



A Prediction of the Resilience, Subjective Well-Being and Marital Adjustment of the Parents Having Children with Disabilities based on Psycho-Social Competence

Mehmet Palancı ¹

Abstract

This study aims to analyze the resilience, subjective well-being, and marital adjustment of parents having children with disabilities (PHCD) based on the relevant variables within the scope of observed psychological symptoms and coping skills. PHCDs' resilience and subjective well-being were addressed based on marital adjustment, depression, anxiety, hopelessness, coping, conflict resolution skills, perception of control, vulnerability, and life satisfaction level; and compared with the parents who do not have any children with disabilities. In the study, the intermediary model was tested and multinomial logistic regression analysis was made. Compared to studies conducted in this area, a larger spectrum of variables and a relatively larger sample were used. The study group consisted of 530 married couples (a total of 1,060 mothers and fathers) whose children receive supportive education from the rehabilitation centers providing service for at least five years in Ankara, Antalya, Erzurum, Giresun, Gümüşhane, İstanbul, Ordu, Samsun, and Trabzon, as affiliated with the Ministry of National Education. The control group consisted of 242 married couples (a total of 484 mothers and fathers). The data were analyzed with SPSS and LISREL packages. The analyses were carried out using SOBEL and Multinomial Logistic Regression. The significant findings obtained regarding the type and degree of the disability, perceived social support, and resilience level were discussed within the scope of family guidance and counselling, psychological counselling and special education.

Keywords

Children with Disabilities
Marital Satisfaction
Resilience
Subjective Well-Being
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¹ Karadeniz Technical University, Faculty of Education, Special Education, Turkey, mpalanci@gmail.com

Introduction

The prediction that the expectations about the future may meet the expectations of hope and social competence is important for dynamics and the members of the families who try to make this prediction (Gau et al., 2012). Families' levels of happiness and their functioning as a family are affected by any situation that occurs out of their daily routine: sudden changes, traumas, disasters, diseases, and unpredictable life events (Kurt, 2001; Plumb, 2011; Walsh, 1996; Woodman, Mawdsley, & Hauser-Cram, 2015). Especially, having a disabled child, losing a family member or suffering from severe, difficult-to-treat diseases can lead to a high level of depression (Çiğerli, Topsever, Alvur, & Görpelioğlu, 2014; Özbay ve Aydoğan, 2013).

Modern stress theories highlight that competency of coping with stressful life events is more important than the existence and nature of such events. It is also known that coping preferences differ based on personal competencies and situational variables. Planned assistance and resistance in the face of stress, observed symptoms and the following negative effects are explained with competency of coping (Folkman & Lazarus, 1988; Folkman, 1997; Gomes, Lima, Bueno, Araújo, & Souza, 2015). The competence and type of coping is known to affect psychological resistance, perception of health, and competence (Palancı, 2000, 2004) and marital adjustment (Soysal, 2010).

Stress (Uğuz, Toros, İnanç, & Çolakkadıoğlu, 2004), continuous anxiety (Bahar, Bahar, Savaş, & Parlar, 2009; Işcan & Malkoç, 2017) depression (Bahar et al., 2009; Balki & Canbay, 2012; Demir, Özcan, & Kızılırmak, 2010; Eroğlu, Akbaba, Adıgüzel, & Peker, 2014; Ghosh & Parish, 2013; Toros, 2002; Uğuz et al., 2004), and helplessness (Bahar et al., 2009) levels have been found to significantly increase in parents of children who have developmental disabilities and need special education. Parents having children with disabilities (PHCDs) expressed a need for psycho-social support, and particularly mothers reported an increase in their levels of stress, anxiety and depression more than those of fathers (Aybar, 2014). The most significant source of stress for the parents of children with disabilities is that it requires more effort to take care of their children because these children have a low ability to manage themselves. Employed family members are known to have higher levels of depression than unemployed family members. Having children with disabilities affect the factors related to family ecosystem, such as the PHCDs' occupational and social life, career plans, open interaction of other children with the situation, increasing expenses, social pressure, and kinship bonds (Simplican, Leader, Kosciulek, & Leahy, 2015). However, possible marital conflicts and symptoms arise depending on which parent takes on a larger role as a caregiver, whether joint responsibility work fine, and how much caregiver burden is carried. The evaluations and vital decisions made in this regard will differ based on the parent's resistance, coping skills, and the level of resilience (Gau et al., 2012; Patterson, 2002). It is not only the level but also the type of the disability that affects the problems likely to occur and the coping competence. For instance, families having children with autism spectrum disorder were found to have higher levels of depression and anxiety than the normal comparison group. Such families also had active coping strategies, used beneficial social support, and suppressed their other occupations more (Durukan, Erdem, Tufan, & Türkbay, 2010; Karpat & Girli, 2012). The PHCDs' marital problems and personal psychological symptoms are known to decrease as the families' resilience level increases (Bayat, 2007; Bayraklı & Kaner, 2012; McCubbin and McCubbin, 1988; Walsh, 2006).

Periodical stress at a level not eliminating the competence of coping or at a tolerable length and severity naturally improves a family's unity and their competence to be a family. During periods of crisis, families develop and use behavioural strategies through different steps. The primary sources that support these strategies include: (1) personal sources of resilience of the family members; (2) the family's belief system, cultural codes, and the meaning they attach to the difficulty they experience; (3) social support from family, friends, and larger groups or the society; and (4) the continuity of the family's unity based on their coping and problem-solving approaches (McCubbin, Thompson, Thompson, & Fromer, 1998). Llewellyn, McConnell, Gething, and Cant, and Kending (2010) reported that marital satisfaction, subjective well-being, and coping skills differ by the parents' ages and psychological health indicators. Increased age alone is not a negative factor; however, spouses'

support for each other, the nature and continuity of the perceived social support, and the amount of the professional assistance provided by institutions affect family dynamics positively. Men with higher levels of education complain that despite above-mentioned positive support, their life quality decreases more. Mothers' anxiety levels increase as their social functions increase. It is known that in any case their stress levels and perception of well-being increase more than that of fathers' (Boström, Broberg, & Bodin, 2011).

