

**RELATIONSHIP BETWEEN COPING STRATEGIES AND
WELL – BEING OF PARENTS WHOSE NEWBORN
INFANTS WERE HOSPITALIZED IN THE
NEONATAL INTENSIVE CARE UNIT**



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Atchariya Wonginchan

RELATIONSHIP BETWEEN COPING STRATEGIES AND WELL – BEING OF PARENTS WHOSE NEWBORN INFANTS WERE HOSPITALIZED IN THE NEONATAL INTENSIVE CARE UNIT

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ABSTRACT

The purpose of this descriptive study was to examine the relationship between coping strategies and well-being of parents whose newborn infants were hospitalized in the Neonatal Intensive Care Unit (NICU). The 80 subjects were recruited by purposive sampling at Srinagarind Hospital, Khon Kaen Hospital, Udonthani Hospital, Maharat Nakhonratchasima Hospital, Buriram Hospital, Surin Hospital, and Sapprasit Hospital from August 2002 to January 2003. A three part questionnaire was used including a questionnaire for assessing characteristics of parents, Family Crisis Oriented Personal Evaluation Scale (F-COPES), and Family Member Well-being (FMWB) Index .

From the results of this study it was found that the most frequently used coping strategy was mobilizing family to acquire and accept help. The second was seeking spiritual support. The third was reframing. The fourth was acquiring social support. The least used coping strategy was passive appraisal. Considering the level of parental well-being, it was rather low.

Furthermore, it was also found that there were negatively significant correlations between total score of coping strategies ($r=-.26$, $p< .05$), acquiring social support ($r=-.22$, $p< .05$), mobilizing family to acquire and accept help ($r=-.270$, $p< .05$), and well-being.

These results indicated that parents whose well-being was low, would frequently use acquiring social support, and mobilizing family to acquire and accept help. Therefore, NICU nurses, health professionals who are the people closest to parents should counsel and support parents to use diverse coping strategies, especially acquiring social support, and mobilizing family to acquire and accept help. This is because it will help parents to adjust to this stressful situation and maintain their well-being.

KEY WORDS : COPING STRATEGIES / WELL – BEING / PARENTS /
NEWBORN INFANTS / NEONATAL INTENSIVE CARE UNIT

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ความสัมพันธ์ระหว่างกลวิธีการเผชิญความเครียดกับความผาสุกในบิดามารดาที่บุตรเข้ารับการรักษาในหอ
อภิบาลทารกแรกเกิด (RELATIONSHIP BETWEEN COPING STRATEGIES AND WELL – BEING OF
PARENTS WHOSE NEWBORN INFANTS WERE HOSPITALIZED IN THE NEONATAL INTENSIVE
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บทคัดย่อ

การวิจัยครั้งนี้เป็นการวิจัยเชิงบรรยาย เพื่อศึกษาความสัมพันธ์ระหว่างกลวิธีการเผชิญความเครียดกับ
ความผาสุกในบิดามารดาที่มีบุตรเข้ารับการรักษาในหออภิบาลทารกแรกเกิดโดยเลือกกลุ่มตัวอย่างจากบิดา
มารดาจำนวน 80 ราย ตามคุณสมบัติที่กำหนด ณ โรงพยาบาลศรีนครินทร์ โรงพยาบาลขอนแก่น โรงพยาบาล
อุดรธานี โรงพยาบาลมหาราชนครราชสีมา โรงพยาบาลบุรีรัมย์ โรงพยาบาลสุรินทร์ และโรงพยาบาลสรรพ
สิทธิ์ประสงค์ ระหว่างเดือนสิงหาคม 2545 ถึงเดือนมกราคม 2546 เก็บข้อมูลโดยใช้แบบสอบถาม 3 ชุด
ประกอบด้วย แบบประเมินคุณลักษณะของบิดามารดา แบบประเมินกลวิธีการเผชิญความเครียด (F-COPES)
และ แบบประเมินความผาสุกของบิดามารดา (FMWB)

ผลการศึกษาพบว่า บิดามารดาใช้กลวิธีด้านการแสวงหาและยอมรับความช่วยเหลือจากชุมชนและ
บุคคลอื่นมากที่สุด รองลงมาคือการแสวงหาการสนับสนุนช่วยเหลือด้านจิตวิญญาณ อันดับสามคือด้านการได้
รับการสนับสนุนช่วยเหลือจากสังคม อันดับสี่คือการประมวลเหตุการณ์เกี่ยวกับความเครียดใหม่ และใช้ด้าน
การยอมรับประเด็นของปัญหาน้อยที่สุด เมื่อพิจารณาระดับความผาสุกของบิดามารดาพบว่าบิดามารดาที่มีความ
ผาสุกอยู่ในระดับค่อนข้างต่ำ

นอกจากนี้ผลการศึกษาพบว่า คะแนนรวมกลวิธีการเผชิญความเครียด ($r=-.26, p < .05$), การขอและได้
รับการสนับสนุนช่วยเหลือจากสังคม ($r=-.22, p < .05$), การแสวงหาและยอมรับความช่วยเหลือจากชุมชนและ
บุคคลอื่น ($p=-.27, p < .05$) มีความสัมพันธ์เชิงลบกับความผาสุกของบิดามารดาอย่างมีนัยสำคัญทางสถิติ ที่
ระดับ .05

จากผลการศึกษาชี้ให้เห็นว่า บิดามารดาที่มีความผาสุกน้อยจะใช้กลวิธีเผชิญความเครียดด้านการขอ
และได้รับการสนับสนุนช่วยเหลือจากสังคม, และด้านการแสวงหาและยอมรับความช่วยเหลือจากชุมชนและ
บุคคลอื่นมาก ดังนั้นพยาบาลซึ่งเป็นบุคลากรทางการแพทย์ที่มีความใกล้ชิดกับบิดามารดามากที่สุดจึงควรให้คำ
ปรึกษา สนับสนุน ช่วยเหลือให้บิดามารดาใช้กลวิธีเผชิญความเครียดที่หลากหลาย โดยเฉพาะด้านการขอและ
ได้รับการสนับสนุนช่วยเหลือจากสังคม, และด้านการแสวงหาและยอมรับความช่วยเหลือจากชุมชนและบุคคล
อื่น เพื่อให้บิดามารดาสามารถปรับตัวต่อสถานการณ์ความเครียดและคงไว้ซึ่งความผาสุกในชีวิตได้

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CHAPTER I

INTRODUCTION

Background and Rationale

At present, the statistics of admissions of newborn infants to Neonatal Intensive Care Unit (NICU) in Thailand is still unknown. However, the available number of newborn's admission to NICU at Srinagarind Hospital, Khon Kaen in 2000 to 2002 indicated that there were 290 cases in 2000, 117 cases in 2001, and 132 cases in 2002 respectively. There were 331 cases in 2000, 285 cases in 2001, and 269 cases in 2002 at Khon Kaen Hospital during this same time. Although the number of newborn's admission to NICU has decreased recently in some hospitals, the effect of the hospitalization of newborn infants in NICU on their family is still emphasized. These situations are an extremely stressful life event for family members (Affleck, et al., 1991 cited by Roman, et al., 1995: 385; Raeside, 1997: 914) and unique family stress in having newborn infants hospitalized in the NICU has been identified.

Parents are the most important family members that are affected by the hospitalization of newborn infants. In both situations, whether the infant was born at a tertiary center or transported, the father is the first parent able to visit since the mother is usually recuperating. Experiencing multiple stress during the hospitalization of the infant can lead to enormous tension and strain on the father. He is responsible for communicating all the information to his wife. He has a recovering wife and a sick baby and has somehow to maintain the stability of his family alone (Thornton, et al., 1984: 131). When the mother is able to visit their child, the first sight of the NICU and the infant will often be shocking, denial, guilt, distress, depression, hopelessness, powerlessness, loss, isolation and confusion (Pepper & Snapp, 1980 cited by Steele & Georgia, 1987: 15). After the first visit, parents had a high level of stress and anxiety (Parichart Silprasert, B.E. 2542: 62). They feel anxious, angry and envious that they are unable to provide the protection and nurturance inherent the maternal role (Consolvo, 1984 cited by Steel & Georgia, 1987: 15). Parents reported greatest stress related to the alteration in the parental role (Seidman, et al., 1997: 175). In addition,

this situation produced negative physical health in parents. Parents may be irritable and have difficulty concentrating. They experience sleep and appetite disturbances, and have repetitive dreams of the birth and of the child (Kristensson Hallstrom & Elander, 1997: 363; Logsdon & Davis, 1998: 196; Steele & Georgia, 1987: 15). In other words, having newborn infants hospitalized in the NICU seems to negatively influence the parent's health outcomes. According to, McCubbin and Patterson (1982 cited by McCubbin, Thompson & McCubbin, 1996: 753) this concern towards physical and mental health of family member as family member well-being. Therefore, this event seems to influence the well-being of parents.

Low level of well-being in parents results in an interruption of effective communication and learning, a decrease in effective parental roles (Shellabarger & Thompson, 1993 cited by Parichart Silprasert, B.E. 2542: 1) and a decrease in maternal attachment behaviors (Mercer, 1981: 75). Parents feel deprived of parental responsibilities during the infants' hospitalization. It may interrupt the satisfaction of the usual parents-newborn interaction and bonding (Weinstock, 1986 cited by Landen, 1990: 516). Parents will show a loss of warmth in relationships with other people including other family members (Thornton, et al., 1984: 127). When parents have poor adjustment, they may refuse the next visit and interaction with their infants (Grant cited by Nesson & May, 1986: 1091). Therefore, it can lead parents to leave their newborn infants in the hospital.

A study to help parents have well-being should be studied because it could bring about understanding and seek factors related to their well-being. Previous studies on parental coping with hospitalization of newborn infants in NICU revealed that mothers whose premature baby were admitted to NICU used problem focused coping methods more than emotional focus coping methods (Prachayawadee Yamanantakul, B.E. 2539: 52). According to Seidman and associates (1997: 174), the coping subscale with the highest mean for parents with children in the NICU was problem focused coping. In contrast, Parichart Silprasert (B.E. 2542: 62) reported that parents used emotional focused coping methods more than problem focused coping methods. Thus, these studies presented that parents of newborn infants hospitalized in NICU used both emotional and problem focused coping for decreasing stress. In addition, there were reports on parents of the other area presented that there was a

correlation between coping and well-being. For example, the study of parents whose children between 1 month and 15 years old were hospitalized in PICU, reported emotional focused coping was negatively correlated with well-being (Vimonwan Varolarn, B.E. 2535: 53). She explained that emotional focused coping decreased parental anxiety and helped the parents to accept of the actual situation. However, they can not accept that severe illness threatens the live of their child. Thus, It leads them to have a low level of well-being.

Parents under stress used coping strategies to manage a balance. In the study of Sakul Kongpan (B.E. 2533: 34) it is reported a subscale of coping such as friend resources is a predictor of mothers of hospitalized infant, toddler, and preschool child well-being. These studies showed that coping strategies such as friend resources influence parental well-being. There were some reports that present the correlation between coping strategies and well-being such as the study of Rungreangkulkij, S. (2000: 72) which found a positive correlation between seeking spiritual support and psychological morbidity in mother of a person with Schizophrenia. When reviewed other coping strategies found that acquired social support was negatively correlated with family distress (Rauktis, et, al., 1995). Contrary, Cohen and Wills (1985: 310 - 357) found that social support positively influenced well-being. It was also consistent with the study of Chudjuajeen, S. (2001) found positive correlation between social support and maternal role adaptation in first time pregnant women. And Gottlieb (1983: 74-76) who found that social support was a significant factor that helped in easier maternal role adaptation. Reframing, and mobilizing family to acquire and accept help were not present in the correlation with well-being in the previous research. And, no study reported which coping strategies are the most frequently used of parents while they are faced with such a stressful event as newborn infants hospitalized in NICU. Synthesizing these findings indicates that parents of newborn infants use quite different coping strategies, and live dissepate level well-being. Therefore, the researcher is interested in examining the manner in which parents cope with the stress of newborn infants hospitalized in NICU when their well-being is low and the relationship between coping strategies and well-being. And the result of this study is likely to provide specific and helpful information for nurses to understand

parental coping abilities during the hospitalization of their newborn infants in the NICU.

Conceptual Framework

The conceptual framework basis of this study was the Family Stress Theory. A stressor is defined as a life event that occurs at a discrete point. Acute illness of family member is a stressor impacting on the family, producing change in the family social system. The seriousness of the family member's illness influences the intensity of the demand. Therefore, it seems to impact family member well-being (Patterson, 1988: 218). A family tries to maintain its functioning and meet demands by using coping. Coping is defined as a specific effort by which an individual attempts to reduce demand (Patterson, 1988: 218). Coping strategies included five strategies as follows: acquiring social support, reframing, seeking spiritual support, mobilizing family to acquire and accept help, and passive appraisal (McCubbin, Thompson, & McCubbin, 1996: 458).

In this study, the researcher will focus on the first week after parents visit their infants in NICU, because it is a critical period that affects the family member's well-being. Therefore, when families are faced with a stressful event such as the hospitalization of their newborn infant in NICU, this event affects the individual family member's well-being. Parents are the most important family members affected by these situations.

When parents are faced with newborn infants hospitalized in NICU, their parental roles are altered (Miles, Funk & Kasper, 1992: 264). The family life style is changed, such as house work, caring for other children or other family members, and cooking etc. In addition, family financial strain is increased while their baby is admitted to NICU. Parents consider these situations as parental stressors and strains. When parents visit their infant in NICU for the first time, they experience negative mental health such as shock, denial, guilt, distress, hopelessness, powerlessness, sadness, anger, confusion and anxiety (Consolvo, 1984 cited by Steele and Georgia, 1987: 15). Furthermore, parents presented negative physical health signs such as they were irritable, had difficult concentrating, experienced sleep and appetite disturbances (Kristensson- Hallstrom & Elander, 1997: 363; Logsdon, 1998: 196; Steele & Georgia,

1987: 15). Therefore, after the first visit parents faced a lot of stressors which caused them to have negative physical and mental health, or a low level of well-being.

After the first visit, parents try to adjust by using coping behaviors that consists of 5 strategies or subscales such as acquiring social support, reframing, seeking spiritual support, mobilizing family to acquire and accept help and passive appraisal for meeting demands. The theory does not indicate what coping strategies will be used when parents are faced with stress. There were previous studies as follow, the study on parents of children who were hospitalized, Sakul Kongpan (B.E. 2533: 34) found that friends resources was negatively correlated with general well-being in mothers of hospitalized children. It indicated that mothers used a coping strategy such as friend resources for managing this event. The reason for this is because friend resources can help the mother adjust to the difficulty of their child being hospitalized. Therefore, friend resource was the predictor of the mother's general well-being. Furthermore, Vimonwan Vrolarn (B.E. 2535) indicated that problem focused coping was the predictor of well-being of parents whose child was admitted to PICU.

In conclusion, previous research showed the negative correlation between coping strategies and well-being during the first week of their children hospitalization. However, these findings are contrary to the Family stress theory stating the Family's management and coping skills are related to family adjustment, and this is a positive relationship (McCubbin & Thompson, 1987: 12)

Therefore, in this study, the researcher is interested in what coping strategies are used within the first week after visit by parents and the relationship between coping strategies and well-being. The relationships between variables in this study can be summarized and depicted in Figure 1:

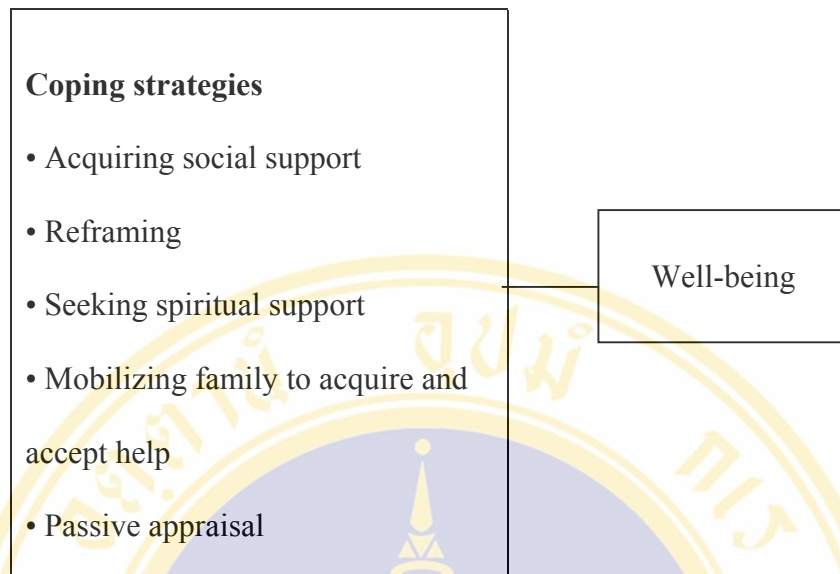


Figure 1: Research Framework of this study

Objectives

The objectives of this study are addressed:

1. To describe coping strategies used by parents whose newborn infants were hospitalized in the NICU.
2. To describe well-being of parents whose newborn infants were hospitalized in the NICU.
3. To examine the relationship between coping strategies and well-being of parents whose newborn infants were hospitalized in the NICU.

