

PERSONALITY CHARACTERISTICS OF GREEK MOTHERS OF CHILDREN WITH SPECIAL NEEDS WHO ARE INVOLVED IN SPECIAL NEEDS SUPPORT CENTRES

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Abstract – It is generally accepted that support of the family is critical for effective intervention in the case of a child with special educational needs (SEN). The quality of this support highly depends on the personality characteristics and the mental health of the parents. It has also been argued that, because of the increased pressure and the strain of having to care for a child with SEN, the opportunity to learn from and share problems with other families is very beneficial. It is also essential to seek emotional support at times of crisis through the means of parent support groups. This empirical study focuses on the mothers' personality since they are more directly affected by their child's disability. The aim of the study was to examine whether participation in parent support groups and sharing with others the care of a child with SEN affect the self-esteem, the coping mechanisms and the depression of mothers with such children.

Introduction

Antil the 1980's Special Education in Greece was not targeted towards provision for pupils with Special Educational Needs (SEN) within the ordinary school. Since then there has been a consistent effort to include these children and cater for their needs alongside those of other children. In the years 1983-84 the Greek Ministry of Education moved away from the strategy of integration in the primary school and implemented the practice of special classes. Support is provided using the method of withdrawal of children with learning difficulties. The aims of special education as described in the Greek Law of 1985 are: (a) the effective development of children's potential and abilities; (b) their participation in the productive process, and (c) their acceptance by society. Special classes as a model of inclusion were first implemented in 1984 and from seven they have expanded to more than 700 today. According to this model the pupil is removed from his/her class to receive support from a special teacher within a group of pupils with similar problems.

Although only a limited number of studies exist who evaluate the effectiveness of the support system in Greece, some problems have been identified. Lack of specialist staff such as speech therapists, educational psychologists and physiotherapists, less than adequate provision in rural areas, no emphasis on the problems of adolescents with SEN and, finally, lack of systematic career guidance and counselling to inform pupils with SEN of routes to future employment (Polychronopoulou, 1999). Throughout the stages of special education the absence of parents as partners in their children's education is particularly evident. Apart from parents' groups formed through parental initiative (parents of children with Down syndrome, autism, and so on) the State has been less than willing to operate schemes where the parents would occupy the central role. Currently, there is a renewed interest in special education due to a new development in legislation. According to the new law, there has to be at least one centre for diagnosis and counselling in each local authority. This support must be aimed at children, parents and teachers with the aim of inclusion, early intervention and support of parents and teachers. Within the responsibilities of each centre lie guidance counselling and training for parents (either at the centre or at home) through early diagnosis and early intervention.

The study of the development and the adjustment of children with disabilities has been largely focused on the characteristics of the children themselves. This approach has ignored the family systems perspective, which takes into consideration the family's direct and indirect effects on the child's adjustment and progress. Moreover, rather than emphasising the unidirectional influence of parents on children or children on parents, child functioning is now seen more in the context of the family as a system where there is a mutual influence of family and child leading to child outcome (Martin, 1987; Hinde & Stevenson-Hinde, 1988; Halverson & Wampler, 1993). The application of a conceptual framework that emphasises the context of the family as critical among the various systems in which disabled children develop, such as the school and the community, will facilitate an understanding of disability and negate possible negative family influences on the child's development.

The closer the parent is to the education of the child, the greater the impact on child development and educational achievement (Fullan, 1991). Working with parents' is a concept that has a long history in special needs education internationally. Parent partnership schemes, parent-professional relationships, home-school liaisons are terms used to describe the initiatives which have taken place in Western Europe in recent years (Wolfendale & Cook, 1997; Mittler, 1995, 2000). It is a well established professional view that appropriate education for children with special needs should start at birth with family support schemes which will enable the family to grow strong and functional and will not allow the

development of pathological conditions and/or pathological dependencies on professionals for any of its members (Carpenter, 1994).

A growing base of studies of children with disabilities exists documenting that parenting, quality of marital relationships, parental personality and whole family functioning are related to child outcome (Rutter, 1988; Powers *et al.*, 1989). This applies also to families of children with learning disabilities during middle childhood and adolescence (Mink *et al.*, 1983; Mink & Nihira, 1986). Halverson & Wampler (1993) propose that the match-mismatch model can be used in order to examine the relative importance of aspects of the family environment that moderate the direction of influence between family and child. According to this model, when disabled children are raised by problem families, both families and children will get worse over time with the direction of effects going from the disabled child to the family (child-driven model). When disabled children are raised in competent, low problem families, however, children will become less a source of problems and the families will continue to be competent over time. The direction here is from the family to the child (family-driven model).

In the Greek context, a number of studies have revealed that the central family role seems to be that of parent-child, and mainly mother-child role (Christea-Doumanis, 1978; Katakis, 1984; Makri-Botsari, 1999; Nasiakou, 1978).

Bringing up a child with learning disabilities can be particularly disruptive for the family system. (The term learning disabilities is used here to refer to children with mental retardation, mild or severe, and children with multiple physical handicaps which prevent them from reaching their education potential.) On the one hand, parents are expected to deal with the situation effectively and support their child alongside professionals. On the other hand, caring for a disabled child can be extremely demanding despite its rewards (Beresford, 1994). The specific problems associated with disabled children may adversely affect the family's adjustment and in turn decrease the levels of parental support. The effects of the disability on the family are evident in several areas such as increased cost, limited time and psychological strain. The way that parents deal with the problems related to the special needs of their child is critical for the effective support of the disabled child.

