PEDiatric Nursing Care with Post-Divorce Families: A Multiple Segment Factorial Vignette Investigation

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by

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PEDIATRIC NURSING CARE

The undersigned, appointed by the dean of the Graduate School, have examined the dissertation entitled

PEDIATRIC NURSING CARE WITH POST-DIVORCE FAMILIES:
A MULTIPLE SEGMENT FACTORIAL VIGNETTE INVESTIGATION

Presented by Luke T. Russell

A candidate for the degree of doctor of philosophy,

And hereby certify that, in their opinion, it is worthy of acceptance

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Dedication

For my remarkable wife, Chang Su-Russell, I could not have imagined a more intelligent, caring, strong, ambitious, and empathetic spouse. Thank you for always pushing me to greater accomplishments, providing a sympathetic and understanding ear in the face of challenges, and sage advice whenever it was requested (and even when it was not). To my encouraging parents, Douglas and Sara Russell, inspiring grandparents, Sid, Lori, Ann, and Fran, and caring sister, Anna. Thank you all for being strong scaffolds for me as I worked through this project. Your love, understanding, and extension of a plethora of supports (tangible and intangible) are, as always, immensely appreciated. I am truly blessed to have such an amazing family.

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Abstract

Recent trends in family formation and dissolution necessitate adapting healthcare procedures to better serve contemporary families. This study investigated nurse responses to variability in children’s family structure and common post-divorce coparenting or custody dynamics. Data from 150 nurses were collected using an online survey made up of a series of short vignettes describing a hypothetical child patient newly diagnosed with a chronic illness (type 1 diabetes) and their family. Follow-up interviews with a subset of 23 nurses who participated in the online survey were used to explore how nurses navigated the hypothetical situations presented in the online survey, and factors that might ease or inhibit their interactions. Results provided evidence that nurses’ perceived preparedness for working with patients differed across post-divorce family structures, and that complications regarding coparenting conflicts and custody disagreements reduced nurses’ perceived preparedness. A grounded theory was developed positing that how nurses’ respond to parents depends on whether they were more relationally-oriented or educationally-oriented in their beliefs about working with families. Further statistical tests revealed that education may influence the orientation nurses endorse. Implications for practice, theory, and future research are discussed.
Chapter 1: Literature Review

As part of the Healthy People 2020 initiative, the U.S. Department of Health and Human Services (2010) defined social determinants of health (SDOH) as conditions in the social, physical, and economic environment in which people are born, live, work, and age that affect their health and wellbeing. Often, this definition has been utilized to study health inequities that occur on the basis of socioeconomic status (SES), gender/sexuality, and race/ethnicity within and across societies (Commission on the Reduction of Social Inequalities in Health in Spain, 2011; Kelly, Morgan, Bonnefoy, Butt, & Bergman, 2007; Marmot, Friel, Bell, Houweling, & Taylor, 2008). In this chapter I propose that family structure is an important social determinant of health overlooked in previous SDOH research. This is a critical oversight, as families encompass one of the most pervasive institutions in which people are born, live, work, and age. Furthermore, I suggest that despite often utilizing deficit-comparison lenses when studying the impact of family structure on health outcomes, much of the previous research family scientists have developed in this area provides support for conceptualizing family structure as a social determinant of health. I argue that this lack of conceptualization in previous research means an important intermediate mechanism for understanding family structure as a SDOH remains understudied, specifically the contribution of interactions between families and health care systems. I then propose that a multiple segment factorial vignette (MSFV) method framed through an SDOH lens, guided by the integrated behavioral model, can operate as an effective approach to address this gap in the current literature. In chapter 2 I present the methods of an investigation into how nurses respond to variability in patient family structure and post-divorce coparenting/custody dynamics when working
with a pediatric patient newly diagnosed with type 1 diabetes mellitus. Finally, in chapter 3, I present the results from this study, and end with a summation of the study’s implications for practice, theory, and future research.

**Identifying a Social Determinant of Health**

In the landmark Whitehall I & II studies, Marmot and colleagues (1991) convincingly demonstrated the effect that social status has on physical health by revealing graded health inequalities among British civil servants. Using salary information and the civil service’s own categorization of “grades of employment,” a clearly differentiated pattern of morbidity across six categories demonstrated a positive relationship between individual’s employment position and health. Individuals with more prestigious positions experienced more positive health outcomes than did those in less prestigious positions. In follow-up studies, it became apparent that patterns of overall mortality, and their relation with employment positions, existed across the lifespan in that those with lower grades of employment were significantly more likely to die at earlier ages (Marmot & Shipley, 1996). Furthermore, this pattern lasted well past retirement, and the health disparities became exaggerated as individuals grew older (Marmot & Shipley, 1996). These studies became the basis for research on how disease, illness, and mortality could be traced through both the exchange of pathogens, and also through social structures (i.e., social epidemiology). The recognition that some populations within and across societies were more susceptible to disease and illness than others, on the basis of their power, prestige, and access to resources was paradigm-shifting and was an important predecessor to current international action to promote health equity by addressing the social determinants of health (Marmot et al., 2008).
In working to address social determinants of health, several national and international commissions have developed models to explain how social groupings ultimately lead through the distribution of resources and intermediary mechanisms to differences in health outcomes (Commission on the Reduction of Social Inequalities in Health in Spain, 2011; Kelly et al., 2007; Marmot et al., 2008.) Figure 1 provides a synthesized version of several of these models. Using this theoretical model as a guide, identifying a social grouping that functions as a SDOH would rely upon the following three criteria:

1. Differences in health and wellbeing outcomes across different categories of a given social grouping would need to be demonstrated;
2. Differences in benefits and costs of membership in categories of a social grouping would need to be evident, with some categories having higher levels of prestige, power, and resources than others;
3. On the basis of distributions of prestige, power, and resources, intermediate mechanisms would need to demonstrate how differences in social grouping categories predict the initially identified differences in health and wellbeing outcomes.

By meeting these three criteria, it could be demonstrated that the social grouping represents a social determinant of health. Evidence that such health disparities across a social grouping are potentially adjustable and resultant of institutional and political choices would confirm that the initially identified health inequality may serve as a health inequity. In the following sections, I will review the current body of literature on health
in post-divorce families and argue that there is sufficient evidence for this conceptualization.

**Inequalities and Inequities Across Family Structures**

Over the past two and a half decades, researchers using a social determinants of health framework have differentiated between health inequalities and health inequities. In an academic glossary developed to clarify these differences, Kawachi, Subramanian, and Almeida-Fiho (2002) defined health inequalities as the presence of differences in health outcomes, illness diagnoses, or mortality across a set of populations. It is a measurable dimension that can be determined straightforwardly through statistical analyses. In contrast, health inequities refer to inequalities that may be deemed unjust or unfair. Kawachi and colleagues suggested that differentiating between an inequality and an inequity depended on one’s theories of justice, society, and the underlying bases of health differences. Unlike identifying a health inequality, which is a purely scientific question, identifying a health inequity is both a scientific and a theoretical exercise.

To help demonstrate this theoretical difference, consider individuals who, of their own agency, choose to participate in heli-skiing (a recreational sport in which one drops out of a helicopter and skis down a previously undisturbed snow-covered mountain-side). We would likely find that compared to their non-heli-skiing peers, heli-skiers are at significantly more risk for death or injury due to blunt-force trauma or pneumonia/frostbite after experiencing an avalanche. Heli-skiers thus might experience an inequality in their health outcomes as compared to non-heli-skiers, and though it is still important to find ways to reduce these health inequalities (for example, by finding or producing safety equipment that might reduce such injuries), most would likely agree that
such a health-inequality is not inherently unjust, but rather a difference that ought to be expected.

Children of divorced parents also experience differences in their health outcomes, but rather than choosing to participate in such circumstances, they are born or adopted into their families and do not elect or choose their parents. Children in post-divorce families have been repeatedly shown, across their lifespan, to have higher incidences of psychiatric, neurological, and chronic illness diagnoses and hospitalizations (Blackwell, 2010; Kogan et al., 2009; Laubjerg, Christensen, & Petersson, 2009; Miller, 2000; Scharte, Bolte, & GME Study Group, 2013; Victorino & Gauthier, 2009), lower reported well-being (Amato & Keith, 1991; Amato & Sobolewski, 2001; Fomby & Cherlin, 2007; Strohschein, 2005), and higher rates of depression (Afifi, Boman, Fleisher, & Sareen, 2009; Brown, 2006; Gilman, Kawachi, Fitzmauric, & Buka, 2003) than their peers in first-marriage families. It seems evident that there are health inequalities across family structures, meeting the first criteria for identifying a social determinant of health. Like the inequalities among heli-skiers, this inequality too, deserves attention and resources, but the question remains somewhat open: Are these differences inequalities borne out of inevitability? Or might they be due to differences in prestige, power, resources, and interactions with social institutions designed for a different social grouping (i.e., nuclear first-marriage families)? I argue that though much of the current body of family science research on children’s health in post-divorce families has assumed the former, there is ample evidence to consider the later. Furthermore, I believe it would improve family science and allow us to more effectively serve families and children if we made a
deliberate effort to study this well-documented inequality as the unjust inequity it appears to be.

**Values and theory in the study of family structure.** Clingempeel, Flescher, and Brand (1987) critiqued the body of research on the effects of stepfamily structure on children by articulating how epistemic values (e.g., social science and discipline-specific guidelines regarding how knowledge should be constructed – particularly in regards to the use and application of appropriate research methods) and nonepistemic values (e.g., beliefs learned from family, faith, school, and culture) influenced the type of research conducted on stepfamilies and the ways in which findings from such research were interpreted. Beginning in the late 1970’s, when the divorce rate had reached a peak, and continuing through the new millennium, many politicians, researchers, and clinicians have described the frequency of divorce in the United States as a societal and moral failure that threatens families, children, and the country as a whole (Daly & Wilson, 1980; 1998; Popenoe, 1988; 1993; Wallerstein & Kelly, 1979; Wallerstein, Lewis & Blakeslee, 2000; Wilcox, 2009). These nonepistemic values reflect nuclear family normativity, the pervasive cultural belief that families consisting of a married pair of opposite-sex parents and their biological children who all reside in a single household are the best (and only acceptable) form for raising children (Bermúdez, Muruthi, & Jordan, 2016; Coontz, 2016; Stacey 1993). When combined with epistemic values that place a premium on statistical analyses and between-group comparisons (Clingempeel et al., 1987), the common result has been that when scientists studied family structures, their first step was often to compare all other families to the first-marriage nuclear family ideal (Barber & Demo, 2006; Ganong, Coleman, & Russell, 2015).
This “deficit-comparison approach” (Ganong & Coleman, 1986) often operates with an unstated theoretical presumption that post-divorce families and family members will perform worse than first-marriage nuclear families and family members, and that the fault for any deficits are caused by the family structure or some failing of the individuals living within it. In their decade reviews of research on divorce and remarriage/stepfamilies, respectively, Amato (2010) and Sweeney (2010) contended that the field of family science had progressed well beyond the simple comparative approaches of the past. Both authors pointed to more complicated analyses that better evaluated the role of stressors associated with family transitions and selection effects that suggested individuals who lived in post-divorce families may have had (presumably ruinous) genetic, personality, or relationship predispositions prior to divorce that accounted for their comparably worse family and personal outcomes (rather than divorce in and of itself being the cause). Despite advances in methods and data analytic strategies, a focus on personal or family deficiency remains an ongoing preoccupation in the research literatures on family structure. Though Amato (2010) and Sweeney (2010) both acknowledged that some sub-populations might benefit from divorce or remarriage, they still largely perpetuated the presumption that the success and failures of these individuals or families could best be evaluated by looking at how individuals or dyads within various family structures behave (primarily because this is the combination of nonepistemic and epistemic values that tend to permeate current family science theory and methodology). In her closing recommendations for future research, Sweeney (2010) recognized this shortcoming of the literature, and stressed the need for exploring “the intersection
between stepfamilies and other institutions” (Sweeney, 2010, p. 679) as a priority for future research.

A social determinant of health (SDOH) lens would be beneficial in providing a framework for meeting this need and reinterpreting the knowledge we have already discovered. Instead of interpreting differences among family structures as evidence of the superiority of the nuclear-family model (or the individuals who live within that model), researchers using a SDOH framework would suggest that our current system is not doing well enough at meeting the needs of post-divorce families. Instead of asking what divorced or remarried families ought to do in order to successfully navigate a system designed for first-marriage nuclear families, researchers using a SDOH framework would ask: How could we change our health, educational, and legal institutions (e.g., hospitals, schools, and government agencies) to better serve families in all their forms?

**The Distribution of Prestige, Power, and Resources across Family Structures**

**Prestige.** Do the current data regarding post-divorce families fit the SDOH model? The strongest evidence for differences in prestige across family structures is the common presence in American society (and too-often echoed in family research) of negative stereotypes and stigmas related to residence in non-nuclear family structures. Divorced or single parent families are often referred to by politicians, researchers, and the general public as “broken” or “pathological” (Gustafson, 2009). Wicked, mean, or ugly stepparents and abused or neglected stepchildren are prevalent throughout fairy tales, films, and other modern media, and have become ingrained tropes throughout the world (Claxton-Oldfield, 2008; Leon & Angst, 2005). In both lay discourse and the research literature, it is not unusual for the step- prefix to be used as an indicator that something is
neglected, lesser, or ignored (Ganong & Coleman, 2017; Planitz & Feeney, 2009).

Searching academic databases for information on stepfamily relationships can elicit titles like: “The ugly stepsister”—Inheriting the defects of Nebraska’s inheritance tax,” and, “Self-forgiveness: The stepchild of forgiveness research.” The Merriam-Webster dictionary even provides a secondary definition of stepchild as “someone or something that does not receive enough care or attention” (Stepchild, n.d.).

**Power.** The privileging of one specific way of orienting family relationships results in biases and discrimination in many social settings, perhaps most notably political and legal realms (Moore & Stambolis-Ruhstorfer, 2013; Stacey, 1993; Troilo, 2011). Lawyers, judges, and divorce mediators who regularly interact with the family court system have consistently pointed out that the United States’ adversarial legal system is poorly positioned for managing the divorce process in a way that better supports family wellbeing and adjustment (Emery, 2011; Irving, 1980). The U.S. legal system, as it relates to family law, is largely constructed on the assumption that the most important family ties are based in biology and that children can have at most two parents at a time (Gregory, 1998; Jacobs, 2007; Troilo, 2011). As a result, the U.S. legal system generally lacks the complexity, nuance, or will to extend parental rights across step-relationships unless a biological parent first gives up his or her parental rights (Jacobs, 2007; Troilo, 2011). This makes stepparents’ roles in the lives of their stepchildren a legally ambiguous position, legally liable to contribute financially to a stepchild when married to the stepchild’s parent, but no longer economically responsible (nor having any legal rights to visitation) should the couple separate or should custody arrangements change among the child’s biological parents (Jacobs, 2007; Troilo, 2011). Though the
New York State Appellate Court has recently challenged this general practice by ruling that a non-biological or non-adoptive parent may be permitted to ask for custody and visitation rights following the dissolution of a romantic relationship (Matter of Brooke S. B. v. Elizabeth A.C.C., 2016), in most states, stepparents are legal strangers to their stepchildren (Mason, Harrison-Jay, Svare, & Wolfinger, 2002). Legal ambiguity regarding steprelationships can also prove challenging in health care or educational settings where stepparents or stepsiblings consideration as “immediate family” may depend on the teacher or the nurse on duty that day (Ganong, & Coleman, 2017). If post-divorce families held power, we would expect an adjustment of the legal system to better meet their needs.