Research Questions

The following three research questions are addressed:

1. What coping strategies are commonly used by parents whose newborn Infants were hospitalized in the NICU ?
2. What are the level of well-being of parents whose newborn infants were hospitalized in the NICU ?
3. What are the relationship between coping strategies and well-being of parents whose newborn infants were hospitalized in the NICU ?

Research Hypothesis

Coping total scores and subscales scores of acquiring social support, reframing, seeking spiritual support, mobilizing family to acquire and accept help, and passive appraisal are correlated with well-being of parents whose newborn infants were hospitalized in the NICU.

Scope of the Study

The purpose of this descriptive study research is to examine the relationship between coping strategies and well-being of parents whose newborn infants were hospitalized in the NICU. The sample includes parents of newborn infants hospitalized in NICU in seven hospitals (Srinagarind Hospital, Khon Kaen Hospital, Udonthani Hospital, Maharat Nakhonratchasima Hospital, Buriram Hospital, Surin Hospital, and Sapprasit Hospital). Data was collected between August 2002 to January, 2003.

Expected outcome and Benefits

The results of this study are likely to

1. Help nurses to understand the coping strategies used by parents who visit their newborn infants within 7 days after admission in the NICU.
2. Be a guideline for nursing instructors to teach nursing students to understand relationship between parental coping strategies and well-being of parents whose newborn infants are hospitalized in the NICU.
3. Suggest for future research to develop and promote appropriate coping strategies to maintain well-being of parents whose newborn infants are hospitalized in the NICU.

Assumption

When parents acknowledge about admission of their newborn infants in NICU, this event is a stressor for parents.

Definition of Terms

Coping strategy is defined as a group of specific coping behaviors that consist of thinking and behavior of parents whose newborn infants were hospitalized in the NICU. Coping strategies are measured by using a questionnaire for assessing coping strategies which was translated and modified from Family Crisis Oriented Personal Evaluation Scale (F-COPES) (McCubbin, Olson & Larsen, 1981) that contains five coping subscales or strategies:

- 1) **Acquiring social support** is defined as parental ability to actively engage in acquiring support from relatives, friends, neighbors and extended family.
- 2) **Reframing** is defined as the parental ability to redefine stressful events of having an infant hospitalized in the NICU in order to make them more manageable.
- 3) **Seeking spiritual support** is defined as the parental ability to acquire spiritual support.
- 4) **Mobilizing family to acquire and accept help** is defined as the parental ability to seek out community resources and accept help from others.
- 5) **Passive appraisal** is defined as the parental ability to accept problematic issues and minimize reactivity.

Higher scores indicate that parents using diverse coping strategies and frequently used these coping strategies.

Well-being is defined as regarding the physical and mental health of parents. Well-being is measured by using a questionnaire for assessing well-being of parents which was translated and modified from Family Member Well-being (FMWB) Index (McCubbin & Patterson, 1982) that contains the questions regarding health, tension, energy, cheerfulness, fear, anger, sadness, and general concern. High scores of well-being indicate parents that have a greater well-being.

CHAPTER II

LITERATURE REVIEW

Literature related to coping strategies and well-being of parents whose newborn infants were hospitalized in the Neonatal Intensive Care Unit (NICU) was reviewed. The topics are presented as follows:

- 1) Well-being.
- 2) Coping Strategies.
- 3) Relationship between Coping Strategies and Well-being.

Well-being

McCubbin and Patterson (1982 cited by McCubbin, Thompson & McCubbin, 1996: 753) defined family member well-being as the level of concern regarding the physical and mental health of the family member.

Patterson (1988: 227-228) mentioned that when a family faced a stressful event, it will affect their family members' adjustment. Good adjustment is reflected in positive physical and mental health of individual family members, meaning family member well-being. Therefore, the family members' well-being is an indicator for measuring family member adjustment.

Dupuy (1977 cited by McDowell & Newell, 1996: 206-207) believed that you can assess personal adaptation of a person coping with the stress or problematic situation by their behavior such as anxiety, depression, health status, well-being and controlling themselves.

Campbell (1976: 119-122 cited by Vimonwan Vrolarn, B.E. 2535: 19) mentioned personal well-being as comparison of learning experience, perception of the occurring situation and the expected experience. A conflict between the occurring situation and the expected experience could be viewed in terms of satisfaction or unsatisfaction. If the person had high level of satisfaction, they had high well-being.

Kaplan and associates (1984: 85) mentioned measuring personal well-being by following personal responsibility, carrying out their daily activities and social activity that is the result of coping.

Consequently, well-being is an important indicator for measuring the success of coping with a problematic situation or stressful life event. Furthermore, it is an indicator for measuring personal adjustment to the problematic situation. So studying personal well-being while experiencing a stressful life event or problematic situation is very important for health care professionals. High level of well-being indicated a personal good adjustment or adaptation to a problematic situation.

The affect of the hospitalization of newborn infants in NICU on parental well-being is emphasized. The birth of child is a stressful life event under normal circumstances (Davis, Richards, & Robertson, 1983 cited by Steel, & Georgia, A., 1987: 13). When a child is critically ill at birth because of prematurity, congenital defects or disease, or other perinatal problems, the birth precipitates a crisis for the parents (Kaplan & Mason, 1960 cited by Steel, & Georgia, 1987: 13). It can lead a parent to negative physical and mental health that means a low level of well-being. For most families, after the admission of the infant to the intensive care nursery communication takes place by telephone until the parents are able to visit. In both situations, whether the infant was born at a cure tertiary center or transported, the father is the first parent able to visit since the mother is usually recuperating. Experiencing multiple stress during the hospitalization of the infant can lead to enormous tension and strain on the father (Thornton, et. al., 1984: 131).

When parents go to visit their infants in NICU, sources of stress for parents are the environmental of NICU; signs and sounds of the unit, infants appearance, parental role alteration, staff communication and the greatest source of stress for the parents were the changes in parent-infant interaction that were brought about by the hospitalization, they can not take the normative parental role (Mile, et al, 1992: 261; Miles, et al., 1993: 148; Steel & Georgia, 1987: 13-18). In a qualitative study Hughes, McCollum and associates (1994, cited by Seideman, et al., 1997: 171) found that the majority of stressors pertained to the separation due to the hospitalization and to the infant's appearance, health, and course of hospitalization. Another source of stress is the perception of uncertainty and severity of their infants illness producing a higher level of stress (Miles, 1989b: 69; Miles, et al., 1992: 261; Prudhoe & Peter, 1995: 141).

The first sight of the NICU and the infant will often leave a negative feeling such as shocking, denial, guilt, distress, depression, hopelessness, powerlessness, loss, isolation, confusion, and anxiety (Pepper & Snapp, 1980 cited by Steele & Georgia, 1987: 15). According to, Harper and associates (1979 cited by Gennaro, 1988: 82) reported parents of infants in the intensive care unit had high anxiety level. Furthermore, mother feels anxious, angry and envious that she is unable to provide the protection and nurturance inherent to the maternal role (Consolvo, 1984 cited by Steel & Georgia, 1987: 15). These feeling lead to negative mental health.

In addition, these situations affect parental physical health such as parents may be irritable, have difficult concentrating, experience sleep and appetite disturbances, and have repetitive dreams of the birth and of the child (Kristensson-Hallstrom & Elander, 1997: 363; Logsdon & Davis, 1998: 196; Steele & Georgia, 1987: 15). All of these present that the hospitalization of newborn infant in NICU affect parental negative physical and mental health, poor adjustment, and reflect a low level of well-being.

Stress and low level of well-being can interrupt effective communication, learning and decrease the effectiveness of parental roles (Shellabarger & Thompson, 1993 cited by Parichart Silprasert, B.E. 2542: 1) and affect increasing maternal attachment behaviors (Mercer, 1981: 75). Parents feel deprived of parental responsibilities during the infants' hospitalization. It may interrupt the satisfaction of the usual parents-newborn interaction and bonding (Weinstock, 1986 cited by Landen, 1990: 516). Parents will show a loss of warmth in relationships with other people including the other family members (Thornton & Santo, 1984: 127). When parents have poor adjustment, they will refuse the next visit and the interaction with their infants (Grant cited by Nesson & May, 1986: 1091). Therefore, it can lead parents to leave their newborn infants in the hospital.

Evidence suggests that poor adjustment or low well-being has harmful effects on many aspects of family functions, including life satisfaction, attitudes, and interactions with the child (Cornic, et al cited by Prudhoe & Peters, 1995: 141). Seidman and associates (1997) noted parents of children in both the NICU and the PICU experience interruption of the family's normal activities and their parental responsibilities. In addition, low well-being and stress impact upon the family by

inducing separated families (Waechter, Philips & Holiday, 1985 cited by Sakul Kongpan, B.E. 2533: 1). In the case of a sick infant the discrepancy is much more obvious, resolution potentially more threatening to the integrity of the family unit (Steel, & Georgia, 1987: 13).

Patterson (1988: 210) defined a life event that occurs at a discrete point in time and produces change in the family social system as a stressor. According to McCubbin and McCubbin (1987: 5) defined stressor as a life event, or transition (e.g., death, purchase of a home, parenthood, etc.) impacting upon or with in the family unit, or has the potential of producing, a change in the family social system. This change may be in various areas of family life, such as the health status of one of its member. In addition Reeder and associates (1997: 48) presented family stress created by acute illness of various family members at any time during the life cycle. Consequently, the hospitalization of newborn infants in NICU are a stressful life event that impacts on family members physical and mental health or family members well-being. The important family members that are affected by this event are the parents.

The reviewed literature related to parents of critically ill child presented the level of parental well-being as rather low. Such as, the study of Vimonwan Vrolarn (B.E. 2535: 48-49) which studied parents with 1-15 year old children admitted in Intensive Care Unit. Additionally, Sakul Kongpan (B.E. 2533) studied mothers of hospitalized children because this sample group has a high need. They want their children recovering from illness while in fact, their children's illness are still severe. When their child does not get better, so they feel so sad. What is revealed about parents with newborn infants hospitalized in NICU is that this feeling and bonding is not present.

Therefore, the study of parents of newborn infants hospitalized in NICU are important to study, because the infant's illness has a critical effect on parental well-being.

The assessment of well-being can be measured both objectively and subjectively (Nugate, B., 1998: 28; McCubbin and Patterson, 1982 cited by McCubbin, Thompson, & McCubbin, 1996: 753) as described below:

1. Objective well-being is assessed by using tangible information that can be seen or measured such as the physical condition, the event's characteristic, or a person's behavior determined by other persons or self from the factual data.

2. Subjective well-being is an assessment of perceived or sense of mind of a person on the experience that is assessed by self from meaning or experience of each individual or measuring personal concern about their physical and mental health.

The instruments for measuring personal well-being are described as follow:

1. The degree of family member well-being as measured by Family Member Well-being (FMWB) Index was developed by Hamilton McCubbin and Joan Patterson (1982). FMWB measure the degree to which a family member is adjusting in terms of concern about health, tension, energy, cheerfulness, fear, anger, sadness and general concern. The Family Member Well-being Index was developed by generating items related to the family member's overall emotional, social, interaction and physical well-being. FMWB is an 8-item instrument which uses a 11-point Likert-type scale ranging from Not to Very on each of the items (McCubbin, Thomson, & McCubbin, 1996: 753). High scores of well-being represent a parent with higher well-being.

2. Dupuy (1977) constructed the General Well-being Schedule (GWB) for offering a brief but broad ranging indicator for subjective feeling of psychological well-being and distress for use in community survey. The GWB assesses how the individual feels about his "inner personal state" rather than about external condition such as income, work environment, or neighborhood. The scale reflects both positive and negative feelings: six dimensions cover anxiety, depression, general health, positive well-being, self control and vitality. It contains 18 items. Its internal reliability in Fazio's study were .91 for males and .95 for females (Monk, 1981 cited by McDewell & Newell, 1996: 207). In Thailand, Somchit Hanucharunkul translated the instrument into Thai and tested reliability with nurses. The reliability was .92 and test with nurse instructor coefficient was .91.

Consequently, the researcher chose Family Member Well-being (FMWB) Index to measure parental well-being because FMWB Index was designed to measure family members adjustment in terms that related to family's over all emotional, social, interaction and physical well-being. And it is more appropriate with the conceptual framework of this research.

Coping Strategies

Patterson (1988: 218) defined coping as a specific effort by which an individual (or a group of individuals such as the family) attempts to reduce or manage a demand. Specific coping behaviors are grouped into patterns or strategies, such as coping directed at “maintaining family integration and cooperation”.

McCubbin and McCubbin (1996: 20) defined coping as the family’s active or passive strategies, patterns, and behaviors designed to maintain or strengthen the family as a whole, maintain the emotional stability and well-being of its members, obtain or use family and community resources to manage the situation, and initiate efforts to resolve family hardships created by a stressor.

A stressor is defined as a life event, or transition (e.g., death, purchase of a home, parenthood, etc.) impacting upon or with in the family unit, or has the potential of producing, a change in the family social system. This change may be in various areas of family life, such as the health status of one of its member, its boundaries, goals, patterns of interaction, or values. The severity of the stressor or transition is determined by the degree to which the event or transition threatens or disrupts the family’s stability, or places demands on the family’s resources or capabilities, the result of which could also threaten the family’ stability. In addition, Danielson and associates (1993: 414) defined parental coping as thinking and behavior of parents for maintaining emotional stability and well-being as parents.

Most of the research on family stress is actually studies of family stress and coping. Several studies (Boukydis, et al., 1987; Frey, Greenberg, & Fewell, 1989; Gowen, Johnson-Martin, Goldman, & Applebaum, 1989) have looked at the different coping mechanisms of parents of preterm infants used to manage their stress (Prudhoe & Peters, 1995: 141).

The research of parents of newborn infants hospitalized in Neonatal Intensive Care Unit defined coping as individuals as followed: Prachayawadee Yamanantakul (B.E. 2539: 52) studied the relationship between stress level, coping behavior and related factors of mothers of premature baby admitted to Neonatal Intensive Care Unit by using the Jalowiec Coping Scale (JCS). She reported that the subjects used both problem focused coping method and emotional focus coping methods. They used problem focused coping method more than emotional focus coping methods.

According to the study of Seidman and associates (1997) using the same instrument presented that parents used problem focused coping more than emotional focused coping. In another survey, Parichart Silprasert, (B.E. 2542: 62) reported that parents use emotional focused coping more than problem focused coping. So, the study of parents of Newborn infants hospitalized in NICU showed that parents used both coping strategies for reducing stress. In addition, The study of this population will have to seek a conclusion as to which coping is more effective and help parents face problem with a high level of well-being.

Steele and Georgia (1987) reported during the course of infant's hospitalization, parents generally deal with the four phase; these phases constitute the entire adaptive process of parents. The adaptive process of parents in NICU has been described in a variety of ways including initial crisis reactions and roles, utilization of various coping mechanism and support system, and attempts to adjust to intense internal affective states and to environmental/situational stressors. The phases are: giving in, letting go, hanging on, and taking hold.

Phase I: giving in; The "giving in" phase encompasses the labor, delivery, and immediate postpartum period. It's within 3 days of postpartum.

Phase II: letting go; The "letting go" phase includes the critical period of time when the infant's survival is most tenuous. It's about 10 days after the giving in phase. During this period parents begin to experience intense grief surrounding the loss of their idealized infant and the actual reality that they may lose their infant. They must temporarily let go of their expected parenting role and allow others to take over the majority of care taking functions for their infant. As a result of this and of the enforced separation from the infant, parent often feel displaced by the hospital and staff.

Phase III: hanging on; The "hanging on" phase is often the most frustrating for parents. It is the period of time, often weeks or months in duration, when the child is still seriously ill and progress appears slow or nonexistent. Parents become depressed and frustrated with the "Two steps forward, one step backward" pattern which many prematurely born infants manifest. Anxiety may become chronic during this time. Parents have a sense of interminable waiting and hanging on.

Phase IV: taking hold; This final phase includes the recovery and discharge of the infants.

When examining the research of parents of newborn infants hospitalized in NICU represent parents the family members coping, there is not a lot of research present. There is more research related to parents of child hospitalized in PICU at present as follow:

The research related to coping of family of critically ill children in PICU reported the family utilized a variety of coping mechanisms, the parent's perceptions of their family's coping strategies, as measured by F-COPES, were used significantly more frequently such as mobilizing of family to acquire and accept help, passive appraisal, and acquiring social support (Philichi, 1989 : 273). Parents perceptions of their family's coping abilities were higher than the norm, possibly because the admission to the PICU is a crisis situation (Philichi, 1989 cited by Seideman, et al., 1997: 171). LaMontagne and Pawlak (1990: 416-421) studied stress and coping of parents of children in intensive care unit. The study represented parental stress and coping as individual and presented all parents using a combination of both problem and emotional focused form of coping. Seeking social support and positive reappraisal were the two most often strategies used by all parents regardless of the classification of stressors.

