-up**     |
|                               | **M**             | **SD**            | **M**             | **SD**            |
| Dyadic adjustment scale, total|                  |                  |                  |
| Mother                        | 111.62            | 17.16             | 110.88           | 17.30             | 51–136           |
| Father                        | 110.72            | 18.05             | 109.14           | 20.80             | 26–142           |
| Dyadic adjustment scale, satisfaction| |                  |                  |
| Mother                        | 37.05             | 6.46              | 37.48            | 6.47              | 17–45            |
| Father                        | 36.53             | 6.50              | 37.83            | 7.16              | 12–47            |
| Beck depression inventory     |                  |                  |                  |
| Mother                        | 8.25              | 5.79              | 5.74             | 5.59              | 0–23             |
| Father                        | 5.59              | 6.57              | 5.79             | 5.99              | 0–23             |
| State anxiety                 |                  |                  |                  |
| Mother                        | 57.52             | 12.86             | 49.56            | 10.09             | 35–76            |
| Father                        | 50.53             | 10.74             | 49.38            | 11.24             | 34–72            |
| Trait anxiety                 |                  |                  |                  |
| Mother                        | 53.44             | 10.75             | 50.07            | 10.45             | 33–80            |
| Father                        | 47.91             | 8.65              | 49.27            | 11.14             | 35–80            |
state anxiety nor trait anxiety scores differed from the norms for nonclinical adults. The approximate percentage of mothers whose scores were clinically elevated at follow-up were: state anxiety \((T \geq 70)\), 2%; trait anxiety \((T \geq 70)\), 5%; depression \((BDI > 16)\), 7%; and marital distress \((DAS total < 100)\), 19%. For fathers, corresponding percentages of clinically elevated scores were state anxiety, 5%; trait anxiety, 7%; depression, 7%; and marital distress, 24%. Correlational analyses revealed that none of the demographic variables was related to the follow-up parent self-report variables.

**Health and Treatment Status**

The parents of children whose health status had not improved were compared with the parents of children whose health status had improved with respect to state anxiety, trait anxiety, depression, and marital adjustment \((DAS total)\). \(T\) tests indicated that the fathers of children whose health had not improved reported less marital distress \((M = 128.00 vs. 105.37), t(40) = -2.85, p = .002\). The health status groups did not differ on the remaining parent self-report variables. Mean scores of the five cancer diagnostic groups did not differ on any of the parent self-report variables. The parents of children still in treatment did not significantly differ from the parents of children who were off treatment on any of the parent self-report variables.

**Longitudinal Changes**

**Parental Affect.** When compared with their self-report 2 months after diagnosis, Mothers’ scores at follow-up were significantly lower for state anxiety, \(t(40) = 3.84, p < .001\), and trait anxiety, \(t(38) = 3.34, p = .002\). No change was evident in fathers’ anxiety or depression scores.

**Marital Distress.** Correlations between Time 1 and Time 2 DAS total scores were .56 for mothers and .79 for fathers \((p < .001)\). Paired \(t\) tests indicated that, as a group, neither mothers’ nor fathers’ mean DAS total scores significantly changed over time. The possibility that parents who were already maritally distressed at the time of diagnosis would become increasingly distressed over time, as suggested by Whiffen and Gotlib (1989), was not supported by the data. When only parents who were maritally distressed at diagnosis (those with DAS total scores less than 100) were considered, paired \(t\) tests revealed no significant changes in DAS total scores between diagnosis and follow-up for either mothers or fathers.

**Predictors of Marital Distress**

Correlational and multiple regression analyses were conducted to determine the relationship between marital distress \((DAS total scores)\) at follow-up and (a)
Parents of Children with Cancer

Table II. Correlations Between the Independent Variables and Parents' Dyadic Adjustment Scale (DAS) Marital Adjustment Scores at Follow-up

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mother's DAS total</th>
<th>Father's DAS total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression*</td>
<td>-.47*</td>
<td>-.55*</td>
</tr>
<tr>
<td>State anxiety*</td>
<td>-.25</td>
<td>-.25</td>
</tr>
<tr>
<td>Trait anxiety*</td>
<td>-.42*</td>
<td>-.50*</td>
</tr>
<tr>
<td>Health status*</td>
<td>.25</td>
<td>.41*</td>
</tr>
<tr>
<td>Spouse's marital satisfaction*</td>
<td>.65*</td>
<td>.66*</td>
</tr>
<tr>
<td>Repression–sensitization*</td>
<td>.01</td>
<td>-.43</td>
</tr>
<tr>
<td>Combined repression–sensitization*</td>
<td>-.21</td>
<td>-.31</td>
</tr>
<tr>
<td>State anxiety difference*</td>
<td>-.32</td>
<td>-.29</td>
</tr>
<tr>
<td>Marital adjustment at diagnosis</td>
<td>.56*</td>
<td>.79*</td>
</tr>
</tbody>
</table>

*Measured at follow-up.