Higher educational levels of the PHCDs increases their problem-solving skills. However, living with constant feelings of problem-solving and struggle can cause hopelessness and loss of motivation in time (Izgar, 2009). Social and expert support, and financial contributions provided for the children with severe disabilities receiving home care service decrease the level of hopelessness (Erdoğan, 2013). In addition, families' income levels and the governmental or institutional support they receive are known to affect their well-being and feelings (Ghosh & Parish, 2013). Psychological well-being can be affected by a lot of variables. From a general perspective, psychological well-being can be defined with three models. In the first model, psychological well-being is explained by the lack of psychopathology. In the second model, a definition of "normal" has been developed for psychological well-being. Healthy normal individuals have a satisfactory job and friends. Such individuals will develop a high level of self-perception and adapt to life, which in return help them to have a better well-being. The third model that defines psychological well-being is the positive model: psychologically healthy individuals have a psychological situation that arise from personal developmental efforts beyond an average adaptation to life. These individuals define themselves as better instead of good and produce new behaviours. Clearly, sleep and any other variable affecting physical strength negatively will create psychological stress (Chu & Richdale, 2009). Well-being can be affected by any kind of unexpected situation that will affect family dynamics and satisfaction with life (Chu & Richdale, 2009; Kalmijn & Monden, 2006). Higher marital adjustment, depression and anxiety scores of the parents with children in need of special education negatively affect their psychological well-being (Hauser, Kover, & Abbeduto, 2014; Richard, 2014; Toros, 2002).

Meşe (2013) reported that societies' negative point of view towards children with mental disabilities have negative effects on the families' points of view, and that mothers feel themselves hindered and insufficient. In addition, the sibling birth order, financial conditions, the duration of education of the children with disabilities, and the way that families use the benefits of the education lead to statistically significant differences. Having children with disabilities affects family functions (Akmeşe, Mutlu, & Kayhan, 2012; Özşenol et al., 2003). They also indicated that mothers' blaming themselves, difficulties in perceiving their roles, and emotional reactions negatively affect their general life functions, and their relationships are affected by their assumption of the situation that their close relatives and friends will be alienated. Those authors reported that fathers mostly feel guilty, blame their wives for the disability, and perceive problematic and decreased communication, problem solving approaches, and family functions. Parents' overprotective attitudes increase the protective attitudes of the siblings without any disabilities. Conflicts between mothers and fathers, and adoption of repressive and disciplinary attitudes decrease empathic approach and attention (Ünal & Baran, 2012). On the other hand, it is indicated that fathers are mostly criticized about providing care and they tend to undertake responsibility for the development and education of their children with special educational needs (Meral, 2006).

It is known that PHCDs can display a variety of behaviours like ignoring or rejecting their child's condition when the child is diagnosed as disabled; and later, they can harbor suspicions about the diagnosis and possible diagnostic errors. Marital conflicts increase based on the parents' helplessness, reactions, tension, increased responsibilities due to their children's need for care, increased financial problems, and isolation from social life. The main areas of conflict include isolation from social relationships, receiving support or not from similar families, guilt, trying not to disturb people, concerns for the future, and spouses' blaming each other for insufficiency in providing care and assisting the child's development (Ciğerli et al., 2014). Parents frequently feel blame and disappointment, and expect something worse. About 80 out of 100 parents reported that they had

problems with communication, sharing, and cooperation, and they needed psychological support to cope with these problems (Lafçı, Öztunç, & Alparslan, 2014). Another study by Şengül and Baykan (2013) revealed that parents of children with special educational needs had higher levels of depression and anxiety than the parents of healthy children. These authors also reported that most PHCDs exhibit behaviours of denial and disregard. Studies conducted to understand the problems experienced by the PHCDs mostly focus on depression and the situations to be treated in the ensuing discussion.

The existing literature reports the symptoms observed within the context of demographic variables or depression, and the severity of these symptoms depending on each variable. No studies were found to analyze the PHCDs' marital adjustment, resilience, and subjective well-being in a holistic approach based on their competence for coping and their personal characteristics. The literature includes a limited number of meta-analyses or meta-syntheses that are generally related to demographic data or the contributions of support provided by institutions. It has been important to analyze the factors making the PHCDs resistant to stress or, conversely, weakening them in an explanatory multi model with a set of data. The literature on special education and psychology related to the current research includes important studies on the effects of having children with disabilities on families and their functionality. However, there is only a limited number of studies on the multidimensional relationships between the variables that can provide in-depth data for intervention-based assistance programs. Having kind and healthy attitudes affect families' functionality and developmental characteristics. As individuals, families also have development and adjustment processes and developmental crises. Families' life cycles are affected by having children with disabilities varying by type, severity, and continuity of the disability; also by the family socio-economic conditions, educational opportunities, and the perception of the family regarding their situation. Having a child with a disability can negatively affect marital functions by causing many situations that form a basis of conflicts such as decreased marital satisfaction, anxiety, depression, divorce, blaming, and postponement. The approaches that individuals use to cope with the sources of stress play an important role on symptoms and behavioural choices. The main basis of the present study is the assumption that the intermediate variables, such as the sense of controllability and level of hope that families can use against the sources of the attributions related to the disability, can affect the coping approaches, as well as the types and severity of the psychological symptoms that may be observed. In addition, the results of this study will help the specialists in this area and the experts who provide family guidance and counselling as well as psychological assistance to evaluate the significance of the concepts to be studied and the relationships between them.

