HAIGAZIAN UNIVERSITY

Factors Influencing Mental Health of Lebanese Parents of Children with Special Needs

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTERS OF ARTS TO THE DEPARTMENT OF SOCIAL AND BEHAVIOURAL SCIENCES AT HAIGAZIAN UNIVERSITY

GHANIA KABBARA

BEIRUT- LEBANON

February 2013

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Factors Influencing Mental Health of Lebanese Parents of Children with Special Needs

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DEDICATION

TO ALL THE PARENTS WHO HAVE CHILDREN WITH SPECIAL NEEDS

Author Note

ACKNOWLEDGEMENTS

From Ghania F. Kabbara, Department of Social and Behavioral Sciences

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TABLE OF CONTENTS

ABSTRACT

The purpose of the present study aimed at assessing the mental health of Lebanese parents of children with special needs and the extent to which factors such as coping skills, gender differences, socio-demographic status (monthly income and education level), and types and severity of their children's disabilities affect their wellbeing. The sample of this study consisted of 320 parents of children with special needs. The instruments used were 3 questionnaires demographic information, Family Crisis Oriented Personal Evaluation Scale (F-COPES) and Wellbeing Assessment Tool distributed in special needs schools and associations. The results revealed that the total *F-COPES* scores were positively correlated to Total Wellbeing. Besides, further findings confirmed that parents' educational level and income had an effect only on the Intellectual Health wellbeing subscale. In addition, mothers proved to have a higher wellbeing as compared to fathers. Last but not least, parents of children with mental disabilities scored significantly higher on the Physical Health Wellbeing scale than parents whose children have a physical disability. Finally, this study uncovered major findings, which will help contribute and improve the wellbeing of the Lebanese parents in the near future.

Factors Influencing Mental Health of Lebanese Parents of Children with Special Needs

This study is about the mental health of Lebanese parents of children with special needs. As I have been working with children with special needs, I have noticed the despair, the frustration and the distress of their parents. In fact, many studies have confirmed that parents of children with special needs or disabilities experience high level of stress accompanied with feelings of shame, shock, guilt, depression and denial among others. Other mediating factors such as socio-demographic status of parents (monthly income and education level), gender differences (mothers vs. fathers), types and severity of the disabilities play a significant role too. Yet, it has also been proven that parents who acquire coping skills such as social support or intervention programs, have a better and a healthier lifestyle.

The Background of the Study

A growing body of literature has been sustaining the numerous stressful effects children with special needs cause to their parents. First, when parents discover that their child has special needs, they go into shock. Then, when they realize and accept their child's physical or psychological particular condition, feelings of guilt, sorrow and helplessness arise usually accompanied with psychological distress such as anxiety and depression (Bumin., Gunal., & Tukel., 2008). Indeed, according to Gupta et al (2004), parents of children with disabilities are overwhelmed with feelings of pessimism, hostility, shame, denial, guilt, shock, withdrawal, rejection, helplessness, depression and self-blame. Besides, quality of life of the parents and their commitments in dependent daily living activities destroy the dynamics of the family. Accordingly, the roles of the family members change leading to

further tension and anxiety between them (Bumin., Gunal., & Tukel., 2008). Jealousy and antipathy may also build up in siblings if the special need child requires most of his parent's attention (Gupta., & Kaur., 2010). In addition, mothers are so involved with their children that they become relatively unavailable to their husbands, hence marital conflicts arise often resulting to divorce (Clarkson., Dittmer., Flett., Linsell., Mullen., & Mullin., 1986).

Furthermore, most studies found that the severity of the disability, the age and gender of the child (depending on the case), the level of education of the parents and their financial situation were all factors that affect the quality of life of parents of children with special needs (Bumin., Gunal., & Tukel., 2008).

Finally, there has been an increasing acknowledgment and evidence showing that parents of children with special needs who have good coping skills show a better quality of life and a healthier wellbeing. Coping skills may include acquiring social support, reframing, seeking spiritual support, mobilizing family to acquire and accept help, and passive appraisal (McCubbin et al., 1981).

The Problem Statement

This study is a replication of a combinations of studies performed around the world. However, up until today, there are few studies reflecting the mental health of Lebanese parents who have children with special needs. Accordingly, it is necessary to conduct such a study in Lebanon so as to assess the mental health of parents, analyze the mediating and contributing factors such as the socio-demographic status of parents, types of disabilities and their coping skills, in order to compare the results with previous studies while taking account of the cultural differences and implications. In view of this present study, the following hypotheses were made:

1. Coping skills scores of parents of children with special needs are positively

correlated with their Wellbeing scores.

2. Mothers of children with special needs score lower on the Wellbeing scale than fathers.

3. Parents with a higher monthly income range will score higher on the Wellbeing scale.

4. Parents of children with mental disabilities score lower on the Wellbeing scale than parents of children with physical disabilities.

5. Parents with a higher level of education will score higher on the Wellbeing scale.

The Professional Significance of the Study

This study is important and fundamental to be conducted in Lebanon because there is a significant number of children with special needs whose parents are left unattended. Indeed, there has been a growing number of schools, associations and centers for children with special needs but no assistance granted to these parents. Therefore, in determining the mediating factors that will help improving the mental health of parents, we will be able to provide them with the right services and attend to their needs.

Overview of Methodology

The sample of this study consisted of 320 parents of children with special needs. The instruments used were 3 questionnaires (demographic information, Family Crisis Oriented Personal Evaluation Scale and Wellbeing Assessment Tool) distributed in schools, centers, institutions or associations who receive children/adolescents with special needs such as Iidad (Friends of the Disabled Association), Baabda Lebanese School for Visual/Hearing

Impairment, Lebanese Association for Autism, Learning Center for Deaf, Lebanese Association for Down Syndrome, Khaled bin al – Walid / al Horj College (Makassed School), Learning Emotionally Academically Physically and Socially (LEAPS) and Beirut Baptist School (BBS). The surveys were either given directly to the parents or via their children and were answered by the parents without my assistance. The demographic questionnaire included the age and gender of parents, their marital and employment status, their level of education, and the total number of children they have with or without special needs. The purpose of the Family Crisis Oriented Personal Evaluation Scale (F-COPES) is to identify problem-solving attitudes and behaviors of families who have children with special needs. The F-COPES coping strategies are divided into five subscales: acquiring social support, reframing, seeking spiritual support, mobilizing family to acquire and accept help, and passive appraisal. Moreover, the Wellbeing Assessment Tool is to assess the individual's wellbeing. It is also divided into five subscales, which are: physical health, social health, emotional health, spiritual health and intellectual health. Cronbach Alpha Reliabilities, Descriptive statistics, Pearson Correlations, Group statistics, ANOVAS, Multiple comparisons and Regressions were the statistics used in order to determine the results.

Delimitations

Several limitations were encountered. First, this study was not representative of the Lebanese population as it was performed only in Beirut. Accordingly, there are many schools and institutions, which receive children with special needs that I did not visit. Second, for logistics purposes, the surveys were sent to the parents via their children. It was not possible for me to meet personally and interview all the parents. As a result, parents had to fill the questionnaires on their own. Even though I ensured to have the directions very clear, a considerable amount of surveys were not answered properly by some parents. Subsequently, had I been physically present with the parents, I would have been able to assist them, thus

guaranteed to have an increased number of valid responses. Finally, the types of disabilities were not equally numbered as the surveys were randomly distributed in the centers.

Definitions of Key Terms

Children with Special Needs/ Disabilities/ Disorders: are children with a range of different disabilities such as mental, medical/biological, sensory or motor/physical health conditions that may impair or restrain a child's ability from developing cognitively, physically, and emotionally, and which necessitate special intervention, services, or professional support (www.211la.org/parenting/specialneeds.pdf, 2008) (Pueshel, Bernier, & Weidenman, 1988).

The types of disabilities or special needs are explained in details as follows:

Types of Mental Disabilities/ Disorders:

- Learning Disabilities: According to the DSM-IV-TR (Diagnostic and Statistical Manual of Mental Disorders Fourth Edition), a learning disability is when the individual's achievement on individually administered standardized tests in reading, mathematics, or written express is substantially below that expected for age, schooling, and level of intelligence. The learning problems significantly impede with academic achievement or activities of daily living that require reading, mathematical, or writing skills (DSM-IV-TR, 2011).

- Autism: According to the DSM-IV-TR (Diagnostic and Statistical Manual of Mental Disorders Fourth Edition), the official Autism definition is a qualitative impairment in social interaction and in communication, and restricted, repetitive, and stereotyped patterns of behavior, interests, and activities (DSM-IV-TR, 2011).

- Mental Retardation: According to the DSM-IV (Diagnostic and Statistical Manual of

Mental Disorders Fourth Edition), mental retardation is a significantly sub-average intellectual functioning of an IQ of approximately 70 or below on an individually administered IQ test which involve concurrent deficits or impairments in present adaptive functioning (i.e.. the person's effectiveness in meeting the standards expected for his or her age by his or her cultural group) in at least two of the following areas such as communication. self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety (DSM-IV-TR, 2011).

Types of Medical Disorders:

- Down Syndrome: It is a birth defect that is usually due to an extra chromosome 21 (trisomy 21). Down syndrome causes mental retardation, a characteristic facial appearance, and multiple malformations. It occurs most frequently in children born to mothers over age 35. It is associated with a major risk for heart problems (Medicinenet, 2012).

Types of Motor/Physical and Sensory Disabilities:

- Visual impairment: It is a total blindness is the inability to tell light from dark, or the total inability to see. Visual impairment or low vision is a severe reduction in vision that cannot be corrected with standard glasses or contact lenses and reduces a person's ability to function at certain or all tasks (medical-dictionary, 2013).
- Hearing impairment: It is a generic term including both deaf and hard of hearing which refers to persons with any type or degree of hearing loss that causes difficulty working in a traditional way (www.apt.gc.ca, 2008).
- Physical Impairment: It is the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be

expected to last or has lasted for a continuous period of not less than 12 months (medical-dictionary, 2013).