Admittedly, we have seen the rise of family mediation, an alternative that is often effective for those co-parents who are able to put aside their anger and negotiate with one another (Emery, 2011). The movement towards mediation, however, is predominately a result of court officials’ frustrations with managing the conflicts and litigiousness of divorcing parents. As a result, many courts mandate mediation as a possible solution for hostile parents who are unable to agree on custody or parenting plans (a group for whom such interventions are often ineffective and sometimes detrimental; Emery, 2011). The result is that many divorcing Americans lack access to a fair, expedient, and inexpensive court system or skilled and effective mediators (Emery, 2011; Henderson, 2003).

**Resources.** That the divorce process is generally expensive compounds the lack of resources experienced by many post-divorce households. In the aftermath of divorce, whether a former spouse moves out of the marital home and gains expenses for a new mortgage and utilities or remains in the marital home and inherits full responsibility for
costs that were once shared among partners, changes in economic expenses and responsibilities are common. Most previous studies have suggested that due to changes in employment and the costs of separating, women often see steep declines in their financial wellbeing in both the years prior to (when couples first physically separate) and immediately following a legal divorce (Gadalla, 2008; Zagorsky, 2005). Women often face further wage penalties for their marital and childbearing statuses (Budig & England, 2001) that in turn further amplify other gender disparities such as having median annual earnings that are 75.7% of men’s (U.S. Census Bureau, 2011). Following a cohort of families from 1990-2005 in the Survey of Income and Program Participation, Hill and Schaefer (2011) found that due to accompanying changes in residence or employment, children whose parents divorced during this time were, respectively, two to three times more likely to lose access to public or private health insurance than their peers in married families. In sum, these comparably low levels of prestige, power, and resources among post-divorce families meet the second criteria for recognizing family structure as a social determinant of health.

Intermediate Mechanisms Linking Family Structure and Health

Digging further into the research literature surrounding family structure reveals that intermediate mechanisms like material circumstances, psychosocial factors, behavioral/biological factors, social cohesion, and interactions with health care systems appear to have a consistent association with health outcomes and one another. There is considerable evidence that variables such as poverty, depression, poor relationships with family members, a lack of social capital, and genetics covary with or mediate the relation between family structure and the wellbeing of children of divorced parents (Amato &
Sobolewski, 2001; D’Onofrio et al., 2005; Strohschein, 2012; Sun, 2001). In their interpretations of these findings, authors often conceptualize these associations as selection effects, having designed their studies to show that these genetic, relational, or interpersonal issues existed prior to the occurrence of the parental divorce. At the same time, family scientists and demographers have repeatedly shown that the effects of divorce are transmitted over generations (Amato, 2010; Diekmann & Shermidheiny, 2013; D’Onofrio et al., 2007), in many ways similarly (and in accordance with) the reproduction of poverty across generations of families (Musick & Mare, 2004).

In applying a social determinants of health lens to this same evidence, one might wonder if these associations can solely be considered selection effects, or whether generational legacies might be further evidence of the ingrained effects of membership in stigmatized social categorizations playing out over multiple lifetimes. Researchers operating from a biopsychosocial paradigm of health have now found increasing evidence that chronic psychosocial stress has demonstrable effects on physiological dysregulation and can affect physical health and illness susceptibility through its impact on the neuroendocrine, immune, metabolic, and cardiovascular systems (Juster, McEwen, & Lupien, 2010; Seeman, Epel, Gruenewald, Karlamangla, & McEwen, 2010). This allostatic load model, (a term drawn from systems theory that describes the achievement of a new “normal” through adaptation) suggests that stressful experiences like chronic poverty, racism, and social exclusion create “wear and tear” on the human body over time by way of individuals’ physiological responses to perceived threats, concerns, or social rejections (Ganzel, Morris, & Wethington, 2010; Juster et al., 2010; Seeman et al., 2010). McEwen (2008) has proposed that when individuals experience high degrees of stress on
a regular basis, responses that usually would only occur in extraordinary circumstances, instead become the baseline way that the body operates. This results in changes within the human body that might gradually wear out its various components, and, in turn, be transmitted across generations. If ongoing pernicious experiences of stress and social devaluation are able to change neurological and physiological development of children and adults, it becomes conceivable that such selection effects ought to be conceptualized as intermediate mechanisms that link familial membership in disempowered social groups and poor health outcomes (Thoits, 2010). This re-interpretation of previous research would then provide strong evidence that family structure would meet the third criteria for identifying a social determinant of health. That is, that differences in health and wellbeing outcomes identified across family structures can be associated with the distributions of prestige, power, and resources on the basis of a wide variety of intermediate mechanisms. One mechanism, however, remains chronically understudied - the role of interactions between families and health care systems.

**Studying Family Structure and Interactions with Health Care Systems**

Though there is some evidence that interactions with health care systems differ across family structures, this intermediate mechanism has historically gained little attention from both health care and family researchers (Brown et al., 2008; Ganong, 1995; 2011). What evidence does exist, is predominantly present in the family nursing literature. This is largely due to physicians often equating families with trouble (Levine & Zuckerman, 1999; Riley, White, Graham, & Alexandrov, 2014) and nurses often functioning as the primary point-of-contact between health care systems and families (Hopla, Tomlinson, Paavilainen, & Astedt-Kurki, 2005). Over the past several decades,
nursing researchers have increasingly recognized that families play important roles in pediatric patient regimen adherence and health maintenance (Chesla, 2010), and that family variables are often more predictive of children’s overall wellbeing than more commonly studied variables like socio-economic status and disease related variables (Lavigne & Faier-Routman, 1993). Much of the previous research focused on health care providers’ interactions with families, however, has been designed and conducted overwhelmingly with nuclear families and/or solely mother-child dyads (Phares, Lopez, Fields, Kamboukos, & Duhig, 2005).

A small, but growing body of literature, provides evidence that nurses, physicians, and health care systems as a whole, continue to struggle with providing support to increasingly common non-nuclear family structures, particularly divorced and remarried families wherein pediatric patients may have residence in two households (Gayer & Ganong, 2006; Kelly & Ganong, 2011a; 2011b; Russell, Coleman, Ganong, & Gayer, 2016; Zarelli, 2009). Though caretaking for children with chronic conditions is often burdensome on mothers, women in post-divorce families (i.e., single mothers, remarried mothers, and stepmothers) often must contend with additional responsibilities, potentially contentious coparenting partners, and economic constraints (Gayer & Ganong, 2006; Russell et al, 2016). Additionally, stepparents are often unsure of their role in regards to children’s illnesses, and it is not unusual for medical professionals to act in ways that actively push them away from involvement (Kelly & Ganong, 2011a; 2011b; Ganong, & Coleman, 2004; Zarelli, 2009). As a result, additional resources stepparents can bring to child care or illness management are often underutilized (Kelly & Ganong, 2011a; 2011b; Zarelli, 2009).
In a previous grounded theory study, Russell and colleagues (2016) found that in some post-divorce families, co-parents’ interactions with health care providers became embroiled in issues of mistrust and harsh feelings that remain from the dissolution of the marital relationship. Some parents reported that their health care providers were able to skillfully navigate these contentious relationships by building independent relationships with each parent and developing creative health care schedules. Other parents, however, reported health care providers who simply refused to work with their families, or took sides in the ongoing conflict between parents, eroding trust and sometimes putting children’s treatment in jeopardy. What differentiated these different responses by medical professionals, however, remained unclear.

Each of these previous investigations have been predominately exploratory and theoretical in nature and primarily conducted with the parents of medical patients. Understanding how medical professionals can develop best practices for working with post-divorce families remains an important priority for family health researchers (Carr & Springer, 2010; Ganong, 2011). Methodological and ethical challenges, however, have largely prevented direct assessment of the effects of family structure on family-provider interactions (Brown et al., 2008).

**Methodological and Ethical Challenges in Family and Health Care System Research**

The classical experiment has long been upheld as the gold standard for determining to what extent one variable causes change in another (Babbie, 2016). When attempting to study the effects of family structure in health care settings, however, researchers must contend with challenges in measurement and research design, such as confusing the concepts of households and families, the inability to randomly assign
individuals and families to specific family structures, and ethical health privacy requirements. Obtaining a sample (or sampling frame) and operationalizing the measurement of post-divorce families can prove to be surprisingly challenging for family researchers. Large national studies often confound households with families (Ganong & Coleman, 2017; Teachman & Tedrow, 2008). Divorced parents are often collapsed into single-parent or stepfamily categories depending on which adults are present within a given household (Teachman & Tedrow, 2008). This is problematic because even when a child may live primarily with a divorced single parent, if a researcher does not ask about family members outside of the home, they may not recognize the presence of nonresidential co-parents or stepparents. Furthermore, changing demographic patterns mean that many stepfamilies today are formed through cohabitation or the first marriage of one or both adults, resulting in the possibility of further misidentification (Teachman & Tedrow, 2008).

A second inherent challenge to family structure research, and one that largely prevents the opportunity for experimental research on such families, is the ethical impossibility of randomly assigning individuals or families to different statuses (e.g., divorced, married, re-married). As a result, any investigation into family structure often brings with it a number of non-controllable selection or co-effects. If researchers are interested in studying how health care systems respond to patients based on their family structure, they are often limited to solely associational investigation designs. Yet even evaluating family-provider interactions can prove challenging due to extensive (and appropriate) regulatory requirements intended to protect the privacy of potential research participants, medical patients, and the integrity of patient-provider relationships (Sung et
al., 2003). A multi-segment factorial vignette (MSFV) method, however, allows solutions for each of these challenges within an experimental framework.

**Utility of the MSFV Method**

Ganong and Coleman (2006) developed the multiple segment factorial vignette (MSFV) method by merging survey and experimental research components of factorial surveys with the detailed stories and open-ended questions of expanded vignettes. The resultant mixed-method design allows for the exploration of attitudes and social cognitions related to sensitive topics, such as medical provider responses to family structure, in a systematic fashion. MSFV’s provide a detailed story to participants in a set of segments. Within and across each segment, a series of variables are embedded, the dimensions of which are manipulated across participants (or segments). As an example, if a researcher sought to evaluate the role of gender, some participants would randomly receive a series of vignette segments about a father named Paul, while others would receive segments with the same details, but about a mother named Paula. At the end of each segment, participants can be asked a series of both closed- and open-ended questions depending on the research questions under investigation. Each segment may introduce new variables, some of which may be constant across versions of the vignette; others may be manipulated. The design allows researchers to draw conclusions of how specific dimensions of a given independent variable impact the measured outcomes (dependent variables) of interest.

Using an MSFV design, a researcher can assign the family structure of a hypothetical patient randomly to health care providers, and control (or strategically manipulate) other variables about these hypothetical patients without having to
intrusively interrupt medical treatment and the health privacy of actual patients. Data can be collected relatively quickly and provide insight into the cognitive processes of health care providers. MSFV designs also lend themselves well to exploring the complexity of post-divorce family structures, such as the roles of residency and parent/stepparent involvement, which are often ignored or overly-simplified in other designs (Ganong & Coleman, 2017; Teachman & Tedrow, 2008). Given the abundance of deficit-comparison research that already exists within family science literature and ongoing calls for additional within-structure research, exploring variety across post-divorce family structures seems to be a pressing need (Ganong et al., 2015; Sweeney, 2010). Within-structure exploration is also desirable because of the importance of identifying graded hierarchies within social determinants of health (Marmot et al., 2008). Studying complexities like differing marital statuses of mothers or fathers, and the influence of custody arrangements and children’s residency could help identify the existence of such gradients within post-divorce families, and provide insight for practitioners.

The Integrated Behavioral Model

The integrated behavioral model (IBM), which grew out of the theory of reasoned action and the theory of planned behavior, posits that one of the most critical predictors of any behavior is the intention to perform that behavior (Montaño & Kasprzyk, 2008). This proposition (and the IBM as a whole) lends itself well to MSFV investigations, which are particularly effective at evaluating intended behaviors, attitudes, and norms (Ganong & Coleman, 2006). Drawing from additional behavioral-aligned research, the IBM points to the importance of knowledge, saliency, habit, and the role of environmental constraints on the enacting of a given behavior (Montaño & Kasprzyk,
In order to properly implement and evaluate the application of the IBM on a given subject (such as provider interactions with post-divorce families) it is often important to first qualitatively interview members of a given population in order to understand what salient behavioral outcomes, affective responses, sources of normative influences, and barriers or facilitators exist (Montañó & Kasprzyk, 2008). Supplementing MSFV designs that already include open-ended questions with further exploratory in-depth interviews would allow for the discovery of some of these less proximate cognitive and environmental impacts on health care provider interactions with post-divorce families; this would be valuable for designing more specific and contextually-sensitive survey instruments in the future.

**Focusing the Investigation: Type 1 Diabetes Mellitus**

In order to allow for control of factors across vignettes (internal validity), and for generalization to a broad population of parent and family caretakers of children with a chronic illness, it is pertinent to focus on a chronic condition that is prevalent, has a relatively standardized treatment regiment, and requires high-levels of caretaker involvement. Type 1 diabetes mellitus meets these criteria. The Centers for Disease Control and Prevention (CDC; 2011) estimates that Type 1 Diabetes Mellitus (T1D) is one of the most common childhood chronic illnesses in the United States. Approximately 15,600 new diagnoses of T1D occur in children every year. Type 1 diabetes mellitus is the result of the body’s inability to produce insulin, a hormone necessary for converting sugar in the blood into energy. Too little sugar in the bloodstream (hypoglycemia – often colloquially referred to as “lows”) makes the body unable to function and can lead to immediate consequences such as unconsciousness or seizures. Too much sugar in the
blood (hyperglycemia – “highs”) results in an overworking of the organs and increases the likelihood of organ failure and other long-term consequences such as diabetic neuropathy or loss of sight. Without insulin, the body begins to convert fat into energy, causing severe weight-loss, and as the body attempts to expel the excess sugar, dehydration and more immediate experiences of sluggishness, drowsiness, or moodiness occur. Individuals diagnosed with type 1 diabetes mellitus spend much of their lives trying to keep their blood sugar and metabolic system at a balanced level between these extremes. This requires being aware of the amount of carbohydrates in any given meal and taking doses of insulin in appropriate ratios.

To accomplish this, children and their caretakers must monitor blood glucose levels through daily blood glucose monitoring (regular finger-pricks in which a meter is used to test the blood-sugar level) as well as a measure of glycated hemoglobin (HbA1c) at routine physician visits. The American Diabetes Association (ADA; 2013) recommends that diabetics ought to maintain an HbA1c that is < 7% in order to avoid the negative complications often associated with diabetes. Nondiabetic individuals generally have an HbA1c that is < 6.4%. HbA1c values above 7 are indicative of sustained high blood glucose levels and increases in HbA1c values have an exponential relationship to individual’s likelihood of experiencing negative complications. A qualitative analysis of youth (age 8-19) with T1D-parent dyads conducted by Schilling, Knafl, and Grey (2006) identified that between the ages of 8 and 11 (preadolescence) parents perform much of their children’s diabetes care. In this parent-dominant stage, parents oversee insulin dosing, are involved in blood glucose monitoring, and are often responsible for treating both “highs” and “lows.” Newly diagnosed youth and their families are often provided
with strict schedules for blood glucose monitoring, eating, and insulin dosage in order to better scaffold habitual regimen adherence (Silverstein et al., 2005). Overall, type-I diabetes is prevalent, requires parent involvement, and generally involves a standardized treatment regiment, which makes it an appropriate choice for an MSFV investigation of nurse-parent interactions in post-divorce families.