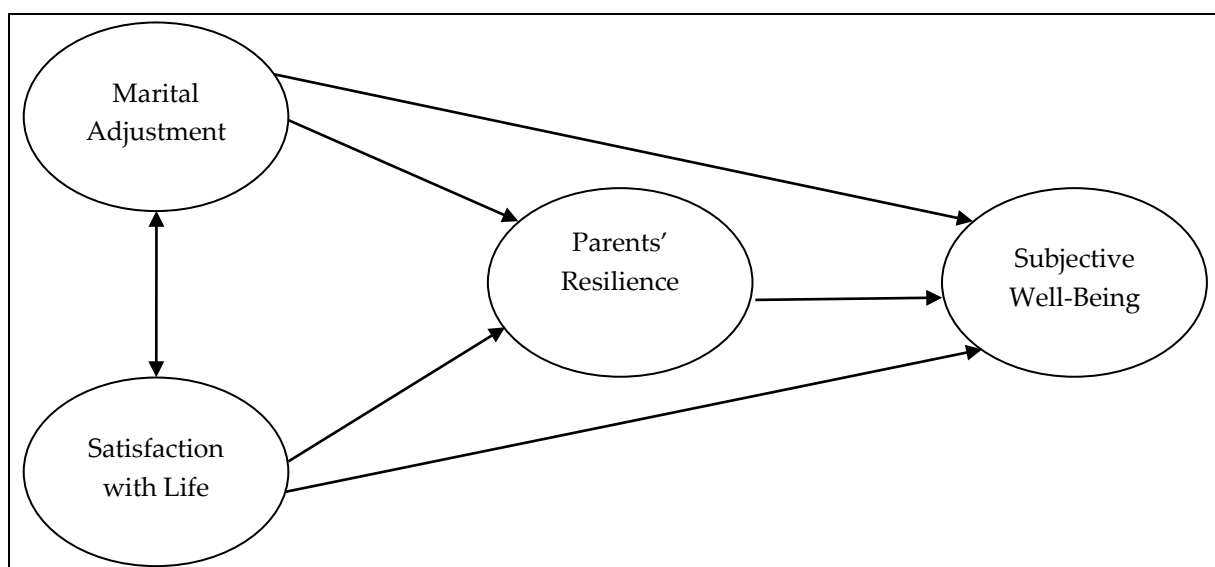


Figure 1. The Intermediary Model Recommended for the PHCDs' Subjective Well-Being

This study sought answers to the following questions:

1. How do the PHCDs psychological symptom levels differ by the types of disabilities?
2. What differences are observed between the PHCDs and the families having healthy children?
3. How does gender cause differences in the parents' perceptions of positive family dynamics, including marital adjustment or symptoms?
4. How can subjective well-being be explained based on resilience level and the relevant variables?

Method

Study Group

The study group consisted of 552 married couples (a total of 1,104 mothers and fathers) who have only one child with a disability and whose children receive supportive education from the rehabilitation centers providing service for at least five years in Ankara, Antalya, Erzurum, Giresun, Gümüşhane, İstanbul, Ordu, Samsun and Trabzon, as affiliated with the Ministry of National Education. The parents volunteered to participate in the study. Those PHCDs consenting to participate in the study completed the data collection tools independent of each other. The forms were administered in two parts because of the large number items. Due to research principles, simultaneity was observed during data collection to minimize sources of mistake resulting from external diffusion, and the tests that were not completed within 10 days were excluded from the study. The PHCDs were asked to complete the forms within the obligatory accompaniment duration in the rehabilitation center where their children receive education. The analyses were made on responses by 530 couples (1,060 mothers and fathers) after some parents were excluded because only one of the parents completed the data form, some parents changed their institution, or some parents were excluded by homogeneity tests. The control group consisted of 242 couples (484 individuals). The average age of the mothers and fathers were 32.72 (SD=12.65) and 38.98 (SD=8.21), respectively. Of the mothers, 36.02% were employed for at least the previous six months. Of the fathers, 84.17% were employed in a regular job for at least the previous six months. Of the parents, 26% had low, 63% had medium, and 11% had a high socio-economic level. Of them, 64% had another child without any disabilities, 21% had two or more children without any disabilities, and 15% had only one child with a disability. The parents were the children's biological parents. The control group consisted of 442 couples having at least one healthy child at three years of age and no first-degree relatives with disabilities. The data were collected from the volunteering parents who attended the parental education seminars provided by the researcher in Trabzon, Ankara, İstanbul, Giresun, Rize, Ordu, Samsun, Bayburt, and Erzurum. The average ages of the mothers and fathers in the control group were 39.01 (SD=11.96) and 42.44 (SD=10.11), respectively.

Data Collection Tools

Subjective Well-Being Scale (SWBS): This scale was developed by Tuzgöl (2004) and includes 46 items, each scored between 5 and 1. The scale has 26 positive and 20 negative statements. The minimum and maximum scores of the scale are 46 and 230, respectively. Higher scores indicate higher subjective well-being levels. The Cronbach's Alpha reliability coefficient was 0.93 for the SWBS. The instrument was administered to a group of 39 participants twice at two-week intervals to find the stability factor of the scale. The Pearson's product-moment correlation coefficient was 0.86. The scale has a 12-factor structure. The common variance of the variables ranged between 0.51 and 0.75.

Marital Adjustment Scale (MAS): This scale was translated into Turkish by Tutarel Kışlak (1999). The MAS has 1 question on general adjustment, 9 questions on possible areas on adjustment, and 6 questions on conflict resolution, commitment, and communication. The participants rank the items such as "Management of the family budget" and "Spare time activities" using the 6-point scale on the right side of the items ranging between "We always agree" and "We never agree." Scores higher than 43.5 indicate higher marital adjustment, and vice versa. Tutarel Kışlak (1999) found the MAS's internal consistency coefficient to be 0.90, the split half (odds and evens) reliability coefficient

to be 0.84, and the test-retest (at two-weeks interval) reliability coefficient to be 0.57. In addition, the MAS was found to be related with the Interpersonal Relationships Scale and the Relationship Attribution Measure with the scores of 0.12 ($p < 0.05$) and -0.54 ($p < 0.01$), respectively. In this study, the MAS Cronbach's alpha reliability coefficient was 0.72.