The subscales of each instrument, the Family Crisis Oriented Personal Evaluation Scale (F-COPES) and Wellbeing Assessment Tool, are explained as follows:

F-COPES (Coping Skills):

- Acquiring social support: It is the family's ability to obtain support from relatives, friends, neighbors, and extended family (e.g., sharing our difficulties with relative) (McCubbin et al., 1981).

- Reframing: It evaluates the family's capability to reinterpret stressful events in order to make them more manageable (e.g., knowing that we have the strength within our family to solve our problems) (McCubbin et al., 1981).

- Seeking spiritual support: It is using spiritual beliefs in order to gain comfort (e.g., participating in religious or spiritual activities) (McCubbin et al., 1981).

- Mobilizing family to acquire and accept help: It is the family's ability to reach out to the community resources and accept help from professionals (e.g., seeking assistance from community agencies and programs designed to help families in situation) (McCubbin et al., 1981).

- Passive appraisal: It is the family's ability to acknowledge problematic issues that reduces reactivity (e.g., believing if we wait long enough, the problem will go away) (McCubbin et al., 1981).

Wellbeing Assessment Tool:

- Physical health: It assesses the individual's frequency of physical exercise (i.e., I engage in vigorous exercises such as brisk walking).

- Social health: It evaluates the social interaction (i.e., I participate in a wide variety of social activities and enjoy being with people who are different than me).

- Emotional health: It is the individual's ability to regulate his emotions (i.e., I recognize when I am stressed and take steps to relax through exercise, quiet time, or other activities).

- Spiritual health: It measures the individual's serenity and insightfulness (i.e., I take time alone to think about what's important in life - who I am, what I value, where I fit in, and where I'm going).

- Intellectual health: It is the individual's ability to rationalize and analyze situations before taking action (i.e., I consider the alternatives before making decisions).

CHAPTER 2

Review of Literature

The purpose of the present study was to assess the extent to which factors, such as coping skills, gender differences, types and severity of the disabilities and their socio-demographic status (monthly income and education level), affect their wellbeing.

Studies performed in Lebanon

In Lebanon, during the past decade, there has been a major awareness regarding the types of disabilities. Accordingly, Lebanese parents are able to detect and identify the warning signs or symptoms of the disability and treat their children. In fact, the Lebanese statistics show that there is a significant number of children with special needs (see Appendix A). In an inventory conducted in December 2012, the number of children with special needs aging from less than 5 years old up to 66 years old and above was a total of 80,703. Disabilities ranged from motor/physical, mental, hearing, visual and learning consisted of a total number of 89,823 with around 7638 individuals having more than one disability (see Appendix A).

Furthermore, two cross-sectional studies were realized in Lebanon by Azar and Kurdahi Badr (2006, 2010). The first one aimed at examining the factors, which contribute to the mother's adaptation of their intellectually impaired children. In this study, there were 127 Lebanese mothers of children with intellectual disability (Azar & Kurdahi Badr, 2006). Results proved that a high percentage of mothers presented symptoms of depression. Last but not least, family strain, parental stress and family income were, by order of importance, the determining factors (Azar & Kurdahi Badr, 2006).

The purpose of the second research was to determine predictors which may influence the coping behaviors of parents of children with an intellectual disability. In this study, 147 Lebanese parents with a child with intellectual disability (101 mothers and 46 fathers) were selected. Contributing factors such as the child's and parent's characteristics, informal social support, and stress on the coping behaviors of fathers and mothers were taken into consideration (Azar & Kurdahi Badr., 2010). Multiple regression analysis showed that the father's education, informal social support, and stress were the best predictors of coping (Azar & Kurdahi Badr., 2010). However, the child's age, severity of illness, and parental health were not contributing factors to predicting coping behaviors. Moreover, both fathers and mothers accounted similar levels of stress, perceived informal social support, and coping (Azar & Kurdahi Badr., 2010).

Mental health of parents of children with special needs

A growing body of literature has been sustaining the numerous stressful effects children with special needs cause to their parents. First, when parents discover that their child has special needs, they go into shock. Then, when they realize and accept their child's physical or psychological particular condition, feelings of guilt, sorrow and helplessness arise usually accompanied with psychological distress such as anxiety and depression (Bumin., Gunal., & Tukel., 2008). Indeed, according to another study done by Gupta et al (2004), parents of children with disabilities are overwhelmed with feelings of pessimism, hostility, shame, denial, guilt, shock, withdrawal, rejection, helplessness, depression and self-blame. Besides, quality of life of the parents and their commitments in dependent daily living activities destroy the dynamics of the family. Accordingly, the roles of the family members change leading to further tension and anxiety between them (Bumin., Gunal., & Tukel.,

2008). Jealousy and antipathy may also build up in siblings if the special need child requires most of his parent's attention (Gupta., & Kaur., 2010).

In India, as quoted by Gupta & Singhal (2004), parents of children with special needs perceive the disability of their child in a different way. In fact, in a study conducted by Dalal & Pande (1999), cultural beliefs play an important role in the perception of a disability. Karma, for instance, is a spiritual credence helping in justifying or accepting major life events. Since the Indian population has a strong faith in karma, Indians profess their disabilities as a punishment and even a curse, as a consequence from their past karmas (Ghai., 2000). Accordingly, parents of children with disabilities experience acute psychological effects such as depression, in particular dysthymia, generalized anxiety disorder including psychosomatic symptoms, social isolation, and marital dissatisfaction (McCormack., 1992).

Mediating Factors

As stated above, children with special needs have serious and distressing repercussions within the nuclear family. However, many mediating factors may decrease or increase the level of distress of the family such as the parent's coping skills, gender differences (mothers vs. fathers), the types and severity of the disabilities and the socio-demographic parameters.

Coping Skills of Parents

There has been an increasing acknowledgment and evidence showing that parents of children with special needs who have good coping skills show a better quality of life and a healthier wellbeing.

Mainly, coping strategies can be defined as cognitions and behaviors used by the

individual to assess stressors that entail either active or avoidant coping strategies aimed at reducing the amount of stress (Folkman & Lazarus, 1988; Lazarus & Folkman, 1984; Margalit et al., 1992). Coping is a major determinant in the relationship between stressful events and adaptation outcomes (Judge, 1998, p.263). Even though some strategies have been found to be more effective than others, it is difficult to assess the outcomes of coping because some people strive for different means, and some approaches may be helpful in the short-term, but problematic in the long run (Pargament, 1997). The objective of coping strategies is to support or preserve family resources (Judge, 1998), reduce the source of stress or negative emotions (McCubbin, 1979), and reach a balance in family functioning (McCubbin et al., 1980). In prior research, strategies aimed at coping with the source of stress, such as problem solving and seeking information were more adaptive strategies as compared to others (Bailey, Jr. & Smith, 2000; Judge, 1998). Furthermore, parents of children with special needs who think in a positive way had more rewarding adjustment and family bonds (Abbott & Meredith, 1986; Burr et al., 1994). Seeking social support (Judge, 1998; McCubbin et al., 1982) and spiritual support (Abbott & Meredith, 1986; Koenig, 1999) were also methods that were proficient and often used. However, in a study by Judge (1998), passive appraisal was negatively correlated to family strengths. Besides, in a study conducted by Pritzalaff (2001), results denoted highest means for social support and reframing. Passive appraisal had the third highest mean, followed by mobilizing family members to acquire and accept help and spiritual support (Pritzalaff., 2001). In addition, Gupta (2004), spoke of additional coping skills which included problem-focused coping, having a social support, generating positive appraisal/ perceptions and attending intervention programs (Gupta., & Singhal., 2004). Problem-focused coping consisted of attempts in solving or managing the distressful problem which contains strategies for gathering information, making decisions, planning, and resolving conflicts (Gupta., & Singhal., 2004). It also included efforts aimed at obtaining

resources such as seeking knowledge or information about the situation, in order to handle the underlying issue. Positive appraisal or perceptions, on the other hand, were cognitive strategies that enabled one to perceive a situation in a more positive way.

Gender differences and Socio-demographics status of parents of children with special needs

In a study performed by Romans-Clarkson et al (1986), parents of children with mental and physical disabilities as well as parents of healthy children were assessed while controlling the demographic differences such as the social class and the employment status. The social network of the parents of mentally and physically disabled children were also considered to define the elements that may influence psychiatric morbidity (Romans-Clarkson et al., 1986). In this experiment, the control group consisted of the parents of healthy children and the subject group of the parents with mental or physical disabled children (Romans-Clarkson et al., 1986). The results showed that mothers of physically disabled children exhibited more psychiatric symptoms than mothers of healthy children in spite of their demographic differences (Romans-Clarkson et al., 1986). Yet, the fathers did not show the same distressing effects. This difference is due to the fact that the childcare relies mostly on the shoulders of the major caregivers who are mothers. In addition, mothers in the support group are so involved with their children that they become relatively unavailable to their husbands, hence marital conflicts arise often resulting to divorce (Romans-Clarkson et al., 1986).

In addition, Buman et al (2008) also proved that the most affected person in the family is the mother as she undergoes through greater amount of stress and emotional needs compared to mothers of healthy children. Besides, most studies found that the severity of the disability, the age and gender of the child (depending on the case), the level of education of

the parents and their financial situation were all factors that affect the quality of life of parents of children with special needs (Bumin., Gunal., & Tukel., 2008).

On the other hand, Romans-Clarkson et al (1986) also demonstrated that parents in the control group benefit from higher average socioeconomic state compared to the parents in the subject groups because mothers of healthy children are employed. Along with that, this research proved that the social interaction differed between the control group and the subject group. Indeed, parents in the subject group exhibited lower scores in their social relations. Finally, many mothers diminish their social activities not only because they barely have time for their social life, but because they fear the reaction of others as well (Clarkson., Dittmer., Flett., Linsell., Mullen., & Mullin., 1986).

In a study realized in the UAE, Khamis (2009) found that the employment status of the fathers had an impact on their level of stress. Indeed, unemployed fathers experienced higher level of stress.

Types and Severity of the Disabilities

Types of disabilities and the level of severity have a significant impact on the parents' mental health. Children with special needs require more attention and assistance depending on the disorder they suffer from and how much they are dependant on their caregivers.