The majority of empirical evidence in this area consists of studies on the psychological well being and adjustment of the disabled child in the educational setting and, later in society. By comparison, fewer studies have been carried out investigating the effects of a child's disability on the family in terms of psychological impact and stress on the parents (Ferguson & Watt, 1980; Carr, 1985). Finally, the link between psychological aspects of parents such as self-esteem, depression and coping strategies has received considerably less attention, especially in cases where parents were involved in parental groups.

The study reported in this article investigated levels of self-esteem and depression in mothers of learning disabled children who participate in parent support groups, and the coping strategies they use in order to deal with the strain of disability. The emotional reactions and the psychological health of mothers have been traditionally investigated in the special needs literature regarding infants or very young children. Older children and adolescents have largely been ignored. Nevertheless, disabled children stay at home and continue to be cared for by parents well beyond school-age days, so it is expected that the pressure on the family is considerably higher. The review will encompass three linked areas. Firstly, the effects of the disability on the family's - especially the mother's - psychological adjustment will be presented. Secondly, the issue of parental participation in the child's education for families with a disabled child will be discussed. Then, the review will describe the different coping strategies that parents employ in order to deal with the problems they face.

Effects of disability on the family

All parents, and especially mothers, develop anticipation regarding their infant. They have plans and project their expectations into the future. As a result of the diagnosis, the parents realise that their children may not fulfill their expectations and their 'life plan' can be irrevocably changed (Robin & Josse, 1986).

The effects on the family of bringing up a child with a developmental disability such as autism or Down syndrome can often be overwhelming. The exceptional pressures that parents and the whole family system face start very early from the birth or the time of diagnosis (if these are different) of the child with disabilities. The birth of a child with disabilities or a high-risk child is a stressful event that often leads the mother to inadequate coping styles, difficulties in relationships and reduced social contact (Brooks-Gun & Lewis, 1982). The adaptation process that parents go through following the diagnosis of learning disabilities in one of their children is long and difficult and has often been compared to a bereavement process (Hornby, 1994; Miller *et al.*, 1994; Gath, 1985). The key difference is that the child with learning disabilities continues to live with the family and the parents continue to provide care for him/her. The parental stages of adaptation to the diagnosis of learning disability consist of shock, denial, anger, sadness, detachment, reorganisation and adaptation (in order of occurrence). Given time and support parents and other family members will progress from the initial stages of shock and denial to the adaptation to their child's disability (Manthorpe, 1995). However, it has been argued that not everyone progresses at the same pace and there are people who often regress at a previous stage or different members of the

family may be at different stages of adapting at any given time (McCormack, 1992).

The effects of disability on the family have been documented through empirical studies comparing families with a disabled child to families with healthy children, and through qualitative studies where parents - in most cases mothers - discussed their feelings and problems. Problems refer specifically to anxiety and stress, marital adjustment and family cohesion in general, depression and low levels of confidence as well as maladaptive coping styles.

Parental stress can also be linked with the presence of a disability in the family. This relates to the limited time and the social restriction described above. Research has been conducted with children with Down syndrome and children with autism where the effects on parents - usually mothers - were contrasted with families with healthy children. Results indicated that families in the first situation reported more problems (Sanders & Morgan, 1997; Cuskelly *et al.*, 1998).

High levels of parental stress and psychological ill-health are known to lead to decreased interaction between the parent and the child and as a result less support for the child (Field, 1980; Lewis & Sullivan, 1996). Since engaging in high levels of interaction and actively participating in the education of the disabled child is highly correlated with the child's progress, the latter is irrevocably damaged.

A great body of research has further indicated that maternal depressive mood state, even in non-clinical samples, may be a contributing factor to problems in children's functioning and adjustment across a wide variety of domains. This includes pro-social, cognitive, internalising and externalising behaviour (Forehand & McCombs, 1988; Gelfand & Teti, 1990; Silverberg *et al.*, 1996).

The bulk of evidence converged to suggest that living with a disabled child causes a great deal of problems both for the family as a system, its members separately, and their interaction. However, certain findings presented a reverse picture. Specifically, in some studies, mothers of severely disadvantaged children did not necessarily report greater levels of stress than those of 'normal' children (Holroyd & McArthur, 1976; Bradshaw, 1980; Carr *et al.*, 1983) or indeed in others a positive impact of children with an intellectual disability on the family was reported (Stainton & Besser, 1998).

Coping strategies

In the 1990's a shift was observed from a pathological model of disability to an emphasis on employing 'coping strategies' (Russell, 1994). Families differ greatly in their reactions, coping styles and resources. According to McConachie

(1994), the coping styles of families differ in that different families can perceive the challenges they face in a different way.

Many factors were identified as assisting family adaptation to a child with a disability. Some of them are the early provision of information by the professionals, the quality of relationships with the professionals and the involvement of parents in decisions about their child (Grant *et al.*, 1998; Barr, 1997; McCormack, 1992).

Visits by a trained professional ('home visitor') provide parents with support and encourage them to lead ordinary lives and develop relationships with the local community (Cunningham & Davis, 1985). Parents who were provided with support at the initial stages following the diagnosis seemed to be more confident and optimistic and had higher expectations for their children (Cunningham & Davis, 1985) than those who did not receive similar support.