Beck's Depression Inventory (BDI): This inventory developed by Beck (1961) is a self-report inventory assessing the severity of the depression symptoms. It was tested for validity and reliability by Hisli (1988) and by Savaşır and Şahin Hisli (1997). The BDI is administered to the people older than 15 years of age and includes 21 items on depression categorized under the following 4 factors: Reduced Performance, Individuals' Negative Feelings of Themselves, Somatic Disorders, and Guilt. The BDI's split half reliability coefficient was 0.74. Its score of correlation with the MMPI was 0.63 for a sample of psychiatry; 0.50 for a sample of university students; and 0.47 for a sample of secondary education students with MMPI's Depression subscale and 0.55 with the total score. The Inventory was found to diagnose treatment-required depression with an accuracy higher than 90% when its scores are at the breakpoint of 17 and higher. Each item is scored between 0 and 3. Higher scores indicate higher depression level.

Beck's Hopelessness Scale (BHS): This scale was developed by Beck, Schuyler, and Herman (1974) and consists of 20 statements. Of these statements, 11 have true and 9 have false key answers. The participants answer the scale themselves. Each item is given 1 point for compliant answers and 0 point for noncompliant answers with the key. The obtained arithmetical sum is accepted as the hopelessness score. The possible variance of the scores ranges between 0 and 20. Items 1, 6, 13, 15, and 19 measure the feelings about the future; items 2, 3, 9, 11, 12, 16, 17, and 20 measure motivation loss; and items 4, 7, 8, 14, and 18 measure expectations about the future. The statements consist of emotional, motivational and cognitive factors.

Satisfaction with Life Scale (SWLS): This scale was developed by Diener, Emmons, Larsen, & Griffin (1985) and was translated into Turkish by Köker (1991). It is a 7-point Likert-type scale consisting of 5 items. The sum of the scores of each item yields the total score of the Scale. Köker (1991) used the test-retest method to determine the stability of the answers, and item analysis to determine how well the scale measures the intended subject. The scale was administered twice at 3-week intervals; its test-retest reliability coefficient was 0.85. During the item analysis, the correlation coefficient between the scale's item scores and the test scores was calculated using the Pearson Product-Moment Correlation Coefficient. The correlation coefficient scores between the scale's total score and each of its 5 items were 0.73, 0.73, 0.76, 0.75, and 0.90, respectively. The Cronbach's alpha coefficient of the scale was 0.76. In the present study, the Cronbach's alpha coefficient of the scale was 0.84.

Conflict Communication Styles Questionnaire (CCSQ): This scale translated into Turkish by Uysal (2002) is comprised of 2 dimensions. It focuses on the communication process as well as individual and cultural differences in conflict resolution. It is a 5-point Likert-type scale with 2 subscales: approach/avoidance and expression of the feelings. The reliability of the scale was tested on a sample of 202 people, and 32 items were excluded based on the breakpoint of 0.25 and according to the total-item correlation. The Cronbach's alpha coefficient of 43 items was 0.89. Through the Stepwise Multiple Regression Analysis, these 43 items were found to be dependent, and all items of the scale were found to be independent variables; 32 items that contribute to the total variance at a rate below 10% were excluded from the scale. Factor analysis was performed for the remaining 43 items, and 2 factors were found to explain 27% of the total variance: approach/avoidance and expressing the feelings. The Cronbach's alpha coefficient was 0.85 for the approach/avoidance subscale and 0.81 for the Expressing the Feelings subscale. A statistically significant difference was found between the two subscales after the Pearson's product-moment correlation coefficient was calculated on a sample of 400 people ($r = 0.35$; $p < 0.01$).

Vulnerability Scale (VS): This scale was developed by Sinclair and Wallston (1999) to assess the cognitive factor that cause the negative reactions leading to stress. Erözkan (2004) translated the scale into Turkish. The scale reflects the cognitive reactions that impair compliance in relationships, the coping process, and the main vulnerability situations that affect physical and psychological well-being. The content validity of the scale showed positive correlations with perceived helplessness, negative mood, compliance, coping, physical disease activities; there were negative correlations with positive mood, life satisfaction, perceived social support, and personal sources of coping. It is a 5-point Likert-type scale that consists 6 items. Its intratest consistency coefficient was $\alpha=0.73$.

Perception of Control Scale: The scale was developed by Palancı (2000) to assess individuals' perception of control against fictional stress conditions. The items cover the stress stimulants such as the death or loss of an important person, exams, social interaction, living separate from family, financial bottleneck, social rejection, speaking before powerful and important people, and intrafamilial disturbance. The items are listed from very stressful factors to less stressful factors. Intratest and test-retest reliability coefficients of the scale are 0.74 and 0.71, respectively. The participants are asked to rank their controllability of the possible effects of each situation between 1 and 7 (from "I cannot control at all" to "I completely can control) using a Likert-type scale. The score of the scale shows the participants' general perception of the controllability of stress. Higher scores indicate higher controllability.

Inventory of Coping with Stress Attitudes (WCSA): The original scale was developed by Özbay (1993) for foreign university students in the United States of America. It was translated into Turkish by Özbay and Şahin (1997). It is a 5-point Likert-type scale that assesses individuals' efforts to cope with different stressful situations. In the Turkish translation of the inventory, 43 out of 56 items are categorized under 6 factors as a result of the factor analysis. These 6 factors are active planning, seeking external assistance, avoidance-isolation (emotional or actional), avoidance-isolation (biochemical), and acceptance-cognitive restructuring. The criterion validity of the scale has also been proven using a similar scale as well as structure factor analysis. The Cronbach's alpha coefficient was used to test the reliability of the scale, and its general reliability coefficient is 0.81.