**Research Questions**

Drawing on previous research and the conceptualization of family structure as a social determinant of health, it is evident that researchers and practitioners could benefit from additional knowledge regarding how family interactions with health care systems might operate as an intermediate mechanism between family structure and health inequities. As a beginning step of inquiry, the purpose of this study was to investigate how nurses respond to variability in patient family structure and common post-divorce coparenting/custody dynamics when working with a pediatric patient newly diagnosed with type 1 diabetes mellitus. Specifically, I used an MSFV-based investigation guided by the integrated behavioral model and a SDOH framework to address the following research questions:

RQ1: How do nurses’ beliefs about their preparedness for working with pediatric patients in divorced families change if it becomes apparent parents have contentious relationships?

RQ1a: How do nurses’ beliefs about their preparedness for working with pediatric patients differ by patients’ post-divorce family structure, parent gender, and custody arrangement?
RQ2: How do nurses respond to and make decisions about working with a pediatric patient who has divorced parents with contentious relationships?

RQ2a: What eases or inhibits nurses’ interactions with caretakers in post-divorce families?

RQ2b: How are nurses’ training and experiences related to their responses and decisions about working with a pediatric patient who has divorced parents with contentious relationships?
Chapter 2: Methods

Sample

The final sample for this study was made up of 150 self-identified pediatric and family nurses recruited through the Society of Pediatric Nurses and word-of-mouth. Announcements that included a web-link to an online survey (administered through the Qualtrics online platform) were distributed via the Society of Pediatric Nurses e-mail list-serve. Those who received the e-mail were asked to share the survey link with others who met the study criteria. The final sample was rather homogenous in regards to gender and race, being predominately female (96%) and white (94%). There was more diversity, however, regarding family background and nursing experience. A slim majority of participants were currently in their first marriage (51.3%), and most had biological or adopted children (64%). Most participants highest nursing degree was either a Bachelor’s (42.7%) or a Master’s (34%), and the majority worked in a hospital setting (64.4%). Table 1 provides sample characteristics of those who completed the online survey. Interview participants were selected from those who volunteered their contact information at the conclusion of the online survey. As possible, Corbin and Strauss’s (2014) theoretical sampling was used to recruit 23 participants for interviews with diverse experiences (e.g., who varied in professional and family history, vignette responses, and nursing experience). Table 2 provides summary sample characteristics of participants in the follow-up phone interviews, with Table 3 including a more detailed sample description by participant. The characteristics of participants roughly matched those of the larger online survey, though due to the sampling frame, was likewise extensively homogenous regarding gender (100% female) and race (95.7% White or Caucasian).
**Procedure and Measures**

To answer the research questions, I used a transformative mixed methods design (Creswell, 2014) that includes an online administered multiple segment factorial vignette investigation (MSFV; Ganong & Coleman, 2006) eliciting both quantitative and qualitative responses, supplemented by semi-structured phone interviews conducted with a subsample of nurses. Transformative mixed-methods designs are recommended when a researcher desires to develop an understanding of needed changes for a marginalized group (in this case post-divorce families; Creswell, 2014). In this method, the researcher attempts to bridge the gap sometimes found between subjective and objective ways of knowing and utilizes qualitative and quantitative findings to reinforce one another (Creswell, 2014). Table 4 displays the specific analyses performed, and the associated variables and research questions. Embedded survey items within the MSFV would allow for the estimation of nurses’ comfort and perceived preparedness for handling common challenges that might arise in working with pediatric patients in post-divorce family structures (RQ1). The MSFV method also allowed for an investigation of how nurses’ responses to family structure and process disclosures during clinical visits might vary through the manipulation of post-divorce family structure, parent gender, and custodial arrangements across vignettes (RQ1a). Open-ended MSFV questions supplemented with semi-structured interviews provides the opportunity to gather additional details regarding how nurses navigate these hypothetical vignette situations, as well as identify and explore how perceptions of institutional, personal, legal, or other factors might ease or inhibit nurses’ interactions with caretakers in post-divorce families (RQ2; RQ2a). Finally, a brief demographic and personal history questionnaire provided information for evaluating
how personal experience and expertise might also influence responses to parental disclosures (RQ2b).

**Multiple segment factorial vignette (MSFV).** The MSFV for this study was designed to complete a 2 (custodial parent remarriage status) x 2 (ex-spouse remarriage status) x 2 (custodial parent gender) x 2 (custody arrangement) between-subjects’ experiment (see Appendix A). All variations of the vignette versions may be found in Table 5. During the MSFV, participants were presented with a single segment that described a pediatric (8-year-old) patient, named Casey, who had recently been diagnosed with type 1 diabetes mellitus and assigned a typical medical regimen for this condition. In this first segment nurses received information from either a mother or father (parent gender) about Casey’s family structure (the divorce/remarriage status of both the custodial parent and their ex-spouse). The hypothetical parent then explains to the health care provider that they have either a current custody arrangement in which their child spends about 30% of their time in the custodial parent’s ex-spouse’s household (presented in the vignette as “every other weekend, Wednesday nights, four weeks over the summer, and some holidays”) or about 50% of their time in the custodial parent’s ex-spouse’s household (presented in the vignette as “every other week”). The first segment ends with the custodial parent requesting advice for how they might best handle Casey’s type 1 diabetes mellitus given their custody arrangement. After this segment, nurses were asked an open-ended question inquiring how they would respond to Casey’s parent. To address the integrated behavioral model’s concept of perceived control, participants were then asked a yes or no question regarding whether anything might prevent their ability to respond the way they think is ideal. If participants answered yes to this question, they
were offered a text-box in which to answer what might prevent their ability to respond. The participant then responded to three forced-choice questions, asking them to rank on a scale from 1-6 with 1 being completely unprepared to 6 being completely prepared, how prepared they think they are to handle the health-related components of a case such as Casey’s, the family-related components of a case such as Casey’s, and a question such as that posed by Casey’s parent.

In the second segment of the vignette, new information that is constant across vignettes is introduced - the disclosure that the relationship between Casey’s parents is contentious. In this segment Casey and the care provider from the first segment return for a check-up appointment. It is revealed that Casey’s Hba1c (a measure of glycemic control) is 9.5 (this is high, typical clinical recommendations are < 7) and has significant room for improvement. The parent then reveals that he or she believes the other parent(s) (e.g., Casey’s other parent, and potentially new stepparent) is(are) not taking treatment seriously enough, not sticking to the agreed-upon schedule, and that he or she believes that their ongoing arguments are adding further stress for Casey that is negatively influencing Casey’s glycemic control. Following this segment, the nurses were again given a series of questions inquiring how they think they would respond, if anything might prevent them from responding the way they think is ideal, and forced-choice questions about their preparedness for handling various components of Casey’s case.

In the third and final segment of the vignette, another constant across vignettes is introduced. The disclosing parent indicates that they believe sharing custody with the ex-spouse was a mistake and that he or she plans to stop Casey from spending time in the other parent’s home. The custodial parent concludes by asking the health care provider
what they think about this decision. Again, participants responded to a series of questions about how they would respond, if anything might prevent them from responding the way they think is ideal, and forced-choice questions about their preparedness for handling various components of Casey’s case. One additional forced-choice question after this segment then asks participants: “On a scale from 1 to 6 with 1 being completely unwilling and 6 being completely willing, how willing would you be to testify on this parent’s behalf that Casey’s other parent was a danger to Casey’s health and wellbeing?”

**Demographic questionnaire.** After completing the vignette, participants responded to a short demographic questionnaire (see Appendix B). This questionnaire collected information on participant’s age, gender, race, marital status, family background, education, and years/experience in the nursing field. Nurses were also asked (separately) how often they worked with pediatric patients with type 1 diabetes mellitus, and how often they worked with children from post-divorce families on a scale of 1 = Never to 5 = Very Frequently. At the end of the questionnaire, participants were provided the opportunity to volunteer to participate in a follow-up phone interview.

**Interview protocol.** Interviews were conducted by phone with a subsample of 23 volunteers who completed the MSFV. Using Holstein and Gubrium’s (1995) active interview technique, the goal of the interview was to elicit additional information and detail regarding how nurses navigate decisions in working with pediatric patients who have divorced parents with contentious relationships. The semi-structured format allowed for the investigation of influences on participant responses to the vignette that were not hypothesized a priori within the MSFV. The live interviews began by reviewing the MSFV framework (Appendix A) with the nurse participant and inquiring about how they
came to their responses to the online questionnaire, or how they would make decisions about the vignette given different circumstances (e.g., would they have answered differently if there had been a different family structure, parent, or custody arrangements). Interviews then explored the lived experiences nurse participants have had with patients in post-divorce family structures or whose caretakers had conflict over care regimens/adherence. Specifically, nurses were asked about successes or challenges they had faced, and best practices for managing or preventing those challenges (for the full interview protocol see Appendix C). All interviews were audio-recorded and, with the help of an undergraduate research assistant, transcribed word-for-word.

**Data Analysis**

The first research question, regarding how nurses’ beliefs about their preparedness for working with pediatric patients in divorced families changes if it becomes apparent parents have contentious relationships, was answered through a repeated measures ANOVA of the forced-choice preparedness responses provided by nurses at the end of each segment of the MSFV in accordance with Tabachnick and Fidell’s (2012) guidelines. The sub-question regarding how family structure, parent gender, and custody arrangements might affect nurses sense of preparedness was evaluated by a 2 (custodial parent remarriage status) x 2 (former spouse remarriage status) x 2 (parent gender) x 2 (custody arrangement) multivariate analysis of variance, again in accordance with Tabachnick and Fidell’s (2012) guidelines. Post-hoc ANOVA and pairwise comparisons were used to identify differences on specific items and between specific sub-groups. An a priori calculation using the G*Power 3 calculator developed by Faul, Erdfelder, Lang, and Buchner (2007) suggested that in order to detect
a medium ($f^2 = .0625$) effect size across the 16 vignette possibilities, with limited probabilities for type 1 and type 2 errors ($\alpha = .05; 1 - \beta [\text{power}] = .80$ respectively) an estimated 144 participants would be required.

The second research question, regarding how nurses respond to and make decisions about working with a pediatric patient who has divorced parents with contentious relationships, and its sub-question regarding factors that ease or inhibit nurses’ interactions with care-takers in post-divorce families were investigated through analysis of the open-ended items from the MSFV and the responses to the follow-up phone interviews. Specifically a grounded theory was created using Corbin and Strauss’s (2015) constant comparative method to develop codes, categories, and themes out of the interview data and qualitative responses. Exemplar codes, associated categories, and emergent themes can be found in Table 6. The coding process began with line-by-line coding in which participants own words and phrases were used to develop codes. Initially, both me and a trained undergraduate research assistant independently conducted line-by-line coding of transcripts. During weekly meetings, we compared our codes and grouped them into conceptually-related categories. Any differences in interpretation were discussed until agreement was reached. From these categories came the development of themes using Owen’s (1984) criteria of repetition, recurrence, and forcefulness. Based in communications theory, the criteria of recurrence and repetition focuses on the importance of multiple incidences of reported information during a conversation. Themes identified on the basis of repetition included words or situations that were discussed repeatedly throughout and between participant’s reports. Building on this criterion, recurrence involves ideas, thoughts, feelings, or experiences that are implied
through different language, or expressed in alternative formats, but still appear repeatedly throughout and across transcripts. The final criterion, forcefulness, is based on how the information of participants was presented rather than its’ specific content. Topics that were exclaimed, stressed, or otherwise presented as important (through voice or tone) to the participants lived experiences in providing care to children who have divorced parents with contentious relationships. Forcefulness was evaluated through memos made by me and the undergraduate research assistant during the conduction and transcription of interviews. For example, in one memo, I detailed how a nurse took a dismissive tone to some questions about involvement in family dynamics, continually reiterated her role as a “neutral” educator, and was seemingly skeptical of my questions about engaging with family processes that she implied were beyond her role and expertise. These memos were later used in the development of categories and themes surrounding neutrality and being educationally-orientated.

Memos were used throughout data collection, coding, and analysis to document forcefulness, as well as thoughts, theoretical propositions, and impressions of the participants, their reported experiences, and how they may relate back to the larger literature on nurses’ interactions with patients in post-divorce families (For example memo excerpts, see Appendix D). These memos were utilized for informing and developing thematic codes as well as to explore the ways in which themes theoretically relate to one another. Throughout the coding process consultations with faculty advisors on my doctoral committee were used to establish validity and ensure the rigor and trustworthiness of our coding and interpretations of data. In collaboration with the other forms of analysis used in this project, the overall process of memoing, coding,
categorization, and theme development were used to develop a theoretical model of how nurses navigate decisions about working with pediatric patients who have divorced parents with contentious relationships.

Based on the emerging grounded theory, an additional analysis was conducted to evaluate the second subquestion of the second research question, regarding how nurse’s training and experience are related to their responses and decision-making process when working with a patient whose parents are divorced and have a contentious relationship. First, based on open-ended responses participants provided in the MSFV, each nurse was coded into one of two nursing orientations identified through the emerging grounded theory. Following this coding process, a logistic regression was used to evaluate whether years as a licensed registered nurse, highest level of nursing education (1 = Diploma to 6 = PhD), and personal experiences of divorce or remarriage (0 = no, 1 =yes) as an adult, or during their childhood in their family of origin differentiated categorization in either of the two nursing orientations. As with other quantitative analyses, the logistic regression was conducted in line with Tabachnick and Fidell’s (2012) guidelines.
Chapter 3: Findings and Implications

How do Nurses’ Beliefs about their Preparedness for Working with Pediatric Patients in Divorced Families Change if it Becomes Apparent Parents have Contentious Relationships?

After reading the first segment of the vignettes, before complications regarding family conflict were introduced, nurses’ appeared to be mostly confident in their perceived preparedness to provide care to the hypothetical patient of Casey. As evidenced in Table 7, across segments, nurses generally reported perceptions of preparedness closer to the highest (6 – completely prepared) end of the scale (i.e. ratings of 4 or above) than they did ratings closer to the lowest (1- completely unprepared) end (i.e., preparedness ratings of 3 or below) for handling the various components of the hypothetical MSFV case. A series of three repeated measures ANOVAs with Greenhouse-Geiser corrections determined that the mean perceived preparedness of nurses differed significantly across vignette segments for all three preparedness questions: Perceived preparedness for health-related components $F(1.81, 269.12) = 22.85 \ p = .000$ partial $\eta^2 = .13$, for family-related components $F(1.83, 272.55) = 45.548 \ p = .000$ partial $\eta^2 = .23$, and for handling specific disclosures $F(1.84, 274.74) = 45.548 \ p = .000$ partial $\eta^2 = .31$. Post-hoc tests using a Bonferroni correction revealed statistically significant reductions from segment 1 to both segment 2 ($I-J = .280 \ p = .000$) and segment 3 ($I-J = .387 , p =.000$) in regards to nurses’ preparedness for handling the health-related components of the hypothetical case. The differences between segment 2 and 3 themselves were not statistically significant ($I-J = .107 \ p =.156$). Additionally, statistically significant reductions were identified across all three segments for nurses’ perceived preparedness for dealing with the family-related
components and specific disclosures of parents within the MSFV (see Table 8). These analyses provide evidence that complications regarding coparenting conflicts and custody disagreements reduced nurses’ reported preparedness for working with pediatric patients from post-divorce or remarried families.