'Measured 2 months after diagnosis.

*p < .01.

R-S, (b) the child's health status, (c) the spouse's marital satisfaction, and (d) the variables Dahllquist et al. (1993) found predicted marital adjustment at diagnosis: the emotional distress of the parent (anxiety and depression), the combined repression–sensitization score for the couple, and the absolute value of the difference between the parents' current state anxiety scores.

As can be seen in Table II, depression, trait (but not state) anxiety and the spouse's marital satisfaction were significantly correlated with total DAS scores for both mothers and fathers. The child's health status was significantly related to fathers' marital adjustment but not to mothers' marital adjustment.

Hierarchical multiple regression analyses were then conducted separately for mothers and fathers (Table III). To control for individual differences in gener-

Table III. Regression Analyses Predicting Marital Adjustment at Follow-up

<table>
<thead>
<tr>
<th>Step and variables in model</th>
<th>Mother's marital adjustment (Dyadic adjustment scale total score)</th>
<th>Father's marital adjustment (Dyadic adjustment scale total score)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Depression</td>
<td>-.48*</td>
<td>-.56*</td>
</tr>
<tr>
<td>2. Trait anxiety</td>
<td>-.13</td>
<td>.38*</td>
</tr>
<tr>
<td>3. Father's marital satisfaction</td>
<td>.60*</td>
<td>.49*</td>
</tr>
<tr>
<td>4. Health status</td>
<td>.13</td>
<td>.30</td>
</tr>
<tr>
<td>5. Mother's marital satisfaction</td>
<td>.49*</td>
<td>.45</td>
</tr>
</tbody>
</table>

*Measured at follow-up.

'p < .05.

"p < .01.

*p < .001.

R-S.
al level of emotional distress and differences in willingness to self-report affective distress (Kelly & Conley, 1987), the BDI score and then the trait anxiety score were entered into the regression equation. Mothers’ BDI scores accounted for 23% of the variance in mothers’ DAS total scores. Fathers’ BDI scores accounted for 32% of the variance in DAS total scores. Because trait anxiety and depression were significantly correlated for mothers and fathers, $r(41) = .77$ and .82, respectively, $p < .001$, it was not surprising that adding trait anxiety to the model did not significantly improve the prediction of marital adjustment for either mothers or fathers.

The next phase of regression analyses investigated the degree to which the child’s health status at follow-up predicted fathers’ marital distress. (Health status was not significantly correlated with mothers’ DAS scores and therefore was not entered into the regression equation for mothers.) Health status accounted for an additional 14% of the variance in fathers’ DAS total scores.

The final predictor considered was the spouse’s DAS marital satisfaction score. Adding the spouse’s marital satisfaction score to the regression model significantly improved the prediction of both mothers’ and fathers’ total DAS scores. The resulting regression model accounted for 58% of the variance in mothers’ total DAS scores and 67% of the variance in fathers’ total DAS scores.

**DISCUSSION**

**Affective Arousal**

The mothers who participated in this study, as a whole, demonstrated the decreases in anxiety levels expected to occur over the course of their child’s illness. This pattern of peak emotional distress at the time of diagnosis followed by eventual adaptation to near normal levels of affective arousal is consistent with the clinical observations of a number of writers (see Dahlquist & Taub, 1991). The present study adds to the literature by providing objective, longitudinal documentation of this heretofore primarily subjective or cross-sectionally derived impression.

An unexpected gender difference in longitudinal changes in affective states was observed. Although mothers appeared to become less anxious over time, no change in fathers’ affective arousal was observed. This difference appeared to be primarily due to baseline differences in levels of emotional distress between mothers and fathers. The fathers who participated in this follow-up study were significantly less anxious 2 months after diagnosis than were their spouses, and also were less anxious at diagnosis than the fathers who declined to participate in the follow-up evaluations. Thus, the failure to detect changes in their affective...
state may be related to the unrepresentative nature of the sample of fathers who participated in follow-up.

**Marital Distress**

The stable mean levels of marital distress at diagnosis and follow-up are somewhat misleading. Informal examination of the distributions of DAS total change scores and the correlations between Time 1 and Time 2 DAS total scores suggests that considerable (> 15-point) changes in marital distress occurred for some subjects, but that this change occurred both in positive as well as negative directions. In fact, the obtained correlation between mothers' DAS scores over time (.56) was considerably lower than has been reported in distressed couples over an 11-week period (.96) or in new parents over a 1-year period (.82) (Spanier, 1989). Unfortunately, a much larger sample would be needed to detect factors associated with change in one direction or the other.