The stages that parents typically go through when their child is identified with a disability have been described above. After the initial shock and disbelief, comes anger, sadness and finally parents begin to enter the coping stage. According to the theory of coping, there are three coping dimensions: task-oriented, emotion oriented and avoidance oriented (Endler & Parker, 1990a, 1990b). Task-oriented coping is defined as active, problem oriented efforts to change the situation or the problem. Emotion-oriented coping is the tendency to focus on negative affective reactions. Finally, avoidance-oriented coping is defined as a reluctance to confront a stressful situation. This is subdivided in two sub-scales, distraction and social diversion. The second and the third coping style are considered maladaptive since they do not help the individual address the problematic situation effectively. The emotion-oriented coping style carries for the individual a tendency to be highly self-focused and engaged in excessive self-blame and wish fulfillment. Individuals who use this type of coping experience their emotions with great intensity and often feel unable to regulate their negative emotions. As a result, there is a greater likelihood that they present depressive symptoms in conjunction with negative cognitive operations, self-consciousness and dysfunctional attitudes (Billing & Moos, 1984; Folkman *et al.*, 1986). Finally, people who are more negative about regulating their negative mood have a tendency to avoid rather than approach problems (Catanzaro & Greenwood, 1994).

The life stress that parents, and especially mothers, of children with disabilities face has already been discussed. Feelings of disappointment and distorted cognitive mechanisms prevent them from functioning normally and can often be linked to low self-esteem and depression (Patterson, 1992; Beresford, 1995). Counselling of families suffering from the stress of having disabled children indicate that a focus on parental attributions may have the best chance of altering the family dynamics. Typically these programmes consist of discussions with

parents aimed at dealing with the cognitive attributional style of parents. It is common for parents to refuse to face the reality of their child's problem and to cope with anxiety and guilt by denying the presence of the disability. Moreover, levels of guilt and self-blame are high. Counselling helps reduce self-blame and guilt in parents. It also helps reduce depression and restructure negative attributions (Nixon & Singer, 1993).

Participating in parent support groups can act as an effective coping strategy for the problems that parents face due to their child's disability. It is assumed that through parent groups and with the support of trained professionals parents become better equipped to help their child and cope with their own difficulties. Moreover, it has been established that coping variables can emerge as significant predictors of maternal and paternal involvement as well as a mediator variable between family functioning and parental involvement.

Parent support groups

Throughout Europe and the USA it is the disability associations (MENCAP, The National Autistic Society) and the community who run parent groups. These involve parental meetings with professionals at varying intervals (from weekly to monthly) in a variety of settings (such as hospitals, universities and schools). The models have been described elsewhere (Callias, 1980). Parents are taught to assess their children, identify problems and set targets. They are also taught principles of behaviour modification. When at home, they work towards specific objectives and report on their children's progress at the next meeting. The aim is to include both parents but in practice mothers usually constitute the majority in these groups. Attendance in parental groups is reported between 72 and 82 per cent (Holland and Hattersley, 1980; Firth, 1982).

Family support is conceptualised from a social model of disability involving a consideration of the wider context in which the families live. There is a wide variety of schemes aimed at supporting parents and families of people with disabilities (Mittler & Mittler, 1994).

Through participation in support groups, it is expected that parents (a) systematically learn new behavioural methods from trained professionals; (b) release some of the pressure that they experience by sharing their feelings with others in a similar position and, (c) exchange information about their children.

Participation in parent groups can be evaluated through the use of questionnaires circulated to parents after the end of the training. Respondents are usually very positive, mainly emphasising that the approach has helped them to see their child in a more positive light, and to be more objective and constructive.

In addition, it has enabled them to feel more confident and to cope with the problems associated with learning disabilities (Holland & Hattersley, 1980; Firth, 1982). Many family support initiatives address the lack of resources in families of children with special needs necessary to cope with the increased stress they face from day to day. In terms of the effect of family support programmes on family stress, some evidence exists showing increased factual knowledge about the disability, increased knowledge about stress and stress management but no reduction in overall stress (Peck, 1998).

Given the different criteria used to assess the success of the programmes it is often difficult to reach a conclusion. Perhaps parents are grateful for any type of help provided and do not assess the effectiveness of the programmes with objective criteria such as skills' improvement in their children.

According to Carr (1985) some drawbacks of parent groups may be summarised as follows:

1. The importance of including both parents in the teaching sessions is emphasised but almost all projects had difficulty in including the fathers.
2. Difficulties are highlighted when the children of the parents present diverse problems, abilities and are of different age. It was argued that parents of the younger and the more able children benefited more. Those with children who present more difficulties feel discouraged and embarrassed and may be unwilling to attend further meetings.
3. Other problems arise when the new skills parents learn bring them in conflict with other professionals (i.e. teachers) who may not be aware of such new methods.

From this review it emerged that children cared for at home constitute a demanding situation for parents and especially for mothers who are the primary carers. Within a transactional model the difficulties of the children can adversely affect the parents' and especially the mothers' mental health, increase stress, lower self-esteem and increase levels of depression. As a result, the study of family variables has become increasingly critical in understanding outcomes typically considered programme driven. The coping styles that mothers use are often maladaptive and, given that the child stays and continues to receive care in the family long after the normal school years, it becomes increasingly difficult for mothers to redress the balance. The problems faced are often aggravated if no support is provided. One could expect that in a normal family less care is needed when the child becomes an adolescent and is prepared for employment. The opposite stands true for families with a disabled child.

Identification of the problems the mothers face is needed in order to provide appropriate support through formal and informal services. Only then will it be possible to enable families to adjust to disability. Given that a number of problems have been associated with mothers of disabled children, this study investigated the self-esteem, depression and coping strategies of a sample of mothers who participated in parental support groups.