Nurse comments within the semi-structured follow-up interviews confirmed that even those nurses who had reported being “6 – completely prepared” for handling the family components of the hypothetical MSFV case sometimes felt that they lacked training or appropriate preparation for working with post-divorce or remarried families, particularly in the context of contentious coparenting relationships. Gail and Sophia, nurses involved in training and education pointed out that this area had gained little attention in the research literature, and that their participation in the online survey and follow-up interviews had made them realize that current programming for working with post-divorce families was deficient:

I’d have to tell you that I also teach nursing students, and there’s not education and very little curriculum. In a nursing textbook and a chapter on the family, there’s maybe a paragraph on divorce. I do not believe we prepare our health care professionals to deal with the dynamics of families and the diversity of families and people only know from their life experiences and their formal education. If you’re fortunate enough to come from a home with two parents then you go into the profession of nursing or health care and you have a family case that’s different from your own and… you do not have anything to draw on it except your formal education and… the formal education isn’t there.
I am a clinical educator in the hospital that I work at. We do these choice mission requirements that are population specific and for the longest time it was the infant or the adolescent and then we started going through the patient population, orthopedic, cerebral palsy I did one year. But no, this is a topic for next year, I’m working with divorced families. I do not think we are necessarily prepared to avoid problems like this or figure out a way to help them.

**How do nurses’ beliefs about their preparedness differ by pediatric patients’ post-divorce family structure, custodial parent gender, and custody arrangement?**

In a second set of analyses, three multivariate analysis of variance (MANOVA) tests were performed, one for each segment of the MSFV, to evaluate how aspects of family structure, parent gender, and custody arrangement were related to nurses’ self-reported preparedness for handling various aspects of a medical case. In interviews with nurses, participants uniformly assured me that these aspects of cases were unlikely to influence their preparedness or approach to working with families. When directly questioned, nurses responded with comments like: “Conversations I have for my patient’s parents are no different if they’re a single parent or if there are five parents in the room.”; “I try to be very gender non-biased”; or, “The custody part has nothing to do with it.”

Additional quantitative results from the MSFV design revealed that though there was some veracity to these disclosures evidenced across the study sample, family structure, gender, and custody arrangements did appear to impact some aspects of nurses’ sense of preparedness. In each of the MANOVA tests conducted, four independent variables created a 2 (custodial parent remarriage status) x 2 (ex-spouse remarriage status) x 2 (parent gender) x 2 (custody arrangement) design. There were three
dependent variables in each analysis regarding nurses’ self-reported preparedness for handling the: (1) health components, (2) family components, and, (3) specific disclosure by parents in each segment. Table 9 displays results from the MANOVAs conducted on each segment. The only significant MANOVA occurred among the segment 2 items, revealed a significant three-way interaction for the custodial parent remarriage status by parent gender by custody arrangement, $F(3, 132) = 3.47, p = .018$; Wilk's $\Lambda = .927$, partial $\eta^2 = .073$ (observed power = .765). Post-hoc ANOVA tests, displayed in Table 10, revealed significant differences in nurses’ preparedness for dealing with the family components of the case $F(1,134)= 5.90, p = .016$ partial $\eta^2 = .042$ (observed power = .674). Figure 2 displays the three-way interaction plot for this outcome. Additional post-hoc comparisons revealed a statistically significant difference existed between two sets of pairs. The first difference was between custodial mothers with 50-50 custody arrangements who were remarried and custodial mothers with 50-50 custody arrangements who were single ($I-J = .752 p =.036$). The second pair was between (again) custodial mothers with 50-50 custody arrangements who were remarried, and custodial fathers with 70-30 custody arrangements who were single ($I-J = .777 p = .024$). These results provide evidence that nurses perceive themselves to be less prepared for handling family-related issues when working with a pediatric patient who resides with a divorced mother with a 50-50 custody arrangement who is single, or with a divorced father with a 70-30 custody arrangement who is single, as compared to when working with a patient who resides with a divorced mother with a 50-50 custody arrangement who is remarried.

Both sets of initial analyses provided insight into how prepared nurses perceived themselves to be for handling various aspects of a medical case when working with post-
divorce families. Specifically, how post-divorce conflict, family structure, parent gender, and custody arrangements affected their sense of preparedness. In applying more in-depth grounded theory analyses to qualitative interviews I sought to explore how nurses made decisions about responding to patients and their family-members, and what they perceived to be beneficial or detrimental to their ability to work with post-divorce families.

**How do Nurses Respond to and Make Decisions about Working with a Pediatric Patient who has Divorced Parents with Contentious Relationships?**

In their illness beliefs model, Wright and Bell (2009) contend that health care providers’ beliefs about families lay the groundwork for how such providers interact with patients and their families (or avoid interacting with them). Across interviews conducted with nursing professionals, beliefs about working with families were a salient and common justification nurses used to explain their goals, behaviors, and approach to addressing both the hypothetical patient of Casey presented in the MSFV, and real-world patients from post-divorce families who they interacted with in their everyday careers. Some nurses believed it was their job to reach out and connect to all members of a family. In an exemplar quote, Sophia, explained her philosophy as “The best thing for the child is to have a lot of eyes helping to support the condition that affects the whole family and everybody should be in the know”

Others thought working with whomever showed up at a clinic was sufficient, on the presumption that it was the family-members’ obligation to exchange any information shared by health care providers. As one nurse, Kelly, put it:
As long as we have one parent there, I do not think our clinic is open to reaching out to the other parent to see if they want to hear the same stuff. I think sometimes they just expect, whether you’re divorced or not, that the person who came to the appointment relays the information.

Drawing on Wright and Bell’s (2009) illness beliefs model the concept of beliefs about working with families emerged as the core theme in this investigation. Specifically, two distinct patterns of beliefs were identified. The first of these patterns, in which nurses’ primary focus was on transferring medical knowledge to family members while avoiding entanglements with family drama, was labeled “educationally-oriented.” The second pattern, in which nurses instead focused on promoting effective support systems within families and often made deliberate attempts to engage with all members of a patient’s family, was labeled “relationally-oriented.” The dominant beliefs, strategies, and perceived strengths or liabilities of each of these orientations are elaborated upon below, followed by a discussion of considerations that may affect the likelihood of a nurse adopting either of these orientations or the effectiveness of their implementation.

**Educationally-Oriented Nurses.** Nurses identified as educationally-oriented in interviews (n = 10) described education and the transference of health knowledge as the primary purpose of interactions between themselves and pediatric patient’s family members. If caregivers had appropriate knowledge, they contended, the pediatric patient’s health would be optimally managed, and that, as Claire put it: “If you have resistance, it’s due to the lack of knowledge and lack of education.” Furthermore, educationally-oriented nurses suggested that moving beyond the transfer of knowledge would require engaging in actions that went beyond their roles as a nurse and, often, their
expertise. These nurses stressed the importance of clear boundaries, particularly with structurally-diverse families, like Kristy did in the following quote:

I think especially now, where there are more divorced families and complicated family social situations; the boundaries for me are being knowledgeable but not trying to change it because it’s not really my life. (My job is) ensuring that (parents are) knowledgeable.

When these nurses witnessed conflictual coparenting, or if a parent attempted to share relational concerns, they reported that they either demurred and returned again to a focus on education and knowledge, or immediately recommended the family member to get in touch with a social worker or child services. As Dianne explained, setting clear boundaries early and often with families was an important tool for keeping clear the nurse’s role as a neutral medical resource for the family:

In the in-patient setting we’ll have a family meeting to say we’re all there for the patient or the child and not for anybody else’s benefit really. We’re here to help teach and provide resources.

Generally, educationally-oriented nurses sought to fit post-divorce and remarried families into their educationally-based institutional norm for working with families. This involved providing structured information about diagnoses, prescriptions, and care regimens to any caregivers present in the hospital or clinic setting. In post-divorce families, however, it is not unusual for some caregivers and family members to not be present due to custody arrangements or conflictual relationships among parents and caregivers. One consequence of this reality was that occasionally educationally-oriented
nurses, like Joan, reported that they were unaware of patients’ family structures unless a conflict or complication manifested itself.

I will say that sometimes we do not always know that the families are split up because it may not come up until an issue arises. The family is, the biomom and the biodad are not together. A lot of times, when families come together, we think mom and dad, but it could really be stepdad and we won’t even know. (…) Sometimes we’ve been seeing patients for a couple years and then, all of a sudden, they come with an appointment and we ask the kids, “Oh who did you bring with you today?” and they say, “Oh this is my dad.” I thought I knew who dad was but apparently he was stepdad, and we were super unaware of that. I do not think that happens super frequently, but it is something that happens.

When conflicts among caregivers occurred, these nurses were quick to bring up concerns about medical neglect, involving social services, or “hot-lining” noncompliant parents, compared to those classified as relationally oriented. In fact, all 10 of the educationally-oriented nurses mentioned such solutions to parental conflict or disagreement during their interviews or in their open-ended responses to the MSFV, compared to just four of the 13 relationally-oriented nurses. In contrast to relationally-oriented nurses, who generally referred to calling social services as a measure of last resort, educationally-oriented nurses like Dianne sometimes described using such strategies as a way to ensure conformity to their directives:

Typically if (divorced parents) are a hassle, we’ve had instances where it’s a hassle and they won’t (attend educational courses together). We’ve had some of our providers call child protective services and say they feel that is medical
neglect. Usually that direction and the discussion of that certainly leads parents to just agree to have to go to one day that they have to be there at the same time.

An educational orientation towards working with families had clear benefits in providing obvious boundaries for nurses, and allowing them to largely stick to the expertise for which they had been trained. It could, however, inhibit their ability to be flexible in response to families that failed to cooperate or coordinate as they expected. As some, particularly more relationally oriented nurses pointed out, this could leave gaps in the care provided to children, especially those who resided in post-divorce family structures. As Sophia noted:

“I think this is a health care problem. [Family dynamics] affect the child’s health and their emotional wellbeing. It’s a very grey zone that I think health care promoters try to avoid most. They do not want to be social. Let me fix the ear infection, the wounds, the broken bones due to the injury, but I do not want to get into all that baby mama drama or baby daddy drama.”

**Relationally-Oriented Nurses.** In contrast to educationally-oriented nurses, relationally-oriented nurses \((n = 13)\) emphasized the importance of building connections with patients’ families and “being real” across their follow-up interviews. These nurses believed that children received the most effective care when they had a reliable support system that could communicate and work collaboratively to meet their health needs. Relationally-oriented nurses noted that developing such a network of support could be particularly difficult in post-divorce contexts where hurt feelings, anger, disengagement, or jealousy among parents could manifest in the management of a child’s illness.
Relationally-oriented nurses, like Candace, emphasized the importance of recognizing and either managing or validating parents’ experiences:

At the end of the day, this is about a sick child in a bed, so what can we do to keep the people that are important to this child here and support them through their illness. If everyone can get along and remind them that we’re all here for this child, then it would be easy. Everyone comes. If they aren’t putting the child first, and they all have disagreements, then we’ll have to get involved and have to come with a plan. (Gail)

Being human. Being a person who they feel comfortable coming to you and verbally vomiting if they have to, or just listening. Being for the parent as much as the child is a huge part of my job. I have a patient in the bed, but I have a family with the patients as well. Just listening. Knowing the nurse is there, if you need to talk. Sometimes all we need is an ear. All they need is someone who can acknowledge, “I know this is hard for you. I understand it’s difficult,” people just need validation sometimes.

In order to provide effective support, relationally-oriented nurses stressed the importance of being aware of family dynamics. These nurses’ initial inquiries about the hypothetical patient Casey were often about the quality of the coparenting relationship and communication across households. At the start of an interview, when asked how they would approach the hypothetical case of Casey, relationally-oriented nurses often responded with a long list of family and relationship related questions they would seek to find answers to, as Lori did in the following example:
First of all, I have a lot more questions. What is the parents’ relationship with each other? Are they able to talk about the care of the child? How it is best managed? I’d start off with an assessment of what the situation is here. Are there any other players? Are there caretakers? Siblings? I typically do an entire family assessment anytime I deal with an illness of a child. They’re all in the room at the same time, (I am) paying attention, where they sit, what’s the communication patterns like, and then the questions. Tell me how it is with your family. How are you managing it now? What do you think about how that is working for you.

Like their educationally-oriented peers, relationally-oriented nurses also stressed the importance of neutrality. Instead of describing neutrality as a process of avoiding family drama, however, they instead characterized it as engaging fairly and equally with all members of a patient’s family without judgment. As Patricia pointed out in the following quote, if such a relationship between health care providers and family members was missing, ensuring appropriate care of a child could become more difficult or impossible.

You try to not let perceptions or feelings come into the picture. You want to be able to treat both parents with respect regardless of the situation. As a pediatric nurse, your ultimate goal is what’s best for that patient, what’s best for that child. (…) If you do not gain the respect or trust of the parents, they’re not going to listen to you. They’re not going to get what they need to take care of that child. By staying as the neutral party, hopefully they trust you enough to listen to you and get the information that they need.
Relationally-oriented nurses noted that it was not an easy process to remain neutral in this way. They reported that, particularly in the early stages of their careers, it was easy to get sucked into parental conflicts or to judge parents as more or less effective, and that doing so undermined their ability to work with families. As one nurse, Kelly, reflected:

It is difficult to navigate. When I was younger, I definitely would get sucked in. I had an opinion about who is right. The older I’ve gotten, I can see both sides. It usually isn’t that someone is doing something wrong, it’s that the parents are doing something different and aren’t in agreement.

Another nurse in a management role, Felicia, noted that she often saw this issue, of getting pulled onto one side or the other of family conflicts, arise among inexperienced nurses:

I think that you forget that sometimes you’re here to care for that child and it can get to where you’ve got muddy waters. I’ve had situations where nurses were so involved with the family and when other nurses came in, the family didn’t like them. (...) Especially that complex dynamic family where you got grandma or mom in custody related issue. You have to train nurses to recognize where their limits can be and help them avoid getting so involved in the social aspect of it.

More experienced relationally-oriented nurses had found effective ways to handle parents who were caught in cycles of conflict and drama. Specifically, they sought to pull parents out of that cycle by challenging them to “get serious” about their child’s illness. These nurses discussed having to become blunt or harsh at times in their interactions with parents. Lori described a patient from a divorced family who struggled
repeatedly due to disagreements among his parents regarding his care and the severity of his illness.

I’ve had an asthmatic child who was admitted four times in one month and the parents weren’t working it out with each other. Finally, I stood in the room and told them I was about taking care of children and helping them get healthy. I was not about killing children and that’s what they were doing. If they were going to continue down that road, I would be happy to help them find somebody who would participate in that kind of situation but it wasn’t me. However, if they wanted to get on board and take care of the child in a way that was reasonable, I would get on board.

This speech proved to be effective. Lori noted, however, that this was likely only because she had put in the time and effort to build a sustainable relationship with the family before the speech, and continued to give positive reinforcement afterwards.

Gradually they come to trust you, and you have to reinforce them for that. “I appreciate your willingness to work with me on this. I want you to take credit when this is what you’re going to see.” That was the last admission for him. He played non contact sports. He was very well managed even if he was with his dad or his mom. It was very fun to have a family that could work together as a system.