Family Resilience Scale (FRS): This scale was developed by Kaner and Bayraklı (2010) on a sample of 524 parents (parents of 105 students in special education institutions and 419 students showing normal development) to assess parents' perception of resilience. They administered an 87-item draft form to the parents and carried out some validity tests such as exploratory factor analysis, confirmatory factor analysis, total-item correlation, and correlations between subscales. The correlations between the FRS and the Beck's Depression Inventory, Learned Resourcefulness Scale, and the Parental Self-Efficacy Scale were also calculated. The Cronbach's alpha, the Spearman-Brown split half reliability coefficient, and the test-retest reliability coefficients were used to assess the reliability of the scale. The analyses indicated that 37 items were categorized under 4 factors that explained 45.79% of the total variance. The FRS was found to have sufficient psychometric characteristics.

Data Analysis

Incomplete and ineffective tests were eliminated from the dataset. One of the participants were excluded from the dataset due to having extreme values in one-way and multi-way extreme value analyses. Histogram graphic was used to analyze univariate normality. Kurtosis and skewness analyses showed that the variables were normally distributed.

A multivariate normality test performed with the LISREL program indicated that the variables ensured the multivariate normality. The correlation coefficients between the variables, the VIF values, and the tolerance values were used to analyze multi collinearity and singularity; multi collinearity was not observed. The linear connection between the independent variables (for a non-categorical dataset), which is required for Multinomial Logistic Regression (LR), was analyzed. After obtaining the values calculated for the averaged measurement values, Spearman correlation values were calculated for categorical variables. Table 1 shows the findings of model summary for the parents having children with or without disabilities as well as the -2 LL, Cox & Snell and Nagelkerke fit values. The model was structured with the highest probability estimation of covariance matrices. The model was tested through random assignment parcelling for the variables analysed for PHCD and the control group.

Results

Table 1. Model Fit Calculation

	Model's Fit			Fit Content	Pseudo	R ²
	-2 LL	χ^2	p			
Model					CoxandSnell	.37
Fixed	1.19			Pearson .000	Negelkerke	.44
Saturated	921.16	162.13	.001	Sapma .000	McFodden	.41

Table 2. Logistic Regression Model Classification Status

Predicted	Observed	
	0	1
0	168	257
1	170	396
Total		

Perception of Having Relatively Worse Type of Disability, 0=Disabilities Perceived as Milder (hearing impairment, mild mental disability) 1=Disabilities Perceived as Severer (Severe mental disability, negative spectrum and autism with a severe intellectual disability. The participants diagnosed with atypical autism were excluded from this analysis.)

Analysis of the logistic regression model classification in Table 2 shows that for disability types perceived as milder out of 425 families, 168 of them were categorized correctly and 257 incorrectly. For disabilities perceived to be heavier, out of 566 students 170 students were classified incorrectly and 396 correctly. For the multivariate analysis, univariate regression significance test was run as a prerequisite and significant independent variables were analysed multiple times according to disability types at the following stage.

The variance explained by the regression model set in Table 3 is statistically significant ($p < .001$). It is seen that the variance explained between the dependent and independent variables corresponds to 44% (Nagelkerke R²). To calculate the significance of an independent variable in a logistic regression analysis, likelihood ratio test is utilized. Results of the likelihood ratio test are given in Table 3.

Table 3. The Likelihood Ratio Tests for the Predicted Model

Effect	-2LLLikelihood	χ^2	p
Fixed	894.41	.780	.813
Gender	839.46	18.598	.01
MES	877.87	15.223	.02
ToM	875.76	2.965	.397
SWB	872.34	22.875	.000
PSS	888.64	19.104	.008
MA	890.56	20.033	.004
DL	889.66	5.324	.27
HL	871.87	9.857	.05
SwL	891.61	21.927	.001
TCC	888.47	2.553	.47
V	891.98	3.344	.39
PC	845.47	10.157	.04
APLAN	865.66	10.429	.04
EMOAV	886.59	3.161	.41
FRL	845.66	14.711	.02

MES: Mother's Employment Status; ToM Type of Marriage; SWB: Subjective Well-Being; PSS: Perception of Social Support; MA: Marital Adjustment; DL: Depression Level; HL: Hope Level; SwL: Satisfaction with Life; TCC: Type of Conflict Communication; V: Vulnerability; PC: Perception of Control; APLAN: Active Coping; EMOAV: Emotional Avoiding; FRL: Family Resilience Level

As a result of the likelihood ratio test, gender, mother's employment status, subjective well-being, perception of social support, marital adjustment, hope, life satisfaction, perception of control, active coping and family resilience are found to be statistically significant. Therefore, these variables are taken into the data analysis pool in the second stage. Table 4 shows the independent variable multinomial logistic regression analysis results based on the type of the disability and statistically significant variables.

Table 4. Multinomial Logistic Regression Analysis based on the Type of the Disability

Variable	Hearing Disability		Mild Mental Disability		Mental Disability		Autism	
	B	Exp β	B	Exp β	B	Exp β	B	Exp β
Gender ¹	.13	.14	-.06	.93	-1.28	.36**	-1.09	.15**
MES ²	.15	.81	.28	1.13	-1.54	.28*	-1.11	.80**
SWB	.26	.14	-1.41	.68	.64	1.07**	1.15	1.16**
PSS	.25	1.29	.39	1.05*	.87	1.52**	.24	1.09
MA	.74	2.10	-.07	.35	.74	2.15	-.007	.86
HL	.49	1.76**	.82	2.54	.83	2.31**	.19	1.12
SWL	-.06	.94	-.14	1.14	.39	1.49*	-.06	.92
PC	.27	1.17	1.39	1.42	.74	2.02	.19	1.22*
APLAN	.13	1.21	2.08	1.32	.28	1.23	.78	1.34
FRL	.78	2.70	.99	2.48**	1.78	.26**	1.63	.32**