In Turkey, a study was conducted to examine the relationship among anxiety and depression with the quality of life mothers with disabled children (Bumin., Gunal., & Tukel., 2008). Results of this study showed that mothers with disabled children, such as cerebral palsy, autism, mental retardation, mental-motor retardation and other disabilities, have higher anxiety, depression and a lower quality of life. Moreover, as giving birth to a child with physical or mental disabilities may cause shock, denial, guilt and helplessness to the family members, spending time with such a child may increase the level of anxiety, especially in

mothers, since they are the dominant roles in care giving (Bumin., Gunal., & Tukel., 2008). In addition, Bumin et al (2008) also found these mothers displayed decrease energy level and sleep disturbances accompanied with emotional reactions. Besides, depression and social isolation were significantly correlated. Indeed, as mothers are overwhelmed enormous daily care, they barely have time for social activities. Along with that, parents of children with Down syndrome devoted more time to their child, hence less time to their social life. Finally, because mothers dedicated their time to the childcare, they could not be employed. As a result, the family had a lower income affecting, in return, its quality of life (Bumin., Gunal., & Tukel., 2008).

Similarly, in the UAE, for instance, a research study was realized to recognize predictors of parental stress and psychological distress among parents of children with mental retardation (Khamis., 2009). It studied the major contributions of child characteristics, parents' socio-demographics, and family environment to parental stress and psychological distress. The sample consisted of 225 parents of mentally retarded children, of whom 113 were fathers and 112 were mothers (Khamis., 2009). Findings showed that the child was significantly connected with the parents' feelings of distress and psychiatric symptom status, as the parental stress decreased when the child was older (Khamis., 2009). In addition, psychiatric symptoms were positively correlated with the level of disability. In other terms, the higher the severity of the children's disability, the more psychiatric symptoms were reported by the parents (Khamis., 2009).

In light of the above literature, the following hypotheses were predicted:

1. Coping skills scores of parents of children with special needs are positively correlated with their Wellbeing scores.

2. Mothers of children with special needs score lower on the Wellbeing scale than

fathers.

3. Parents with a higher monthly income range will score higher on the Wellbeing scale.

4. Parents of children with mental disabilities score lower on the Wellbeing scale than parents of children with physical disabilities.

5. Parents with a higher level of education will score higher on the Wellbeing scale.

CHAPTER 3

Method

The purpose of the present study was to assess the extent to which factors, such as coping skills, gender differences, types and severity of the disabilities and their socio-demographic status (monthly income and education level), affect their wellbeing.

Participants

A total of 884 surveys were randomly distributed to parents of children with special needs in various locations. However, among those 884 questionnaires, only 320 parents have responded with their full consent. Moreover, while the expected number of returned surveys is usually about 26% of the total distribution, the response rate in this study was about 36.1%, which is much better than expected.

The number and the percentage of parents who responded from different locations is represented in the table 1 as displayed below:

Table 1: *Descriptive Data on number and percentage of distributed and returned surveys from different locations*

	Number of Surveys Distributed	Number of Surveys Returned	Valid Percentage of Returned Surveys
Iidad	210	51	15.94
Baabda Lebanese School	130	67	20.93
Lebanese Autism Association	90	17	5.312
Learning Center for Deaf	88	21	6.56
Lebanese Association For Special Education	144	78	24.37
Makassed	76	39	12.18
LEAPS	20	16	5
BBS	126	31	9.68
Total	884	320	100

Materials

The materials for this study consisted of three parts: demographic information, Family Crisis Oriented Personal Evaluation Scale (F-COPES) and Wellbeing Assessment Tool.

Demographic Questionnaire. The demographic questionnaire included descriptive information about the parents of children with special needs such as the age and gender of parents, their marital and employment status, their level of education, and the total number of children with or without special needs they have.

Family Crisis Oriented Personal Evaluation Scale (F-COPES). The purpose of this 5-point Likert self-report scale was to identify problem-solving attitudes and behaviors of families who have children with special needs. The scale represents the extent to which a person agrees or disagrees with each statement (1= strongly disagree and 5= strongly agree).

The F-COPES encloses 30-items that have been divided into five coping pattern subscales which are: acquiring social support, reframing, seeking spiritual support, mobilizing family to acquire and accept help, and passive appraisal (McCubbin et al., 1981). Acquiring social support is the family's ability to obtain support from relatives, friends, neighbors, and extended family (e.g., sharing our difficulties with relative) (McCubbin et al., 1981). Reframing evaluates the family's capability to reinterpret stressful events in order to make them more manageable (e.g., knowing that we have the strength within our family to solve our problems). Seeking spiritual support is using spiritual beliefs in order to gain comfort (e.g., participating in religious or spiritual activities). Mobilizing family to acquire and accept help is the family's ability to reach out to the community resources and accept help from professionals (e.g., seeking assistance from community agencies and programs designed to help families in situation). Passive appraisal is the family's ability to acknowledge problematic issues that reduces reactivity (e.g., believing if we wait long enough, the problem will go away) (McCubbin et al., 1981). An additional open-ended question was added to assess what were the most helpful coping skills to deal with their problems (i.e., seeking spiritual support, maintaining a positive attitude, family, friends, community resources, etc.).

Wellbeing Assessment Tool. The purpose of this 4-point Likert self-report scale is to assess and identify the physical, social, emotional, spiritual and intellectual health of an individual's potential. The scale represents the frequency to which a person is healthy or unhealthy (1= rarely, if ever and 4= always). The Wellbeing Assessment Tool encloses a total of 50-items that have been divided into five wellbeing subscales (10-items each), which are: physical health social health, social health, emotional health, spiritual health and intellectual health. Physical health assesses the individual's frequency of physical exercise (i.e., I engage in vigorous exercises such as brisk walking). Social health evaluates the social interaction (i.e., I participate in a wide variety of social activities and enjoy being with people who are different

than me). Emotional health is the individual's ability to regulate his emotions (i.e., I recognize when I am stressed and take steps to relax through exercise, quiet time, or other activities). Spiritual health measures the individual's serenity and insightfulness (i.e., I take time alone to think about what's important in life - who I am, what I value, where I fit in, and where I'm going). Intellectual health is the individual's ability to rationalize and analyze situations before taking action (i.e., I consider the alternatives before making decisions). The Wellbeing Assessment Tool is adapted from that at the McKinley Health Centre at the University of Illinois (2012).

Procedure

In order to distribute the surveys to parents of children with special needs, I met with heads and directors of schools, institutions and associations who receive children with special needs. After presenting the purpose of this study, all of the administrators agreed to have the surveys distributed to the parents of the children enrolled in their establishments. To solicit the parents to participate in the study, the administration sent an additional letter encouraging the parents to fill the questionnaires and return them as soon as possible. . Furthermore, the survey was translated into Arabic and reviewed by Dr. Marwan Gharzeddine so as to decrease the chances of language impairment. Surveys including three questionnaires (demographic information, Family Crisis Oriented Personal Evaluation Scale and Wellbeing Assessment Tool) were distributed in schools, center, institutions or associations who receive children/adolescents with special needs. After meeting with the director or principal of every school, institutions or associations and after taking their approval and consent for taking part of this study, the surveys were either given directly to the parents or via their children. Parents answered the questionnaires with their full consent and on their own (without my personal assistance). The surveys needed about 15 minutes at most to be completed. The

instructions were clear and simplified to guarantee maximum valid responses. Moreover, each envelope contained two questionnaires, for both parents to fill individually, one for the mother and one for the father. The survey was put in envelopes in order to ensure privacy and confidentiality of the parents. In addition, parents were provided with guidelines, which explained the purpose of the study and how to answer the questionnaires. Finally, my mobile number was provided in case the parents failed to understand some of the questions.

CHAPTER 4

Results

The purpose of the present study was to assess the extent to which factors, such as coping skills, gender differences, types and severity of the disabilities and their socio-demographic status (monthly income and education level), affect their wellbeing.

Reliabilities of Scales

F-Copes

The F-COPES has a good internal consistency with an original Cronbach alpha of 0.86. In addition, it has a good stability with a four-week test-retest correlation of 0.81 and subscales ranging from 0.61 to 0.95 (McCubbin et al.,1991). While the individual subscales have original Cronbach alphas ranging from 0.63 to 0.83, in this study the F-COPES had a Cronbach Alpha Reliability of 0.73 with subscales ranging from 0.46 to 0.75 as shown in table 2 below. However, since passive appraisal showed a low Cronbach Alpha Reliability, it was not used in this present research.

Table 2: *Coping Skills (F-COPES) Reliabilities of the Translated Version*

		Cronbach Alpha Reliability of Current Study	Original Cronbach Alpha
F-COPES Scales	Social Support	0.756	
	Reframing	0.722	
	Mobilizing	0.661	
	Spiritual Support	0.752	
	Passive Appraisal	0.464	
	Total F-COPES	0.731	0.86

Wellbeing Scale

The Wellbeing Assessment Tool has a Cronbach Alpha Reliability of .87 with subscales ranging from .58 to .76 as shown in table 3:

Table 3: *Wellbeing Assessment Tool Reliabilities of the Translated Version*

	Wellbeing Assessment Tool Subscales	Cronbach Alpha Reliability of Current Study
Wellbeing Scales	Physical Health	0.758
	Social Health	0.668
	Emotional Health	0.581
	Spiritual Health	0.764
	Intellectual Health	0.676
	Total Wellbeing Assessment Tool	0.878

Descriptive Statistics

The sample consisted of 320 participants. 145 were male and175 were female. Out of this sample, 300 individuals are married while 20 were not married (divorced or widowed) (see table 4).

Table 4*: Gender and Marital Status Frequencies and Percentages*

		Number (n)	Percent (%)
Gender	Male	145	45.31
	Female	175	54.68
Marital Status	Married	300	95.2
	Not Married	20	4.8
	Total	320	100

As shown in the pie chart below, the majority of this sample consisted of children with Learning Disabilities (19%), followed by children with hearing impairment and mental retardation (14%), children with visual impairment (12%) and Down Syndrome (11%). However, in an inventory conducted in Lebanon on December 2012 on the state of children with special needs, results showed that 53.76% had a motor disability, 27.656% a mental disability, 8.69% a hearing disability, 7.67% a visual disability and 2.43% a learning disability (see Appendix A). The percentages of this present study differ from the Lebanese statistics because they are not representative of the total Lebanese population.