Method

Sample

The sample of the study consisted of 69 mothers of children with special needs selected from two Special Needs Centres in Greece. The centres catered for children from 5 to 18 years with developmental disabilities (autism, Asperger syndrome), mild learning difficulties and severe learning difficulties with mobility problems. Both centres were running parent groups where, under the guidance of a psychologist and a social worker (for the first and second centre respectively) parents met weekly in groups of 4 to 8 to discuss matters of their children's progress and to learn techniques in order to cope with their children's disability. The mothers were aged 45-55 years and had on average two children with the second child having the disability. The majority were unemployed because of the disability of their child. Although the aim of the study was to include both parents, that proved impossible. It was mainly the mothers who participated in the groups. With the permission of the centres' directors, the mothers were approached, informed about the scope of the investigation and agreed to meet at a time convenient to them. The questionnaires were filled in individually by the mothers and were returned to the centre at the following parent meeting.

Measuring instruments

(a) Self-esteem: *Self-esteem* was assessed using the Rosenberg Self-Esteem Scale (Rosenberg, 1965). Each of the ten items in this instrument is intended to measure global self-esteem in the way described by Rosenberg. The respondent is asked to rate each statement from 1 to 4 (e.g. Generally, I am satisfied with myself). High scoring implies high self-esteem while low scoring implies low self-esteem.

For Rosenberg, when a person is characterised as having high self-esteem, this implies that s/he has self-respect and considers him/herself a person of worth. Rosenberg claimed that we should acknowledge the individual's general sense of

self-worth in addition to one's self-perceptions across the specific domains of one's life. Rosenberg has argued that, in all likelihood, the various discrete elements of the self are weighted, hierarchised and combined according to an extremely complex equation of which the individual is probably unaware. Accordingly, he has taken the direct approach to item writing, assuming that each individual, in developing his or her self-esteem, has consciously and/or unconsciously taken into account and weighted a unique set of varying personal attributes.

(b) Depression: For the assessment of the *depression* of the mothers of the sample we used the Depression subscale of Goldberg's General Health Questionnaire GHQ28 (Goldberg & Williams, 1988), as adapted for use with a Greek population by Moudzoukis *et al.* (1990). This questionnaire is widely used for the identification of the mild forms of psychopathology in the general population. It consists of 28 questions investigating the general mental and psychosomatic state of the individuals in the weeks previous to the questionnaire. It focuses on two important categories of psychological states: (a) the person's inability to continue his/her normal way of living and (b) the onset of factors that are responsible for the problems.

Apart from the overall scoring, the questionnaire provides individual scoring and information on four sub-scales: psychosomatic symptoms, stress and insomnia, social malfunctioning and depression. The respondent is asked to pinpoint whether s/he has a symptom or behaviour (e.g. Do you feel that you are always under pressure?) over the previous weeks and to what degree: 'never', 'no more than usual', 'a little more than usual' or 'a lot more than usual'.

(c) Coping: To assess the *coping strategies* used by the sample of the study we employed the coping measure of Folkman and Lazarus (1980), as adapted for use with a Greek population by Besevegis and Karadimas (1997). This questionnaire assesses 5 types of coping strategies used by individuals to deal with a stressful problem.

The five types of coping strategies are:

- Positive approach: this strategy involves attempts of the individual to reassess the stressful situation in a positive way (e.g. 'I tried to see the positive side of the situation').
- Search for social support: this scale involves items that refer to the individual looking for support in his/her social surroundings in order to deal with these problems (e.g. 'I talked to someone to help me comprehend my situation better').

- **Wishful thinking/dreaming:** this strategy consists of items that assess the tendency of the individual to overcome problems by wishing for a miracle or dreaming of how the situation would be if something like that hadn't happened (e.g. 'I wish this situation would disappear').
- **Avoidance:** this subscale assesses the individual's tendency to re-evaluate the situation by minimising or ignoring its true importance (e.g. 'I tried to forget by working or being involved with something else').
- **Assertive handling of the problem:** this subscale assesses the individual's effort to find a solution by dealing directly and assertively with the situation or the person who is perhaps responsible for it (e.g. 'I expressed my anger to the person who was responsible for the problem').

Results

In Table 1 the numbers of mothers are presented by level of participation in organised support groups and level of sharing with others the care of the child with special needs.

TABLE 1: Number of mothers by level of participation in organised support groups and level of sharing the care of the SEN child with others

Participation in organised support groups	Sharing with others the care of the child with special needs		Total
	No	Yes	
No	33	12	45
Yes	15	9	24
Total	48	21	69

As Table 1 shows, the majority of mothers did not participate in parent groups in the centres of the sample.

Self-esteem

The mean scores and standard deviations of the mothers' *self-esteem* by level of participation in organised support groups and level of sharing the care of the SEN child with others are presented in Table 2.

TABLE 2: Self-esteem mean scores and standard deviations by level of participation in organised support groups and level of sharing the care of the SEN child with others

Participation in organised support groups	Sharing with others the care of the child with special needs				Total	
	No		Yes		Mean	SD
	Mean	SD	Mean	SD	Mean	SD
No	2.66	.22	3.02	.30	2.76	.28
Yes	2.87	.43	3.31	.35	3.04	.45
Total	2.73	.31	3.14	.35	2.86	.37

Table 2 shows that the self-esteem mean scores are above the midpoint of the scale ($\bar{X}=2.86>2.50$). However, there are differences associated with both level of participation in organised support groups and level of sharing with others the care of the child with special needs.