MES: Mother's Employment Status; SWB: Subjective Well-Being; PSS: Perception of Social Support; MA: Marital Adjustment; HL: Hope Level; SwL: Satisfaction with Life; TCC: Type of Conflict Communication; V: Vulnerability; PC: Perception of Control; APLAN: Active Coping; FRL: Family Resilience Level

*p<05; **p<01

¹: Based on women

²: Based on employed women

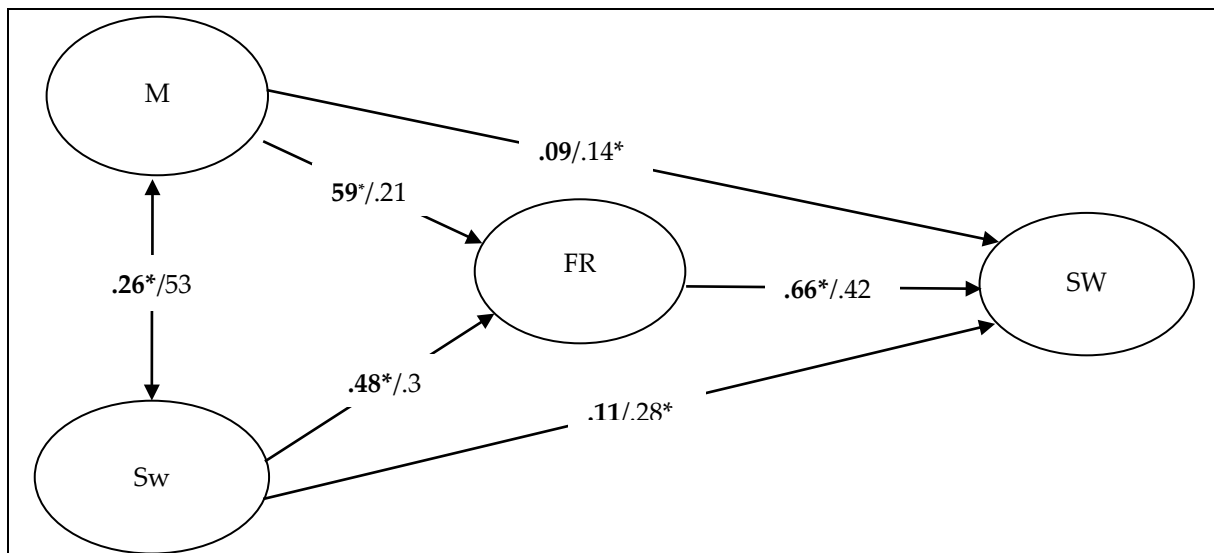


Figure 2. Comparison of the Recommended Model between the Groups (The calculations shown in bold are for the parents having children with disabilities.)

When the models are compared, a lower level of relation between MA and SWL is calculated for PHDCs in comparison to the control group. There has been found a significant relation between MA and FRL for both groups, however, for PHDCs there is a higher calculation value for PHCDs. A significant relation between FRL and SWB is found for both groups but a higher relation value is calculated for PHCDs. The relation between SWL and SWB and the relation between MA and SWB is found to be insignificant for PHCDs but a more significant calculation value has been obtained for the control group. As a result of the SOBEL test, the SWB values of the PHCDs and of the families in the control group have been found to be significantly related and are calculated as ($z=2,84, p<.01$; $z=2,66, p<.01$) respectively.

Table 5. Model Fit Values

Fit Index	Value	Recommended Value	Reference
χ^2	5688,22	Insignificant difference $p<0.05$	Klem (2000), Kline (2005), McDonald and Ho (2002)
χ^2/df	2,039	< 3	Gefen, Karahanna, and Straub (2000)
SRMR	0.04	< 0.05	Hu and Bentler (1999), Wheaton et al. (1977)
RMSEA	0.042	< 0.05 (perfect fit)	McDonald and Ho (2002)
CFI	0.91	$\Rightarrow 0.90$	Klem (2000), McDonald and Ho (2002),
TLI	0.90	$\Rightarrow 0.90$	Klem (2000), McDonald and Ho (2002)

Discussion, Conclusion and Suggestions

The differences between the general attitudes of the PHCD can be explained by different family dynamics peculiar to each family. This peculiarity is related with the families' existential dynamics and personal competencies of coping (Dale, 1996; Cunningham & Davis, 1985). The birth of a different child usually starts a process that leads parents and siblings to re-evaluate and explore their views about themselves and their lives (Woodman et al., 2015). Social conditions and belonging are among the sources shaping resistance and competency of coping in this process, which may be more radical and traumatic than it would be for parents with normal children. Particularly adverse parental attitudes lead to emotional and behavioural problems that can typically be observed in children in need of special education (McStay, Trembath, & Dissanayake, 2014). Findings of the study revealed how the resistance and personal resources of the families that experience negative situations would be affected under which conditions, depending on the type of the disability. A statistically significant difference was found between the subjective well-being and resilience levels of the families having children with disabilities and the families having healthy children. It is understood that using the remaining personal resources, not being exposed to negative symptoms, and using particularly the active coping skills for necessary situations in the process depend primarily on the resilience levels. For this reason, it is important to analyse the level of resilience first in the examination of psychological symptoms to be observed in PHCDs and in psychological assistance to be provided. Practitioners should consider that improvement in the resilience will directly influence the support and development programs during psychological assistance for PHCDs.