In Thailand, The research related to parental stress and coping with critically ill children are presented such as, the study by Pornsiri Chaisom (B.E. 2536) studying stress and coping strategies of parents of children hospitalized in Pediatric Intensive Care Units. Data was collected through questionnaires, F-COPES (McCubbin, Olsan & Larsen, 1981). The questionnaire consists of 8 coping strategies. The result of the study indicated that the reframing family problem-solving was the most frequently used strategy and the least frequently used strategy was the neighbor resource. This is conformed with the study by Sakul Kongpan (B.E. 2533) who studied the relationship among coping strategies and general well-being in mothers of hospitalized children. Data was collected through questionnaires, F-COPES (McCubbin, Olson & Larsen, 1981). The result showed that the most frequently coping strategy mothers used was reframing family problem, and the least was neighbors resource. Vimonwan Vrolarn's (B.E. 2535) study of parental coping strategies as individuals in parents of children admitted in Intensive Care Unit and used Jalowiec Coping Scale (JCS) for assessing

coping. She reported that a total coping score for parents was at a low level. And they used emotional focus coping more than problem focused coping.

When reviewing the research related to perception of helpful coping strategies, in the study by Seideman and associates (1997) they studied parent stress and coping in NICU and PICU showing parents in both units considered problem- focused coping more helpful than appraisal or emotional-focused coping.

Lazarus and Folkman (1984: 141) defined coping as constantly changing cognitive and behavioral efforts to manage specific external and/ or internal demands that are appraised as taxing or exceeding the resources of the person. Coping was referred by the former as problem-focused coping and emotion-focused coping (Lazarus & Folkman, 1984: 151-153).

The instrument for assessing coping was the Jalowiec Coping Scale : the JCS that was developed in 1979 contained with 40 items. In 1988 Jalowiec revised the instrument to 36 items. Each items is scored on a 5-point Likert-type scale. It consisted of coping subscales such as confrontive coping, emotive coping, and palliative coping (Lazarus & Launier, 1978 cited by Jalowiec & Power, 1981: 11).

McCubbin, McCubbin, Nevin, and Cauble (1981 cited by McCubbin & McCubbin, 1996: 409) divided coping into three strategies or patterns as follows:

1. Family Integration, Cooperation An Optimistic Definition of the Situation, defined as strengthening family life and relationships, and the parents outlook on life with chronically ill child.

2. Maintaining Social Support, Self Esteem and Physiological Stability, defined as parents' efforts to develop relationships with others, engage in activities which enhance feeling of individual identity and self worth, plus behaviors to manage physiological tensions and pressure.

3. Understanding the Health Care Situation Though Communication with Health Care Team, defined as Parental relationships with health care professionals and other parents of chronically ill children. These behaviors include developing more knowledge and understanding of the illness, and mastering any home care treatments and prescribed medical regimens.

The instrument for measuring these coping strategies as a study of family member is Coping Health Inventory for Parents (CHIP). Coping Health Inventory for

Parents (McCubbin, McCubbin, Nevin & Cauble, 1979 Cited by McCubbin & McCubbin, 1996: 175-176) was designed to assess parents' perceptions of behaviors they are currently using to manage family life when they have a seriously or chronically ill child. CHIP is a self report instrument consisting of a checklist of forty-five specific behaviors. Parents are asked to record how helpful (on a scale of 0 to 3) each behavior is in their particular family situation. If the situation is not used, the respondent records why by either checking a) "I do not cope this way because I/we chose not to use it" or b) "coping behavior not possible in our family, not applicable to us"

McCubbin, Olson and Larsen (1981 cited by McCubbin & McCubbin, 1996: 453) divided coping into five strategies as follows:

1. Acquiring social support is defined as a family's ability to actively engage in acquiring support from relatives, friends, neighbors and extended family.
2. Reframing is defined as the family's capability to redefine stressful events in order to make them more manageable.
3. Seeking spiritual support is defined as the family's ability to acquire spiritual support.
4. Mobilizing family to acquire and accept help is defined as the family's ability to seek out community resources and accept help from others.
5. Passive appraisal is defined as the family's ability to accept problematic issues minimizing reactivity.

The instrument for measuring these coping strategies as the study of family member is Family Crisis Oriented Personal Evaluation Scales (F-COPES). F-COPES was created to identify problem-solving and behavior strategies utilized by families in difficult or problematic situations (McCubbin, Olson & Larsen, 1981 cited by McCubbin & McCubbin, 1996: 453). The instrument features 30 coping behavior items, rating items on a five-point Likert-type scale indicating the extent to which they agreed or disagreed with statements describing attitude and behavior in response to problems or difficulties. F-COPES was used in different population such as, Philichi (1989) used F-COPES for assessing problem-solving and behavioral strategies that aid

family adaptation during a pediatric intensive care hospitalization. Reider (1994) used F-COPES for assessing coping strategies of family members of adult critically ill patients. Dougherty (1995) used F-COPES for assessing families of sudden cardiac arrest patient. Stephenson (1999) used F-COPES for assessing coping that identifies problem solving and strategies used by family with healthy and technology-assisted infants in the home. Rungreangkulkij, S. (2000) used F-COPES for assessing problem-solving and behavioral strategies of Thai families with a person with schizophrenia.

In Thailand, Sakul Kongpan (B.E. 2533) translated this instrument for assessing coping strategies in mothers of hospitalized children. Rating items on 5-point Likert-type scale indicate the extent to which they strongly disagree or strongly agree of the statement describing attitude and behavior in response to problems or difficulties. After that Pornsiri Chaisom (B.E. 2536) modified the instrument of Sakul Kongpan to assess coping strategies of parents of children age 1 month to 15 years hospitalized in Pediatric Intensive Care Unit. She combined 2 items in seeking spiritual support subscale or strategy to be one item. Thus, total 29 coping behavior items, consist of 8 subscales including: 1) confidence in family problem solving 4 items, 2) reframing family problem 4 items, 3) family passivity 4 items, 4) church/religious resource 3 items, 5) extended family 4 items, 6) friends 4 items, 7) neighbors 3 items, and 8) community resource 3 items. Rating item on a 5-point Likert-type scales indicated the extent to which they never or always use that coping behavior. In this study the researcher choose F-COPES for assessing parental coping strategies.

Acquiring social support

McCubbin, Olson and Larsen (1981 cited by McCubbin & McCubbin, 1996: 453) defined acquiring social support as a family's ability to actively engage in acquiring support from relatives, friends, neighbors and extended family.

Cohen and Willis (1985: 310-357) stated social support is an important factor having an effect on health both direct and indirect and on an individual's safety. They suggested 2 roles of social support as follows: 1). Support as a main effect. Large social support networks provide person with regular positive experiences and a set of stable, socially rewarded roles in the community and cognitive self-worth. This kind of

support could be related to overall well-being, because it provides a positive effect. 2). Support as a stress buffer. Social support plays a vital role in solving a problem since the realization of a problem takes a great effect on the hormone system. In addition, social support can help a person have a better understanding in an incident and urge a person to encounter a problem both in therapy and recovery in severe cases.

Tilden (1985: 199) defined social support as psychological, material helping which one receives from one's social network.

Brown (1986: 4-9) defined social support as interaction between one another consisting of a variety of dimensions. Social support has the potential to decrease demand, which causes stress. It could protect one from disease and maintain good health.

Andrew and Roy (1991: 17) stated that support would be a great benefit in helping mothers to acquire their maternal role.

Therefore, acquiring social support means family ability to acquire and accept help and support from relatives, friends, neighbors.

When reviewing research related to acquiring social support, it was found as follows: Miles, Carlson, and Funk's (1996: 45) study of sources of support reported by mothers and fathers of infants hospitalized in a Neonatal Intensive Care Units, presented that fathers and mothers experienced a moderately high level of support. Philichi's (1989: 273) study in coping of family of critically ill child in PICU reported the family utilized a variety of coping mechanisms, the parent's perceptions of their family's coping strategies, as measured by F-COPES, acquiring social support was used significantly more frequently. According to the study of family members of patients on active list for cardiac transplantation (Nolan, et, al., 1992 cited by McCubbin & McCubbin, 1996: 485) it was reported that a higher number of family members relied on acquiring social support. In addition, Sakul Kongpan (B.E. 2533: 22) studied the relationship among coping strategies and general well-being in mother of hospitalized children. The result presented mother frequently used extended family resource. The reasons for parents in this study using acquired social support in high level was parents could engage in acquiring support from relatives, friends, neighbors and extended family (Friedman, 1981 cited by Sakul Kongpan, B.E. 2533: 29) that seem to get help from many resources. According to Cronenwett (1985:45) presented

social support into emotional, comparison, information, and material support that helps a person to solve the problem. So their relatives, friends, neighbors and extended family can support parents in many dimensions of support. According to, Roth (1989, cited by Pornsiri Chaisom, B.E. 2536: 97) stated neighbors are one important resource that families can engage. According to the study of McHaffie (1992, cited by Pornsiri Chaisom, B.E. 2536: 97) on social support parents of NICU, it was found that parents seeked mental support from their grandparents. Because they are close with their grandparents and their grandparents can help them in many activities such as visiting their infants at the hospital, helping housework etc. Parents perceive that the most useful activity that grandparent support them in is to help them to understand the situation.

Consequently, acquiring social support is an important factor having an effect on health both direct and indirect and on an individual's safety. In addition, it is a social factor long accepted for having influence on people's physical and mental health behaviors. Therefore, acquiring social support coping strategy was used to a high level.

Reframing

McCubbin, Olson and Larsen (1981 cited by McCubbin & McCubbin, 1996: 453) defined reframing as the family's capability to redefine stressful events in order to make them more manageable.

Lazarus and Folkman (1984: 53) defined reframing as reappraisal. They defined reappraisal as a changed appraisal based on new information from the environment and/ or the person. The reappraisal differs from an appraisal only in that it follows an earlier appraisal. Some time reappraisal are the result of cognitive coping efforts; distinguished from an appraisal based on new information.

When reviewing literature related to reframing, it was found as follows: Nolan and associates (1992: 544) study of family members of patients on active list for cardiac transplantation reported that family member used reframing to a high level. According to the study of mother of hospitalized child (Sakul Kongpan, B.E. 2533: 60) represented mothers used reframing family problem to a high level and reframing was most frequently used. According to the study by Friedman (1981 cited by Sakul

Kongpan, B.E. 2533: 29) reported coping behaviors contain internal and external personal resource, internal personal resource are self-reliance, acceptance the problem and problem solving. Therefore, when parents are faced with these problematic situations, they will use internal personal resource such as capability, self-reliance, self-esteem for managing these situations by solving the problem, learning and understanding the situation. Consequently, when a person is faced with a problematic situation, they will use their internal personal resource such as capability, self-reliance, self-esteem for managing the situation, that means they used a reframing coping strategy for managing problematic situations, to a high level.

Seeking spiritual support

McCubbin, Olson and Larsen (1981 cited by McCubbin & McCubbin, 1996: 453) defined seeking spiritual support as the family's ability to acquire spiritual support.

Burkhardt and Jacobson (2000: 91) defined spirituality as the essence of our being, which permeates our living and infuses our unfolding awareness of who and what we are, our purpose in being, and our inner resources; and shapes our life journey.

Soeken and Carson (1987: 603) defined spirituality as, a belief that relates a person to the world, giving meaning to existence.

Ellerhorst-Ryan (1985: 93) defined spirituality as, the central philosophy of life which guides peoples conduct.

Bugental (1984: 49) defined spirituality as, a force that impels humans forward into living a personal quest to find meaning and purpose in life.

Harrison and Burnard (1993: 33) stated the concept of spirituality appears to be an important aspect of nursing practice. According to Burkhardt and Jacobson (2000: 101) stated care of the spirit is a professional nursing responsibility and an intrinsic part of holistic nursing. Therefore, spirituality is an important dimension that nurses can help a person seek.

Therefore, spirituality was a belief that relates a person to the world, a force that impels humans forward into living a personal quest to find meaning and purpose in life

When reviewing literature related to seeking spiritual support, it was found as follows: Rungreangkulkij, S. (2000: 72) studied the experience of Thai families of a person with schizophrenia: family stress and adaptation by using F-COPES instrument, the subjects in this study were Buddhist and lived in rural and suburban Thailand where traditional treatments provided by Buddhist monks, fortunetellers, and the shamans were widely used. These Thai families seemed to use spiritual support more than other coping strategies (Ratanatikanon, Assanangkornchai, and Tanchaiswad, 1997; Rujirapipat, et al., 1992; Visutthikoson, et al. 1980 cited by Rungreangkulkij, S., 2000: 72). Buppha Chobchai (B.E. 2536: 43) studied the spiritual needs of aging patients with cancer, the results presented religion as a meaningful factor. Its purpose, optimal goal of life, and a source of hope and strength. Sakul Kongpan (B.E. 2533: 22) studied the relationship among coping strategies and general well-being to mothers of hospitalized children. The results showed mothers used church/ religious resources in rather high level. On the contrary, the study of family members of patients on active list for cardiac transplantation (Nolan, et al., 1992 cited by McCubbin & McCubbin, 1996: 485) reported that family member use of seeking spiritual support was much lower.

Consequently, seeking spiritual support is an important coping strategy that a person can use for maintaining a central philosophy of life which guides people's conduct. Furthermore, when a person is faced with a problematic situation, they will use seeking spiritual support coping strategies to a high level.

Mobilizing family to acquire and accept help

McCubbin, Olson and Larsen (1981 cited by McCubbin & McCubbin, 1996: 453) defined mobilizing family to acquire and accept help as the family's ability to seek out community resources and accept help from others (community resources such as professional, community agencies, and family doctor, and others such as person in other families)

When reviewing research related to mobilizing families to acquire and accept help, it was found as follows: Miles, Carlson, and Funk (1996: 45) studied sources of support reported by mothers and fathers of infants hospitalized in a Neonatal Intensive Care Unit, presented that fathers and mothers experienced a moderately high level of

perceived support from NICU nurses being very helpful. Nolan and associates (1992 cited by McCubbin & McCubbin, 1996: 485) study of family members of patients on active list for cardiac transplantation. The result presented that family member used mobilizing family to acquire and accept help at a high level.

Consequently, acquiring and accept help from the community and others, indicated mobilizing family to acquire and accept help coping strategies as a group of coping behavior that people seek help and support from community and others. In addition, when a person faces a problematic situation they used mobilizing family to acquire and accept help at a high level.

Passive appraisal

McCubbin, Olson & Larsen (1981 cited by McCubbin & McCubbin, 1996: 453) defined passive appraisal as the family's ability to accept problematic issues minimizing reactivity. When reviewing literature related to passive appraisal, it was found as follows: Nolan and associates (1992 cited by McCubbin & McCubbin, 1996: 485) study of family members of patients on active list for cardiac transplantation. The result showed that family member used passive appraisal at a low level. Similarly with the study of Sakul Kongpan (B.E. 2533: 22) mothers of hospitalized children sometimes used family passivity.

Summary

Consequently, in this study the researcher choose F-COPES to measure coping strategies that parent used to manage stressful situations such as the hospitalization of their newborn infants in NICU. Because the situation acutely affect parental role alteration, parents can not care for their infants as usual, it affects their parental role to other family members. In addition, parents in this research setting, the researcher experience with parents of Thai culture, who are likely to use spiritual support for manage this situation. And this instrument presented these coping strategies (seeking spiritual support) clearer than the other ones. In addition, the items for asking parents in this instrument are more appropriate for parents in NICU than CHIP and JCS.

Relationship between Coping Strategies and Well-being

Patterson (1988: 209) explained capabilities as resources and coping that is used to meet demands (stressor and strains). The outcome of the family's efforts to achieving balanced functioning is conceptualized in terms of family adjustment, ranging on a continuum from good to poor. Good adjustment reflected in positive physical and mental health of individual members, presented in family members well-being. (1988: 227-228). Relationship between coping strategies and well-being are presented as follows:

Coping total scores

The research related to parents in Pediatric Intensive Care Unit (Vimonwan Vrolarn, B.E. 2535: 41) and the study of mothers of hospitalized children (Sakul Kongpan, B.E. 2533: 23) presented total coping scores was not correlated with well-being. On the other hands, coping strategies or coping subscales were correlated with well-being as follow: Vimonwan Vrolarn (B.E. 2535: 53) presented emotional-focused coping in a significantly negative correlation with general well-being. Sakul Kongpan (1990: 34) presented that coping strategies such as friend resource were the predictor of mothers general well-being. In addition, the study in mothers of children with acute lymphoblastic leukemia presented a coping pattern of family integration and an optimistic definition of the situation that was positively correlated with perceive total family well-being (Bunga Phuchacram, B.E. 2533: 57). Therefore, in the previous research presented parental total scores of coping were not correlated with well-being. While, the subscale scores of coping were negatively correlated with well-being.