The results of the two-way ANOVA of the self-esteem scores are presented in Table 3. The eta statistic, whose squared value indicates the proportion of variance explained by each factor and the interaction term, was used as index of the effect sizes. The proportion of variance in the dependent variable accounted for by level of participation in organised support groups, level of sharing with others the care of the child with special needs and their interaction, the adjusted R^2 , was used as index of the model goodness-of-fit.

TABLE 3: Two-way ANOVA of the mothers' self-esteem scores by level of participation in organised support groups and level of sharing the care of the SEN child with others

Effects	F	p	eta ² (%)
Main effect			
Sharing with others the care of the child	23.128	.000	26.2
Participation in organised support groups	9.399	.003	12.6
Interaction	.266	.608	.4

According to Table 2, the mothers' self-esteem was lower both when mothers did not participate in organised support groups and when they were not sharing the care of their child with others ($\bar{X}=2.66$). The self-esteem appeared higher when mothers had both types of help available ($\bar{X}=3.31$). The ANOVA revealed highly significant main effects for both the independent variables of sharing [$F(1,65)=23.128$, $p<.001$] and participation [$F(1,65)=9.399$, $p<.003$], but no interaction effects.

The proportion of variance in the self-esteem scores explained by sharing with others the care of the child with special needs was $\eta^2 = 26.2\%$, while the respective proportion for participating in organised support groups was $\eta^2=12.6\%$. Thus, it appears that sharing with others the care of the child with special needs has a stronger effect on mother's self-esteem than her participation in organised support groups. The total variance in the self-esteem scores explained by the differences in the levels of participating in organised support groups and sharing with others the care of the child with special needs, the adjusted R^2 , was 33.1%.

These additive and very systematic effects are also evident in the profile plot (Figure 1) of the means in Table 2. These findings imply that both variables combine to produce a mother's level of self-esteem and that one does not offset or compensate for the other.

FIGURE 1: Mother's self-esteem as a function of levels of participating in organized support groups and sharing with others the care of her child with special needs

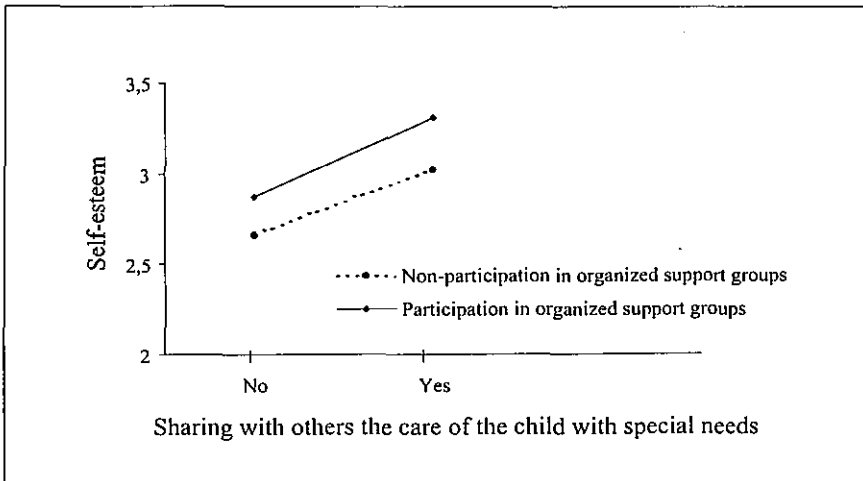


Figure 1 also illustrates that the mothers with the highest self-esteem were those who both participated in organised support groups and shared with others the care of their child. These are the mothers scoring in the $\bar{X}=3.31$ range on self-esteem. The mothers with the lowest self-esteem are those who displayed the opposite pattern, non-participation in organised support groups coupled with non-sharing with others the care of her child with special needs. These are the mothers scoring in the $\bar{X}=2.66$ range on self-esteem. The difference between these two groups is marked, indicating the impact that both these predictors have on the mothers' self-esteem.

Depression

In Table 4 mothers' *depression* mean scores and standard deviations are presented by level of participation in organised support groups and level of sharing with others the care of the child with special needs.

TABLE 4: Depression mean scores and standard deviations by level of participation in organised support groups and level of sharing the care of the SEN child with others

	Participation in organised support groups		Sharing with others the care of the child with special needs		Total	
	No		Yes			
	Mean	SD	Mean	SD	Mean	SD
No	10.49	3.45	4.83	4.95	8.98	4.60
Yes	5.53	2.53	2.33	1.12	4.33	2.62
Total	8.94	3.93	3.76	3.95	7.36	4.58

On the whole, depression levels were average. Taking into account that 12 is a cut-off score for a diagnosis of depression, it can be said that the sample was not expected to be clinically depressed, however they did present some depressive symptoms. In terms of the two independent variables, participation in organised support groups and sharing the care of the SEN child with others have a positive effect in the mothers' level of depression. Depression levels were lower for those mothers who received help at home for their child and participated in support groups ($\bar{X}=2.33$). Higher depression levels were observed for mothers who did not have any of this support ($\bar{X}=10.49$).

These effects are also evident in the results of the two-way ANOVA of the depression scores by level of participation in organised support groups and level of sharing with others the care of the child with special needs, presented in Table 5. Main effects were found for both independent variables [participation in support groups: $F(1,65) = 16.477$, $p < .001$, sharing with others the care of the child with special needs: $F(1,65) = 23.250$, $p < .001$], but no interaction effects were detected.