Frequencies of Types of Disabilities

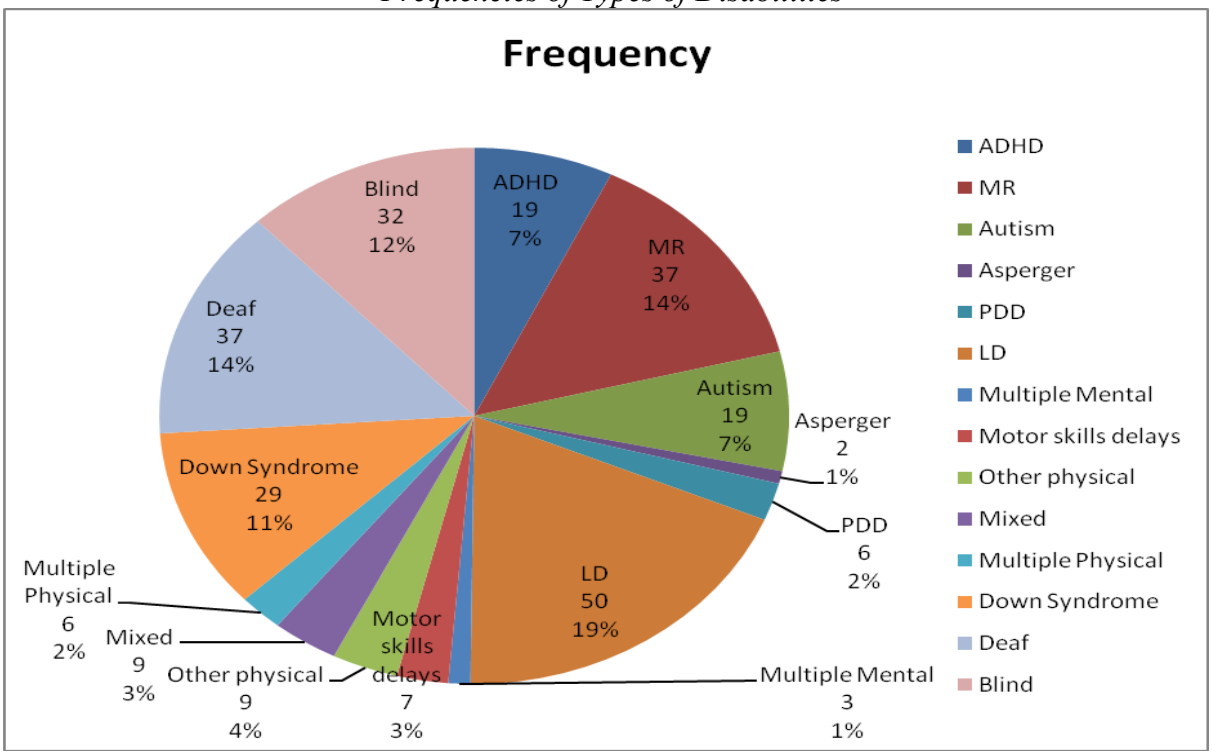

Table 5: *Frequencies of Groups of Disabilities*

		Frequency	Valid Percent
Valid	Mental	126	51.4
	Physical	110	44.9
	Mixed	9	3.7
	Total	245	100.0
Missing	System	75	
Total		320	

Table 6: *Frequencies of Respondents' Monthly Income*

Income			
		Frequency	Valid Percent
Valid	Less Than 500	16	8.6
	500-1000	99	52.9
	More Than 1000	72	38.5
	Total	187	100.0
Missing	System	133	
Total		320	

Hypotheses Testing

Hypothesis 1: Coping skills scores of parents of children with special needs are positively correlated with their Wellbeing scores.

To test this hypothesis, a Pearson correlation coefficient was computed between the Wellbeing and F-COPES scales and between their respective sub-scales. Results showed that the total F-COPES positively correlated to the total Wellbeing scores. Therefore, hypothesis one is confirmed.

In addition, further correlational analysis between the respective subscales of F-COPES and Wellbeing showed the following relationships:

First, from most to least, the *F-COPES Reframing* sub-scale scores are positively correlated to Total Wellbeing as well as five Wellbeing subscales as follows (see table 8):

Total Wellbeing with r (217) =0.377, p<. 0001

Intellectual Health (Wellbeing) with r (267) =0.333, p<. 0001

Spiritual Health (Wellbeing) with r (264) =0.306, p<. 0001

Emotional Health (Wellbeing) with r (270) =0.273, p<. 0001

Social Health (Wellbeing) with r (264) =0.256, p<. 0001

Physical Health (Wellbeing) with r (272) =0.171, p<. 005

Second, from most to least, the *F-COPES Mobilizing Family* subscale scores are positively correlated to Total Wellbeing as well as four Wellbeing subscales as follows (see table 8):

Total Wellbeing with r (227) =0.146, p<. 028

Spiritual Health (Wellbeing) with r (281) =0.223, p<. 0001

Emotional Health (Wellbeing) with r (285) =0.154, p<. 009

Social Health (Wellbeing) with r (279) =0.145, p<. 015

Intellectual Health (Wellbeing) with r (279) =0.132, p<. 026

Third, from most to least, the *F-COPES Acquiring Social Support* sub-scale scores are positively correlated to two Wellbeing subscales as follows (see table 8):

Emotional Health (Wellbeing) r (267) =0.157, p<. 01

Social Health (Wellbeing) r (261) =0.124, p<. 04

Finally, the *F-COPES Seeking Spiritual Support* sub-scale scores are positively correlated to Social Health Wellbeing subscales with r (273) =0.123, p<. 04 (see table 8).

Moreover, the F-COPES Reframing had the most correlations with the Wellbeing Scales, followed by the F-COPES Mobilizing, and the F-COPES Acquiring Social Support, and the F-COPES Seeking Spiritual Support.

For further analysis, a multiple regression analyses were conducted to examine the relationship between F-COPES Reframing scores and various potential Wellbeing Scale score predictors. As can be seen in Table 7, the *Emotional Health Wellbeing scale* had significant positive regression weight, indicating that respondents with higher scores on this scales were expected to have higher F-COPES Reframing scores, after controlling for the other variables in the model. However, the Physical, Spiritual, Intellectual, and Total Health Wellbeing did not contribute to the multiple regression models.

Table 7: *Summary of Multiple Regression Analysis for F-COPES Reframing*

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	18.672	2.512		7.433	.000
	Physical Health (Wellbeing)	.058	.094	.063	.616	.538
	EmotionalHealth (Wellbeing)	**.250**	**.126**	**.235**	**1.989**	**.048**
	Spiritual Health (Wellbeing)	.133	.118	.135	1.122	.263
	Intellectual Health (Wellbeing)	.126	.139	.106	.907	.365
	Total Wellbeing	-.008	.067	-.030	-.119	.905

a. Dependent Variable: F-COPES Reframing

Table 8: *Correlations F-COPES and Wellbeing Assessment Tool*

Correlations

WELLBEING	F-COPES	Acquiring Social Support	Re-framing	Mobilizing Family	Seeking Spiritual Support	Total F-COPES
Physical Health (Wellbeing)	Pearson Correlation		.171**			
	Sig. (2-tailed)		.005			
	N		272			
Social Health (Wellbeing)	Pearson Correlation	.124*	.256**	.145*	.123*	
	Sig. (2-tailed)	0.04	.000	.015	0.04	
	N	261	264	279	273	
Emotional Health (Wellbeing)	Pearson Correlation	.157*	.273**	.154**		
	Sig. (2-tailed)	0.01	.000	.009		
	N	267	270	285		
Spiritual Health (Wellbeing)	Pearson Correlation		.306**	.223**		
	Sig. (2-tailed)		.000	.000		
	N		264	281		
Intellectual Health (Wellbeing)	Pearson Correlation		.333**	.132*		
	Sig. (2-tailed)		.000	.026		
	N		267	284		
Total Wellbeing	Pearson Correlation		.377**	.146*		.207**
	Sig. (2-tailed)		.000	.028		.005
	N		217	227		186

**. Correlation is significant at the 0.001 level (2-tailed).

*. Correlation is significant at the 0.01 level (2-tailed)

Hypothesis 2: Mothers of children with special needs will score lower on the Wellbeing scale than fathers.

To test this hypothesis an Independent Sample t-test was performed on the total Wellbeing between fathers and mothers. Results showed that there was a significant effect for gender, however, women scored higher than men on the Total Wellbeing scale t (277) = 2.54, $p < .01$. Therefore, hypothesis 2 was not confirmed (See table 9).

Table 9: *Wellbeing Means, Standard Deviation, and t-test values for males and females*

Group Statistics

	Male		Female			
	M	SD	M	SD	t-test	Sig.
Total Health Wellbeing	141.00	19.24	147.00	15.71	2.54	.01
Social Health Wellbeing	31.21	6.61	32.52	4.24	1.96	.01
Emotional Health Wellbeing	26.72	4.40	28.26	4.40	2.98	.001

Moreover, further analysis showed that women scored higher scores on the Social Health Wellbeing scale with t (212) = 1.96, $p < .01$ and on the Emotional Health Wellbeing scale t (282) = 2.98, $p < .001$ (See table 9).

Hypothesis 3: Parents with a higher monthly income range will score higher on the wellbeing scale.

To test this hypothesis a one-way ANOVA was used to test for the wellbeing scales score differences among the various monthly income groups. Results showed that there was no differences between the various monthly income on the total health Wellbeing score where

F (2, 136) = 0.76, p = .469. Yet, the findings demonstrated that respondents with a monthly income between 500-1000$ had significantly higher scores on the *Intellectual Wellbeing* scale than those whose income was less than 500$ with a mean difference =3.45, p = .011. Similarly, the results show that respondents with a monthly income between over 1000$ had significantly higher scores on the *Intellectual Wellbeing* scale than those whose income was less than 500$ with a mean difference =2.85, p = .045 (see table 11 and 12). On the other hand, the spouse income had no significant effect on any of the respondent's wellbeing scales.