**What eases or inhibits nurses’ interactions with caretakers in post-divorce families?** Figure 3 presents a theoretical model describing what contributes to nurses’ adoption of educationally-oriented or relationally-oriented beliefs about working with families, the common consequences of those beliefs, and how institutional factors and resources might alter those consequences. Throughout the semi-structured interviews,
the topics of nurses’ education, and both personal and professional experience arose as common explanations for responses to the MSFV and beliefs about the best way to interact with post-divorce families and children. Institutional contexts, specifically, availability of resources and the presence of an interdisciplinary and cooperative work culture, were also highlighted as important to affecting nurses’ decision-making and responses to family challenges.

*Education.* As noted earlier, there was universal agreement among study participants that nursing education programs spent little time on family dynamics and even less on structurally diverse families. Several nurses with advanced degrees noted that their training had predominately focused on biological aspects of health and medicine. As Myrtle noted:

> I have two Master’s degrees, and in that training, they always assumed that the child had a mommy and a daddy, and that they all lived happily ever after. We didn’t discuss the psychosocial issues… that didn’t exist.

When such education was the dominant training nurses had experienced, they were more likely to take an educational orientation to working with families and report that family dynamics were something for a social worker or other professional to handle. Other nurses, however, had sought out or received education that helped them to independently navigate relational concerns or complications. Lori, who recognized the toll her initial lack of training had on her own health and ability to help patients, explained how she ended up returning to school to figure out how to address family issues prevalent in her practice:
I was a pediatric nurse practitioner for about 5 years when I realized I was going home two days a week with headaches. What was going on? (...) I’m going home two days a week because I’m seeing things in the office that I have no business seeing at that point. There’s behavior problems, family problems, and school problems and all this kind of stuff. I thought I had to go back to school. Initially, I had a masters degree in mental health nursing with a focus on children and families. Then when I did my doctoral work, I did a minor in family science. That’s when I focused on all the family theory and therapy (...). The marriage of the pediatric knowledge and the mental health knowledge is an amazing marriage because it makes it an advantage when children have complex health care issues. When they have a chronic illness, whether it’s asthma or sickle cell disease, if you do not have the family system in the child’s life on a daily basis, lack of support can be what triggers them to be ill. You’re wasting a lot of time and energy.

Lori’s education had sensitized her to the family and psycho-social aspects of working with families, and she found that rather than traditional nursing interventions and education, some cases required more creative (and family-systems oriented) interventions. She went on to give an example of one such case with a chronically ill child in a remarried family:

I had one four-year-old, he was in a reconstituted family. Mom and dad each brought different kids to the marriage and the family and they had a three-month-old. I got them all in the room, even with the three month old, which is really interesting with a baby in the room because you can see who interacts and who doesn’t. Everybody told me what a bad kid Jimmy was because it became a
behavioral problem. He didn’t like having two families. When we got to Jimmy, I said, “Everyone in your family is so worried about you. Why did you come to the clinic today?” and he said, “I think we’re here because mom is sleeping upstairs and dad is sleeping downstairs and none of my buddies’ parents do that.” I ask the parents if there were things they’d like to discuss without the children’s input, and they think that’s a fine idea. I never had to see Jimmy again. He didn’t have an understanding of what was happening, but his mother had post-partum depression at three months, and their relationship was strained. We got the parents in couples therapy and everything else turned out to be fine. Kids are marvelous barometers for what’s going on in their families. If they have a chronic illness, they are even better barometers.

Advanced education seemed to be particularly helpful in preparing nurses to be creative in their responses to challenges and think “outside the box.” It should be noted, however, that not all relationally-oriented nurses had such extensive training in family systems or therapeutic techniques. In fact, most nurses reported that their orientations towards working with families was largely based on their own personal and professional experiences in adulthood or from their family of origin.

*Personal Experience.* Nurses with both educational and relational orientations towards working with families noted how their own personal, family, and professional experiences shaped their approach to working with post-divorce families and responding to the MSFV. Nurses who had spent several years in the profession commonly pointed to their experience as playing a key role in shaping their approach and philosophy about engaging with (or avoiding engaging with) conflict or family disagreements. In
describing how nurses can learn to work with post-divorce or remarried families, a nurse educator, Patricia stressed: “I think truly you have to experience it to become really comfortable with it and your responses to the situation.”

Nurses who had spent time in post-divorce or remarried families as adults or previously during their childhood, also noted how such experiences impacted their beliefs about working with families. Below are excerpts from Danielle and Miriam reflecting on how their experiences may have shaped their approach to care, and likelihood of reaching out to various family members:

Especially when I’m thinking about blended families or separated families. I’m a part of a blended family. My husband had a wife before me, and they had a separated family where they had two kids who were grown by the time I met my husband. One of them had repeated health concerns, and I always appreciated it when the health care team was respectful of my role in involvement though it was limited.

It depends on whether you’re from a divorced family or not from a divorced family and what your experiences are with divorce. That probably has a lot to do with how you perceive the divorced parents and how they act amongst each other and what is said to each other. My father has been married three times. My mother was married twice. My stepmother who raised me, who is no longer my stepmother but is still my mom, she has been married three times. My perception of how parents play when they get divorced and how they like to play tug of war with the kids is probably different compared to other providers.
On the other hand, as Danielle noted, assuming their own experiences were like the experiences of their patients was potentially precarious.

I think there are times when it does give me insight, and I can rely on my own experience. Other times though, I might assume that it’s theirs, when it’s not. It’s a double-edged sword. I think our experiences are the same; I need to verify it with them.

Relationally-oriented nurses viewed this danger as an important reason to engage with parents and listen to their needs and concerns. In contrast, educationally-oriented nurses, viewed such precariousness as a reason to avoid getting pulled into conflicts, and to ensure that such family issues were handled by individuals with the experience and expertise to do so effectively. One educationally-oriented nurse, Kelly, explained:

I was in a home where I thought a child needed to be removed from that home, but it didn’t work that way. I thought for sure I was right about this. Maybe I was. Maybe I wasn’t. You have to respect it. I can’t be certain that people might be manipulative of [the children’s division’s] agenda. If parents are able to demonstrate that they’re doing good care, sometimes the medical system might not know everything.

Institutional Context. Whether such trained professionals were easily accessible by the provider or patient, however, also played a part in the orientation nurses took toward working with families. Nurses regularly brought up the importance of institutional resources, policies, and the presence (or absence) of a cooperative interdisciplinary community in expanding or limiting the options available to them in providing care to children and families. Patricia, an educationally-oriented nurse, explained how she had
the luxury of relying on other trained specialists to address family conflicts or
disagreements but that such an option may not be available in all contexts.

It depends on the hospital. I think it depends on resources. There are a lot of
factors. I’m very fortunate that at the hospital I’m in, I have all those people at my
disposal that we can utilize. If we were at a smaller rural hospital, that area is a
little different where you might not have those resources. That might be a hospital
that needs to do more simulation and role playing and help develop those aspects
of those nurses.

When resources like trained social workers, child life specialists, psychiatrists, or
therapists were present, both relationally- and educationally-oriented nurses were more
likely to develop creative solutions for addressing family-specific needs and challenges.
Cooperation with colleagues who varied in life experiences and expertise could serve as
an important catalyst for such creativity. Some nurses talked about the benefits of having
designated interdisciplinary care teams, or a policy of “huddling” that facilitated care
providers in brainstorming ideas or strategies for working with families. Gail highlighted
that the family-oriented and collaborative culture of her institution primed her and her
colleagues to reach out and engage with all members of a patient’s family:

Everyone is partners in care, the physicians, the nurse, the respiratory therapists,
the parent. There isn’t a hierarchy where somebody’s voice is more important.
Here the physician doesn’t have this alternate heavy voice; it’s equal as the
parent, as the nurse, as the paramedic. Everybody who cares for the child is a
partner in care. The stepparent is a partner in care, if the stepparent is important to
the child; they’re here just as much.
Other nurses, however, noted that the lack of such resources, or the time to engage in collaborative meetings and consultations sometimes limited their options in providing care and support to their patients. The consequences of being unable to bill insurance for phone calls, team meetings, or additional efforts to reach out to noncustodial parents and family members meant that such “extra” efforts relied entirely on nurses and their colleagues’ willingness to provide additional non-reimbursed services to patients and their families. Relationally-oriented nurses were often willing to provide these additional services, educationally-oriented nurses, however, described passing off patients to therapists, or if available, in-house social workers. If such professionals were unavailable, and if parents continued to be argumentative or difficult to work with, educationally-oriented nurses would dismiss parents or refer them to seek health care elsewhere.

How are nurses’ training and experiences related to their responses and decisions about working with a pediatric patient who has divorced parents with contentious relationships? To conduct a final analysis evaluating how training and personal experiences impact nurses’ responses and beliefs about working with families, codes were assigned to each nurse by using the emergent grounded theory to evaluate their responses to the open-ended questions after each segment of the MSFV. Nurses were coded as educationally-oriented ($n = 68$) when their open-ended responses to the MSFV segments predominately focused on providing additional knowledge or training to the parents or caregivers of Casey. In contrast, nurses were coded as relationally-oriented ($n = 79$) when their responses involved asking questions about Casey’s parents’ relationships, cooperativeness, or ability to communicate with one another, and/or
investigating potential barriers that parents or their ex-spouse may be facing in providing care to Casey (and potentially generating creative solutions to such barriers). Finally, three nurses were not coded into either grouping due to responses that lacked enough information to indicate the nurse’s orientation. Using responses only from those nurses who could be coded into one or the other orientations, a logistic regression was performed to ascertain the extent to which nursing education, years licensed as a registered nurse, personal experiences of divorce and remarriage in adulthood, and personal experiences of divorce and remarriage in childhood predicted the likelihood that nurses would have an educationally or relationally oriented approach to working with post-divorce families (see Table 11). The logistic regression model was statistically significant $\chi^2(4) = 10.621, p = .031$. The model explained 9.4% ($R^2$) of the variance in nurses’ orientation toward working with post-divorce families and correctly classified 64.4% of cases. The only significant predictor in the model was levels of nursing education, $OR = 1.543, p = .025$, indicating that higher levels of nursing education was associated with an increased likelihood of being relationally oriented.

**Family Training and Resources in Medical Settings**

Findings from this investigation show that nurses desire and could benefit from additional training for working with pediatric patients in post-divorce families. A substantial body of literature in the family nursing field provides evidence that family-based interventions that increase provider knowledge and awareness of family dynamics can help health care professionals improve the health and quality of life of both patients and their families (Chesla, 2010; Östlund, & Persson, 2014). In fact, family nurses have developed a wide range of interventions that involve structured conversations and tasks
with pediatric patient’s family members, including the 15-minute family interview (Wright & Leahy, 2012), nurse-family meetings (Nelms & Eggenberger, 2010), and the use of clinical genograms or ecomaps (Rempel, Neufeld, & Kushner, 2007). Findings that a slim majority of nurses who participated in the online survey and interviews were relationally oriented, though not always experienced in how to effectively work with families, suggests that expanding the training and adoption of these efficacious and relationally-based interventions may be well received by pediatric nursing professionals. Though it is also important to consider that this sample’s relationally-oriented characteristic could also reflect a selection bias of those willing to partake in a study on nursing and post-divorce families.

One hypothesis that follows from my findings is that additional training and relational orientations may be particularly needed in low-resource and rural settings where nurses may be the dominant providers of both physical and mental health care for their patients. Without additional training and expertise, nurses who adopt relational orientations may be at increased risks for being pulled into ongoing disagreements among divorced parents with conflictual coparenting styles (Russell et al., 2015). Learning how to recognize such circumstances and carefully navigate family dynamics could be particularly valuable if other trained professionals are difficult to access. On the other hand, if well-trained family-oriented professionals (e.g. social workers, child life specialists, family therapists) are available, it could be more efficient for less experienced nurses to stick to more educational orientations. Though such an arrangement could still prove to be an imperfect solution, given that many family professionals may lack expertise for working effectively with children in remarried and post-divorce families.
For example, in recent overviews, family therapists have themselves critiqued the lack of attention their own field has given to working with remarried families and the different approaches to therapy and interventions divorce or remarriage may require (Browning & Artelt, 2012; Papernow, 2013).

A perhaps more easily achievable adjustment that could benefit nursing professionals working with post-divorce families, is the encouragement of interdisciplinary care teams and collaborations among health care professionals treating pediatric patients and their families. As referenced by several nurses across interviews, “huddling” and interdisciplinary teams allow for the presentation and inclusion of diverse professional and personal experiences that may increase the likelihood of generating creative solutions for managing children’s care or stressful family dynamics. Previous research has found that such approaches are effective at preventing the development of problems from escalating to the level of crisis, and at increasing stakeholder satisfaction with care (Cooper & Meara, 2002). Creating both formal and informal policies that allow or even actively encourage such collaborations might be particularly beneficial for providers to, and patients in, post-divorce or remarried families.

Healthcare Providers and Divorced Parents’ Gender, Marital Status, and Custody

Another important takeaway finding from this study is that nurses perceive themselves to be most prepared to handle family issues when working with biological remarried mothers who have a 50-50 custody arrangement, and least prepared for single mothers with 50-50 custody, and single fathers with 70-30 custody. Though not discussed by interviewees (who asserted such factors would not impact their approach or preparedness), a possible interpretation of this discrepancy is that the presence of a
custodial mother and stepfather make families appear similar to the nuclear family norm. Perhaps in this “normalized” context, the 50-50 custody split may have been interpreted by nurses as an indicator of some level of cooperativeness among the divorced parents, or this nuclear normativity allowed them to overlook other aspects of the family structure and custody arrangement. In contrast, unmarried single mothers lack of primary custody may have been viewed instead as an indicator of deficiency in her ability to provide care, and perhaps potential challenges in managing a case. The U.S. has a long history of stigmatizing and negatively judging single mothers (Bennett, & Jamieson, 1999; Bryan, Coleman, Ganong, & Bryan, 1986; Valiquette-Tessier, Vandette & Gosselin, 2016). A single mother who is unmarried and not the primary caregiver to her children may be violating multiple social expectations of women (as wife and childrearer) that exist as modern remnants of the feminine mystique (Friedan, 1963; Coontz, 2011). That only 15% of children in post-divorce families live primarily with their fathers, rather than their mothers, (and that this represents relatively recent increases in this arrangement; Melli & Brown, 2008) may also contribute to these discrepancies in nurses’ perceived preparedness.

**Limitations**

It is important to interpret the results of this study within the context of its limitations. One limitation of this study is in regards to the sample size, which, while large enough to reliably detect medium effect sizes, was not large enough to reliably detect small differences in nurses’ reported preparedness for working with the hypothetical case presented in the MSFV. Future research could address this limitation by gathering a larger sample of nurse participants, perhaps by increasing financial
incentives for participation or seeking additional outlets for advertising the study. A related issue is the homogeneity of the sample, which was predominantly white and female. Although this may in part reflect the demographics of the nursing profession, seeking out the perceptions and experiences of male and racial or ethnic minority nurses would be a wise direction for future investigations. As the nursing profession continues to grow to include a more diverse workforce, understanding the roles of gender dynamics or culturally-based family beliefs and practices among care providers will likely be critical to establishing universally effective care (Allan & Aldebron, 2008).

Another limitation is the reliance on responses to a hypothetical situation rather than observation of interactions with actual patients (or even simulated actors). It is not unusual for individuals to differ in how they report they would respond to a given situation and how they actually respond in the “real world”. Despite this reality, much previous research conducted from the perspective of the integrated behavioral model has found that though intentions and behaviors may differ from one another, intentions are often strongly predictive of behavior (Montaño & Kasprzyk, 2008). As a result, though MSFVs are an excellent tool for researching nurses’ intended responses to patient family dynamics and disclosures, surveys, interviews, and clinical observations of real patients, families, and their providers could help solidify our knowledge and understanding of these processes.