TABLE 5: Two-way ANOVA of the depression scores by level of participation in organised support groups and level of sharing the care of the SEN child with others

Effects	F	p	eta ² (%)
Main effect			
Sharing with others the care of the child	23.250	.000	26.3
Participation in organised support groups	16.477	.000	20.2
Interaction	1.783	.186	2.7

The total variance in the depression scores explained by the differences in the levels of participating in organised support groups and sharing the care of the SEN child with others, the adjusted R^2 , was 47.4%.

Coping mechanisms

Tables 6-10 present the mean frequencies and standard deviations of the five types of coping mechanisms examined in the study by level of participating in organised support groups and level of sharing the care of the SEN child with others.

The mothers who received counselling and had some help for their child were more likely to use the positive approach type of coping ($\bar{X}=27.44$) whilst those who had neither of these types of support were the least likely to be positive about their situation ($\bar{X}=22.76$).

Table 7 shows that higher means for search for social support were achieved by the mothers who shared their care of their child with others but did not receive any counselling ($\bar{X}=13.33$) and the lowest means were achieved by those who participated in support groups but did not share their care of their child with others in the family ($\bar{X}=11.00$).

TABLE 6: Mean frequencies and standard deviations of the positive approach coping mechanism by level of participation in organised support groups and level of sharing the care of the SEN child with others

Participation in organised support groups	Sharing with others the care of the child with special needs				Total	
	No		Yes			
	Mean	SD	Mean	SD	Mean	SD
No	22.76	2.97	26.00	3.57	23.62	3.02
Yes	22.93	4.61	27.44	3.24	24.63	4.64
Total	22.82	3.15	26.62	3.43	23.97	3.66

TABLE 7: Mean frequencies and standard deviations of the search for social support coping mechanism by level of participation in organised support groups and level of sharing the care of the SEN child with others

Participation in organised support groups	Sharing with others the care of the child with special needs				Total	
	No		Yes			
	Mean	SD	Mean	SD	Mean	SD
No	11.94	1.62	13.33	1.67	12.31	1.73
Yes	11.00	3.16	12.56	4.13	11.58	3.55
Total	11.65	2.23	13.00	2.92	12.06	2.51

As Table 8 shows, there were no particular differences in wishing coping strategy in terms of counselling and support group participation. It is interesting to note that the group which least used this strategy, in other words wishing that the problems would disappear, were those who had both types of support.

Table 9 shows that the second negative coping strategy, i.e. avoidance, was most frequently used by those mothers who had both types of support.

The mothers who received help for their situation both through counselling and sharing the care of their child were those who were equipped to deal more assertively with the situation ($\bar{X}=8.67$). No participation in parent groups resulted in the lowest scoring for those who had someone to help them for the care of their child ($\bar{X}=5.83$).

TABLE 8: Mean frequencies and standard deviations of the wishful thinking coping mechanism by level of participation in organised support groups and level of sharing the care of the SEN child with others

Participation in organised support groups	Sharing with others the care of the child with special needs				Total	
	No		Yes			
	Mean	SD	Mean	SD	Mean	SD
No	16.21	2.30	16.42	3.34	16.27	2.58
Yes	16.27	3.37	16.11	3.65	16.21	3.40
Total	16.23	2.64	16.29	3.93	16.25	2.87

TABLE 9: Mean frequencies and standard deviations of the avoidance coping mechanism by level of participation in organised support groups and level of sharing the care of the SEN child with others

Participation in organised support groups	Sharing with others the care of the child with special needs				Total	
	No		Yes			
	Mean	SD	Mean	SD	Mean	SD
No	17.58	2.56	15.25	3.74	16.96	3.06
Yes	16.13	2.64	19.78	5.59	17.50	4.28
Total	17.12	2.65	17.19	5.02	17.14	3.51

Table 11 presents the results of the two-way ANOVAs for the mean scores of the coping strategies.

It can be seen that sharing with others the care of the child with special needs has a significant main effect on two out of the five coping mechanisms examined here: positive approach [$F(1,65)=19.456, p.<.001$] and search for social support [$F(1,65)=4.966, p.<.05$]. This finding implies that when mothers received some kind of help in the caring of their child they were more likely to use a positive approach in order to cope with their stressful situation and also look for support in their social settings. No significant differences in their coping strategies were found in terms of their participation in organised support groups. Moreover, an interaction effect (sharing x participation) was found for the dependent variables

TABLE 10: Mean frequencies and standard deviations of the assertive solution of problem coping mechanism by level of participation in organised support groups and level of sharing the care of the SEN child with others

Participation in organised support groups	Sharing with others the care of the child with special needs				Total	
	No		Yes			
	Mean	SD	Mean	SD	Mean	SD
No	8.33	1.47	5.83	2.48	7.67	2.09
Yes	6.60	2.78	8.67	2.12	7.38	2.70
Total	7.79	2.10	7.02	2.69	7.56	2.30

TABLE 11: Two-way ANOVAs of the frequencies of the coping mechanisms by level of participation in organised support groups and level of sharing the care of the SEN child with others

Coping mechanism	Main effects						Interaction		
	Sharing with others the care of the child with special needs			Participation in organised support groups					
	F	p	eta ² %	F	p	eta ² %	F	p	eta ² %
Positive approach	19.456	.000	23.0	.850	.360	1.3	.521	.473	.8
Search for social support	4.996	.029	7.1	1.683	.199	2.5	.015	.903	.0
Wishful Thinking	.001	.975	.0	.025	.874	.0	.052	.821	.1
Avoidance	.545	.463	.8	2.984	.089	4.4	11.172	.001	14.7
Assertive Solution	.149	.701	.2	.962	.330	1.5	16.577	.000	20.3

of avoidance [$F(1,65)=11.172, p<.001$] and assertive solution of the problem [$F(1,65)=16.577, p<.001$].