Acquiring social support

Literature reviewed of the relationship between acquiring social support and well-being are presented as follows: Cohen and Wills (1985: 310-357) viewed social support as "main effect" and "stress buffer". Main effect was a term of providing service or information regarding the benefits of behavior that positively influence health and well-being. In addition, many researchers (Cobb, 1976: 300-314; Thoits, 1986: 416-423; Robert, 1988: 1-11) suggested that social support could protect people in crisis from a variety of pathological states. Social support contributed to health by

creating a growth-promoting environment that enhances self-esteem and well-being. Loss of support could lead to negative effects on the person's well-being. According to Ziegel and Cranley (1984: 467) noted that the literature on child abuse strongly supported the proposal that mothers without support from significant others were at risk of maladaptive parenting. According to the study of Vipamaneeroj, T. (2002: 8) parents of chronically ill child who received both role preparation of spouse support and conventional care had well-being scored higher than those who received only conventional care. It seems to conclude that spouse support affected parental well-being. Thus, social support had a positive correlation with parenting adjustment and adaptation, or parental well-being. To the contrary, Sakul Kongpan (B.E. 2533: 33) presented that coping strategies such as friend resources had negatively correlation with general well-being. She explained that mothers who had low well-being will use or rely on friend resources more. According to Ventura (1982: 272) mothers of 2-3 months infants tried to acquire social support more. Consequently, acquiring social support is an important factor having an effect on health both directly and indirectly and on an individual's safety. In addition, it is as a social factor long accepted for having an influence on people's physical and mental health behaviors. Therefore, it seems to affect personal well-being.

Reframing

Literature reviewed on relationship between reframing and well-being is presented as follows. Sakul Kongpan (B.E. 2533: 27) studied the relationship between coping strategies and general well-being of mothers of hospitalized children. The study found that reframing family problems was not correlated with well-being. There was no study between both variables in other research. Therefore, it is crucial to examine the relationship between these variables in this study.

Seeking spiritual support

Literature reviewed on relationship between seeking spiritual support and well-being are presented as follows. Seeking spiritual support is the coping strategy that a person will use to try to maintain their spirit when they are faced with a stressful event. Sakul Kongpan (B.E. 2533: 27) studying the relationship between coping

strategies and general well-being in mothers of hospitalized child, found that church/religious resource had a negative correlation with general well-being. She explained that mothers who had low well-being will use or rely on church/religious higher. On the contrary, Rungreangkulkij S. (2000:105) study found that there was a positive significant relationship between individual psychological morbidity and seeking spiritual support for both mothers and relatives of a person with schizophrenia. Therefore, when parental well-being was low, they will seek spiritual support on a high level. So that it can help them maintain their well-being. Consequently, the research shows that there is a correlation between parental coping strategies and well-being. However, there are not enough studies on parents whose newborn infants are hospitalized in the NICU. That is the critical area, so we have to examine this before the conclusion is made.

Mobilizing family to acquire and accept help

Literature reviewed on the relationship between mobilizing family to acquire and accept help and well-being is presented as follows. Sakul Kongpan (B.E. 2533: 27) studied the relationship between coping strategies and general well-being of mother of hospitalized children. The study found that community resource (that is the resources of mobilizing family to acquire and accept help) was negatively correlated with well-being at a low level. She explained mothers who had low well-being will use or rely on mobilizing family to acquire and accept help to a higher level.

Passive appraisal

Literature reviewed on the relationship between passive appraisal and well-being are presented as follows. Sakul Kongpan (B.E. 2533: 27) studied the relationship between coping strategies and general well-being of mothers of hospitalized children. The study found that family passivity was positively correlated with well-being at a low level. She explained that these coping strategies were problem-focused coping that would lead mothers to have high well-being. According to Moos and Billings (cited by Sakul Kongpan, B.E. 2533: 33) the person who used passivity coping will succeed in coping with problems more than the person who avoided the problem.

From the review of literature and related studies, it was found that the hospitalization of newborn infants in NICU is a stressful event for parents. After the first visit parents presented high level of stress and showed negative physical and mental health. The negative physical and mental health means a low level of well-being or poor adjustment. Therefore, it seem to conclude that after the first visit parental well-being was low, indicated in poor adjustment. Helping parents to use effective coping strategies with the stressful event is important for their adjustment.

The literature review concerning coping of parents whose newborn infants hospitalized in NICU reflected that parents used both strategies, problem-focused coping and emotional-focused coping for reducing stress and maintaining their well-being but did not specify what coping strategies had the highest affect on parental well-being. While the studies of parents of hospitalized children and parents whose children were hospitalized in PICU presented a total coping score that was not correlated with well-being. In other words, the score of each coping strategy such as family passivity, religious, friend , and community resource were correlated with well-being. In addition, friend resource was the predictor of mothers general well-being. Therefore, coping strategies are correlated with parental well-being or parental adjustment.

However, because of no present research related to the relationship among coping and well-being of parents of newborn infants hospitalized in NICU. Research in parents whose newborn infants hospitalized in NICU is very important to study.

CHAPTER III

METHODOLOGY

This study was a descriptive research. The purposes of this study were two fold 1) to describe coping strategies and well-being of parents whose newborn infants were hospitalized in the NICU, and 2) to examine the relationship between parental coping strategies and well-being of parents whose newborn infants were hospitalized in the NICU. The research design, population and sampling, instrumentation, data collection procedure, and data analysis are presented in this chapter.

Population and Sampling

The target population of this study was parents of newborn infants hospitalized in NICU.

Samples were selected by purposive sampling.

Inclusion criteria

1. Fathers and mothers whose newborn infants were admitted to the NICU for the first time. (Parents were not only the same of parents of the newborn but also fathers or mothers of each newborn case)
2. The first visit were no longer than 7 days after their newborn infants were admitted to NICU. (The researcher anticipated that stress would increase in the first week of admission so level of parental stress and anxieties are high. Then the stress would decrease in the week after.)
3. Fathers and mothers were able to answer the questionnaire within 3-7 days after the first visit (So parents would use more coping strategies.
4. Mothers were not admitted to the hospital while they were answering the questionnaire.
5. Fathers and mothers were able to understand and communicate in Thai.
6. Fathers and mothers agreed to participate in this study.

Sample Size

The sample size justification was calculated by the formula of single-sample hypothesis testing as follow: (Lemeshow, et al., 1992: 38)

$$n = \frac{\sigma^2 [Z_{1-\alpha/2} + Z_{1-\beta}]^2}{[\mu_0 - \mu_a]^2}$$

σ^2 represent the highest variance of caring needs from the pilot study of 30 subjects = 225.447

$Z_{1-\alpha/2}$ represent the number of standard errors from the mean at $1 - \alpha/2 = 1.96$

$Z_{1-\beta}$ represent the number of standard errors from the mean at $1 - \beta = 0.842$

α represent type I error = 0.05

β represent type II error = 0.2 (Cohen (1987) suggests that for the behavioral scientist, a power ($1 - \beta$) of 0.80 is reasonable, given no other bias for selecting the desired level.)

μ_0 represent the actual μ in the sample

μ_a represent the actual μ in the population

$\mu_0 - \mu_a$ represent the error allowed for estimation the differentiate of the mean of μ_0 and $\mu_a = 5$

The result from calculation was shown as follows:

$$\begin{aligned} n &= \frac{(225.447) (1.96 + 0.842)^2}{5^2} \\ &= 70.80 \end{aligned}$$

Consequently, the sample size of this study was at least 70. However, in practice the number of subjects should be approximately 80, which were recruited between August, 2002 to January, 2003.

Setting

The researcher collected data at Neonatal Intensive Care Unit (NICU) in seven hospitals in North Eastern Region of Thailand. (Srinagarind Hospital, Khon Kaen Hospital, Udonthani Hospital, Maharat Nakhonratchasima Hospital, Buriram Hospital, Surin Hospital, and Sapprasit Hospital)

The characteristics of seven settings are the tertiary care hospitals that consists of 7-24 beds for admission of newborn infants. These seven hospitals did not allow mothers and infants to remain together 24 hours a day (rooming-in). However, parents can visit their newborn infants any time during the day at the first visit. In the next visit, they have to visit their infants at a usual time scheduled by the ward. The number of beds, visiting time, and statistics of admission of each setting are as follows:

Srinagarind Hospital consists of 7 beds for admission of newborn infants. Parents can visit their newborn infants at 11.00–13.00 pm and 18.00–20.00 pm. The statistics showed that there were approximately 16 – 18 new cases / month of newborn infants admitted to NICU of Srinagarind Hospital. Parents who met the inclusion criteria were approximately 3-5 cases/month.

Khon Kaen Hospital consists of 8 beds for admission of newborn infants. Parents can visit their newborn infants at 6.00-8.00 am, 12.00-13.00 pm and 18.00-20.00 pm. The statistics showed that there were approximately 24 – 26 new cases / month of newborn infants admitted to NICU of Khon Kaen Hospital. Parents who met the inclusion criteria were approximately 5-8 cases/month.

Udon thani Hospital consists of 8 beds for admission of newborn infants. Parents can visit their newborn infants at 6.00-8.00 am, 12.00-13.00 pm and 18.00-20.00 pm. The statistics showed that there were approximately 25 – 27 new cases / month of newborn infants admitted to NICU of Udon thani Hospital. Parents who met the inclusion criteria were approximately 5-8 cases/month.

Maharat Nakonratchasima Hospital consists of 12 beds for admission of newborn infants. Parents can visit their newborn infants at 11.00 am -18.00 pm. The statistics showed that there were approximately 24–26 new cases / month of newborn infants admitted to NICU of Maharat Nakonratchasima Hospital. Parents who met the inclusion criteria were approximately 5-8 cases/month.

Buriram Hospital consists of 8 beds for admission of newborn infants. Parents can visit their newborn infants any time during the day. The statistics showed that there were approximately 20-22 new cases / month of newborn infants admitted to NICU of Buriram Hospital. Parents who met the inclusion criteria were approximately 5-8 cases/month.

Surin Hospital consists of 8 beds for admission of newborn infants. Parents can visit their newborn infants 10-12 am. The statistics showed that there were approximately 41-43 new cases / month. month of newborn infants admitted to NICU of Surin Hospital. Parents who met the inclusion criteria were approximately 10-12 cases/month.

Sapprasit Hospital consists of 24 beds for admission of newborn infants. Parents can visit their newborn infants at 6.00-7.00 am, 12.00 am -13.00 pm. , and 18.00-19.00 pm. The statistics showed that there were approximately 54-56 new cases / month of newborn infants admitted to at NICU of Sapprasit Hospital. Parents who met the inclusion criteria were approximately 18-20 cases/month.

The reason of less parents in each setting met inclusion criteria because of the criteria is restricted to the visiting time, the date of answering questionnaire and the willing of parents for sending the questionnaire to the researcher. Therefore, the researcher had to collect the data by purposive sampling in many setting. Moreover, the researcher can not use stratified random sampling because of the limitation of the time frame in collecting data. If the researcher used stratified random sampling the number of hospital would be 3 hospitals (select from the upper part, middle part and lower part of North Eastern Region of Thailand.). Therefore, the time for collecting data was longer than collecting in every setting of North Eastern Region of Thailand.

Instruments

The instrument of this study consisted of three parts : 1) Questionnaire for assessing characteristics of parents, 2) Family Crisis Oriented Personal Evaluation Scale (F-COPES) , and 3) Family member well-being (FMWB) Index.

1. Questionnaire for assessing characteristics of parents

The characteristics of parents included: 1) parental status, 2) age, 3) religion, 4) marital status, 5) education level, 6) occupation, 7) family incomes, 8) medical expense payment, 9) number of family member, 10) number of child, 11) perceived severity of their newborn infant's illness.

2. Family Crisis Oriented Personal Evaluation Scale (F-COPES)

Coping strategies were assessed by the Family Crisis Oriented Personal Evaluation Scale (F-COPES) which was developed by Hamilton McCubbin, David Olson, and Andrea Larsen (1981) to identify problem-solving and behavior strategies utilized by families in difficult or problematic situations. The instrument features 30 coping behavior items, rating items on a 5-point Likert-type scale indicating the extent to which they strongly agree or strongly disagree of the statement describe attitude and behavior in response to problems or difficulties.

In this research, the researcher asked permission from Professor Halminton McCubbin for translation F-COPES by e-mail. After that the researcher translated and modified F-COPES from the original instrument of McCubbin, Olson and Larsen (1981 cited by McCubbin, Thompson & McCubbin, 1996: 494-495) by using Sakul Kongpan's instrument as a guideline. For interpretation of scores, the researcher used strongly disagree or strongly agree with the statement describe attitude and behavior in response to problems or difficulties (personal discussion with Dr. Halminton McCubbin by e-mail). The researcher modified statement of F-COPES by changing each item from "we" to "I" because the researcher would like to assess parental coping as individuals. Furthermore, the researcher deleted items No. 18 "Exercising with friends to stay fit and reduce tension" in McCubbin's F-COPES because McCubbin stated that "Item No. 18 was not included in analysis due to low factors loading". The researcher modified "participate in church activities" to "pay obeisance to the sacredness" Therefore, the questionnaire for assessing coping strategies consists of 29 items of coping behaviors, which the parent scores on a 5-point Likert-type scales ranging from 1 (strongly disagree) to 5 (strongly agree).

1 means that parent strongly disagree with the statement about coping response.

2 means that parent moderately disagree with the statement statement about coping response.

3 means that parent neither agree nor disagree with the statement statement about coping response.

4 means that parent moderately agree with the statement about coping response.

5 means that parent strongly agree with the statement about coping response.

The instrument contains 5 coping subclass or strategies:

1. Acquiring social support: 9 items; 1, 2, 5, 8, 10, 16, 19, 24, 28
2. Reframing: 8 items; 3, 7, 11, 13, 15, 18, 21, 23
3. Seeking spiritual support: 4 items; 14, 22, 26, 29
4. Mobilizing family to acquire and accept help: 4 items; 4, 6, 9, 20
5. Passive appraisal: 4 items; 12*, 17*, 25*, 27*

(* These items must be reversed when scoring)

Scoring system:

A total coping strategies score is obtained by summing the number marked by the respondent for each item in the questionnaire for assessing coping strategies. However for four select items (12, 17, 25, and 27), the score must be reversed (i.e., 1=5, 2=4, 3=3, 4=2, 5=1). This will ensure that all items are weighted in the same position. Therefore, total scores are 29-145 points. The original instrument does not present cutoff point.

Subscale scores are obtained by summing the number marked by the respondent for the items in each subscale. Items of passive appraisal subscale (12, 17, 25, and 27) are reversed before summing the scores. Therefore, subscale scores ranging from 9 to 45 (Acquiring social support), 8 to 40 (Reframing), 4 to 20 (Seeking spiritual support), 4 to 20 (Mobilizing family to acquire and accept help), and 4 to 20 (Passive appraisal). The scoring is obtained by summing the number marked by respondent (i.e., 1=Strongly disagree/Never, 2=Disagree/Seldom, 3=Neither agree nor disagree/Sometimes, 4=Agree/Frequently, and 5=Strongly agree/Always) (McCubbin, Thompson, & McCubbin, 1996: 46). Therefore, the higher scores indicate that parents using diverse coping strategies and frequently used these coping strategies.

3. Family Member Well-being (FMWB) Index

Well-being was assessed by using questionnaire for assessing well-being of parents which was translated and modified from Family member well-being (FMWB) Index which was developed by Halmilton McCubbin and Joan Patterson (1982) to measure the degree to which a family member is adjusted in term of concerns about: 1) health, 2) tension, 3) energy, 4) cheerfulness, 5) fear, 6) anger, 7) sadness and 8) general concern.

In Thailand, Vipamaneeroj, T. (2002) translated Family member well-being (FMWB) Index and modified three questions of the original form including item number 1, 3, and 8 for assessing family members of chronically ill child's well-being.

In this research, the researcher uses Vipamaneeroj's instrument for assessing well-being of parents whose newborn infants were hospitalized in NICU. Parental well-being is the level of concerns regarding the physical and mental health of parents. A 11-point Likert-type scale ranges from Not to Very in each of the items, such as Not concerned to Very concerned. Both positive and negative items were used in the questionnaire, item number 3 and 4 were positive and items number 1*, 2*, 5*, 6*, 7* and 8* were negative. (* This item must be reversed when scoring) Total scores ranged from 0 to 80. Higher score indicated parents had higher well-being. This instrument does not present cutoff point.