**Future Directions**

Findings from this study raise questions about nurse education and training, family-healthcare interactions, and the health or social consequences of provider beliefs, pointing to several directions ripe for future research. One such avenue is the
transformation of vignettes, such as the one used for data collection in this study, into tools for educating nursing students and staff. A critical challenge facing contemporary nursing education is the lack of adequate availability of trained faculty and clinical resources for developing a comprehensive nursing workforce (Allan, & Aldebron, 2008). The use of simulations has been promoted as one potential way to increase teaching capacity and help meet the ongoing shortage of qualified nurses (Allan, & Aldebron, 2008; Hegland, Aarlie, Strømme, & Jamtvedt, 2017). The vignettes developed for use in this study showed promise for catalyzing nurses’ to thoughtfully consider their perspectives on working with patients in post-divorce families and to generate potential solutions to challenges like a patient’s residence in multiple households or navigating coparenting conflicts and disagreements. Systematically investigating the use of brief vignette or simulation-based interventions as tools for education and training could be used in both further evaluating work with post-divorce families, as well as extending investigations to other challenges nurses may face in working with families in medical contexts, such as the presence of relational violence and abuse.

It also seems worthwhile to investigate how family-based nursing interventions (like the 15-minute family interview, or nurse-family meetings and trainings) operate or may need adjustment to effectively serve post-divorce and remarried families. Many family or relationally-oriented interventions have been created and validated with predominately mother-child dyads within first-marriage nuclear families (Brown et al., 2008; Phares et al., 2005). Since the 1960’s however, the percentage of children residing in non-nuclear family households has increased from 27% to 53% of the population (Pew
Research Center, 2015). Given this growing prevalence, this area ought to be an important priority for researchers and clinicians.

With the completion of this study, I have now personally studied experiences of childhood chronic illness in post-divorce families from the perspectives of divorced parents (Russell et al., 2016), and that of nursing professionals. As far as I am aware, only one previous qualitative investigation has directly sought to include the perspectives of stepparents of children with chronic conditions, exploring their experiences in the context of childhood cancer (Kelly & Ganong, 2011a; 2011b). A handful of other peer-reviewed papers have by happenstance touched on the roles of stepparents who were fortuitously captured by their sampling frames (for a review, see Zarelli, 2009), but direct and deliberate studies of divorced or remarried families in healthcare settings is underdeveloped (Ganong, 1995; 2011). Besides gathering further data and verifying previous observations about these populations, an important priority for future research should be to gather information from the children in post-divorce families, as well as other health care providers they may encounter, such as physicians and social workers.

An additional area in need of further research are the effects of stigma directed towards structurally diverse families. Though several studies have identified such stigma exists (Gustafson, 2008; Planitz & Feeney, 2009), and have examined the role of media or fairy tales in propagating negative images of individuals within divorced and remarried families (Claxton-Oldfield, 2008; Leon & Angst, 2005), an understanding of the consequences of these beliefs remains underdeveloped. The body of literature on social determinants of health has demonstrated that stigma directed towards individuals on the basis of socio-economic status, race, gender, and sexuality can be incredibly powerful in
shaping individual’s long-term health and wellbeing (Kelly et al., 2007; Marmot et al., 2008). Investigating whether similar mechanisms contribute to the observed disparities in health outcomes across family structures seems like a worthwhile and important future topic of study. Example research questions for addressing these disparities may include: How do health care providers’ conceptions of family and attitudes towards divorce or remarriage impact the interventions and resources extended to family members? How might the normativity or rarity of divorce or remarriage within a given geographic region impact the responsiveness, services, or care provided to children and families? Have some hospitals or facilities, particularly those that serve populations with diverse family structures, adopted certain effective techniques or discarded ineffective ones? How does the framing of research, and writing about family relationships shape how family therapists, social workers, child-life specialists, or health care providers approach their work with children in post-divorce or remarried families?

This study was designed to catalyze questions about addressing disparities across family structures in a medical context, but future investigations could also be extended outside of the health care setting to the domains of other societal institutions. For example, is has long been evident that children in post-divorce families experience (small) but consistent and statistically significant reductions in their academic achievement as compared to their peers in first-marriage families (Amato, 2000; 2010). Future research using an SDOH framework might investigate why this pattern is so persistent, and what schools and educators could do to change it (e.g., targeted tutoring services? brief talk-therapy or support-groups? providing additional structured study time?). Given that the future of family in the United States is poised to be filled with a
copious diversity of family structures and forms, exploring how institutions, communities, and families can best support the health and wellbeing of individuals living in contemporary families will continue to be a crucial need for health care providers, family practitioners (e.g., marriage and family therapists, family life educators), and the field of family science more broadly. An abundance of research, theory, and practical innovation will be necessary to address this need. Hopefully this investigation can help contribute to that goal.
References


Greenwich, CT: JAL


Central challenges facing the national clinical research enterprise. *JAMA*, 289, 1278-1287. doi:10.1001/jama.289.10.1278


Table 1.
*Online Survey Sample Characteristics (N = 150)*

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<tr>
<td>Widowed</td>
<td>3.3%</td>
<td>Public health</td>
<td>1.3%</td>
</tr>
<tr>
<td>Remarried</td>
<td>12.0%</td>
<td>Other</td>
<td>16.8%</td>
</tr>
<tr>
<td>Have biological or adopted children</td>
<td>64.0%</td>
<td>Frequency work with patients with type 1 diabetes mellitus</td>
<td>3.09 ± 1.03</td>
</tr>
<tr>
<td>Have stepchildren</td>
<td>16.7%</td>
<td>type 1 diabetes mellitus</td>
<td></td>
</tr>
<tr>
<td>Experienced parental divorce before age 18</td>
<td>18.7%</td>
<td>Frequency work with divorced families</td>
<td>4.01 ± .88</td>
</tr>
</tbody>
</table>
Table 2.  
*Follow-up Phone Interview Sample Characteristics (n = 23)*

<table>
<thead>
<tr>
<th>Demographics</th>
<th>% or M±SD</th>
<th>Nursing Education / Experience</th>
<th>% or M±SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>46.13 ± 12.48</td>
<td>Years in nursing field</td>
<td>19.87 ± 13.74</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Highest level of nursing education</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>100%</td>
<td>Diploma</td>
<td>0%</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td>Associates</td>
<td>0%</td>
</tr>
<tr>
<td>White or Caucasian</td>
<td>95.7%</td>
<td>Bachelors</td>
<td>43.5%</td>
</tr>
<tr>
<td>Black or African American</td>
<td>0%</td>
<td>Masters</td>
<td>43.5%</td>
</tr>
<tr>
<td>American Indian or Alaskan Native</td>
<td>0%</td>
<td>DNP</td>
<td>4.3%</td>
</tr>
<tr>
<td>Asian</td>
<td>0%</td>
<td>PhD</td>
<td>8.7%</td>
</tr>
<tr>
<td>Two or more races/Other</td>
<td>4.3%</td>
<td>Current employment setting</td>
<td></td>
</tr>
<tr>
<td>Hispanic / Latino</td>
<td>8.7%</td>
<td>Academic</td>
<td>17.4%</td>
</tr>
<tr>
<td>Current relationship status</td>
<td></td>
<td>Home health</td>
<td>4.3%</td>
</tr>
<tr>
<td>Single</td>
<td>21.7%</td>
<td>Hospital</td>
<td>65.2%</td>
</tr>
<tr>
<td>First marriage</td>
<td>47.8%</td>
<td>Nursing home / Long-term care</td>
<td></td>
</tr>
<tr>
<td>Divorced</td>
<td>8.7%</td>
<td></td>
<td>0%</td>
</tr>
<tr>
<td>Widowed</td>
<td>0%</td>
<td>Public health</td>
<td>0%</td>
</tr>
<tr>
<td>Remarried</td>
<td>21.7%</td>
<td>Other</td>
<td>13%</td>
</tr>
<tr>
<td>Have biological or adopted children</td>
<td>60.9%</td>
<td>Frequency work with patients with type 1 diabetes</td>
<td>3.26 ± .752</td>
</tr>
<tr>
<td>Have stepchildren</td>
<td>26.1%</td>
<td>mellitus</td>
<td></td>
</tr>
<tr>
<td>Experienced parental divorce</td>
<td></td>
<td>Frequency work with divorced families</td>
<td>4.04 ± .767</td>
</tr>
<tr>
<td>before age 18</td>
<td>17.4%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Table 3.
**Detailed Interview Sample Characteristics by Participant**

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Age</th>
<th>Highest Level of Nursing Education</th>
<th>Years in Nursing Field</th>
<th>Current Employment Setting</th>
<th>Current Relationship Status</th>
<th># Bio kids</th>
<th># Step kids</th>
<th>Frequency work with TID</th>
<th>Frequency work with Divorced</th>
<th>Nursing Orientation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kristy</td>
<td>30</td>
<td>Master's</td>
<td>4</td>
<td>Academic</td>
<td>Single</td>
<td>0</td>
<td>0</td>
<td>Frequently</td>
<td>Frequently</td>
<td>Educational</td>
</tr>
<tr>
<td>Sue</td>
<td>23</td>
<td>Bachelor's</td>
<td>2</td>
<td>Hospital</td>
<td>Single</td>
<td>0</td>
<td>0</td>
<td>Rarely</td>
<td>Rarely</td>
<td>Educational</td>
</tr>
<tr>
<td>Megan</td>
<td>51</td>
<td>Bachelor's</td>
<td>3</td>
<td>Hospital</td>
<td>Divorced</td>
<td>2</td>
<td>0</td>
<td>Occasionally</td>
<td>Frequently</td>
<td>Educational</td>
</tr>
<tr>
<td>Kelly</td>
<td>53</td>
<td>Bachelor's</td>
<td>30</td>
<td>Home Health</td>
<td>Married</td>
<td>3</td>
<td>0</td>
<td>Occasionally</td>
<td>V. Frequently</td>
<td>Educational</td>
</tr>
<tr>
<td>Dianne</td>
<td>28</td>
<td>Bachelor's</td>
<td>4</td>
<td>Hospital</td>
<td>Married</td>
<td>0</td>
<td>0</td>
<td>Frequently</td>
<td>Frequently</td>
<td>Educational</td>
</tr>
<tr>
<td>Miriam</td>
<td>34</td>
<td>Bachelor's</td>
<td>4</td>
<td>Hospital</td>
<td>Remarried</td>
<td>2</td>
<td>0</td>
<td>Frequently</td>
<td>V. Frequently</td>
<td>Educational</td>
</tr>
<tr>
<td>Felicia</td>
<td>45</td>
<td>Bachelor's</td>
<td>22</td>
<td>Academic</td>
<td>Married</td>
<td>0</td>
<td>2</td>
<td>Occasionally</td>
<td>Frequently</td>
<td>Educational</td>
</tr>
<tr>
<td>Joan</td>
<td>34</td>
<td>Master's</td>
<td>13</td>
<td>Clinic</td>
<td>Remarried</td>
<td>1</td>
<td>0</td>
<td>Occasionally</td>
<td>Frequently</td>
<td>Educational</td>
</tr>
<tr>
<td>Claire</td>
<td>45</td>
<td>Master's</td>
<td>18</td>
<td>Hospital</td>
<td>Married</td>
<td>2</td>
<td>0</td>
<td>Frequently</td>
<td>Frequently</td>
<td>Educational</td>
</tr>
<tr>
<td>Adrienne</td>
<td>35</td>
<td>Bachelor's</td>
<td>7</td>
<td>Hospital</td>
<td>Remarried</td>
<td>3</td>
<td>3</td>
<td>Occasionally</td>
<td>Occasionally</td>
<td>Educational</td>
</tr>
<tr>
<td>Sophia</td>
<td>50</td>
<td>Master's</td>
<td>21</td>
<td>Hospital</td>
<td>Divorced</td>
<td>3</td>
<td>2</td>
<td>Rarely</td>
<td>Occasionally</td>
<td>Relational</td>
</tr>
<tr>
<td>Ruth</td>
<td>53</td>
<td>Master's</td>
<td>28</td>
<td>Hospital</td>
<td>Married</td>
<td>2</td>
<td>0</td>
<td>Occasionally</td>
<td>Occasionally</td>
<td>Relational</td>
</tr>
<tr>
<td>May</td>
<td>44</td>
<td>Master's</td>
<td>12</td>
<td>Academic</td>
<td>Single</td>
<td>0</td>
<td>0</td>
<td>Occasionally</td>
<td>Frequently</td>
<td>Relational</td>
</tr>
<tr>
<td>Myrtle</td>
<td>54</td>
<td>Master's</td>
<td>30</td>
<td>Private Office</td>
<td>Married</td>
<td>2</td>
<td>0</td>
<td>Occasionally</td>
<td>Frequently</td>
<td>Relational</td>
</tr>
<tr>
<td>Patricia</td>
<td>48</td>
<td>Master's</td>
<td>10</td>
<td>Academic</td>
<td>Married</td>
<td>3</td>
<td>0</td>
<td>Occasionally</td>
<td>Frequently</td>
<td>Relational</td>
</tr>
<tr>
<td>Lori</td>
<td>68</td>
<td>PhD</td>
<td>43</td>
<td>Hospital</td>
<td>Single</td>
<td>0</td>
<td>0</td>
<td>Frequently</td>
<td>Frequently</td>
<td>Relational</td>
</tr>
<tr>
<td>Monique</td>
<td>25</td>
<td>Bachelor's</td>
<td>3</td>
<td>Hospital</td>
<td>Single</td>
<td>0</td>
<td>0</td>
<td>Frequently</td>
<td>V. Frequently</td>
<td>Relational</td>
</tr>
<tr>
<td>Beth</td>
<td>62</td>
<td>Master's</td>
<td>40</td>
<td>School Nurse</td>
<td>Remarried</td>
<td>0</td>
<td>2</td>
<td>V. Frequently</td>
<td>Frequently</td>
<td>Relational</td>
</tr>
<tr>
<td>Mercedes</td>
<td>58</td>
<td>Master's</td>
<td>38</td>
<td>Hospital</td>
<td>Married</td>
<td>1</td>
<td>0</td>
<td>Occasionally</td>
<td>V. Frequently</td>
<td>Relational</td>
</tr>
<tr>
<td>Danielle</td>
<td>58</td>
<td>PhD</td>
<td>36</td>
<td>Hospital</td>
<td>Married</td>
<td>0</td>
<td>2</td>
<td>Rarely</td>
<td>Frequently</td>
<td>Relational</td>
</tr>
<tr>
<td>Jean</td>
<td>56</td>
<td>Bachelor's</td>
<td>34</td>
<td>Hospital</td>
<td>Married</td>
<td>3</td>
<td>0</td>
<td>Frequently</td>
<td>V. Frequently</td>
<td>Relational</td>
</tr>
<tr>
<td>Candace</td>
<td>56</td>
<td>Bachelor's</td>
<td>25</td>
<td>Hospital</td>
<td>Married</td>
<td>1</td>
<td>0</td>
<td>Occasionally</td>
<td>Frequently</td>
<td>Relational</td>
</tr>
<tr>
<td>Gail</td>
<td>51</td>
<td>DNP</td>
<td>30</td>
<td>Hospital</td>
<td>Remarried</td>
<td>3</td>
<td>2</td>
<td>Occasionally</td>
<td>V. Frequently</td>
<td>Relational</td>
</tr>
</tbody>
</table>
Table 4.