Azad, Blacher, and Morcoulides (2013) summarized the results of their longitudinal and comparative study, where they analyzed the families having children with disabilities and families having healthy children of those families whose children were compared in early childhood period between the ages "3-5" and "6-13", the ones who experienced less stress during the period of 3-5 years of age were found to be more advantageous in the future. Emerson and Giallo (2014) found in their longitudinal study that the negative effects of having a child with a disability on the other siblings are mainly affected by socioeconomic conditions, age disparity, and the duration of being together. The access to health services and social support required for families to cope with the negative factors affect their attitudes (Gomes et al., 2015). Stuttard et al. (2014) found that psychological and social support provided to the families having autistic children make positive contributions to the children and domestic lives of these families. These authors indicated that all kinds of active social support provided for Children with Special Educational Needs would positively affect the children based on the improvement observed in the family. Widmer, Kempf, Sapin, and Galli-Carminati (2013) reported that the strength provided by families' social capital, assistance, intrafamilial social support networks, and attachment contribute positively to the adaptation and coexistence process of the children with mental disorders. It is important that families in need of special education have future educational plans designed with psychological features and needs in mind (Cavkaytar, Ceyhan, Adıgüzel, & Uysal, 2012).

Coping with having a child with disabilities is quite difficult for families. Walsh (2006) defines resilience as "an active process that enables one to cope with a difficult situation, to make progress, and to be resistant in a crisis." Families should have high level of resilience (McConnel, Savage, & Breitzkreuz, 2014). Resilience level affects the perceptions of social support and the differences that arise from financial conditions (Özbay & Aydoğan, 2013). The most important factors that contribute to the families' resilience level are social support, spirituality, positive point of view, commitment of the family members, flexibility, and originality / relational originality. Resilience is perceived more than families' general characteristics, individual differences, and the other existing facts of life and enables them to feel better about having children with disabilities. Özbay and Aydoğan (2013) analyzed the resilience level of the families having children with special educational needs and obtained important findings through in-depth data analysis. Resilience increases at a level dependent

upon the social support perceived by the families. Social support, relatives, friends, and neighbors positively contribute to families' lives and adaptation. Flexibility and open communication between spouses, as well as planning and maintaining coexistence activities, affect family resilience and positive moods. Continuous efforts of resilience against difficulties and coping with them enable families to obtain positive results (Lazarus & Folkman, 1984).

Having children with disabilities, and the stress and emotional weaknesses experienced by families can damage their intrafamilial relationships and social life (Aslan, 2010; Lusting, 1999; Sarısoy, 2000). Cantwell, Muldoon, and Gallagher (2014), in their study where they compared families having children with disabilities and a control group, found that the experimental group perceived their physical health to be poorer. Karpat and Girli (2012) reported that the commitment and perceived social support level of the families having children with a pervasive developmental disorder caused these families to be unhappy. Particularly studies aiming to evaluate and to increase the perception and use of social support found that the problems that arise from the spouses' level of acceptance of the disability and whether they perceive their efforts to be equal affect their marital satisfaction and the relationships between spouses negatively (Çiğerli et al., 2014). A study on communication in marriage reported that unlike unhappy couples, happy couples had different communicational habits, did not hesitate to express their problems and feelings, established a good communication, and could understand each other through non-verbal expressions. (Fitzpatrick, 1988). An increase in the level of verbal communication first in their relationships with their spouses and then in their environment decreases their unhappiness. Lafçı et al. (2014) found that mothers experience loneliness at a higher level and have more marital expectations of their husbands. Mothers feel more hopeless, panic, broken and unhappy, and perceive poorer personal development than do fathers. Aksoy and Yıldırım (2008) showed that the other siblings' attitudes towards the disabled sibling, and their tendency to accept their sibling can affect the nature of intrafamilial relationships. Çakan and Sezer (2010) indicated that the mothers having children with chronic diseases showed different attitudes from the mothers having healthy children, and more than half of them needed psychological support. Akandere, Acar, and Baştuğ (2009) analyzed the level of satisfaction with life and hopelessness of the parents having children with mental and physical disabilities; they found that younger mothers expressed more hopelessness than older mothers. Kırbaş and Özkan (2013) found that the mothers of children with Down Syndrome sufficiently fulfill their family functions; and that the mothers who expressed a high level of social support level also perceived higher level of family functions. Özekes, Girli, Yurdakul, and Sarısoy (1998) reported the PHCDs to be more directive, reliable, and independent. Satisfaction with life and hope also depends on a family's educational level, the type of disability, and the age of the child with disability (Akkök, 1989; Beckman, 1983; Çelik, 2004). In particular, the findings of the instrumental variation analysis between the PCHDs and the comparison group are in agreement with the research data given above. However, it is noteworthy that the MA and SWL of PHCD do not have a meaningful relation with SWB like in the families with healthy children. Only MA and FRL variables directly contributing to the FRL can contribute to SWB. This flow diagram was followed as a typical distribution difference in instrumental variation analysis. This finding underlines the fact that PHCDs internal harmony and family dynamics will attain more meaning if there is a strategy and emphasis on being partners. Resilience and coping skills of parents alone do not provide a meaningful contribution to SWB. If all perceived social support, well-being mechanisms and sources of coping do not affect FRL directly final results will not be meaningful for PHCDs. In the light of this information, when researchers and practitioners work on situations like pathology, divorce, unhappiness, depression, extreme stress, reduced marriage adjustment, they should primarily check whether families' coping and problem-solving skills can transform into family resilience. Families coping narratives where there is a singular variable or their use of problem-solving skills will not contribute to the recovery process. Researchers working on the MA or psychological symptoms of PHCDs should primarily evaluate and develop a repertoire of common skills contributing and integral to FRL.