Therefore, Hypothesis 3 is partly confirmed because only scores on one wellbeing subscale (Intellectual) differed between only two income groups. Moreover, the spouses' income of the respondents did not have any relation to their wellbeing scores no matter what the spouses' income was.

Table 10: *Means and standard deviations of each variable*

Intellectual Health Wellbeing Means	N	Mean	Std. Deviation
Less Than 500$	14	25.92	6.33
500-1000$	95	29.27	3.92
More than 1000$	69	28.78	3.37

Table 11: *A one-way ANOVA for the Wellbeing scales score vs. Monthly Income of respondents*.

ANOVA

		Sum of Squares	df	Mean Square	F	Sig.
Total Wellbeing	Between Groups	502.716	2	251.358	**.760**	**.469**
	Within Groups	44291.065	134	330.530		
	Total	44793.781	136			
Physical Health Wellbeing	Between Groups	16.614	2	8.307	.329	.720
	Within Groups	4392.279	174	25.243		
	Total	4408.893	176			
Social Health Wellbeing	Between Groups	54.626	2	27.313	.723	.487
	Within Groups	6267.623	166	37.757		
	Total	6322.249	168			
Emotional Health Wellbeing	Between Groups	84.449	2	42.224	2.167	.118
	Within Groups	3331.345	171	19.482		
	Total	3415.793	173			
Spiritual Health Wellbeing	Between Groups	124.525	2	62.262	2.679	.072
	Within Groups	3857.724	166	23.239		
	Total	3982.249	168			
Intellectual Health Wellbeing	Between Groups	136.695	2	68.348	4.356	.014
	Within Groups	2745.552	175	15.689		
	Total	2882.247	177			

Table 12: *Multiple Comparisons between Monthly Income and Intellectual Wellbeing*

Multiple Comparisons

Bonferroni

Dependent Variable	(I) Income	(J) Income	Mean Difference (I-J)	Std. Error	Sig.
Intellectual Health Wellbeing	500-1000	Less Than 500	3.34511*	1.13392	.011
	More Than 1000	Less Than 500	2.85404*	1.16104	.045

*. The mean difference is significant at the 0.05 level.

Hypothesis 4: Parents of children with mental disabilities will score lower on the Wellbeing scale than parents of children with physical disabilities.

To test this hypothesis an Independent Sample t-test was performed between parents of children with mental and physical disabilities. The results show that there was no difference between parents of children with mental and physical on the total Wellbeing scale where t (174)= -1.62, $p < 0.11$ (see table 13). On the other hand, parents of children with mental disabilities scored significantly higher on the Physical Health Wellbeing scale than parents whose children have a physical disability where t (214) = 2.36, $p < .02$ (see table 13). However, parents of children with mental disabilities scored significantly lower than parents whose children have a physical disability on the Social Health Wellbeing scale, t (206) = -2.19, $p < .03$, and on the Spiritual Health Wellbeing scale, t (210) = -1.95, $p < .05$, as well as lower on the Intellectual Health Wellbeing scale, t (218) = -2.00, $p < .05$ (see table 13).

Therefore, hypothesis 4 was partially confirmed.

Table 13: *Wellbeing Means, Standard Deviation, and t-test values for parents of children with mental and physical disabilities*

Group Statistics

	Mental		Physical			
	M	SD	M	SD	t-test	Sig.
Physical Health Wellbeing	24.01	4.77	22.51	4.66	2.36	.02
Social Health Wellbeing	30.97	5.43	32.67	5.95	-2.19	.03
Spiritual Health Wellbeing	31.18	4.75	32.42	4.50	-1.95	.05
Intellectual Health Wellbeing	28.54	4.02	29.60	3.86	-2.00	.05
Total Wellbeing	141.72	18.36	146.00	16.41	-1.62	.011

Hypothesis 5: Parents with a higher level of education will score higher on the wellbeing scale.

To test this hypothesis, a one way ANOVA analysis was conducted. The results show that there was no differences between the various educational group on the total health Wellbeing score where F (5,191) =.679, p = .64 (see table 15 and 16). On the other hand, findings proved that Educational Level of respondent had a significant effect only on the *Intellectual Health Wellbeing* scale where F (5, 237) = 4.39, p = .001 (see table 15 and 16). Mainly, respondents with a Brevet had significantly higher scores on the *Intellectual Health Wellbeing* scale than those with a Masters Degree with a mean score difference= 3.4, $p<0.001$ (see table 15 and 16). Moreover, respondents with a Ph.D. degree had significantly higher scores on the *Intellectual Health Wellbeing* scale than those with a Masters Degree with a mean score difference= 5.03, $p<0.01$ (see table 15 and 16).

Therefore, hypothesis 5 is partly confirmed.

Table 14: *Means and standard deviations of each variable*

Intellectual Health Wellbeing Means	N	Mean	Std. Deviation
Brevet	60	30.15	3.12
High School	60	28.76	4.18
BA/BS	68	28.63	2.94
MA/MS	20	26.75	3.53
PhD	9	31.77	2.33
Technical	21	29.38	3.98

Table 15: *A one-way ANOVA for the Wellbeing scales scores vs. Educational Levels of respondents.*

ANOVA

		Sum of Squares	df	Mean Square	F	Sig.
Total Wellbeing	Between Groups	1056.699	5	211.340	.679	.640
	Within Groups	57855.629	186	311.052		
	Total	58912.328	191			
Physical Health Wellbeing	Between Groups	194.761	5	38.952	1.569	.170
	Within Groups	5859.272	236	24.827		
	Total	6054.033	241			
Social Health Wellbeing	Between Groups	148.976	5	29.795	1.026	.403
	Within Groups	6708.652	231	29.042		
	Total	6857.629	236			
Emotional Health Wellbeing	Between Groups	138.947	5	27.789	1.391	.228
	Within Groups	4653.923	233	19.974		
	Total	4792.870	238			
Spiritual Health Wellbeing	Between Groups	98.716	5	19.743	.995	.421
	Within Groups	4502.348	227	19.834		
	Total	4601.064	232			
Intellectual Health Wellbeing	Between Groups	264.189	5	52.838	4.393	.001
	Within Groups	2790.450	232	12.028		
	Total	3054.639	237			

Table 16: *Multiple Comparisons between Educational Levels and Intellectual Wellbeing.*

Multiple Comparisons

Bonferroni

Dependent Variable	(I) Educational Level	(J) Educational Level	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
						Lower Bound	Upper Bound
Intellectual Health Wellbeing	Brevet	MA/MS	3.40	0.90	0.00	0.74	6.06
	PhD	MA/MS	5.03	1.39	0.01	0.90	9.16

CHAPTER 5

Discussion

The purpose of the present study was to assess the extent to which factors, such as coping skills, gender differences, types and severity of the disabilities and their socio-demographic status (monthly income and education level), affect their wellbeing. Accordingly, this chapter will discuss the results of the study in relationship to the material described the literature review. Implications for helping professionals, limitations of the present study, as well as future recommendations will also be addressed.

First of all, results showed that the *F-COPES Reframing* sub-scale scores were positively correlated to Total Wellbeing as well as with the five Wellbeing subscales (from most to least): Intellectual Health, Spiritual Health, Emotional Health, Social Health and Physical Health. Since "reframing" is the family's capability to reinterpret stressful events in order to make them more manageable, it is very logical for these scores to be in this particular order. Also, these findings suggest that parents who have "reframing" as a coping skill have a better general wellbeing health than parents who don't. In other terms, parents who are able to reframe their problems are, in a descending order, consequently better at rationalizing or analyzing situations before taking action, at having better insights, at regulating their emotions, participating in social activities and at engaging in physical exercise. Second, findings revealed that the *F-COPES Mobilizing Family* sub-scale scores were positively correlated to Total Wellbeing as well as four Wellbeing subscales: Spiritual Health, Emotional Health, Social Health, and Intellectual Health. Given that "Mobilizing Family" is the family's ability to reach out to the community resources and accept help from professionals, this implies that parents who seek professional help are better spiritually, emotionally, socially and intellectually. Third, results also demonstrated that the *F-COPES Acquiring Social Support* sub-scale scores were positively correlated to two Wellbeing

subscales: Emotional Health and Social Health. As "Acquiring Social Support" is the family's ability to obtain support from relatives, friends, neighbors, and extended family, parents who share their distress with their nuclear or extended families feel better, yet, only on an emotional and social basis.

Finally, the *F-COPES Seeking Spiritual Support* sub-scale scores were positively correlated to Social Health Wellbeing subscales. While "Seeking Spiritual Support" is using spiritual beliefs in order to gain comfort, parents who confide in their religion to ease their pain have a better social interaction.

In addition, for further analysis, a multiple regression analyses were conducted to examine the relationship between F-COPES Reframing scores and various potential Wellbeing Scale score predictors. The regression analysis showed that the Emotional Health Wellbeing is the main factor affected by Reframing, and thus this wellbeing factor improves individual's Total Wellbeing, as well as their Intellectual Health, Spiritual Health, Social Health and Physical Health.

In conclusion, hypothesis 1- Coping skills scores of parents of children with special needs are positively correlated with their Wellbeing scores- is confirmed with the F-COPES Reframing having the most correlations with the Wellbeing Scales, followed by the F-COPES Mobilizing, the F-COPES Acquiring Social Support, and the F-COPES Seeking Spiritual Support.

In general, the total results (Total F-COPES and total Wellbeing) of this present study were congruent with results existing in previous studies. Nevertheless, while the highest means were reframing, followed by the mobilizing family members, acquiring social support, and seeking spiritual support, in a study conducted by Pritzalaff (2001), results denoted highest means for social support and reframing. Passive appraisal had the third highest mean,

followed by mobilizing family members to acquire and accept help and spiritual support (Pritzalaff., 2001). There are several ways to explain this minor difference in the scores order:

Initially, the goal of coping strategies is to reinforce or maintain family resources (Judge, 1998), lessen the source of stress or negative emotions (McCubbin, 1979), and attain a balance in family functioning (McCubbin et al., 1980). The literature review proposed that there are certain coping approaches that are more adaptive than others. In fact, a family's aptitude to adjust to stressful situations varies according to a number of variables, such as coping skills, the socio-demographic status of parents, types and severity of the disabilities. Therefore, individuals' differences as well as their life stressors determine the choice of coping skills. Moreover, cultural differences are significant here. In the west, societies are more individualized oriented as opposed to collectivistic societies in the Middle East. In other words, people living in the west have to seek out for social support to have a better wellbeing whereas in the Arab cultures, individuals are nurtured in social support.