Research Questions and Analyses

<table>
<thead>
<tr>
<th>Research Question</th>
<th>Analysis</th>
<th>Variables/Responses Analyzed</th>
</tr>
</thead>
<tbody>
<tr>
<td>RQ1: How do nurses’ beliefs about their preparedness for working with pediatric</td>
<td>Repeated Measures ANOVA</td>
<td>IV: Segments</td>
</tr>
<tr>
<td>patients in divorced families change if it becomes apparent parents have</td>
<td></td>
<td>DV: Close-ended preparedness responses</td>
</tr>
<tr>
<td>contentious relationships?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RQ1a: How do nurses’ beliefs about their preparedness differ by pediatric</td>
<td>2 x 2 x 2 x 2 MANOVA</td>
<td>IV: Custodial parent remarriage status, ex-spouse remarriage</td>
</tr>
<tr>
<td>patients’ post-divorce family structure, parent gender, and custody arrangement?</td>
<td></td>
<td>status, parent gender, custody arrangement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DV: Close-ended preparedness responses</td>
</tr>
<tr>
<td>RQ2: How do nurses respond to and make decisions about working with a pediatric</td>
<td>Grounded Theory Constant</td>
<td>Open-ended survey &amp; follow-up interview responses</td>
</tr>
<tr>
<td>patient who has divorced parents with contentious relationships?</td>
<td>Comparative Method</td>
<td></td>
</tr>
<tr>
<td>RQ2a: What eases or inhibits nurses’ interactions with caretakers in post-</td>
<td>Grounded Theory Constant</td>
<td>Open-ended survey &amp; follow-up interview responses</td>
</tr>
<tr>
<td>divorce families?</td>
<td>Comparative Method</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RQ2b: How are nurses’ training and experiences related to their responses and</td>
<td>Logistic Regression</td>
<td>IV: Years as licensed registered nurse, highest level of nursing</td>
</tr>
<tr>
<td>decisions about working with a pediatric patient who has divorced parents with</td>
<td></td>
<td>education, own experience of divorce or remarriage in adulthood,</td>
</tr>
<tr>
<td>contentious relationships?</td>
<td></td>
<td>experience of parental divorce or remarriage in childhood</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DV: educational / relational orientation</td>
</tr>
</tbody>
</table>

Note: IV = Independent variables, DV = Dependent variables
Table 5.  
Permutations of Changing Variables across all Vignette Versions

<table>
<thead>
<tr>
<th>CP gender</th>
<th>CP remarriage status</th>
<th>Ex-spouse remarriage status</th>
<th>Custody arrangement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>CP single</td>
<td>Ex-spouse single</td>
<td>Child spends 30% with ex-spouse</td>
</tr>
<tr>
<td>Female</td>
<td>CP single</td>
<td>Ex-spouse single</td>
<td>Child spends 50% with ex-spouse</td>
</tr>
<tr>
<td>Male</td>
<td>CP single</td>
<td>Ex-spouse single</td>
<td>Child spends 30% with ex-spouse</td>
</tr>
<tr>
<td>Male</td>
<td>CP single</td>
<td>Ex-spouse single</td>
<td>Child spends 50% with ex-spouse</td>
</tr>
<tr>
<td>Female</td>
<td>CP remarried</td>
<td>Ex-spouse single</td>
<td>Child spends 30% with ex-spouse</td>
</tr>
<tr>
<td>Female</td>
<td>CP remarried</td>
<td>Ex-spouse single</td>
<td>Child spends 50% with ex-spouse</td>
</tr>
<tr>
<td>Male</td>
<td>CP remarried</td>
<td>Ex-spouse single</td>
<td>Child spends 30% with ex-spouse</td>
</tr>
<tr>
<td>Male</td>
<td>CP remarried</td>
<td>Ex-spouse single</td>
<td>Child spends 50% with ex-spouse</td>
</tr>
<tr>
<td>Female</td>
<td>CP single</td>
<td>Ex-spouse remarried</td>
<td>Child spends 30% with ex-spouse</td>
</tr>
<tr>
<td>Female</td>
<td>CP single</td>
<td>Ex-spouse remarried</td>
<td>Child spends 50% with ex-spouse</td>
</tr>
<tr>
<td>Male</td>
<td>CP single</td>
<td>Ex-spouse remarried</td>
<td>Child spends 30% with ex-spouse</td>
</tr>
<tr>
<td>Male</td>
<td>CP single</td>
<td>Ex-spouse remarried</td>
<td>Child spends 50% with ex-spouse</td>
</tr>
<tr>
<td>Female</td>
<td>CP remarried</td>
<td>Ex-spouse remarried</td>
<td>Child spends 30% with ex-spouse</td>
</tr>
<tr>
<td>Female</td>
<td>CP remarried</td>
<td>Ex-spouse remarried</td>
<td>Child spends 50% with ex-spouse</td>
</tr>
<tr>
<td>Male</td>
<td>CP remarried</td>
<td>Ex-spouse remarried</td>
<td>Child spends 30% with ex-spouse</td>
</tr>
<tr>
<td>Male</td>
<td>CP remarried</td>
<td>Ex-spouse remarried</td>
<td>Child spends 50% with ex-spouse</td>
</tr>
</tbody>
</table>

Note: CP = Custodial Parent
### Table 6.
**Themes, Categories, and Exemplar Codes**

<table>
<thead>
<tr>
<th>Themes</th>
<th>Categories</th>
<th>Exemplar Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Education-Oriented</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education is key</td>
<td></td>
<td>As long as they’re getting the education, that’s the most important. I think that it’s important that everyone is on the same page and gets the same information. Everybody needs to have the same education.</td>
</tr>
<tr>
<td>Neutrality as avoiding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>being pulled into</td>
<td></td>
<td></td>
</tr>
<tr>
<td>drama</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If struggling, send to</td>
<td></td>
<td>We’ll have a family meeting to say we’re all there for the patient or the child and not for anybody else’s benefit really. From a nursing perspective, and speaking from a nurse educator perspective, I would stick to just saying the medical treatment of the child and defer any other personal things.</td>
</tr>
<tr>
<td>other professionals /</td>
<td></td>
<td>I utilize our social worker and our child life specialist for coping mechanisms and processing therapies because I feel like they’re more knowledgeable in those resources in our institutions than I am.</td>
</tr>
<tr>
<td>experts</td>
<td></td>
<td>I think that’s sort of getting outside the scope of nursing care specifically. (...) I think that’s probably where maybe social work and case services need to probably step up in their role.</td>
</tr>
<tr>
<td><strong>Relation-Oriented</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overcoming barriers is</td>
<td></td>
<td>We listen for barriers that may present themselves. By barriers they can be real barriers or perceived barriers. It just goes back to assessing the situation at each parents’ house, determining what they’re dealing with, anything that would help or hinder them, implementing the path of care for that child.</td>
</tr>
<tr>
<td>key</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neutrality as engaging</td>
<td></td>
<td></td>
</tr>
<tr>
<td>with all caretakers</td>
<td></td>
<td>If you do not gain the respect or trust of the parents, they’re not going to listen to you. They’re not going to get what they need to take care of that child. By staying as the neutral party, hopefully they trust you enough to listen to you. You have to figure out the other side of the story to help the parents. You can’t know the whole situation from just one person.</td>
</tr>
<tr>
<td>without judgment</td>
<td></td>
<td>It makes me a better health care provider, a better nurse, a better advocate for that patient, if I do not make judgments based on what one parent has said about the other parent.</td>
</tr>
<tr>
<td>If struggling, get</td>
<td></td>
<td>I can get very blunt and I only do that as a last resort when I think I have a relationship with them. They need to make decisions and it needs to come back to what’s best for the child. We need to have difficult conversations with parents to help them understand that keeping dad in the dark might not be what’s best for your child.</td>
</tr>
<tr>
<td>serious</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Table 7.
Results from Repeated Measures ANOVAs (with Greenhouse-Geisser Correction) for Nurse Preparedness Across Vignette Segments (N = 150)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Segment 1 (M±SD)</th>
<th>Segment 2 (M±SD)</th>
<th>Segment 3 (M±SD)</th>
<th>F</th>
<th>Error</th>
<th>p</th>
<th>partial η²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparedness for handling health components</td>
<td>5.10±.82</td>
<td>4.91±.10</td>
<td>4.80±.11</td>
<td>1.81</td>
<td>269.12</td>
<td>22.85</td>
<td>0.00</td>
</tr>
<tr>
<td>Preparedness for handling family components</td>
<td>4.99±.88</td>
<td>4.61±.10</td>
<td>4.35±.12</td>
<td>1.83</td>
<td>272.55</td>
<td>45.54</td>
<td>0.00</td>
</tr>
<tr>
<td>Preparedness for handling this disclosure</td>
<td>5.18±.88</td>
<td>4.70±.10</td>
<td>4.34±.13</td>
<td>1.84</td>
<td>274.74</td>
<td>67.25</td>
<td>0.00</td>
</tr>
</tbody>
</table>

Note: shared subscripts denote significant difference at p < .001

### Table 8.
Repeated Measures ANOVA Post-hoc Pairwise Comparisons with Bonferroni Adjustment (N = 150)

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Segment 1 (M±SD)</th>
<th>Segment 2 (M±SD)</th>
<th>Segment 3 (M±SD)</th>
<th>Mean Difference (J-I)</th>
<th>Std. Error</th>
<th>p</th>
<th>95% Confidence Interval Lower Bound</th>
<th>95% Confidence Interval Upper Bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparedness for handling health components</td>
<td>0.280</td>
<td>0.054</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
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<td>0.387</td>
<td>0.068</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
<td>0.511</td>
<td>0.222</td>
<td>0.551</td>
</tr>
<tr>
<td>Preparedness for handling this disclosure</td>
<td>0.380</td>
<td>0.065</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
<td>0.515</td>
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<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
<td>0.410</td>
<td>0.150</td>
<td>0.551</td>
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<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
<td>0.515</td>
<td>0.222</td>
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<tr>
<td>Preparedness for handling this disclosure</td>
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<td>0.065</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
<td>0.515</td>
<td>0.222</td>
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Note: adjusted p-values with Bonferroni correction.
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<tr>
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<td>0.015</td>
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<td>Parent Gender<em>NCP Remarriage</em>Custody Arrangement</td>
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<td>0.015</td>
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<td>Observed Power</td>
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<td>0.001</td>
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<td>-------------</td>
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<td>0.005</td>
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<td>CP Remarriage*NCP Remarriage</td>
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<td>0.361</td>
<td>0.976</td>
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Table 10.
*MSFV Segment 2 Parent Gender*CP Remarriage*Custody Arrangement Post-hoc ANOVA Tests (N = 150)*

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<th>Dependent Variables</th>
<th>(F(1, 134))</th>
<th>(p)</th>
<th>partial (\eta^2)</th>
<th>Observed Power</th>
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Table 11.
*Logistic Regression Model Testing Predictors of Nurses' Orientation Toward Working with Post-Divorce Families. (n = 147)*

<table>
<thead>
<tr>
<th>Variables</th>
<th>(B)</th>
<th>SE</th>
<th>Wald</th>
<th>(p)</th>
<th>OR</th>
<th>95% Confidence Interval</th>
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<td>1.057 - 2.251</td>
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<tr>
<td>Years as licensed registered nurse</td>
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<td>0.015</td>
<td>1.44</td>
<td>0.230</td>
<td>1.018</td>
<td>0.989 - 1.047</td>
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<td>Own divorce or remarriage in adulthood</td>
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<td>0.377</td>
<td>0.028</td>
<td>0.867</td>
<td>0.939</td>
<td>0.448 - 1.965</td>
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<tr>
<td>Parental divorce or remarriage during childhood</td>
<td>-0.334</td>
<td>0.427</td>
<td>0.611</td>
<td>0.434</td>
<td>0.716</td>
<td>0.310 - 1.654</td>
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</tbody>
</table>

Note: OR indicates likelihood of Relational Orientation
Figure 1.

A Synthesized Model of the Social Determinants of Health

*Note: This paper proposes the addition of family structure to these other commonly identified social determinants of health.
Figure 2.
*Three-way Interaction Effect (Custodial Parent Remarriage Status by Parent Gender by Custody Arrangement)* on Segment 2 Preparedness for Handling Family Components.

Note: Shared superscripts denote significant difference at $p < .05$
Figure 3. Proposed Predictors and Consequences of Nurses’ Beliefs about Working with Families.
Appendices

Appendix A – Framework for Multiple Segment Factorial Vignettes
Note: Plain text indicates this component will be constant across vignettes. Red text indicates components that will vary across vignettes. Variable attributes are differentiated by semi-colons.

Vignette Introduction
On the following pages you will be presented a story in three short segments. Please read each segment carefully and respond to all questions before moving on to the next segment. Once you have submitted your responses you will not have the opportunity to change your answers to previous segments.

The following tips will prove useful when taking the survey:

Complete the survey in one sitting

Make sure you have a strong internet connection to avoid / reduce system errors

Once you have finished the survey, close the internet browser window to ensure that answers are saved / submitted

If the next page is not loading, scroll up to check for a reminder message
Segment One:

Casey, is 8 years old, and a new patient who has just been diagnosed with type 1 diabetes mellitus. Casey’s regiment requires that Casey or Casey’s care providers test Casey’s blood glucose level before each meal, 2 hours after each meal, and before bedtime each day. Casey must also take pre-determined insulin shots at both 6 a.m. and 6 p.m. and eat carefully measured amounts of carbohydrates 5 times a day; 3 meals around 8:00 a.m., 12:30p.m., and 6:00 p.m. each day, along with 2 small snacks at 10 a.m. and 3 p.m.

After explaining this process carefully to Casey’s (mother; father), (she; he) makes a brief statement and asks a question: “I realize this may not be in Casey’s file, but I want to let you know that Casey’s (father; mother) and I, though previously married, are now (currently divorced; currently divorced and my ex-spouse has remarried; currently divorced and I have remarried; currently divorced and both of us have remarried). We have a custody arrangement where Casey stays with my (former spouse; former spouse and his new wife; former spouse and her new husband) (every other weekend, Wednesday nights, four weeks over the summer, and some holidays; every other week) the rest of the time Casey stays with (me in my household; with me and my husband in our household; with me and my wife in our household). Do you have any advice for how we could best handle managing Casey’s type 1 diabetes mellitus given this custody schedule?”

Segment One Questions:

Open-ended:
How would you respond to this parent’s question?

Mixed/Contingency question:
Is there anything that might prevent you from responding to Casey’s parent in the way you think would be ideal? (Yes or No) If Yes, what would prevent you from responding to Casey’s parent in the way you think would be ideal?

Forced-choice:
On a scale of 1 to 6 with 1 being completely unprepared, to 6 being completely prepared, how prepared do you believe you are to handle the health-related components of a case such as Casey’s?

How prepared do you believe you are to handle the family-related components of a case such as Casey’s?

How prepared do you believe you are to handle a question such as that posed by Casey’s parent?
Segment Two:
A few months later Casey and Casey’s (mother; father) return for a check-up. Casey’s Hba1c is 9.5 indicating there is significant room for improvement in the management of Casey’s type 1 diabetes mellitus. As the appointment ends, Casey’s (mother; father) independently approaches you and makes a disclosure. (She; He) states: “I just want to let you know that I firmly believe part of the reason we are having trouble controlling Casey’s blood glucose level is because Casey’s (father is; mother is; father and stepmother are; mother and stepfather are) not taking treatment seriously enough. (He does; She does; They do) not stick to the schedule, and whenever I try to point out these issues we seem to get in screaming matches, which I think have been causing Casey even further stress.”