In contrast to findings obtained 2 months after diagnosis (Dahlquist et al., 1993), marital distress at follow-up was not related to state anxiety. Rather, marital distress was significantly related to both depression and trait anxiety, which can be thought of as indicators of more chronic emotional functioning. This pattern of relationship is consistent with the notion that by 20 months after diagnosis, most parents have achieved some level of adaptation to the illness and no longer perceive the situation as an acute crisis. Indeed, in the context of a general adaptation syndrome, this sort of adjustment may be crucial in order to be able to go on with the demands of daily life.

Marital adjustment was predicted by depression and the spouse's marital satisfaction in mothers, and depression, child health status, and spouse's marital satisfaction in fathers. Depression was conceptualized primarily as a measure of general distress response set. After this indicator of distress was entered into the equation, another measure of cognitive set, trait anxiety, added no more to the prediction. Thus the BDI and STAI Trait anxiety variance that overlapped with DAS appeared to represent emotional distress common to the two measures, rather than the unique contribution of anxiety or depression.

Poor child health status predicted a more positive attitude toward the marriage in fathers but not in mothers. It may be speculated that when faced with the stress of the child's declining health, a person needs social support and the spouse is seen as a person who can provide the support. The literature supports the notion that emotional support is important to marital satisfaction (Suitor & Pillemer, 1994), and that a supportive marital relationship can be "a powerful mediating factor in reducing the negative health consequences of such nonnormative events as . . . [the] death of a child" (Schulz & Rau, 1985).

What might account for the gender difference in the contribution of health
status? It may be that women have a broader social support system in which they would more commonly discuss very distressing situations (House & Kahn, 1985). Men may rely more on the marriage for social support and therefore feel increased satisfaction from this one support source in times of stress.

Finally, the spouse's affective reaction toward the marriage (DAS satisfaction) predicted the partner's marital adjustment for both mothers and fathers. Thus, spouses reported feeling more positive toward the marriage when their partners reported higher levels of commitment and/or lower levels of emotional tension. This finding suggests that the spouse's emotional experience of the marriage may have a reciprocal effect on the partner's marital distress. Alternatively, the obtained correlations may merely reflect the fact that both individuals are rating the same relationship.

The fact that the coping style variables that predicted marital distress 2 months after diagnosis did not predict marital distress later in the illness may reflect limitations in the R-S scale. Most studies demonstrating good variability in R-S scores involved highly stressed subjects such as psychiatric patients and professionals with burnout (i.e., Bell & Byrne, 1978; Naisberg-Fennig, Fennig, Keinan, & Elizur, 1991; Ullmann, 1962). R-S may not be a good predictor in lower stress situations.

On the other hand, R-S scores may not be stable over time and may vary depending upon the situation. Although the reported test–retest stability of R-S is high (.88) (Byrne, 1961) these relationships have been reported for nonstressed people over relatively short intervals (i.e., 6 weeks). There is empirical evidence that less than half the population has a tendency to repress or sensitize that is invariant across situations (Lazarus, 1966), and that experience can actually change the tendency to repress or sensitize (Mischel, Ebbesen, & Zeiss, 1973, 1976). Future studies should examine the relationship of R-S and stress through R-S assessment at more frequent intervals. Such repeated assessment could provide information about the stability of coping strategy preferences over the changing demands of the child's illness.

The generalizability of the present findings to the population of families of children with cancer is limited by the small, nonrepresentative sample of parents who completed the follow-up measures. Generalization to non-Caucasian ethnic groups, lower SES families, or to cancer diagnoses other than leukemia or lymphoma cannot be determined. It is also likely that the more extremely marital distressed parents did not complete the follow-up measures. Future studies need to creatively address the problem of obtaining longitudinal self-report data from a more representative sample of parents—especially from fathers. Although the importance of studying fathers' roles in child development and family functioning is widely acknowledged (e.g., Biller, 1993), it is very difficult to get fathers to participate (e.g., Baruch & Barnett, 1986; Brown et al., 1992; deLucie
Parents of Children with Cancer & Davis, 1991; Hauenstein, 1990). It remains to be seen whether larger monetary incentives or home visits would improve participation.

Although the present findings must be considered cautiously, the results suggest that it is important to consider the psychological status of the marital unit as well as the individual parent over the course of the child’s illness. In particular, clinical interventions focusing only on the mother (who is most likely to be present in the medical setting) run the risk of ignoring the potential contribution of the partner as a source of support or affirmation, which may be an important contributor to marital adjustment.

REFERENCES