On the other hand, as mentioned in the literature review (Gupta., & Singhal., 2004), perception of an event is very important and aids at accepting distressing situation. While reframing, parents are able to think positive and adjust more smoothly. Thus, similarities in the results confirm that reframing is a coping skill applicable across cultures as well as mobilizing family and seeking spiritual support. Finally, in Lebanon, passive appraisal, the family's ability to acknowledge problematic issues that reduces reactivity, did not prove to be a significant factor.

Regarding hypothesis 2, (mothers of children with special needs will score lower on the Wellbeing scale than fathers), results demonstrated that there was a significant correlation between genders. Yet, hypothesis 2 was not confirmed because mothers scored higher than men on the Total Wellbeing scale, as well as higher scores on the Social Health Wellbeing and on the Emotional Health Wellbeing scales. These surprising results prove once again the

cultural implications and how much they may considerably affect or differ from studies realized around the world. According to the Romans-Clarkson (1986), numerous researches have confirmed that mothers of physically disabled children exhibited more psychiatric symptoms than mothers of healthy children in spite of their demographic differences while the fathers did not show the same distressing effects (Romans-Clarkson et al., 1986). This dissimilarity is due to the fact that the childcare relies mostly on the shoulders of the major caregivers who are mothers. In addition, Buman et al (2008) also proved that the most affected person in the family is the mother as she undergoes through greater amount of stress and emotional needs compared to mothers of healthy children.

Although the background of studies sustained the fact that mothers suffer more than fathers, in Lebanon, mothers proved to have a better wellbeing. These findings may be explained by the fact that the Lebanese culture is very much supportive of mothers and that the presence of the nuclear and extended family plays a major role. Unlike the west, in the Arab world members of the family are much more connected and available hence, mothers do not feel alone while dealing with stressful situations. Moreover, the Arab culture offers proximity where families can rely on their neighborhood in case of need. Besides, as mothers are women they are generally more expressive by nature. In addition, they are less likely to refuse disclosing or feel ashamed talking about their problems, which justify why their emotional and social health subscales score are higher than fathers. Mothers' communicative nature is reinforced with the Lebanese culture whereby mothers always have someone available around them to talk to and share their concerns. Finally, since the results show that there is a considerable amount of mothers who are unemployed, this implies that they have more time for themselves, hence are more attentive to their emotional needs. Conversely, since fathers are mostly working they become unavailable to themselves resulting in a lower wellbeing on an emotional and social level.

Moreover, results reported that the income of the respondents had a significant effect on only one wellbeing scale. In the present study, results showed that respondents earning 500 and above have a better intellectual health being than respondents earning less than 500$. It is very logical and rational for respondents to feel better if their income is above 500$. Since the life has become more and more expensive, it is imperative to have an average monthly income in order to support the family expenses. Moreover, families who have children with special needs find their operating cost increase due to the heavy fees they need to pay in order to treat their children. Therefore, parents earning less than 500$ find it much more difficult to meet their financial needs hence have a lower wellbeing especially on an intellectual level.

Similarly, three decades ago, Romans-Clarkson et al (1986) also demonstrated that parents of healthy children had higher average socioeconomic state as compared to the parents of children with special needs because mothers of healthy children are employed. Along with that, this research proved that the social interaction differed as parents of children with special needs exhibited lower scores in their social relations (Clarkson., Dittmer., Flett., Linsell., Mullen., & Mullin., 1986). In parallel, in a study realized in the UAE, Khamis (2009) found that the employment status of the fathers had an impact on their level of stress. Indeed, unemployed fathers experienced higher level of stress (Khamis, 2009).

Furthermore, results show that among 245 respondents who listed the type of disability of their children, 51.4% had children with a mental disability, while 44.9% had children with a physical disability. Only 3.7% had both, physical and mental disabilities. Moreover, parents of children with mental disabilities scored significantly higher on the Physical Health Wellbeing scale than parents whose children have a physical disability. However, parents of children with mental disabilities scored significantly lower than parents

whose children have a physical disability on the Social Health, Spiritual Health and Intellectual Health Wellbeing scales.

These results suggest that parents of children with mental disabilities have better physical health than those with children with physical disabilities because it is physically more taxing to take care of a child with a physical problem. On the other hand, parents whose children are only physically disabled but otherwise normal mentally would feel better in the social, spiritual, and intellectual.

Finally, results disclosed that respondents with a Brevet had significantly higher scores on the *Intellectual Health Wellbeing* scale than those with a Masters Degree. Moreover, respondents with a Ph.D. degree had significantly higher scores on the *Intellectual Health Wellbeing* scale than those with a Masters Degree. These uncommon findings propose that parents holding a Brevet degree have a limited, perhaps unsophisticated, rationale hence causing less distress on the mind. However, parents holding a Masters degree, have a higher level of education leading them to strive in understanding and fixing their children's disabilities. Accordingly, they drain their mind hence, the low results on their intellectual health. On the other hand, parents having a PhD degree have reached their maximum mental abilities and realized that there is no need to fight but rather accept and live with their children's special needs, resulting in higher scores on their intellectual health.

Limitations and Future Recommendations

Several limitations were encountered in this study, and therefore, various recommendations are highlighted. First, this study was not representative of the Lebanese population as it was performed only in Beirut. Accordingly, there were many schools and institutions, which receive children with special needs that I did not visit. Second, for logistics purposes, the surveys were sent to the parents via their children. It was not possible

for me to meet personally and interview all the parents. As a result, parents had to fill the questionnaires on their own. Even though I ensured to have the directions very clear, a considerable amount of surveys was not answered properly by some parents. Subsequently, had I been physically present with the parents, I would have been able to assist them, thus guaranteed to have an increased number of valid responses. Finally, the types of disabilities were not equally numbered as the surveys were randomly distributed in the centers.

For future studies, the following recommendations should be taken into account: in order to have a better sample representative of Lebanon, the surveys should be allocated across all Lebanese regions, and handed out to all institutions and schools receiving children with special needs. Moreover, it is preferable that the parents answer the surveys with the presence of the researcher so as to reduce the possible risks of incomprehension. Last but not least, the sample should be representative of the actual distribution of the types of disabilities reflected in the existing Lebanese statistics. In addition, future research should include a control group of parents with healthy children so as to investigate the parent's wellbeing state. In other terms, in order to determine the mental status of parents, there should be 2 groups: one involving parents with healthy children and one with parents of children with special needs. In this way, considering the same mediating factors, the new results will either sustain those of this current research, such as that mothers score higher than fathers, for instance, or disapprove them.

On the other hand, since this study focused on the mediating factors aiding at improving the mental health of parents, mental professionals may make use of them so as to provide such parents with the right services and attend to their needs. Realizing that "reframing" and "mobilizing" were the two highest coping skills correlating with the Lebanese parents' wellbeing, creating group supports and intervention programs for parents should be put in place in order to facilitate the acceptance of their children's impairment and

reduce their distress. It is also important to refer or ask parents to consult professionals, as it will allow them to understand and adapt better to their children's disabilities. Moreover, during therapies, mental health professionals should focus on implementing "reframing" as a coping skill and coach parents how to apply it, so as to get positive and prompt results, and improve their wellbeing.

Finally, an important note is to be pointed out here. In the west, the government takes in charge (financially) of all the individuals and their families suffering from a particular disability. In other words, services catering help to parents of children with special needs are for free. Conversely, in Lebanon, these services are not supported by the Lebanese government. They are very costly and sometimes unaffordable for parents. Indeed, as the results showed, while the average of monthly costs for children with special needs was at least about 1000$, there was a number of parents whose monthly income was below 500$. Therefore, it is imperative that the costs of special services, aiming at helping children with special needs and their parents, are accommodated by the Lebanese government. In other terms, these services should be either free of charge or just have a symbolic fee. Parents and children at risks should be able to seek help without paying an excessive price, and it is the government's responsibility to grant them with this right.

Conclusion

It is undeniable that parents of children with special needs are accompanied with psychological and physiological distress. However, this distress is mediated with certain factors, which help in decreasing their agony, such as socio-demographic status of parents (monthly income and education level), gender differences (mothers vs. fathers), types and severity of the disabilities. Yet, it has also been proven that parents who acquire coping skills such as social support or intervention programs, have a better and a healthier lifestyle.

This correlational study allowed us to comprehend better the coping mechanisms of the Lebanese parents with special needs children. It also shed light on the contributing factors that have a significant impact on their wellbeing. I hope that with these important results, we will be able to attend and provide parents with the adequate services so as to ease their pain and improve their wellbeing.