Segment Two Questions:
Open-ended:
How would you respond to this parent’s disclosure?

Mixed/Contingency question:
Is there anything that might prevent you from responding to Casey’s parent in the way you think would be ideal? (Yes or No) If Yes, what would prevent you from responding to Casey’s parent in the way you think would be ideal?

Forced-choice:
On a scale of 1 to 6 with 1 being completely unprepared, to 6 being completely prepared, how prepared do you believe you are to handle the health-related components of a case such as Casey’s?

How prepared do you believe you are to handle the family-related components of a case such as Casey’s?

How prepared do you believe you are to handle a disclosure such as that made by Casey’s parent?
Segment Three:
After listening to your response Casey’s (father; mother) proceeds to make another
disclosure: “I think sharing custody was a mistake, and from now on I am going to keep
Casey at my house full-time. What do you think?”

Segment Three Questions
Open-ended:
How would you respond to this parent’s question?

Mixed/Contingency question:
Is there anything that might prevent you from responding to Casey’s parent in the way
you think would be ideal? (Yes or No) If Yes, what would prevent you from responding
to Casey’s parent in the way you think would be ideal?

Forced-choice:
On a scale of 1 to 6 with 1 being completely unprepared, to 6 being completely prepared,
how prepared do you believe you are to handle the health-related components of a case
such as Casey’s?

How prepared do you believe you are to handle the family-related components of a case
such as Casey’s?

How prepared do you believe you are to handle a disclosure such as that made by Casey’s
parent?

On a scale from 1 to 6 with 1 being completely unwilling and 6 being completely willing,
how willing would you be to testify on this parent’s behalf that Casey’s other parent was
a danger to Casey’s health and wellbeing?
Appendix B – Demographic Questionnaire

1. How old are you (in years)?: ______
2. Sex: _____ Male _____ Female _____ Other
3. What is your race?
   a. _____ White
   b. _____ Black or African-American
   c. _____ American Indian or Alaskan Native
   d. _____ Asian
   e. _____ Native Hawaiian or other Pacific Islander
   f. _____ Two or more races/Other ___________________________
4. Do you identify yourself as Hispanic/Latino?  _____ Yes  or  _____ No
5. What is your current relationship status:
   a. ___ Single  (go to 6)
   b. ___ Married  (go to 7)
   c. ___ Divorced  (go to 6)
   d. ___ Widowed  (go to 6)
   e. ___ Remarried  (go to 7)
6. Are you in a cohabiting relationship? _____ Yes or _____ No
7. Do you have stepchildren? _____ Yes or _____ No
   If yes, how many? ______
8. Do you have biological or adopted children? _____ Yes or _____ No
   If yes, how many? ______
9. Have you ever been divorced? _____ Yes or _____ No
   If yes, 10a. How many times have you been divorced? _____
10. Were your biological parents married to each other? _____ Yes (go to 11) or _____ No
   10a. Did your parents’ marriage end in divorce before your 18th birthday?
       _____ Yes  or  _____ No (go to vignettes)
   10b. Were both of your parents actively involved in raising you?
       _____ Yes  or  _____ No
   10c. Did your mother ever remarry? _____ Yes  or  _____ No
       How many times? ______
   10d. Did your father ever remarry? _____ Yes  or  _____ No
       How many times? ______
11. a. What is the highest level of nursing education you have completed?
    □ Diploma
    □ Associate’s
    □ Bachelor’s
    □ Master’s
    □ DNP
    □ PhD
    □ Other _______________
b. Identify the highest level of any other degrees (non-nursing)
- Associate’s
- Bachelor’s
- Master’s
- Doctorate

12. Number of years licensed as a registered nurse: _____

13. Please describe your current employment status:
- Full-time
- Part-time
- Per diem
- Volunteer
- Seeking work
- Not seeking work
- Retired

14. Please describe your current employment setting:
- Academic
- Corrections
- Home health
- Hospital
- Nursing home, long-term care, etc.
- Occupational health
- Public health
- Other—Please describe________________

15. Please tell us about your current position:
- Advanced practice nurse
- Consultant
- Clinical nurse
- Nurse executive
- Nurse faculty
- Nurse manager
- Nurse researcher
- Other—health-related (please describe) ______________
- Other—nonhealth-related (please describe)____________

16. Are you a certified diabetes educator? _____Yes or _____No

17. How frequently do you work with patients with type 1 diabetes mellitus?
- Very Frequently
- Frequently
- Occasionally
- Rarely
- Never

17. How frequently do you work with patients from post-divorce families?
- Very Frequently
- Frequently
- Occasionally
- Rarely
- Never
Appendix C – Semi-Structured Interview Protocol

Navigating the MSFV

The interview will begin by reminding the participant about the vignette they completed previously and going over the MSFV framework (in Appendix A) with the participant. During this process the interviewer should inquire about the following:

1. How did (or would) you respond to the MSFV (or to a given segment)? What did you consider when writing your responses to the online questionnaire? If appropriate, probe about training, personal experiences/history.

2. What would you consider, or how would you respond if you had been given different circumstances (e.g. would you have answered differently if you had been told about a different family structure, a different parent gender, or the family had different custody arrangements – go specifically through the MSFV options and consider exploring beyond those options, what if the other parent was very rarely involved, what if it was disclosed that Casey also spent the occasional weekend with grandparents/stepgrandparents?)

3. How prepared would you be for dealing with a case like Casey’s? What would be your general strategy for managing this case? Are there institutional, personal, legal, or other considerations that might affect your ability to respond the way you think would be ideal?

Training and Experience around Family Structure/Conflict in Health care Settings

1. What experiences have you had working with pediatric patients who have divorced parents (or other family structures)? Are there any challenges you have experienced in these situations? Are there any strategies/solutions that you found particularly helpful in these situations?

2. What experiences have you had working with pediatric patients whose caregivers have disagreements about health care regimens or treatments? Are there any challenges you have experienced in these situations? Are there any strategies/solutions that you found particularly helpful in these situations?
Appendix D – Memo Excerpts

Research Assistant Memo Excerpts

March 2017

“Sophia” – This nurse is very flexible and turns to technology like Skype. She looks for opportunities to provide education outside of physical interactions and opportunities. She accepts that every family is different even though the patterns in marital status can be repetitive in her patients. It seems that this technology can really prevent problems with the parents and hold them more accountable, but not every facility can provide this for families.

“Kristy” - The nurse was very confident in her education and willingness to learn that her job is a continuing learning experience. If she didn’t have a solution to a problem, the said she would continue to observe and use her experiences for the future. She does however recognize that her duty is to provide nursing care and not take on the role of a social worker. She knows when to pass on the duties to someone else on the team. Some nurses might not have that luxury so they have to have solutions to those problems aside from calling the police, asking the parents to step out, or stepping out herself. She talked about communicating with the child and asking the child about their opinion and feelings about their parental situation. Other nurses that were interviewed do not involve the child in the conversational aspect of the situation.

“Joan” – The nurse, like many of the other nurses really turns to care conferences as the main strategy. She also looks for the team effort and thinks about how the social worker can come into play. While she does have many experiences in this situation, it seems that they are all similar in a sense where the solution would always be to have the social worker and a care conference fixing the issue. She also stresses that her main duty is to the patient rather than the problems of the parents. Unlike another nurse before, she doesn’t seem to want to be involved in those problems and cares more about the physical health of the child. However, she does know that the relationship of fighting divorced parents is not good for the wellbeing of the patient and says that a child shouldn’t be present in trying to resolve the parental issues.

“Patricia” – Really understands how people behave in vulnerable and testing situations. She really holds the health care professionals accountable for being professional and dealing with somewhat manipulative situations in a consistent and well thought out approach. When the patient’s family has concerns that disagree with professional advice, she approaches it by exploring their concerns rather than negating them. She thinks challenging situations are things you deal with through experience and isn’t something you can really teach. She also really emphasizes how important team work is and that nurses do not take on this role on their own. She solidified my opinion that the management of these situations depends on the hospital’s location and resources.
May 2017

From the nursing for post divorced family data, I’ve found that there are two approaches that can help nurses cope with treating families in a post divorce marriage arrangement. Regardless of whether or not the children share the homes evenly or mainly reside with one parent more than the other, it seems that the level of comfort and confidence that nurses have in intervening with these families is dependent on the amount of experience they have with family systems. If these nurses don’t have much experience taking classes in family systems or more than a decade of experience working in pediatrics, the nurses seem to have a higher chance of collaborating with the rest of the health care team. These nurses might be aware of their role of delegating the amount of care a child needs from their patient and is conscientious of a health care provider’s bioethical obligation through the principle of justice. The more experienced nurses vouched that they have ability to exercise their role beyond treating the patient. They believe they have the expertise to provide solutions for problems. However, this level of confidence was not found in the majority of the nursing that were interviewed. If issues arise regarding these post divorced families, the nurses with less experience and confidence consult with the child life specialists and social workers. They offer to listen to the families as much as they can and often ask leading questions that will make the rest of their team members communicate with these families better, but they often do not take part in the main interventions. Sometimes, the nurses that collaborate with health care teams do so because their hospitals are staffed with ample social workers, child life specialists, and case managers. With these extra health care professionals in the clinical setting, nurses are able to provide more of their physical nursing care to more patients, instead of also being involved in the familial clinic. The kinds of nurses that would be most effective in working in these team settings though are the ones that have less experience in developmental psychology, nursing theory, and years in nursing practice. Overall, both types of nurses have the common goal to keep the patient (child with chronic illness) as their main priority. I believe that the approaches to the confidence and conviction that these nurses have to address these problems has to do with the way they define professionalism and how conscientious they are in their obligations as a nurse. Beyond, treating the children with chronic illnesses, what is the nurse’s duty to a patient? Does it stop at educating and treating the patient and the family? What is their commitment to these families with post-divorce conflicts once they are presented and in the way of their patient’s health? What is the role of the nurse to the patient outside of the clinical setting? What are techniques that nurses have in remaining impartial to each parent’s testament to giving their child proper care? How important is it for the nurse to maintain a congenial image in front of the families? Do they have the ability and obligation to intervene if they notice that there is a (minor or major) barrier to the child’s wellbeing?
Principal Investigator Memo Excerpts

“Claire” - Throughout much of the early segments of this interview the nurse gave short statements, and her tone implied that she often seemed somewhat peeved about the questions I was asking. Her voice was adamant and strong when she asserted that engaging with family dynamics / issues went beyond her role and expertise as a nurse. She then seemed to calmly (and sometimes rather repetitiously) explain to me that her job was to educate patients about medical information, and the justification for treatment decisions, and not really anything else. I suspect this may reflect her approach to working with patients.

“Lori” – This nurse was very patient and warm in her responses to my questions, in fact this interview felt very much like a seminar with an MFT faculty member, much different from my previous interviews (and I was not at all surprised to find out that she had taken significant coursework in family therapy). She used powerful stories and some humor to make her points, like Claire, this I suspect is reflective of her approach to working with patients.

January 2017

Resources, context, and training seem to matter, some nurses seem to think that though they do have to engage with relationships at some points, it’s not really their job – and they seem quite quick to say that they would call in the social worker or child services if they witness coparenting disagreements. (This of course, requires having a social worker on staff, or specialists who are in charge of these other domains, seems particularly common approach at large hospitals where the nurses may be busy managing a large number of other concerns). Nurses with more time/interaction with their students and their families (e.g. school nurse), or additional training (e.g. coursework/background in marriage and family therapy) seem much more prone to being willing to listen to folks and recognize the importance of getting multiple sides of the same story in order to ferret out the truth.

February 2017

From NCFR submission:

“In open-ended responses and interviews nurses discuss the importance of building working relationships across households, “remaining neutral” in ongoing conflicts, and ensuring there are multiple copies of regiment documents shared with all caretakers. Nurses also highlighted barriers related to time, hospital resources, and the inability to bill for non-appointment communications with nonresidential parents that made it difficult to develop effective working relationships. Across interviews, nurses reported a desire for increased education and training in working with contemporary families, and recognized dangers of learning to navigate family dynamics and conflict solely through experience or trial-and-error.”
April 2017

It seems like there are themes in how nurses think about families / working with families. Here are some relevant constructs and a possible emerging model.

Escalate / Get Serious – This involves speaking somewhat harshly with parents / laying down the law and telling them things along the lines of “if you keep this up your child is going to die, you need to follow x, y, z regimen” - I personally think it seems harsh, but Gabby seems to believe this might be one of the things that differentiates more effective nurses from less effective ones.

Build Relationship / Let them be heard – This involves providing parents a chance to express themselves, and to build an ongoing relationship between care providers and the family. I think this may be particularly important with post-divorce families, but Gabby thinks this could be too soft. Looking at the data closer, I’m beginning to think you may need both, that building these relationships allow folks to be more effective when they escalate, or more likely to develop practical solutions, whereas if I move straight to “get serious” without building a relationship first, then perhaps my first move is to dismiss that patient or drop them off on someone else if they don’t adhere to my rules.

Develop Practical Solutions – involves being creative to solve challenges faced in providing care to pediatric patients and their families (e.g., meetings during irregular hours, reaching out to noncustodial parents, finding ways to handle coparenting tensions)

Dismiss / dump off on other – send the family to the social worker, or refuse to offer their services if they don’t adhere to the nurses rules / expectations – this is sort of a way of avoiding working with post-divorce or contentious families.
May 2017

Gabby and I both agree that there appear to be two “types” of nurses, and though we initially thought one might be more effective than the other, I’m beginning to think they simply operate more effectively, or are more appropriate /likely to occur given different conditions. Here is what I currently think are the relevant characteristics / conditions:

<table>
<thead>
<tr>
<th>Educationally Oriented</th>
<th>vs.</th>
<th>Relationally Oriented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure adequate knowledge</td>
<td>Let them be heard</td>
<td></td>
</tr>
<tr>
<td>Neutrality = Uninvolved in “drama”</td>
<td>Neutrality = Engaging all sides</td>
<td></td>
</tr>
<tr>
<td>If struggling – send to others or get team together</td>
<td>If struggling – get serious (or get team)</td>
<td></td>
</tr>
<tr>
<td>Default – fit into current system</td>
<td>Default - Get Creative</td>
<td></td>
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<tr>
<td>More likely to get creative through team</td>
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</table>

Other Thoughts

May be more possible in Urban / high resource areas
May be more necessary in rural / low resource areas
Less likely to recognize diverse families
More likely to recognize diverse families
Theory of Families:
if they have good info they’ll work together
If they can overcome barriers they’ll work together
Good info = good child health
Good support system = good child health

Dangers

May not meet the actual needs
May get sucked into drama/custody battle
May not engage with important caretakers
May waste time listening w/o changing
Quick to call child services / assume neglect
VITA

Luke T. Russell was born in Manchester, Connecticut on November 21, 1988. Luke grew up in South Windsor, Connecticut and graduated from South Windsor High School in 2006. He attended the University of Connecticut and received his B.A. with a double major in Human Development and Family Studies and Political Science as well as a minor in Sociology in 2006. He then attended the University of Missouri for his graduate education where he met and married his wife Chang Su-Russell in 2013, received his M.S. in Family Science in 2014, and completed his doctoral work in Human Development and Family Science in 2017.