Discussion

In the present study mothers of children with special needs presented above average self-esteem. This is an important finding especially if the differences between the groups of the study are taken into account. It is evident that when both

types of support, counselling and help with the care of the child, take place simultaneously they enhance the self-esteem of the mothers. The demands of having a disabled child in the family are significantly reduced when mothers share the pressure of caring for their child throughout the day with another person. As supported in the literature, one of the most important consequences of having a disabled child in the family is the constant responsibility and the overwhelming amount of time devoted to his/her care (Dupont, 1980; Brooks-Gun & Lewis, 1982; Russell, 1994). Lack of - or small steps of - improvement can lead to anxiety and reduced social contact. Self-esteem has been known to be affected from these factors. Mothers who had the opportunity to be involved in a group with other parents in a similar situation and received the help of someone for the care of their child seemed to report higher levels of self-esteem.

Depression may be an additional factor linked to the parents' feelings of anxiety and stress about the current situation as well as the future of the disabled child. Coupled with the mothers' limited time and inability of employment due to restricted hours, this can often lead to a negative self-image, general ill-health and even depression. Mothers in the present study reported on average moderate levels of depression. Although they were not expected to compose a clinically depressed sample they did present certain depressive symptoms. Increased stresses and the strains of care may have resulted in this. The hypothesis that participation in organised parent groups and sharing the care of the child can alleviate a degree of stress that the mothers feel was confirmed in this study, since the group who received this type of help was found to respond better and to present lower levels of depression.

Finally, we examined the frequency in which mothers used both positive and negative types of coping strategies in order to deal with their problems. The findings showed that mothers who were involved in organised social interaction with parents with similar problems and had the opportunity to devote time on matters other than their children's care while someone else in the family looked after the child, employed positive coping techniques more frequently. For example they were involved in positive thinking, were looking for social support and were able to act on the source of stress. It has to be stressed that the way parents react to the stressful situation - whether for example they are task oriented (positive style) or emotion oriented (maladaptive)-, and the way they perceive the challenges they face, is linked with the child's physical and emotional well-being (Fehrenbach & Peterson, 1989). This study has illustrated that there were significant differences in terms of coping styles between the group who received some help and the group who had no help. The tendency to confront the stressful situation directly, by being focused on the problem and not being engaged in excessive self-blame and wish fulfillment enables the individual to regulate

negative emotions, engage in positive cognitive thinking, present fewer negative symptoms and finally hold more positive attitudes (Billing & Moos, 1984; Folkman *et al.*, 1986; Greenwood, 1994).

A number of studies in the UK have also indicated the pressures that parents face due to the needs of their disabled children. Limited time and social restriction is a constraint, since most children with disabilities cannot be left alone for more than a few minutes during the day (Russell, 1994). Dupond (1980) found that in a population sample of thirty-nine learning disabled children, families were spending an average of seven hours in the care and training of the children. In an early study, Wilkin (1979) revealed that there was little help from relatives, friends or neighbours for the day-to-day care of the severely disabled child. As a result there was lack of social support network. That is aggravated when there is evidence of poor housing, low income and one parent families. Social restriction is intensified when the child is cared for at home rather than in a special centre.

An additional factor that may cause high levels of anxiety for parents is home intervention. Studies have shown that the quality of parental participation in their child's education in addition to or in conjunction with the professionals - especially in cases of disability - facilitates and balances the work of the professionals and also reinforces a positive image for the disabled individual. However, parents are expected to find the time to work with their special children in a way that is not expected for their ordinary children (Buckley, 1994). This can be a cause of anxiety for some of them, especially if they have other siblings to care for and their time is limited. This is consistent with the findings of this study which indicated that relieving the mother from the care of her child for some hours every day reduces depression and increases self-esteem.

Despite their supportive role, parent support groups have been faced with negative feelings from the parents. For mothers, the combination of different roles such as therapist and teacher to their disabled child and wife and mother to their other children may prevent them from being themselves, and can often lead to psychopathology (Carr, 1985). The question is whether a small improvement in the child outweighs the psychological cost to the family. Another stressor associated with parental involvement is that parents often feel that they are looked down by professionals, that their efforts are undervalued and their needs are not recognised (Berry *et al* 1981; Gascoigne, 1996). The pressure of the professionals to involve the parents in the education of their children may turn out to be in conflict with the interests of the rest of the family. The need arises to help parents in a way that is acceptable to them, because efforts may be wasted otherwise. This study has indicated the positive effect of

the parent groups on the mothers' self esteem, depression levels and coping strategies but also found that the most significant variable was support from someone at home. A more in-depth investigation of the support mothers received at the centres would reveal more interesting information.

Another significant finding which has many implications for research in this area is the increasing responsibilities taken on by mothers. They are expected to have the main and sometimes the sole responsibility for the child with disabilities. Caring tends to be perceived as the mothers' primary responsibility. This pattern is reinforced by the 'male incompetence' myth (Blain, 1994) which argues that men are less able to provide care, and excuses them from learning the necessary skills. Studies have shown that mothers are unsupported by other members of the family. Moreover, even in cases where other members of the family contributed to domestic tasks, the disabled child was considered the responsibility of the mother. This 'burden' of caring on the mother's shoulders is aggravated when SEN services concentrate on mother and child and indirectly ignore the father's contribution. The absence of fathers from the support groups was noted in this study as well. Perhaps more emphasis should be given on the significance of including them in the helping process.