The quality of the instrument

1. Family Crisis Oriented Personal Evaluation Scale (F-COPES)

Validity

Hamilton McCubbin, David Olson, and Andrea Larsen (1981) tested construct validity from 2,740 family members such as husbands, wives and adolescents. The subjects were obtained and randomly split into two halves, described as sample 1 and 2. In this study, factor analysis was used to further condense the number of factors to 5 such as five coping strategies as follow: 1). Acquiring social support 2). Reframing 3). Seeking spiritual support 4). Mobilizing family to acquire and accept Help, and 5). Passive appraisal.

In Thailand, Sakul Kongpan, (B.E. 2533) translated this instrument for assessing coping strategies in mothers of hospitalized children. Content validity was ensured by

the experts of pediatric nursing, psychiatric nursing, and psychological nursing. Internal validity was performed by using 10 subjects of mothers of hospitalized children. After that, Pornsiri Chaisom (B.E. 2536) modified instrument of Sakul Kongpan to assess coping strategies of parents of children age 1 month to 15 years hospitalized in Pediatric Intensive Care Unit. Ensuring content validity by three nursing educators and two pediatric nursing educators.

In this research, the researcher translated and modified F-COPES for assessing coping strategies of parents whose newborn infants hospitalized in NICU. This instrument was validated by 5 experts of nursing educators whose specialize in family nursing (Appendix A). The experts reviewed the instrument appropriateness of the language used. After that, the researcher revised the instrument in accordance with experts suggestion.

Reliability

Hamilton McCubbin, David Olson, and Andrea Larsen (1981) tested internal reliability from 2,740 family members such as husbands, wives and adolescents. Its internal reliability (Cronbach's alpha) for the total scale was .86, with each subscale range from 0.63 (Passive appraisal) to 0.83 (Acquiring social support). Test-retest reliability for the total scale was 0.81, with each subscale range from 0.61 (Reframing) to 0.95 (Seeking Spiritual Support) (McCubbin & Thompson, 1987: 196-198; McCubbin, Thompson, & McCubbin, 1996: 455-460). Reider (1994) used F-COPES for assessing coping strategies of family members of adult critically ill patients. The Cronbach's alpha for this sample was .63-.86. Dougherty (1995) used F-COPES for assessing families of sudden cardiac arrest coping. The Cronbach's alpha for this sample was 0.87. Stephenson (1999) used F-COPES for assessing of coping that identifies problem solving and strategies used by family in family with healthy and technology-assisted infants in the home. The Cronbach's alpha for this sample was 0.69 for the technology group and 0.69 for the healthy group.

In Thailand, Sakul Kongpan (B.E. 2533) translated this instrument into Thai for assessing coping strategies in mothers of hospitalized children. Its internal reliability was .91 (Cronbach's alpha). When the instrument was used in the sample (N=70) of this research, its internal reliability was 0.98 (Cronbach's alpha). After that, Pornsiri Chaisom (B.E. 2536) modified instrument of Sakul Kongpan to assess coping

strategies of parents of children age 1 month to 15 years hospitalized in Pediatric Intensive Care Unit. Its internal reliability was 0.75 (Cronbach's alpha). The reliability after using in total subjects in her research was not presented. Rungreangkulkij, S. (2000) translated F-COPES into Thai and used F-COPES for assessing problem-solving and behavioral strategies of Thai families of a person with schizophrenia. In a pilot work, the internal consistency of the total scale was 0.78, with each dimension ranging from 0.62 (Passive appraisal) to 0.85 (Mobilizing Family to Acquire and Accept Help).

In this research, the researcher tested internal reliability (Cronbach's alpha) with 30 subjects whose characteristics was the same as the sample group. Its internal reliability was .81. In each subscales were as follow: .76 (Acquire social support), .75 (Reframing), .74 (Seeking spiritual support), .77 (Mobilizing family to acquire and accept help), .72 (passive appraisal) which indicated on acceptable level (more than .70) (Lobiondo-wood, G. & Haber, J., 1994: 374). When tested with 80 subjects, its internal reliability was .78. In each subscales were as follow: .77 (Acquire social support), .78 (Reframing), .75 (Seeking spiritual support), .78 (Mobilizing family to acquire and accept help), .75 (passive appraisal) which indicated on acceptable level too (more than .70) (Lobiondo-wood, G. & Haber, J., 1994: 374).

2. Family Member Well-being (FMWB) Index

Validity

The FMWB was tested construct validity though numerous studies including studies on farm families, investment executive families, rural bank employee families and military families, including Caucasian and African military families (McCubbin & Patterson, 1982 cited by McCubbin, Thompson & McCubbin, 1996: 753-754).

In Thailand, Vipamaneeroj, T. (2002) translated Family member well-being (FMWB) Index into Thai and ensured content validity by five experts.

In this research, the researcher does not test content validity because the researcher used the instrument of Vipamaneeroj, T. (2002) without modifying anything for assessing well-being of parents whose newborn infants hospitalized in NICU.

Reliability

McCubbin and Patterson (1982 cited by McCubbin, Thompson & McCubbin, 1996: 753-754) tested internal reliability through numerous studies including studies on farm families, investment executive families, rural bank employee families and military families, including Caucasian and African military families. Its internal reliability was .85 (Cronbach's alpha).

In Thailand, Vipamaneeroj, T. (2002) tested internal reliability with 20 subjects of parents of chronically-ill children. Its reliability was 0.74 (Cronbach's alpha).

In this research, the researcher tested internal reliability (Cronbach's alpha) by using with 30 parents whose characteristics are the same as the sample group. Its internal reliability was .76 which indicated on acceptable level (more than .70) (Lobiondo-wood, G. & Haber, J., 1994: 374) and was .78 when used with 80 subjects, which indicated on acceptable level too (more than .70) (Lobiondo-wood, G. & Haber, J., 1994: 374).

Protection of Human Subjects

The subjects were informed about the purpose of the study and their right to decline or withdraw from the study any time. Their data were kept in secret. A code number was used on the questionnaires instead of their names.

Data Collection Procedure

Data collection was carried out by mail because of the difficulty of making appointments with parent to answer the questionnaire in the appropriate date (the 3rd-7th date after the first visit) at the hospital, their homes were a long distant from the hospital and most of them had economic problems.

After the researcher got the permission from the ethical committee at Khon Kaen University, a letter asking for permission was sent from the Faculty of Graduate studies, Mahidol University to the directors of 7 hospitals.

1. The researcher contacted the head nurse and staff nurses of Neonatal Intensive Care Units of each hospital to explain the purpose of the study and get cooperation to distribute questionnaire.

2. When the parents visited their newborn infants for the first time, staff nurse approached them to describe the purpose of the study, asked if they were willing to participate in this research, and distributed questionnaires.

3. Subjects took the questionnaire home and completed it within 3-7 days after the first visit. After that, they sent it to the researcher by mail.

4. The researcher checked subject's telephone number from each setting and called asking subjects to answer the questionnaire within 3-7 days after visit.

5. When the researcher got the questionnaire, she verified the appropriate date of answered questionnaire. If the complete date was not within 3-7 days after the first visit, it would be excluded (In this research 32 cases were excluded). If the subject doesn't send the questionnaire to the researcher, it means that they do not agree to participate in this study.

6. The researcher collected the complete questionnaire for data analysis.

Data Analysis

The data analysis procedures were as follows:

1. Parental characteristics were analyzed by using frequency and percentage.

2. Parental coping strategies and well-being were analyzed by using possible range, actual range, mean, standard deviation.

3. The relationships between parental coping strategies and parental well-being were analyzed by using correlation coefficients. Testing assumptions of correlation as follows: (Munro, 2001: 226)

3.1 The sample are representative of the population to which the inference will be made.

3.2 The distribution of variables was tested by one-sample Kolmogorov-Smirnov Test. The result presented that total coping score, acquiring social support, reframing, seeking social support, and well-being score are normal distribution. (Appendix E-F). However, there were some variables including mobilizing family to acquire and accept help, and passive appraisal did not have normal distribution. Thus, Pearson's product moment was used to examine

relationship between total coping score of parents whose newborn infants were hospitalized in NICU, acquiring social support, reframing, seeking social support, and well-being score. Spearman's rho was used to examine the correlation between mobilizing family to acquire and accept help, passive appraisal and well-being score.

3.3 The relationship between the variables were linear; tested by using scatter plot graph for each individual. The result presented when the two scores for each individual are graphed, they tend to form a straight line. Therefore, The relationship between independent variable and dependent variable are linear. (Appendix G)

All statistical analyses was set at the 0.05 level of significance.

CHAPTER IV

STUDY RESULTS

This descriptive study was made to explore the relationship between coping strategies and well-being of parents whose newborn infants were hospitalized in the NICU. The results of the study are presented in three parts: parental characteristics, major variables, and the results of hypothesis testing.

Characteristics of Parents

The sample consisted of 80 parents of newborn infants hospitalized in NICU. Forty subjects (50%) were fathers and forty (50%) were mothers. Parents were not only the same pair of parents but also fathers or mothers per each newborn case. Twenty-three pair of parents answered the questionnaire. Thirty-four subjects were not from the same pair of parents. There were fifty-seven cases of newborn infants. The majority (26.25%) of parents ranged in age from 31 to 35 years. All of the parents were Buddhist. Most subjects (96.2%) were married. Seventy percent of the parents had primary school education and 22.4% had high school education. More than half of the parents (55%) worked in agriculture. Seventy-one percent of the subjects had family income less than or equal to 5,000 bahts per month. The majority (73.8%) of their medical expense payment was social welfare. Fifty-three percent of the subjects were staying with relatives (extended family). Eighty-nine percent of the subjects had less than or equal to three children per family. The majority (70%) of the subjects also perceived their child's illness as severe; 25% as moderate and 5% as mild. All of this data is shown in Table 1.

Table 1: Number and Percentage of Characteristics of Parents (n = 80)

Data	n	%
Parental status		
Father	40	50.00
Mother	40	50.00

Table 1: Number and Percentage of Characteristics of Parents (n = 80) (Cont)

Data	n	%
Pair of parents		
Fathers and mothers (pairs)	23	57.50
Fathers or mothers (persons)	34	42.50
Newborn infants (Cases)	57	100.00
Age		
≤ 20 Years	5	6.25
21-25 Years	20	25.00
26-30 Years	19	23.75
31-35 Years	21	26.25
>35 Years	15	18.75
Religion		
Buddhism	80	100.00
Marital status		
Single	3	3.80
Married	77	96.20
Education level		
Primary school	56	70.00
High school	18	22.40
Bachelor's degree	3	3.80
Higher than Bachelor's degree	3	3.80
Occupation		
House worker	12	15.00
Employee	21	26.25
Commerce/Business person	2	2.50
Government official/State	1	1.25
Agriculture	44	55.00
Family income (Bahts/month)		
≤ 5,000	57	71.25
5,001-10,000	7	8.75
>10,000	2	2.50
No specification	14	17.50
Medical expense payment		
Self paid	5	6.20
Reimbursement	8	10.00
Health insurance	8	10.00
Social welfare	59	73.80
Number of family member		
Single family	27	33.80
Extended family	53	66.30
Number of children		
≤ 3	71	88.75
> 3	9	11.25

Table 1: Number and Percentage of Characteristics of Parents (n = 80) (Cont)

Data	n	%
Perceived severity of their newborn infant's illness		
Severe	56	70.00
Moderate	20	25.00
Mild	4	5.00

Coping Strategies of Parents

Table 2 depicts mean of total coping scores and the highest/lowest subscale scores for present study subjects. Total coping scores for the present study ranged from 44 to 124, with a mean score of 3.34 (SD=14.09). The highest subscale score represented by the parents was mobilizing family to acquire and accept help. The score for mobilizing family to acquire and accept help ranged from 4 to 20, with a mean score of 3.80 (SD=3.94). The lowest subscale score represented by the parents was passive appraisal. The score for passive appraisal ranged from 4 to 20, with a mean score of 2.65 (SD =4.57). Each item of coping strategies used by the study parents were presented in Table 3. (see Table 3). The highest mean score was “pay obeisance to the sacredness”. The lowest mean score was “feeling that no matter what I do to prepare, I will have difficulty handling problems”

Table 2: Possible Range, Actual Range, Mean, Standard Deviation of the Coping Strategies of Parents (n = 80)

Coping strategies	Possible Range	Actual Range	Mean	SD
1.Total F-COPES scores	29-145	44-124	3.34	14.09
2. Acquiring social support.	9-45	9-40	3.28	6.23
3. Reframing	8-40	14-38	3.39	6.29
4. Seeking spiritual support	4-20	4-20	3.62	3.42
5. Mobilizing family to acquire and accept help.	4-20	4-20	3.80	3.94
6. Passive appraisal	4-20	4-20	2.65	4.57

Table 3: Mean and Standard Deviations of Each Item of Coping Strategies Used by The Study Parents (n = 80)

Coping strategies	Mean	SD
Acquiring social support	3.28	6.23
1. Seeking advice from relatives (grandparents, etc.)	3.99	0.96
2. Sharing difficulties with relatives	3.46	1.34
3. Sharing concerns with close friends	3.43	1.06
4. Doing things with relatives (get-togethers, dinners, etc.)	3.43	0.90
5. Seeking encouragement and support from friends	3.41	1.27
6. Asking relatives how they feel about problems I face	3.33	1.13
7. Asking neighbors for favors and assistance.	3.08	1.31
8. Sharing problems with neighbors	2.78	1.20
9. Receiving gifts and favors from neighbors (e.g, food, taking in mail, etc.)	2.64	1.21
Reframing	3.39	6.29
1. Accepting that difficulties occur unexpectedly	3.95	1.32
2. Accepting stressful events as a fact of life	3.94	1.12
3. Defining the family problem in a more positive way so that we do not become too discouraged	3.94	1.04
4. Facing the problems “head – on” and trying to get solution right away	3.78	1.17
5. Showing that I am strong	3.06	1.32
6. Knowing that I have the strength within my own family to solve our problems	3.03	1.33
7. Knowing I have the power to solve major problems	2.73	1.30
8. Believing I can handle my own problems	2.69	1.41
Seeking spiritual support	3.62	3.42
1. Pay obeisance to the sacredness	4.08	0.90
2. Attending church services	3.86	1.23
3. Having faith in God	3.71	1.05
4. Seeking advice from a minister	2.83	1.30
Mobilizing family to acquire and accept help.	3.80	3.94
1. Seeking professional counseling and help for family difficulties	4.00	1.14
2. Seeking information and advice from the family doctor	3.83	1.26
3. Seeking information and advice from persons in other families who have faced the same or similar problems	3.70	1.29
4. Seeking assistance from community agencies and programs designed to help in these situation	3.66	1.40

Table 3: Mean and Standard Deviations of Each Item of Coping Strategies Used by The Study Parents (n = 80) (Cont)

Coping strategies	Mean	SD
Passive appraisal	2.65	4.57
1. Knowing luck plays a big part in how well we are able to solve family problems	3.05	1.65
2. Watching television	2.73	1.73
3. Believing if I wait long enough, the problem will go away	2.49	1.26
4. Feeling that no matter what I do to prepare, I will have difficulty handling problems	2.35	1.38

Well-being of Parents

The parents in this study scored rather low on parental well-being when compared to a mean score with the 11-rating scale of 0 to 10. The score of parental well-being ranged from 0 to 63, with a mean score of 4.69 (SD=14.31) from the full score of 80. All of this data is shown in Table 4. Each item of well-being of study parents were presented in table 5 (see Table 5). The highest mean score was “How much energy, pep, vitality have you felt?” with a mean score of 7.38 (SD=2.64). The lowest mean score was “How depress or cheerful have you been?” with a mean score of 3.31 (SD=2.33).

Table 4: Possible Range, Actual Range, Mean, and Standard Deviations for Family Member Well-being Index for Parents (n= 80)

Data	Possible Range	Actual Range	Mean	SD
Parental well – being	0-80	0-63	4.69	14.31

Table 5: Mean and Standard Deviations of Each Item of Well-being of Study Parents (n=80)

Items	Mean	SD
1. How concern or worried about your health have you been?	3.68	3.07
2. How relaxed or tense have you been?	4.40	2.79
3. How much energy, pep, vitality have you felt?	7.38	2.64
4. How depress or cheerful have you been?	3.31	2.33
5. How afraid have you been?	3.76	2.79
6. How angry have you been	5.50	3.05
7. How sad have you been?	4.11	3.17
8. How concern or worried about the health or another family member have you been?	4.39	2.84

Hypothesis Testing

Hypothesis: Coping total scores and subscales scores of acquiring social support, reframing, seeking spiritual support, mobilizing family to acquire and accept help, and passive appraisal are correlated with well-being of parents whose newborn infants were hospitalized in the NICU.

The result of correlation testing revealed that total score of coping was significantly negatively correlated with well-being of parents ($r = -.26$, $p < .05$). When considering subscales of coping strategies, it was revealed that acquiring social support was significantly negatively correlated with well-being of parents ($r = -.22$, $p < .05$). A significant negative correlation was found between mobilizing family to acquire and accept help subscale and well-being of parents ($\rho = -.27$, $p < .05$). Reframing, seeking spiritual support, and passive appraisal subscales were not significantly correlated with well-being of parents ($r = .08$, $.20$, $\rho = .03$, $p > .05$ respectively). Therefore, these findings lead to partially support the hypothesis. All of these results are shown in Table 6.