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http://www.211la.org/parenting/specialneeds.pdf

Appendixes

Appendix A

Lebanese Statistics on the State of Children with Special Needs

62.19%	50186	MALE	**80703**	**TOTAL NUMBER OF PEOPLE WITH DISABILITIES TILL DATE**
37.81%	30517	FEMALE		

%	NUMBER	
7.51%	6,059	BEIRUT
36.80%	29,696	MOUNT LEBANON
18.14%	14,638	NORTH
13.04%	10,524	SOUTH
8.60%	6,937	NABATIYE
15.92%	12,849	BEKAA

%	NUMBER	
53.76%	48,288	MOTOR
27.45%	24,656	MENTAL
8.69%	7,808	HEARING
7.67%	6,886	VISUAL
2.43%	2,185	Learning
	89,823	**TOTAL**

%	NUMBER	
2.40%	1,933	LESS THAN 5
13.91%	11,224	FROM 6 TO 18
19.01%	15,345	FROM 19 TO 34
38.70%	31,232	FROM 35 TO 65
25.98%	20,969	66 AND ABOVE
	80703	**TOTAL**

around 7638 persons have more than 1 disability or type of disability

AGE					Gender			
66 AND ABOVE	**FROM 35 TO 65**	**FROM 19 TO 34**	**FROM 6 TO 18**	**LESS THAN 5 YEARS**	**FEMALE**	**MALE**	**TOTAL**	
0	3	31	232	87	83	270	353	**AUTISM**
0	0	570	1,623	22	657	1,558	2,215	**LEARNING DISABILITIES**
0	0	520	1,338	25	707	1,176	1,883	**LEARNING DIS + Mental**
0	0	85	210	7	110	192	302	**LEARNING DIS + OTHER DI**
15	776	967	1,217	301	1,335	1,941	3,276	**DOWN SYNDROME***
106	955	1,733	2,176	566	2,297	3,239	5,536	**CEREBRAL PALSY***
14,174	18,731	4,939	3,168	979	14,923	27,068	41,991	**Motor only**
1,533	1,298	1,722	1,607	137	2,669	3,628	6,297	**Motor + another type**
1,791	5,506	5,440	3,800	608	7,091	10,054	17,145	**Mental only**
1,186	1,110	2,257	2,811	147	3,171	4,340	7,511	**Mental + another type**
1,468	2,852	1,694	908	144	2,919	4,147	7,066	**Hearing only**
188	208	185	145	16	275	467	742	**Hearing + another type**
1,897	2,719	906	319	34	2,029	3,846	5,875	**Visual only**
412	281	176	125	17	355	656	1,011	**Visual + another type**

Please Note

***Down Syndrom causes mental impariment, and Cerebral Palsy causes motor & often mental and sensoryimpairment therefore some of the children with DS or CP might be included within the mental / motor / learning /**

Registered Specialized Institutions **135 working through 279** centers

Institutions having contracts with the MOSA for spcial care 70 through **96 centers** see annex in arabic

This data is issued from the registration at the MOSA, that is not mandatory, but it is representative of the general situation of disability in Lebanon

Appendix B

University Consent Form

HAIGAZIAN UNIVERSITY
جـــامعـــة هـــايكـــازيـــان
ՀԱՅԿԱԶԵԱՆ ՀԱՄԱԼՍԱՐԱՆ

July 20, 2012

To whom it may concern,

This is to certify that Ms. Ghania Kabbara is writing her thesis at Haigazian University. Her thesis is about Mental Health of Parents of Children with Disabilities/Disorders. For that purpose, she needs to distribute surveys to the parents who have children with disabilities in order to assess their mental health and coping skills. I am currently supervising her work.

If you have any further questions, please do not hesitate to contact me at 01/735755.

Cordially,

Marwan Gharzeddine, Ph.D.
Licensed Psychologist

Mexique Street, Kantari, P.O.Box: 11 1748 Riad El Solh, 1107 2090 Beirut, Lebanon Telefax: 01-353010/1/2 01-349230/1
www.haigazian.edu.lb

Appendix C

Letter for Parents (in English)

Dear Parents,

I am Ghania Kabbara, a graduate student at Haigazian University, mastering in Clinical Psychology. I am currently writing my thesis on "Mental Health of Parents of Children with Special Needs". My work is supervised by Dr. Marwan Gharzeddine.

The purpose of this study is to assess the mental health of the parents who have children with special needs. In studying the effects children with disabilities have on their parents, we will be able to develop helping services to those parents such as providing them with coping skills or professional help in order to improve their well being. Therefore, your collaboration is of highly importance in order to determine and meet your needs.

Please take the time to fill this questionnaire. Should you need further explanation do not hesitate to contact me.

Thank you very much for your help and your time!

Sincerely,
Ghania Kabbara

Appendix D

Letter for Parents (in Arabic)

عزيزتي الوالدة ، عزيزي الوالد،

أنا غانية كبارة، خرّيجة من جامعة هايكازيان وطالبة ماجستير في علم النفس العيادي. أكتب حالياً رسالة الماجستير لتقييم الصحة النفسية والجسدية و الروحية للآباء الذين لديهم أطفال ذوي الاحتياجات الخاصة أو الصعوبات التعليمية أو نفسية و تحت إشراف الدكتور مروان غرز الدين.

إن دراستنا للآثار التي يتسبب بها الأطفال ذوي الاحتياجات الخاصة تجاه آبائهم سوف تجعلنا قادرين على تطوير خدمات المساعدة لهؤلاء الآباء مثل تزويدهم بمهارات للتغلب على ذلك أو بمساعدة مهنية من أجل تحسين وضعهم.

لذلك، فإن مشاركتكم هي على درجة عالية من الأهمية من أجل تحديد وتلبية احتياجاتكم.
يُرجى أخذ الوقت الكافي لملء هذا الاختبار التقييمي. وفي حال احتجتم لأي توضيح لا تترددوا في الاتصال على هاتفي الجوّال.

شكراً جزيلاً لمساعدتكم ولوقتكم!

مع خالص التقدير،

غانية كبّارة

Appendix E

Explanatory Note for Parents (in English)

Dear Parents,

In this envelope you will find 2 surveys. These surveys are for each parent to fill. There is one for the mother and one for the father. It is very important that you take the time to fill it ***individually***. Once completed, please replace the 2 surveys back in the envelope and seal it in order to ensure a total privacy and confidentiality. As it is an anonymous survey, please do not write your names.

PS: Please return the envelope as soon as possible and address it to Ms. Ghania Kabbara.

Thank you for your time and cooperation!

Appendix F

Explanatory Note for Parents (in Arabic)

حضرة أولياء الأمور الكرام

يرجى ملىء الإستمارتين المرفقتين بشكل فردي من قبل الأب والأم وإعادتها بواسطة ولدكم /إبنتكم وتسليمها للآنسة غانية كبارة مقفلة لضمان سرية المعلومات .

ملاحظه : يرجى عدم ذكر الإسم ،كما أن المعلومات هي سرية وتستخدم لتحقيق الهدف المحدد فقط .

شكراً لتعاونكم

Appendix G

Demographic Questionnaire (English Version)

Survey #: ----------

QUESTIONNAIRES

Demographic Information

Please check the appropriate answer or write the answer in the space provided.

1) **Gender**: ☐ Male ☐ Female

2) **Marital Status**: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

3) **Age**: ----------

4) **Highest Level of your Education** *(i.e. Brevet, High School, BA, MA, PhD, Technical, etc…)*: ----------

5) **Highest Level of Education of your Spouse**: ----------

6) **Your Employment Status**:

☐ Employed ☐ Full-Time ☐ Part-Time
☐ Unemployed ☐ Retired

a) If employed, please specify your Job Title *(i.e. Employee, Freelancer, etc…):* ----------
b) Your Monthly Income (in **$**):☐Less than 500 ☐500-1000 ☐1000-5000 ☐More than 5000

7) **Your Spouse's Employment Status**:

☐ Employed ☐ Full-Time ☐ Part-Time
☐ Unemployed ☐ Retired

a) If employed, please specify your Spouse's Job Title: ----------
b) Your Spouse's Monthly Income (in **$**):☐Less than 500 ☐500-1000 ☐1000-5000 ☐More than 5000

8) **Please fill the *Number of Children* (with/without special needs), their *Age* and *Gender* in the table below**:

Number of Children in Birth Order	Age	Gender (Female or Male)	Type of Special Needs *Attention Deficit Hyperactivity Disorder, Mental Retardation, Autism, Asperger, Pervasive Developmental Disorder, Learning Disabilities (i.e. Communication Disorders, Expressive Language Disorder, Stuttering, Reading Disorders), No Disability. If others, please specify.*
Child 1			
Child 2			
Child 3			
Child 4			
Child 5			

* If you have more than 5 children, please specify their Age, Gender and Special Disability (if they have one):

---

9) **Monthly Cost/Expenses of Children with Special Needs**(in **$**):

☐Less than 100 ☐100-500 ☐500-1000 ☐1000-5000 ☐More than 5000

Appendix H

Family Crisis Oriented Personal Evaluation Scale (F-COPES) (in English)

F-COPES Questionnaire

The purpose of this questionnaire is to identify problem-solving attitudes and behaviors of families who have children with special needs.

Directions:

First, read the list of "Response Choices" one at a time.
Second, decide how well each statement describes your attitudes and behavior in response to problems or difficulties. If the statement describes your response very well, then circle the number 5 indicating that you strongly agree; if the statement does not describe your response at all, then circle the number 1 indicating that you strongly disagree; if the statement describes your response to some degree, then select a number 2, 3, or 4 to indicate how much you agree or disagree with the statement about your response.

Please circle a number (1, 2, 3, 4, or 5) to match your response to each statement. Thank You.

1 = Strongly Disagree
2 = Moderately Disagree
3 = Neither Agree Nor Disagree
4 = Moderately Agree
5 = Strongly Agree

When we face problems or difficulties in our family, we respond by:

1. Sharing our difficulties with relatives.	1	2	3	4	5
2. Seeking encouragement and support from friends.	1	2	3	4	5
3. Knowing we have the power to solve major problems.	1	2	3	4	5
4. Seeking information and advice from persons in other families who have faced the same or similar problem.	1	2	3	4	5
5. Seeking advice from relatives (grandparents, etc...).	1	2	3	4	5
6. Seeking assistance from community agencies and programs designed to help families in situation.	1	2	3	4	5
7. Knowing that we have the strength within our family to solve our problems.	1	2	3	4	5
8. Receiving gifts and favors from neighbors	1	2	3	4	5
9. Seeking information and advice from the family doctor.	1	2	3	4	5
10. Asking neighbors for favors and assistance.	1	2	3	4	5
11. Facing the problems "head-on" and trying to get solution right away.	1	2	3	4	5

12. Watching television.	1	2	3	4	5
13. Showing that we are strong.	1	2	3	4	5
14. Attending religious services.	1	2	3	4	5
15. Accepting stressful events as a fact of life.	1	2	3	4	5
16. Sharing concerns with close friends able to solve family problems.	1	2	3	4	5
17. Knowing luck plays a big part in how well we are able to solve family problems.	1	2	3	4	5
18. Exercising with friends to stay fit and reduce tension.	1	2	3	4	5
19. Accepting that difficulties occur unexpectedly.	1	2	3	4	5
20. Doing things with relatives (get-togethers, dinners, etc...).	1	2	3	4	5
21. Seeking professional counseling and help for family.	1	2	3	4	5
22. Believing we can handle our own problems.	1	2	3	4	5
23. Participating in religious or spiritual activities.	1	2	3	4	5
24. Defining the family problem in a more positive way so that we do not become too discouraged.	1	2	3	4	5
25. Asking relatives how they feel about problems we face.	1	2	3	4	5
26. Feeling that no matter what we do to prepare, we will have difficulty handling problems.	1	2	3	4	5
27. Seeking advice from a minister or spiritual leader.	1	2	3	4	5
28. Believing if we wait long enough, the problem will go away.	1	2	3	4	5
29. Sharing problems with neighbors.	1	2	3	4	5
30. Having faith in God or a higher power.	1	2	3	4	5

Overall, what has been the most helpful for you in coping with your child's disability?
(i.e. seeking spiritual support, maintaining a positive attitude, family, friends, community resources, etc...)?