Traditionally, mothers have been the main focus of family research either by providing information for their children with disabilities or by discussing the effects of the disability on their personality and behaviour. The main body of research on the area of interaction between parents and children with learning disabilities focuses on mother-child interaction.

Less attention has been given to fathers, mainly due to the difficulty in access and co-operation that was reported in many studies. Findings suggest that those fathers who had supportive parents themselves were more likely to have positive feelings and do more with their child (Waisbren, 1980). In another early study, where fathers of children with learning disabilities were compared with fathers of healthy children, the former presented higher levels of depression, less enjoyment of both their disabled child and their other children, lower self-esteem and a sense of paternal incompetence and 'a pattern of neurotic-like constriction' expressed in increased levels of stress' (Cummings, 1976).

An intervening variable that may redress the balance between the lowered self-esteem and the high levels of stress is the mother's employment. Research indicates that women's employment - if desired - is correlated with a positive self-image and feelings of worthiness (Martin & Roberts, 1984). Mothers who were employed in a paid job had fewer psychological problems than those who wanted to work and did not (Bradshaw, 1980). However, caring for a disabled child decreases maternal employment rates since the number of hours that is possible for a mother to work are restricted (Smyth & Robus, 1989). Moreover, mothers

of children with disabilities do not increase their working hours as their children grow up (Baldwin, 1985). Findings from a study by Beresford (1994) suggest that employment rates of parents of disabled children are lower than in the general population.

The majority of the mothers in this sample were unemployed. Although the reasons why this occurred were not investigated, it is evident that lack of opportunity to work can result in extreme personal and financial hardship (Glendenning, 1992). Parents are exposed to increased risk of stress and symptoms such as depression. Employment can offer mothers, and parents in general, an opportunity to escape monotonous household routine and make them move away from their image as parents of disabled children (Beresford, 1994). It has also been found that employment can reduce the levels of stress, ill health and depression among mothers of children with disabilities (Bradshaw & Lawton, 1978; Sloper & Turner, 1993; Sloper *et al.*, 1991) and lead to self-fulfillment (Lewis *et al.*, 1996). It is important to emphasise though that the beneficial effects of mother's employment were only important in cases where the mothers were satisfied with their employment status (Bradshaw & Luton, 1978).

We conclude that the stress anyone involved in the day-to-day care of a learning disabled child, experiences can often be overwhelming. Caring for children with severe impairments often implies help with self-care (toileting, washing, dressing, feeding, watching over) lasting longer than their non-disabled peers. Other special needs may involve special dieting, medication, and physiotherapy. Given these sources of additional stress it is not surprising that the literature has shown increased levels of mental and physical health problems among parents of disabled children (Beresford, 1996).

It has been shown that group counselling programmes aiming at dealing with the cognitive attributional style of parents and increasing the social contacts among parents who face similar stressful situations at home, can help alleviate some of this stress. They can also raise self-esteem, reduce depressive symptoms and help parents learn to use positive coping techniques. In addition, receiving help with the care of their children can lift considerable weight off the shoulders of the mothers who are traditionally the main carers. It can also enable them to be involved in social interactions, or engage in part-time employment which in turn improves their self-image (Martin & Roberts, 1984; Beresford, 1994).

Since one of the findings of this study has been that sharing the care of the child at home leads to improved self-esteem, lower levels of depression and more positive coping strategies, this has certain implications for policy and practice for the provision of special needs support in Greece. An extensive

development of support services for families with disabled children has to take place in order to provide a framework through which parents can use the coping strategies they find most helpful. As described in the literature, there is currently a lack of organised early intervention programmes that involve both parents and children. To be effective, intervention should start early and should address the child, the family, as well as the social environment (De Moor *et al.*, 1995). Parents should be helped to deal with feelings of stress, develop an emotional bond with their child and receive information about professionals and types of programmes that are running in their area. This type of support is almost non-existent in Greece or in very early stages of development and that mainly in urban areas.

According to the stress model developed by Lazarus and Folkman (1984) the coping process mediates the effects of stress on an individual's well-being. Given that support needs for parents and children are inextricably linked, services have to be made available that focus not only on the child but on the mother as well. Lessening the care burden would allow more quality time between parent and child and child-care provision would allow the mother to return to work and feel less isolated and unsupported.

Finally, counselling services should focus on individual ways of coping with the stress of having a disabled child in the family and seek to build on mothers' strengths as well as their preferred ways of coping. Further research should investigate the personal experiences of parents from specialist provision and identify their needs. It should not be forgotten that although the pathological model which many professionals have of parents remains strong (i.e. the need for families to accept and come to terms with their disability) it should not be used as a straightjacket to be applied to all families. These ideas should not distract from the uniqueness of each family and their need for emotional, social and practical support (Mittler, 1995).

Moreover, both mothers and fathers should be included in the support schemes. When professionals organise to meet with parents in their territory (clinics, hospitals and schools) rather than at home, this means that mothers are the ones who are able to come to meetings. This is inconsistent with the ecological model of development which is widely taught but not often implemented. In order to involve fathers in the education and training of their children, more flexibility is needed in the hours worked by professionals and in seeing parents at home rather than office hours (Mittler, 1995). After all, it is the needs of both parents that have to be primarily addressed in these types of programmes since they are the ones who are involved in the care of their children in the long term. All such interventions should ideally involve the whole family and not only the mothers.

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