Table 6: Correlation Coefficients between Coping Strategies and Well – being of Parents (n = 80)

Coping Strategies	r / ρ	P-value
1. Total coping score ^a	-.26	.019
2. Acquiring social support ^a	-.22	.048
3. Reframing ^a	-.08	.456
4. Seeking spiritual support ^a	-.20	.072
5. Mobilizing family to acquire and accept help ^b	-.27	.015
6. Passive appraisal ^b	-.03	.081

a : Pearson's Product-moment

b : Spearman's rho

CHAPTER V

DISCUSSION

This descriptive study was done to describe coping strategies, well-being, and the relationship between coping strategies and well-being of parents whose newborn infants were hospitalized in the NICU. The discussion of the study findings will be organized around two major variables: coping strategies and well-being of parents, and hypothesis testing.

Objective: To describe coping strategies used by parents whose newborn infants were hospitalized in the NICU.

Total Coping Scores

Parents in the present study scored coping strategy in rather high ($M=3.34$) (see Table 2). One possible explanation was parents are stress when parents visit their baby in NICU (Parichart Silprasert, B.E. 2542: 62). Parents in this study were compensating for the stress of having a baby hospitalized in NICU by increasing their use of coping strategies to help them to adjust to the situation. The period of data collection is so short, so parents can not use total coping in frequent level. This finding is consistent with Patterson stated that families try to maintain their functioning and meet demands by using coping. Coping is a specific effort by which an individual attempts to reduce demand (Patterson, 1988: 218). According to McCubbin and McCubbin (1996: 20) they stated that coping was designed to maintain the emotional stability and well-being of family members.

This result is congruent with the findings of Pornsiri Chaisom (B.E. 2536: 90), using the F-COPES instrument for assessing coping strategies. She reported that parents of children hospitalized in PICU sometimes used total coping. She explained that because the level of parental stress was medium, they assess that this situation was moderate severe. So they sometime used total coping. In addition, Philichi (1989: 273) who studied coping of family of critically ill child in PICU reported that parents

perceptions of their family's coping abilities were higher than the norm, possibly because the admission to the PICU is a crisis situation (Philichi, 1989 cited by Seideman, et al., 1997: 171).

Mobilizing Family to Acquire and Accept Help

Parents scored highest on parental coping strategies related to Mobilizing family to acquire and accept help ($M=3.80$) (see Table 2). Mobilizing family to acquire and accept help was the most frequently used coping strategies reported by the parents. It indicated that parents frequently used other resources aside from family including professional counseling, community agencies and programs, family doctor, and persons in other families to cope with the stressful situation. The most frequently used coping behavior of this strategy was "seeking professional counseling and help for my difficulty" ($M=4.00$) (see Table 3). One explanation was parents perceived support from NICU nurses very helpful, so they seek professional counseling. Similar finding have been found in the study of Miles, Carlson, and Funk (1996: 45) which reported that fathers and mothers perceived support from NICU nurses very helpful.

The second reason is possibly because doctors and nurses are the persons that have the knowledge to cure and care for their baby. Parents perceive that health professions are the important people to help them understand and manage this situation appropriately, so parents seek information and help from them. According to Coffman, Levitt and Deets (1991: 406) persons in other families and professional counseling are important resources that parents try to use for moderating the stress of the period. The result of this study is consistent with the study of Youghlout, Brennan, and Swegart (1994 cited by McCubbin, Thompson, & McCubbin, 1996: 492) who studied coping strategies of families with medically fragile children, it reported mean the score on mobilizing family to acquire and accept help subscales was at a moderate high level.

The third reason might be that the majority of parents in this study (70%) were perceived the severity of their newborn infants's illness as severe so they try to seek help and counseling from doctors and nurses. Therefore, they frequently used these coping strategies. Similar to the study of Pornsiri Chaisom (B. E. 2536: 100), a

majority of parents whose children admitted in PICU frequently sought help from doctors and nurses.

Seeking Spiritual Support

Seeking spiritual support was represented as the second strategies used by the parents to cope with the hospitalization of their babies in the NICU. The findings illustrated that the parents in this study participated in religious practices by “attending church services” ($M=3.86$) and “having faith in god” ($M=3.71$) during their babies’ hospitalization in the NICU. However, the most frequently used coping behavior in the seeking spiritual support subscale was “pay obeisance to the sacredness” ($M=4.08$). The possible reason may be because the Thai people readily accommodate Hinduism and animism, the beliefs in spirits and ghosts, into their cognitive-belief systems (Komin, 1998). Since all of the parents in this study were Buddhist (100%) (see Table 1), they normally participate in religious practices. Thus, the Thai people engaged in supernatural related behavior in order to psychologically relieve one’s frustration and an anxiety caused by what is perceived to be impossible to cope with. This coping strategy suggests high stress might be present and the parents engage in these activities to keep their stress levels low. The result of this study is consistent with the study of Youghlout, Brennan, and Swegart (1994 cited by McCubbin, Thompson, & McCubbin, 1996: 492) which showed coping strategies of families with medically fragile children, reported mean score on seeking spiritual support subscale was at a moderately high level.

The second reason the parents in this study engaged more in religious practices might be because believing in religion will help a person to have hope. So they will use seeking spiritual support to help them feel better, and to be hopeful. According to Nyamathi and Servellen (1989 cited by Pornsiri Chaisom, B.E. 2536: 96), religious resource would lead a person to believe in a good way, and to have hope.

A third reason might because they lived in rural and suburban Thailand where traditional treatments provided by Buddhist monks, fortunetellers, and folk healers were widely used. The finding is congruent with the study of Sakul Kongpan (B.E. 2533: 22) who reported that mothers used church/ religious resources at a rather high level to cope with their hospitalized child.

The final reason might be because parents used emotional focused coping to decrease stress within the first week after their newborn infants hospitalized in the NICU (Parichart Silprasert, B.E. 2542: 62). Seeking spiritual support was emotional focused coping, helping people decrease mental suffering. According to Pornsiri Chaisom (B.E. 2536: 95) having faith in God was emotion focused coping, that can decrease stress by helping parents to assess and perceive cause and effect of the situation in a good direction.

Reframing

The third coping strategies subscale reported by the parents was reframing. (M=3.39) (see Table 2) The finding illustrated that some coping behaviors in reframing subscales were used by parents in low level such as “believe I can handle my own problems” (M=2.69), and “knowing I have the power to solve major problem” (M=2.73). This indicated as difficult situation to manage by themselves that hospitalization of their babies in the NICU was a situation perceived by parents. So, they have to seek professional counseling and manage their emotion by using spiritual support. According to Friedman (1981 cited by Sakul Kongpan, B.E. 2533: 29) reported that when parents were faced with these problematic situations, they will use internal personal resource such as capability, self-confidence, self-reliance for managing these situation by solving the problem, learning and understanding the situation. The finding is congruent with the study of mother’s coping strategies while their child was hospitalized (Sakul Kongpan, B.E. 2533: 22) and the study of parents whose children were hospitalized in Pediatric Intensive Care Unit (Pornsiri Chaisom, B.E. 2536: 94) presented that the subjects used reframing in sometimes level.

When considering which was the most frequently used coping behavior of these strategy, “accepting that difficulties occur unexpectedly” (M=3.95) (see Table 3) was the most frequently used coping behavior of these strategy.

Acquiring Social Support

Parents reported acquiring social support subscale as the fourth strategy used to cop with their newborn’s hospitalization in the NICU (M = 3.28) (see Table 2). One possible explanation is because parent can seek support from their friends and

neighbors at some level (see Table 3). Because the period of data collection is early postpartum period, they have to stay at home. As the less frequently used was “Receive gifts and favors from neighbors (e.g. food, taking in mail etc.)”(M=2.64).

The most commonly items identified by the parents was “seeking advice from relatives (grandparents,etc.) (M=3.99)”. It indicated that parents in this study viewed family members(grandparents) and relatives as a first social support resource. Several factors may influence why seeking support from family was performed. First, parents perceive that relatives are important people who can help them to face the stressful situation. According to Susman and Burchinal (1962 cited in Pornsiri Chaisom, B.E.2536: 96) when a family is faced with a stressful situation, relatives were the most important people because family members will bond and seek support from each other before seeking support from external family resources. Second, most parents (66.3%) live with their grandparents or relatives in the same house, so they can engage in seeking help easily from them especially during postpartum period that they were staying home for recuperation and their house was distant from the hospital. According to Friedman (cited by Sakul Kongpan, B.E. 2533: 29).“parents can engage easily in acquiring support from external personal resources including relatives, friends, neighbors and extended family”. Third, most parents were married (96.2%), which can lead them to have support from each other including mental and physical support (Chantiva Trirongjitmoah, B.E. 2539). Lastly, in case of parents who live alone with their spouse or their child, they also received help from their relatives because of people in the North Eastern Region of Thailand tend to live close or nearby to each other as a community. As McHaffie (1992, cited by Pornsiri Chaisom, B.E. 2536: 97) noted, parents seek mental support from their grandparents because they are close with their grandparents and their grandparents can help them in many activities such as visiting their infants at the hospital and helping with housework etc.

This finding is congruent with previous studies, Sakul Kongpan (B.E. 2533: 22) reported that mothers whose children are hospitalized sometimes used extended family resource (relatives). Similarly, Pornsiri Chaisom (B.E. 2536: 96) reported parents of children hospitalized in the Pediatric Intensive Care Unit sometimes used extended family resources (relatives).

Passive Appraisal

Parents whose newborn infants were hospitalized in the NICU scored the lowest on coping strategy related to passive appraisal ($M=2.65$) (see Table 2). One possible explanation might be this coping strategy reflects the parental inability to accept problematic issues. In fact, parents might not accept the actual situation within the first week after visit because it was a crisis situation and data collection period is critical, parents will use emotional focused coping for managing their stress. According to Baldree, Murphy, and Power (cited by Pornsiri Chaisom: B. E. 2536: 91) when a family member was ill, relatives will try to adjust by using emotional focused coping in the first step. Therefore, they might deny and avoid accepting the actual situation by watching television, believing in luck, believing if they wait enough, the problem will go away etc. According to Pepper and Snapp (1980 cited by Steele & Georgia, 1987: 15) when parents visit their child, the first sight of the NICU and the infant will often be shock and denial. Therefore, parents can not accept this situation within the first week after visit of newborn infants, they deny the situation. Therefore, passive appraisal, the parental ability to accept problematic issue, is the least frequently used coping strategies. Similarly with the study of Sakul Kongpan (B.E. 2533: 22) it was found that mothers of hospitalized children sometimes used family passivity.

The reason of passive appraisal is the least frequently used is possibly because this situation is a crisis and complicated. So, it is hard to understand and accept actual situation within the first week by themselves. Therefore, they have to seek support from doctors, nurses, relatives, friends, neighbors, and religion more than family passivity.

Considering the least frequently used coping behavior for over all coping behaviors, “feeling that no matter what we do to prepare, I will have difficulty handling problems” ($M=2.35$) was the least frequently used coping behavior (see Table 3). One explanation is they may feel that they can prevent this situation since they have been pregnant. If they take care themselves and their baby appropriately, their baby will not be admitted in the NICU.

Objective: To describe well-being of parents whose newborn infants were hospitalized in the NICU.

Well-being of Parents

Subjects in the present study scored rather low on the well-being scale, with a mean score of 4.69, (SD=14.31) (see Table 4). This is because their infant's hospitalization during the first week was a very stressful situation. According to Pepper and Snapp (1980 cited by Steele & Georgia, 1987: 15) when parents visit their child, the first sight of the NICU and the infant will often lead to distress, depression, hopelessness, powerlessness, loss, isolation. Parichart Silprasert (B.E. 2542: 62) stated after the first visit, parents had a high level of stress and anxiety. They feel anxious, angry and envious (Consolvo, 1984 cited by Steel & Georgia, 1987: 15). In addition, this situation produced a negative physical health in parents. Parents may be irritable and have difficult concentrating. They experience sleep and appetite disturbances, and have repetitive dreams of the birth and of the child (Kristensson Hallstrom & Elander, 1997: 363; Logsdon & Davis, 1998: 196; Steele & Georgia, 1987: 15). Therefore, having newborn infants hospitalized in NICU seems to negatively influence the parent's health outcomes. These situations produce negative physical and mental health, so their well-being was rather low. In the study of Sakul Kongpan (B.E. 2530: 32), she presented the low level of general well-being of mothers with hospitalized child because this situation is stressful event. Similarly, Vimonvan Vrolarn (B.E. 2535) studied parents with children admitted to the Intensive Care Unit and reported that the parental general well-being was low. She stated that the low level of general well-being of parents with children admitted to the Pediatric Intensive Care Unit might be because parents wish for an improvement in their child's illness. In fact, their child's illness is still severe and has to be hospitalized for a long time. When their child's illness is not improved, so it led them to be anxious.

Considering each items of well-being, finding that highest mean score was "How much energy, pep, vitality have you felt?" with a mean score of 7.38 (SD=2.64). One explanation is because parents try to adjust to this stressful situation, so they feel energetic to manage the situation. The lowest mean score was "How depress or cheerful have you been?" with a mean score of 3.31 (SD=2.33). According to Pep

and Snapp (1980 cited by Steele & Georia, 1987: 15) stated when mother visit their child in NICU, the first sight of NICU and infants will often be depressed. One explanation is because this situation is a crisis situation, so it affects the parental feeling.

Results of Hypotheses Testing

Hypotheses: Coping total scores and subscales scores of acquiring social support, reframing, seeking spiritual support, mobilizing family to acquire and accept help, and passive appraisal are correlated with well-being of parents whose newborn infants were hospitalized in NICU.

The present study found statistically significant negative correlation between coping total score ($r = -.26$, $p < .05$), acquiring social support ($r = -.22$, $p < .05$), and mobilizing family to acquire and accept help ($\rho = -.27$, $p < .05$) and well-being. Furthermore, reframing, seeking spiritual support, passive appraisal were not significantly correlated with well-being ($r = .08$, $.20$, $\rho = .03$, $p > .05$ respectively).

Coping Total Scores and Well-being

Considering the negative correlation between coping total scores and well-being ($r = -.26$, $p < .05$), indicated that the use of more coping strategies was associated with a decrease in well-being. One explanation is because parents try to adjust to the situation within the first week by using diverse coping strategies. They can not adjust within the first week because this situation is a critical period. So their well-being are low while they used more coping. Patterson (1988: 218) stated coping is a specific effort to affect family adjustment. Good adjustment reflected in positive physical and mental health of family member, that is family member well-being (McCubbin & Patterson, 1982 cited by McCubbin, Thompson & McCubbin, 1996: 753). It can be referred from this statement that good adjustment or well-being results from using coping. Thus, studying the relationship between coping strategies and well-being should not be studied at the same period of data collection. Two time assessment may be preferred by allowing the parents to use more coping strategies and the well-being can be assessed. Other previous research failed to demonstrate a significant relationship between total coping score and well-being. Vimonwan Vrolarn (B.E.

2535: 53) found that general well-being was not correlated with total coping scores but negatively related to emotional-focused coping. Sakul Kongpan (B.E. 2533: 34) found no relationship between total coping score and well-being.

Acquiring Social Support and Well-being

The findings indicated a significant negative correlation between acquiring social support and well-being ($r = -.22$, $p < .05$). Therefore, well-being levels decreased as parents used more acquiring social support. One possible explanation is a one-week period after the first visit of their infants may be too short for parents to adjust to a difficult situation. Thus, their well-being level was still low in spite of higher use of acquiring social support. Another potential explanation of this data is the indication that parents experiencing increased suffering (evidenced by low well-being scores) (see Table 5) resulting in heighten anxiety. This actively anxious state may stimulate the parent's utilization of coping strategies, and perhaps the particular stress of having infants hospitalized in the NICU conjures up acquiring social support strategy as a likely response. This finding is congruent with the study of Sakul Kongpan (B.E. 2533: 37), which found that friends resources are negatively correlated with general well-being.

Mobilizing Family to Acquire and Accept Help and Well-being

The findings indicated a significant negative correlation between mobilizing family to acquire and accept help subscale and well-being ($\rho = -.27$, $p < .05$). Therefore, the well-being level decreased as parents used more mobilizing family to acquire and accept help subscale. The reason of negative correlation between mobilizing family to acquire and accept help subscale and well-being in this study, possibly because when parents are faced with this situation, within the first week after visiting their infants, their well-being is decreased, presented as a low level of well-being. Then they will try to used and seeking help from community resource such as professional, community agencies, family doctor and accept help from others such as person in other family. Another potential explanation of this data is the indication that parents experiencing increased suffering (evidenced by low well-being scores) have resulting heighten anxiety. This actively anxious state may stimulate the parent's utilization of coping

strategies, and perhaps the particular stress of having infants hospitalized in the NICU conjures mobilizing family to acquire and accept help strategy as a likely response. This finding is consistent with previous research (Sakul Kongpan, B.E. 2533). It was found that community resource (that is the resource of mobilizing family to acquire and accept help) was negative correlated with well-being in low-level. She explained mother who has low level of well-being will use higher or rely more on mobilizing family to acquire and accept help.