Bahar et al. (2009) reported that anxiety, an important variable, increased in PHCDs over the years. Domestic violence increased depending on an increased perception of helplessness. Parents of children with mental and physical disabilities need more psycho-social support as levels of perceived helplessness increase (Klerk & Greeff, 2011; Meltzer et al., 2012). Eroğlu et al. (2014) indicated that learned resourcefulness had a positive interaction with self-confidence and seeking social support; and negative interaction with helplessness and submissive approach. Llewellyn et al. (2010) reported that the PHCDs' perception of health and satisfaction with life was explained by the nature of the professional support provided for helplessness and its controllability rather than the nature of the source of stress. The most important source of stress was that having children with disabilities requires more responsibilities since these children have difficulty in self-management. Unlike the other studies, Uğuz et al. (2004) found that marriage was not affected by this situation. Erturan and Akbağ (1997) reported no relationship between the disability and anxiety. However, the increase in mothers' anxiety level has a linear relationship with the increase in the anxiety level of the other family members. Yıldırım and Conk (2005) showed that parents having children with mental disabilities had higher levels of depression and exhibited the behaviors of coping such as helplessness and submissive approach at a higher level. Psycho-education was found to significantly affect feeling better and the scores of self-confident coping style. Mind and motor development problems (Vrijmoeth, Monbaliu, Lagast, & Prinzie, 2012), down syndrome (Rajabi, Afrooz, Arjmandnia, & Nojani, 2012) and autism problems (Obeid & Daou 2015; Peters-Scheffer, Didden, & Korzilius, 2012) are known to affect marital adjustment and satisfaction substantially and to have pressure on well-being. Social status, perceived social support, care support and family Dynamics are all defined as important variables in this study. Experts should perform different practices to support the families having children with disabilities. Psychological support increases families' satisfaction with life. Education programs for parents, family therapies, and early education practices meet the needs of parents, and thereby the needs of the children with disabilities (Batk, 2012; Sucuoğlu, 1995). The findings of the study show that especially marital adjustment, resilience, protection from depression, well-being and conflict-communication style are determinants. The significant finding that marital adjustment has an explanatory relation with resilience and conflict-communication style is considered to be an original finding as this relation is predicted with multiple variables calculation and it recommends practitioners to use them together.

Marital conflicts and stress causes an increase in the behavioral problems of children with mental and physical disabilities (Vrijmoeth et al., 2012). The parents' behaviors play an important role in the lives of children with intelligence at average and borderline levels. These behaviors include physical punishment, low-level of encouragement, decreased positive attitudes, rare monitoring of the child, decreased sense of being parents, and perceiving care to be too difficult (Schuiringa, van Nieuwenhuijzen, Orobio de Castro, & Matthys, 2015). Employed PHCDs working in jobs that require status were found to have a higher tendency to perceive the difficulties they experience to be more negative. Families who have more detailed and realistic knowledge about the severity, type, and expected progress of their children's disability experience fewer problems. The most important problems experienced by the families include the concerns about the future, problems in social relationships due to having children with disabilities, a sense of losing social support, and concerns related to having problems in intrafamilial relationships (Kurt et al., 2008). Köksal and Kabasakal (2012) found that the marital adjustment and perception of stress are predicted from having children with disabilities. PHCDs experience stress, social isolation, marital conflicts, self-accusation, helplessness, insufficiency, anger, shock, and fatigue (Eroğlu et al., 2014). One of the prominent supportive recommendations is to receive support for expressing the feelings and need for care services (Aybar, 2014). Coşkun and Akkaş (2009) indicated that PHCDs had high levels of continuous anxiety; their perceived social support showed a negative correlation. Increased education and income level of families increases their perceived social support and decreases their continuous anxiety level. Karadağ (2009) found that the hopelessness level decreases as the families' perceived social support increases. Yıldırım, Hacıhasanoğlu and Karakurt (2012) analyzed the mental symptoms in mothers

and observed significant levels of depression, somatization, anger/hostility, paranoid thinking, and psychoticism. The most frequently observed problems in the families having children with disabilities include depression, anxiety, intra familial relationship problems, financial problems, social isolation, psychological problems, the problems in working life, transportation, neighborhood problems, and the problems in spare time activities. It is understood that coping skills are the main determinant in the emergence of such symptoms. The other original findings of the study are that the variables of the initial and the process intermediate variables which affect the positive direction of the coping skills are determined. The importance and value of coping skills are hard facts revealed by other research. However, knowing the prediction ranking of the nature and quality of coping skills will contribute to creating strategies as well as intervention skills. It is useful information for researchers and practitioners that perception of control, resilience and communication skills affect marital adjustment and subjective well-being directly in relation to the nature of coping and resilience.

Limitations and Suggestions

It is important to do the study at a smaller scale and with families showing typical pathological indicators and with qualitative analysis methods. Through a longitudinal study, it can also be researched how the level of marital adjustment changes according to different family dynamics and how it reflects on the possible symptoms. Such a study will bring more findings and intervention skills to practitioners. Understanding the marriage type, the changing characteristics of families with low and high premarital adjustment levels after having a disabled child may also be important because understanding the dynamics of the change that will encourage a married couple with low adjustment levels to be in harmony again and to act together will lead to a low level of marriage will be important in terms of seeing the causes of psychological stability and the change of family dynamics in difficult times. On the other hand, to provide more comprehensive data and findings, it will also be important to investigate the difference between a trauma that can harm a good marriage and the situation where having a disabled child can make an already bad marriage worse and to see how family dynamics change. Research in this field are primarily categorizations of the relationship levels and causality. Undoubtedly, such findings are important, but it is important to crystallize concepts that will enable practitioners and researchers to make practical predictions and interventions. An important part of the studies carried out in the field of special education, unfortunately, focus on perception, situation, teacher expectation, and so on. This kind of research makes it difficult to access the findings that directly contribute to the 'focus' -the handicapped children. If families and children will studied, it will be more meaningful to determine type, level and scope for the variables.

The research model required using too many surveying tools. It was difficult to gather data and motivate families. If studies like this are made a part of research projects or some social responsibility projects, voluntary participation in the study may increase. Researchers must be prepared for the challenges in this regard. In particular, it is important to conduct research by providing service, support or training. Questions and researches are demoralizing PHCDs. They are looking for people who can provide support, explanation and remedy for their life problems. At the very least, providing training materials, support training or seminars will be more empathic and contributing. Families have given the feedback that even if such research was published, it would not make sense for them when they read it. The fact that the researcher did not organize an event in this context created limitations in terms of professional principles.

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