Reframing and Well-being

Reframing was not significantly correlated with well-being ($r = -.08$, $p > .05$). This finding did not support the hypothesis that reframing was correlated with well-being. According to Sakul Kongpan's (B.E. 2533: 27) study in mothers whose children were hospitalized, found that reframing was not correlated with general well-being. One explanation for this result is because the age of most parents were more than 25 years old (69.75%) (see Table 1), indicating that they have self-confidence, self-reliance in high level so parents can use internal personal resource to redefine stressful events in order to make them more manageable. According to Pornsiri Chaisom (B.E. 2536: 100) when persons are older, their thinking will be more developed. So they can assess and accept the situation. Therefore, reframing was not associated with well-being. Thus, parents would not use reframing differentiate.

Seeking Spiritual Support and Well-being

Seeking spiritual support was not significantly correlated with well-being ($r = -.20$, $p > .05$). This finding did not support the hypothesis that seeking spiritual support was correlated with well-being. One explanation for this result is because the period of data collection. Which is the first week after parents visit their infants in the NICU is a period of crisis. They would use seeking spiritual support in rather high level so they would not use seeking spiritual support (that is the ability to acquire spiritual support) to differentiate within the first week after visiting their infants.

Passive Appraisal and Well-being

Passive appraisal was not significantly correlated with well-being ($p = -.03$, $p > .05$). This finding did not support the hypothesis that passive appraisal was correlated with well-being. It could be explained by the range time of data collection. Which is within the first week after visit their infants in NICU. The parents would not use passive appraisal (that is the ability to accept problematic issues) differentiate within the first week after visit their infants. They will use passive appraisal in low level, indicated that they can not accept the problematic situation or they deny the situation. According to Pepper and Snapp (1980 cited by Steele & Georgia, 1987: 15) stated that “when the mother is able to visit their child, the first sight of the NICU and the infant will often be shock, denial, guilt, distress, depression, hopelessness, powerlessness, loss, isolation and confusion.

CHAPTER VI

CONCLUSION AND RECOMMENDATIONS

In this chapter, a discussion of the limitations of the study, the implications of the findings for nursing practice and education, and recommendations for future research is followed at the end of the chapter.

Conclusion of The Study

This is descriptive research to study the relationship between parental coping strategies including acquiring social support, reframing, seeking spiritual support, mobilizing family to acquire and accept help, and passive appraisal and well-being of parents whose newborn infants had been hospitalized in the NICU. The Family Stress Theory was used as the conceptual framework.

The sample in this study was 80 parents whose newborn infants were hospitalized in the NICU of seven hospitals in North Eastern Region of Thailand. (Srinagarind Hospital, Khonkaen Hospital, Udonthani Hospital, Maharat Nakhonratchasima Hospital, Buriram Hospital, Surin Hospital, and Sapprasit Hospital)

The tools used in this research were the questionnaires consisting of 3 part as follows: 1) questionnaire for assessing characteristics of parents, 2) Family Crisis Personal Evaluation Scales (F-COPES), was translated and modified by the researcher from F-COPES of McCubbin, Thompson, and McCubbin (1996: 494-495) by using Sakul Kongpan's instrument to be guideline, and 3) Family Member Well-being (FMWB) Index, using Tippawan Vipamaneeroj's instrument (2002) that translated and modified from Family member well-being (FMWB) Index of McCubbin and Patterson (1982).

All tool's content validity was confirmed by 5 qualified family nursing educators who made improvements. And then, it was tested for reliability with 30 parents of newborn infants hospitalized in NICU with the same characteristics as the sample group. The reliability of the F-COPES was tested with Cronbach's alpha

coefficient, and the value obtained was 0.81. In each coping strategies were as follow: .76 (Acquiring social support), .75 (Reframing), .74 (Seeking spiritual support), .77 (Mobilizing family to acquire and accept help), .72 (passive appraisal) which indicated on acceptable level (more than .70) (Lobiondo-wood, G. & Haber, J., 1994: 374). When the questionnaire was used with the real sample group consisting of 80 subjects, the value was .78. Each coping strategies were as follow: .77 (Acquiring social support), .78 (Reframing), .75 (Seeking spiritual support), .78 (Mobilizing family to acquire and accept help), .75 (passive appraisal) which indicated on acceptable level too. The reliability of parental well-being questionnaire was tested with Cronbach's alpha coefficient, and the value obtained was .76. When the questionnaire was used with the real sample group consisting of 80 subjects, the value was .77.

The researcher collected the data by mail from the 80 subjects. Data was analyzed. Parental characteristics were analyzed by using frequency and percentage. Parental coping strategies and well-being were analyzed by using possible range, actual range, mean, standard deviation. The relationships between parental coping strategies and parental well-being were analyzed by using Pearson's product – moment correlation coefficients and Spearman's rho coefficients. All statistical analyses were at the 0.05 level of significance. The result can be summarized as follows:

1. Characteristics of the sample group, the sample was equally divided between fathers (50%) and mothers (50%). Parents were not only the same pair of parents but also fathers or mothers per each newborn case. There was twenty-three pair of parents' answer the questionnaire. There were thirty-four subjects do not the same pair of parents. There were fifty-seven cases of newborn infants. The majority of parents were 31-35 years old. All of parents were Buddhist. Most subjects (96.2%) were married. Seventy percent of the parents had completed primary school education and 22.4% had a high school education. More than half of the parents (55%) worked in agriculture. Seventy-one percent of the subjects had family income less than or equal to 5,000 bahts per month. The majority (73.8%) of their medical expense payment was social welfare. Fifty-three percent of the subjects staying with relative. Eighty-nine percent of the subjects had less than or equal to three children per family. The majority

(70%) of the subjects also perceived their child's illness as severe; 25% as moderate and 5% as mild.

2. Mean score on the total coping score was 3.34. Mean scores of each subscales were 3.80 of mobilizing family to acquire and accept help, 3.62 of seeking spiritual support, 3.39 of reframing, M 3.28 of acquiring social support, and 2.65 of passive appraisal.

3. Total coping score was found to negatively correlate with parental well-being ($r = -.26$, $p < .05$). Acquiring social support had a significantly low correlation with parental well-being ($r = -.22$, $p < .05$), mobilizing family to acquire and accept help was had a significantly low negative correlation with parental well-being ($r = -.27$, $p < .05$). While there was no significant correlation between reframing, seeking spiritual support, and passive appraisal and parental well-being ($r = -.08$, $p > .05$, $r = -.20$, $p > .05$, $r = -.03$, $p > .05$) respectively.

Research Limitations

The most prominent weakness of this study was the use of purposive sampling which limited the generalization of the results to other groups of parents whose newborn infants had been hospitalized in the NICU. It cannot be generalized to chronic infant populations. The second was data might not be answered at the specified time as the parents stated on the top of the questionnaire. Since the data was collected by mail so it was not impossible to know the exact date of answering the questionnaire. The third was scaling of the questionnaire which uses disagree/agree for interpretation. This indicated the subjects' opinion about coping strategies rather than indicating how often coping strategies used. The last was the negative relationship between acquiring social support and well-being raises questions of causal inferences, It can not be assumed that because the parents were under stress and their well-being was worse, they therefore used more acquiring social support. To understand direction of this association, data should be correct in time sequence, the first is collecting coping strategies and the second is collecting well-being. It may be helpful.

Recommendations

Based on the results of this study, the researcher has the following recommendation.

Implications for nursing practice

From the study results, it was found that parents used diverse coping strategies for managing stress including acquiring social support, reframing, seeking spiritual support, mobilizing family to acquire and accept help, and passive appraisal. Furthermore, it was found that total coping strategies, acquiring social support and mobilizing family to acquire and accept help are negatively correlated with well-being. It indicated that parental well-being was low in the first week after they visited their baby in the NICU. Parents try to seek help and support from doctors and nurses, relatives, and friends. Therefore, health care professionals who are close to parents should be aware of the importance of giving counseling and help parents to solve the problem about admission of their baby in the NICU. Therefore, when applied generally to the situation of having newborn infants hospitalized in the NICU during the first week, NICU nurses should:

1. Be aware that the parents cannot adjust to the situation within the first week after parents visit their newborn infant in the NICU (evidenced by low well-being scores) and they need help and support from nurses.
2. Help parents to adjust with this situation as follows:
 - 2.1 Providing information and mental support to parents while they are visiting their infants.
 - 2.2 Supporting parents to use more coping strategies especially in acquiring social support and mobilizing family to acquire and accept help.
 - 2.2.1 Supporting and guiding the parents in developing and acquiring additional resources from relatives, friends, neighbors and extended family.
 - 2.2.2 Guiding parents in acquiring community resources, seek and accept help and support from its.
 - 2.2.3 Guiding parents to seek and accept help from others such as professional, family doctor, community agencies, and persons in other families.
 - 2.3 Advise parents to seek spiritual support by using religious resource.

2.4 Advise relatives, friends, neighbors and extended family to support parents as much as possible.

Implications for nursing education

The study results should be disseminated to nursing students, and it should be stressed for nursing students about the important of family and health professions to give help and support to decrease stress and support parents to use diverse coping strategies.

Implications for nursing research

Based on the limitations and the findings of this study, several recommendations for future research are presented as follows:

1. Selection of the sample should be done by random sampling in order that the study results may be generalized to a wider population of parents whose newborn infants had been hospitalized.
2. Data collection should be collected at the hospital, or collected face to face with the researcher or researcher assistant in stead of taking the questionnaire home.
3. The questionnaire should be considered for appropriate of scaling (disagree/agree) for interpretation to never/always in case the researcher is interested in identifying the frequently used coping behaviors.
4. Future endeavors would best be conceptualized as prospective designs, as it is likely that parents utilized different coping strategies at certain points during the course of their infant's illness (e.g., diagnosis, active treatment) than at others (e.g., stable period). One-time assessments do not allow for determining the efficacy of each coping strategies in ameliorating negative symptomatology as well as promoting the presence of position outcomes. Two-time assessments, the first assessment is assessing coping strategies, the second is assessing well-being, would be necessary for mapping of the stress-coping-adaptation pattern.
5. Although the non-significant relationship was found between seeking spiritual support and parental well-being, the most frequently used coping behavior was "pay obeisance to the sacredness". The suggestion does bear conceptual examination in provoking thought for future work. Therefore, the investigation of

spirituality as a coping mechanism for amelioration of stress related to having infants hospitalized in the NICU would be interesting for future research .



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APPENDIX A

LIST OF EXPERTS

List of Experts for validating Family Crisis Oriented Personal Evaluation Scales (F-COPES)

1. Associate Professor Dr. Rutja Phupaiboon
Nurse educator of Faculty of Medicine Ramathibodi Hospital, Mahidol University
2. Associate Professor Wilai Leesuwana
Nurse educator of Faculty of Medicine Ramathibodi Hospital, Mahidol University
3. Assistant Professor Dr. Wanida Senasutipun
Nurse educator of Faculty of Nursing, Mahidol University
4. Associate Professor Dr. Darunee Jongudomkarn
Nurse educator of Faculty of Nursing, Khon Kaen University
5. Assistant Professor Pimpa Sutra
Nurse educator of Faculty of Nursing, Khon Kaen University

The background of the page features a large, faint, circular seal of Khon Khaen University. The seal is gold-colored with a blue center. It contains Thai text: 'จุฬาลงกรณ์' (Chulalongkorn) at the top, 'มหาวิทยาลัยขอนแก่น' (Mahavithayalai Khon Khaen) at the bottom, and 'ขอนแก่น' (Khon Khaen) on the right. In the center is a stylized golden stupa or temple structure.

APPENDIX B
PERMISSION FORM

Permission Form of Ethical Committee from Khon Khaen University



มหาวิทยาลัยขอนแก่น

หนังสือฉบับนี้ให้ไว้ เพื่อแสดงว่า

โครงการวิจัยเรื่อง: กลวิธีการเผชิญความเครียดและความผาสุกของบิดามารดาที่บุตรเข้ารับการรักษาในหออภิบาลทารกแรกเกิด
(Coping strategies and well-being among parents of newborn infants hospitalized in Neonatal Intensive Care Unit.)

ผู้วิจัย: นางอัจฉริยา วงษ์อินทร์จันทร์ และคณะ

หน่วยงานที่สังกัด: นักศึกษาปริญญาโท สาขาการพยาบาลเด็ก คณะแพทยศาสตร์
โรงพยาบาลรามารัตน์ มหาวิทยาลัยมหิดล

ได้ผ่านการพิจารณาของคณะกรรมการจริยธรรมการวิจัยในมนุษย์มหาวิทยาลัยขอนแก่น แล้ว
โดยยึดหลักเกณฑ์ตามคำประกาศเฮลซิงกิ (Helsinki's Declaration)

ให้ไว้ ณ วันที่ 19 ธันวาคม พ.ศ. 2545

(ศาสตราจารย์เอก กุ่มพิกานนท์)

ประธานคณะกรรมการจริยธรรมการวิจัยในมนุษย์มหาวิทยาลัยขอนแก่น

ลำดับที่ 4.2.16: 12/2545

เลขที่: HE 450909

ฝ่ายวิจัย คณะแพทยศาสตร์ มหาวิทยาลัยขอนแก่น 123 ถนนมิตรภาพ อ.เมือง จ.ขอนแก่น 40002

โทร. (043) 348360-9 ต่อ 3723 สายตรง 348373

โทรสาร (043) 243064, 348373



APPENDIX C

INFORM CONCENT

Consent to Participant in Research Study

My name is Atchariya Wonginchan. I am a graduate nursing student in Nursing Department at the Faculty of Medicine, Ramathibody Hospital, Mahidol University. I am studying in the topic of relationship between coping strategies and well-being of parents whose newborn infants were hospitalized in the Neonatal Intensive Care Unit. I am going on collecting data. I would like to ask you to participate in the study. If you agree to participate you would complete the questionnaire for assessing your characteristics, coping strategies and well-being. All of your response and information will remain confidential. I will analyze data to be useful for development and improve pediatric and family nursing.

I would like you to complete data within 3–7 dates after your visiting. It will take you about 20 minutes to complete the questionnaire. After that please send it to me as the specified address that specify on the letter. When I receive the questionnaire, I will send towel to you to the informed address. If you have any question about the study, please inquire me at all time by phone or letter as your convenient.

Whether you participate in this research or not, your newborn infants still get the best cure and care from the hospital officer. You have right to willing or deny participating in this research.

Atchariya Wonginchan

The researcher

I read those content form and understand it, and I sign this consent form with willing.

Signature.....

Date.....



APPENDIX D

QUESTIONNAIRE

Hospital.....

The date of first visit.....

The date of answering questionnaire.....

Part I The questionnaire for assessing parental characteristics

Instruction : Please mark $\surd$ in the appropriate box of each item.

1. Parental status ☐ Father ☐ Mother
2. Age.....Years
3. Religion ☐ Buddhism ☐ Christianity
☐ Islam ☐ Other (specify).....
4. Marital status ☐ Single ☐ Marry
☐ Widow ☐ Divorce
5. Education level ☐ Primary school education ☐ Secondary school education
☐ Diploma ☐ Bachelor's degree
☐ Higher than Bachelor's degree (specify).....
6. Occupation ☐ House worker ☐ Employee
☐ Commerce / Business person ☐ Government official / State
☐ Agriculture ☐ Other (specify).....
7. Family income (average Baths/mth).....Baths

8. Medical expense payment ☐ Self paid
 ☐ Reimbursement
 ☐ Partial reimbursement
 ☐ Social welfare
 ☐ Other (specify).....

9. Number of family member.....persons
Including.....

10. Number of child.....

11. Perceive severity of their newborn infant's illness
 ☐ Severe
 ☐ Modeerate
 ☐ Mild

Part II Family Crisis Oriented Personal Evaluation Scales (F-COPES)

Instruction :

This statement are describe attitude and behavioral of parents while their newborn infants hospitalized in Neonatal Intensive Care Unit. If you agree with this statement, please mark O circle the number as follows:

- 5 If the statement describe your response very well indicating that you strongly agree
- 4 If the statement describe your response many part indicating that you agree
- 3 If the statement describe your response some part indicating that you are not sure
- 2 If the statement describe your response few part indicating that you disagree
- 1 If the statement does not describe your response at all indicating that you strongly disagree

Please read the statement of each items. Then mark O circle the number (1, 2, 3, 4 or 5) to each statement to match your response after the first visit of your newborn infant 3 – 7 days. Thank you

Example :

While my newborn infants hospitalized in Neonatal Intensive Care Unit, I face problems or difficulties by:	Strongly Disagree	Moderately Disagree	Neither Agree Nor Disagree	Moderately Agree	Strongly Agree
1. Sharing difficulties with relative	①	2	3	4	5

Explanation :

You mark O circle number 1 indicated that You are not share difficulties with relative

[illegible]

Part III Family Member Well-being (FMWB) Index

Instruction :

The objective of this questionnaire is to assess your well-being since your newborn infants hospitalized in Neonatal Intensive Care Unit. It consists of 8 statements. Please note that the words at each end of the 0 to 10 scale describe opposite feelings. Please answer every question by marking ☐ circle the number which seems closest to your feeling. There is the one appropriate answer which is closest to your actual feeling.

Example :

Since your newborn infants hospitalized in Neonatal Intensive Care Unit

1. How concerned or worried about your health have you been?

Not
CONCERNED 0 1 2 3 4 5 6 7 8 9 10 Very
at all CONCERNED

Explanation : indicated you are rather concerned.

1. How concerned or worried about your health have you been?

Not CONCERNED
at all

0 1 2 3 4 5 6 7 8 9 10

Very CONCERNED

2. How relaxed or tense have you been?

Very RELAXED

0 1 2 3 4 5 6 7 8 9 10

Very TENSE

7. How sad have you been?

Not SAD
at all

0 1 2 3 4 5 6 7 8 9 10

Very SAD

8. How concerned or worried about the health of another family member have you been?

Not CONCERNED

At all

0 1 2 3 4 5 6 7 8 9 10

Very CONCERNED



APPENDIX E

TEST NORMALITY

Test Normality by Kolmogorov-smirnov of Variables

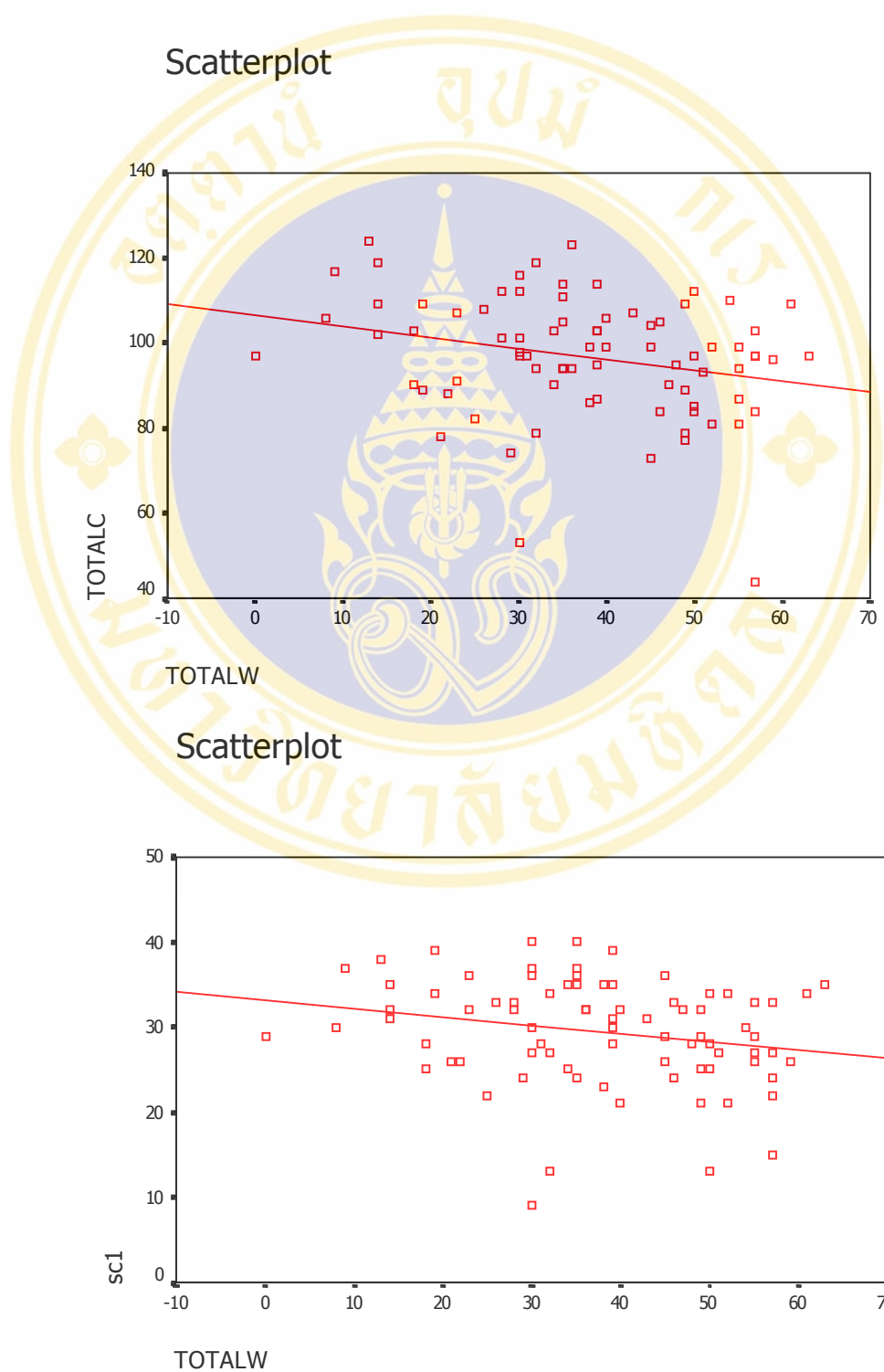
		TOTALC	SC1	SC2	SC3
N		80	80	80	80
Normal Parameters ^{a,b}	Mean	96.90	29.52	27.10	14.48
	Std. Deviation	14.09	6.23	6.29	3.42
Most Extreme	Absolute	.093	.104	.069	.124
Differences	Positive	.042	.053	.048	.103
	Negative	-.093	-.104	-.069	-.124
Kolmogorov-Sminov Z		.836	.934	.621	1.105
Asymp. Sig. (2-tailed)		.487	.348	.835	.174

		SC4	SC5	TOTALW
N		80	80	80
Normal Parameters ^{a,b}	Mean	15.19	10.61	37.53
	Std. Deviation	3.94	4.57	14.31
Most Extreme	Absolute	.182	.188	.089
Differences	Positive	.111	.188	.049
	Negative	-.182	-1.44	-.089
Kolmogorov-Sminov Z		1.625	1.682	.793
Asymp. Sig. (2-tailed)		.010	.007	.556

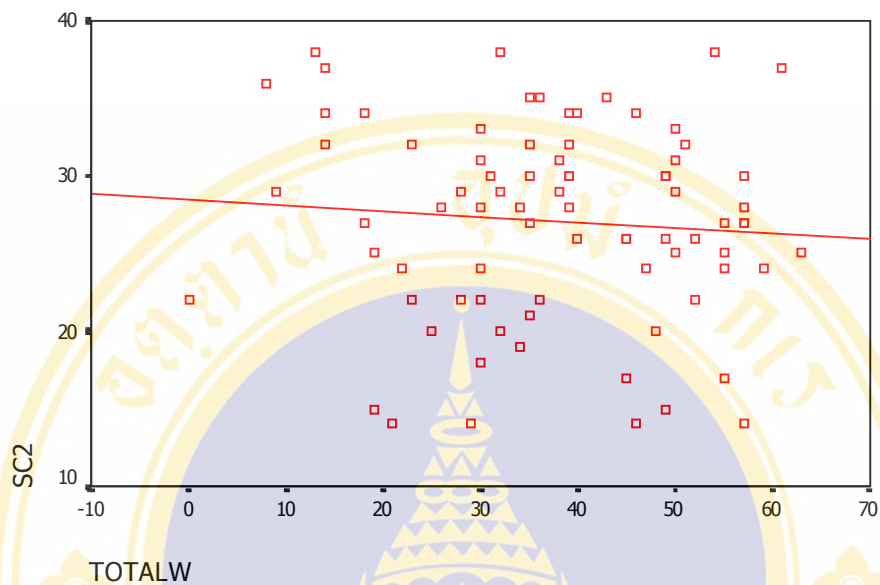


APPENDIX F

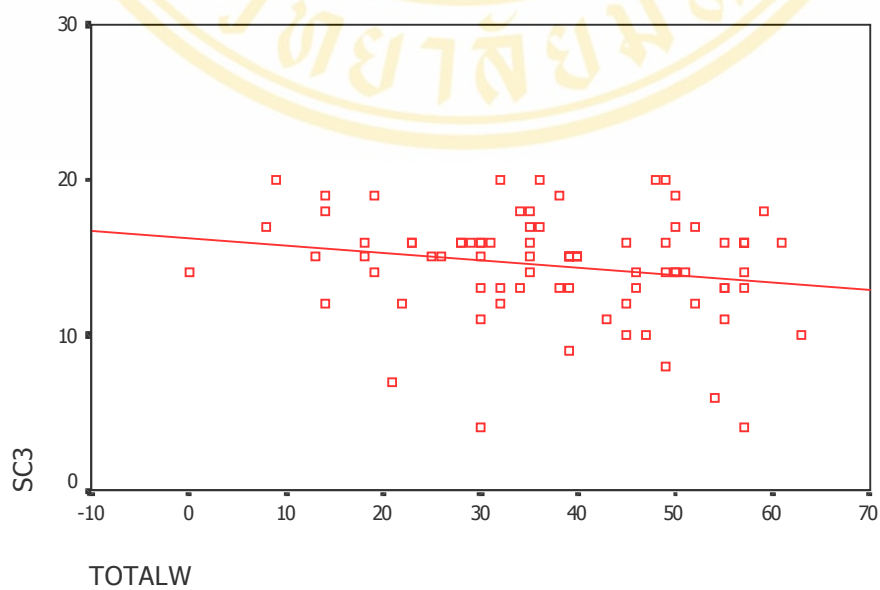
SCATTERPLOT OF VARIABLES



Scatterplot

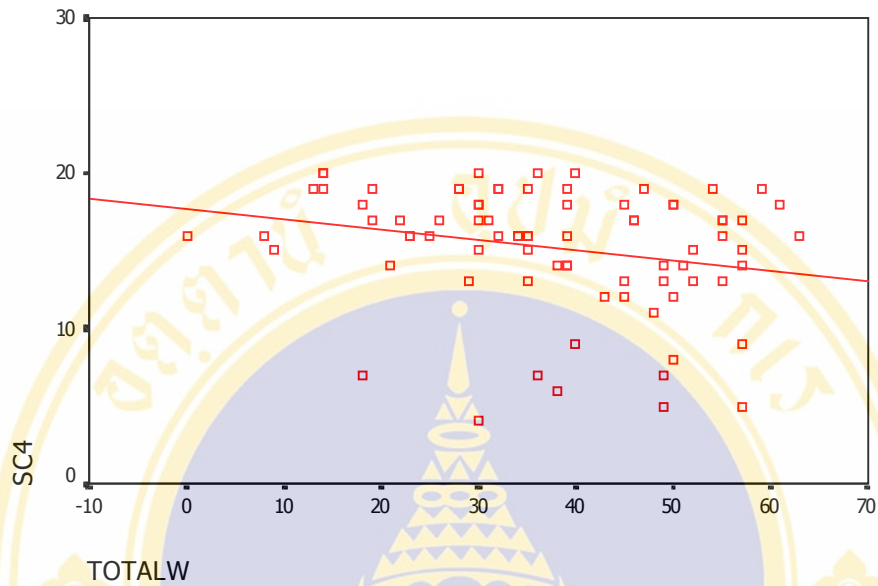


Scatterplot



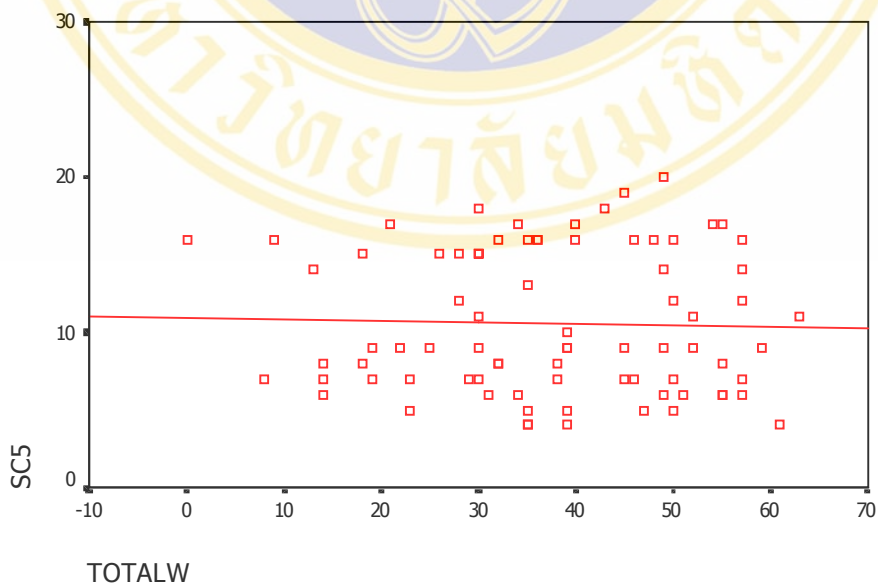
Scatterplot

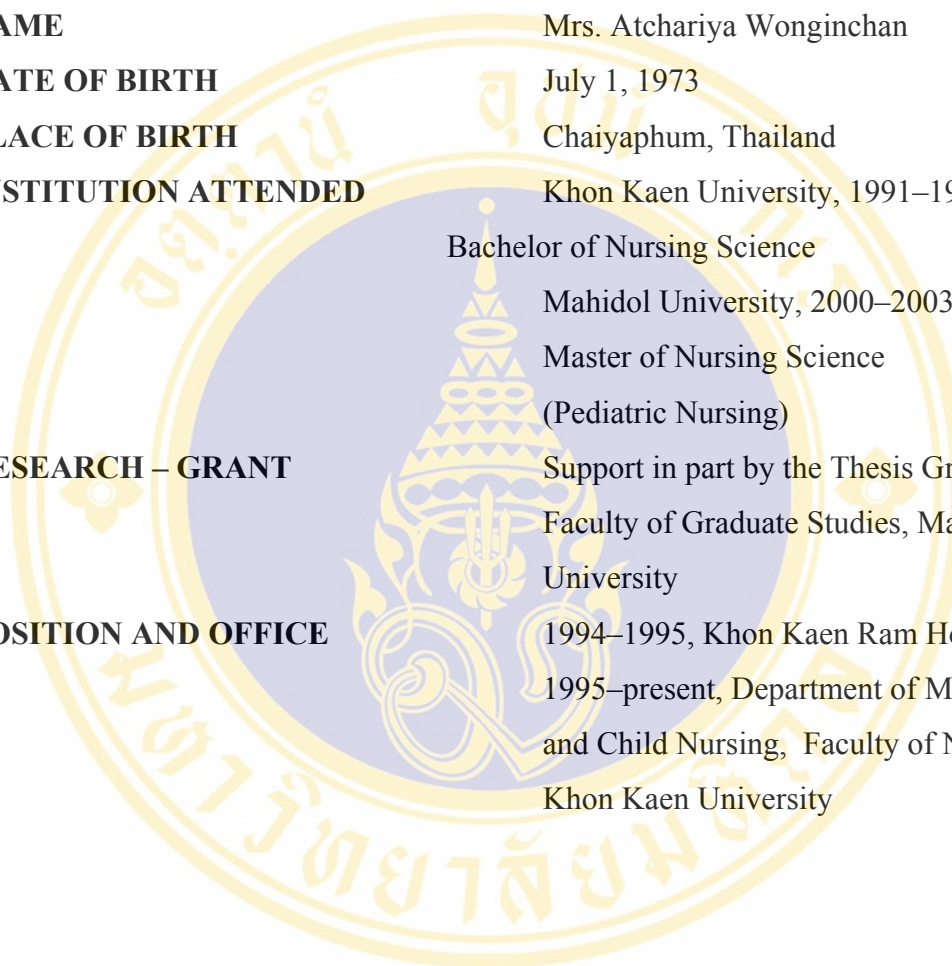
Dependent Variable: Totalw



Scatterplot

Dependent Variable: Totalw



BIOGRAPHY

NAME	Mrs. Atchariya Wonginchan
DATE OF BIRTH	July 1, 1973
PLACE OF BIRTH	Chaiyaphum, Thailand
INSTITUTION ATTENDED	Khon Kaen University, 1991–1994 : Bachelor of Nursing Science Mahidol University, 2000–2003 : Master of Nursing Science (Pediatric Nursing)
RESEARCH – GRANT	Support in part by the Thesis Grant, Faculty of Graduate Studies, Mahidol University
POSITION AND OFFICE	1994–1995, Khon Kaen Ram Hospital 1995–present, Department of Maternal and Child Nursing, Faculty of Nursing, Khon Kaen University