Appendix I

Wellbeing Assessment Too (English Version)

Wellbeing Assessment Questionnaire

The purpose of this questionnaire is to identify the physical, social, emotional, spiritual and intellectual health of families who have children with special needs.

Please circle a number (1, 2, 3, or 4) to match your response to each statement.

	Rarely, if Ever	Sometimes	Most of the Time	Always
Physical Health				
1. I maintain a desirable weight.	1	2	3	4
2. I engage in vigorous exercises such as brisk walking.	1	2	3	4
3. I do exercises designed to strengthen my muscles and joints.	1	2	3	4
4. I warm up and cool down by stretching before and after vigorous exercise.	1	2	3	4
5. I feel good about the condition of my body.	1	2	3	4
6. I get 7-8 hours of sleep each night.	1	2	3	4
7. My immune system is strong and I am able to avoid most infectious diseases.	1	2	3	4
8. My body heals itself quickly when I get sick or injured.	1	2	3	4
9. I have lots of energy and can get through the day without being overly tired.	1	2	3	4
10. I listen to my body; when there is something wrong, I seek professional advice.	1	2	3	4
Social Health				
1. When I meet people, I feel good about the impression I make on them.	1	2	3	4
2. I am open, honest, and get along well with other people.	1	2	3	4
3. I participate in a wide variety of social activities and enjoy being with people who are different than me.	1	2	3	4

	Rarely, if Ever	Sometimes	Most of the Time	Always
4. I try to be a "better person" and work on behaviors that have caused problems in my interactions with others.	1	2	3	4
5. I get along well with the members of my family.	1	2	3	4
6. I am a good listener.	1	2	3	4
7. I am open and accessible to a loving and responsible relationship.	1	2	3	4
8. I have someone I can talk to about my private feelings.	1	2	3	4
9. I consider the feelings of others and do not act in hurtful or selfish ways.	1	2	3	4
10. I consider how what I say, might be perceived by others before I speak.	1	2	3	4
Emotional Health				
1. I find it easy to laugh about things that happen in my life.	1	2	3	4
2. I avoid using alcohol as a means of helping me forget my problems.	1	2	3	4
3. I can express my feelings without feeling silly.	1	2	3	4
4. When I am angry, I try to let others know in non-confrontational and non-hurtful ways.	1	2	3	4
5. I am a chronic worrier.	1	2	3	4
6. I recognize when I am stressed and take steps to relax through exercise, quiet time, or other activities.	1	2	3	4
7. I feel good about myself and believe others like me for who I am.	1	2	3	4
8. When I am upset, I talk to others and actively try to work through my problems.	1	2	3	4

	Rarely, if Ever	Sometimes	Most of the Time	Always
9. I am flexible and adapt or adjust to change in a positive way.	1	2	3	4
10. My friends regard me as a stable, emotionally well-adjusted person.	1	2	3	4
Spiritual Health				
1. I believe life is a precious gift that should be nurtured.	1	2	3	4
2. I take time to enjoy nature and the beauty around me.	1	2	3	4
3. I take time alone to think about what's important in life - who I am, what I value, where I fit in, and where I'm going.	1	2	3	4
4. I have belief in the importance of things beyond myself.	1	2	3	4
5. I engage in acts of caring and good will without expecting something in return.	1	2	3	4
6. I feel sorrow for those who are suffering and try to help them through difficult times.	1	2	3	4
7. I feel confident that I have touched the lives of others in a positive way.	1	2	3	4
8. I work for peace in my interpersonal relationships, in my community, and in the world at large.	1	2	3	4
9. I am content with who I am.	1	2	3	4
10. I go for the gusto (enjoyment) and experience life to the fullest.	1	2	3	4
Intellectual Health				
1. I tend to act impulsively without thinking about the consequences.	1	2	3	4
2. I learn from my mistakes and try to act differently the next time.	1	2	3	4

	Rarely, if Ever	Sometimes	Most of the Time	Always
3. I follow directions or recommended guidelines and act in ways likely to keep others and myself safe.	1	2	3	4
4. I consider the alternatives before making decisions.	1	2	3	4
5. I am alert and ready to respond to life's challenges in ways that reflect thought and sound judgment.	1	2	3	4
6. I tend to let my emotions get the better of me and I act without thinking.	1	2	3	4
7. I actively try to learn all I reasonably can about an issue before making decisions.	1	2	3	4
8. I manage my time well, rather than time managing me.	1	2	3	4
9. My friends and family trust my judgment.	1	2	3	4
10. I think about my self-talk (the things I tell myself) and then examine the real evidence for my perceptions and feelings.	1	2	3	4

Thank you for your time and your cooperation ☺!!!

Appendix J

Demographic Questionnaire (Arabic Version)

إستمارة رقم : .....

إختبار تقييمي

معلومات ديموغرافية

الرجاء إختر الجواب المناسب أو أكتبه في الفراغ المخصّص له.

1) **الجنس:** ذكر □ أنثى □

2) **الوضع الإجتماعي:** عازب □ متزوج □ مطلّق □ أرمل □

3) **السن:** .....

4) **أعلى شهادة علمية حصلت عليها:**(بروفيه، بكالوريا،إجازة جامعية، ماجيستير، دكتوراه، شهادة مهنية، إلخ).....

5) **أعلى شهادة علمية حصل عليها زوجك/زوجتك:**.....

6) **وضعك المهني:**

تعمل □ بدوام كامل □ بدوام جزئي □

لا تعمل □ متقاعد □

أ) إن كنت تعمل، الرجاء تحديد طبيعة العمل:(موظف، عمل حر،إلخ...).....

ب) راتبك الشهري بالدولار الأميركي: أقل من 500 □ بين 500 و 1000 □

بين 1000 و 5000 □ أكثر من 5000 □

7) **الوضع المهني لشريكك:**

يعمل □ بدوام كامل □ بدوام جزئي □

لا يعمل □ متقاعد □

أ) إن كان يعمل، الرجاء تحديد طبيعة العمل:(موظف، عمل حر،إلخ...).....

ب) راتبه الشهري بالدولار الأميركي: أقل من 500 □ بين 500 و 1000 □

بين 1000 و 5000 □ أكثر من 5000 □

8) الرجاء تحديد عدد الأطفال ذوي الحاجات الخاصة أو ذوي الصعوبات التعليمية، سنّهم و جنسهم في الجدول التالي

عدد الأطفال وفقاً لتدرّج أعمارهم	السن	الجنس (ذكر أو أنثى)	**نوع الحاجات الخاصة أو الصعوبات التعليمية** *Attention Deficit Hyperactivity Disorder, Mental Retardation, Autism, Asperger, Pervasive Developmental Disorder, Learning Disabilities (i.e. Communication Disorders, Expressive Language Disorder, Stuttering, Reading Disorders), No Disability. If others, please*
الطفل رقم 1			
الطفل رقم 2			
الطفل رقم 3			
الطفل رقم 4			
الطفل رقم 5			

* إذا كان لديك أكثر من خمسة أطفال، الرجاء تحديد سنهم، جنسهم ونوع **الحاجات الخاصة أو الصعوبات التعليمية** (إن وجدت)

.....

9) **التكاليف أو النفقات الشهرية (بالدولار الأميركي) للطفل ذو الحاجات الخاصة أو ذو الصعوبات التعليمية:**

أقل من 100 □ بين 100 و 500 □ بين 500 و 1000 □ بين 1000 و 5000□ أكثر من 5000 □

Appendix K

Family Crisis Oriented Personal Evaluation Scale (F-COPES) (Arabic Version)

F-COPES Questionnaire

الهدف من هذا الاختبار هو تحديد كيفية حل مشاكل العائلات في تصرفاتهم وسلوكياتهم في حال وجود أولاد ذوي الحاجات الخاصة أو الصعوبات التعليمية في العائلة.

إرشادات:

أولاً، إقرأ لائحة الأسئلة وخياراتها مرة واحدة.

ثانياً، قرّر إلى أي مدى يصف كل بيان سلوكياتك وتصرفك في الرد على المشاكل أوالصعوبات. إذا كان البيان يصف ردك بشكل جيد، عندها ضع دائرة حول الرقم 5 كدليل على أنك موافق بشدة، إذا كان البيان لا يصف ردك إطلاقاً ، عندها ضع دائرة على الرقم 1 كدليل على أنك لا توافق قطعاً، إذا كان البيان يعكس ردك إلى حد معين ، عندها اختر الرقم 2 ، 3، أو 4 لتحديد إلى أي مدى انت توافق او لا توافق مع هذا البيان فيما يتعلق بردك.

الرجاء ضع دائرة حول الرقم (1-2-3-4- أو 5) الذي يتطابق مع ردك على البيان . شكراً.

1= لا اوافق قطعاً

2= لا أوافق نوعا ما

3= لست موافقاً ولا غير موافق

4= أوافق نوعاً ما

5= أوافق بشدة

حين نواجه مشاكل وصعوبات ضمن العائلة نتصرف على الشكل التالي:

1. مشاركة صعوباتنا مع الأقارب.	1	2	3	4	5
2. طلب التشجيع والدعم من الأصدقاء .	1	2	3	4	5
3. معرفة أن لدينا القدرة على حل المشاكل الكبرى.	1	2	3	4	5
4. البحث عن معلومة أو نصيحة من أشخاص في عائلات أخرى، واجهوا ذات المشكلة أو مشكلة أخرى مشابهة لها.	1	2	3	4	5
5. طلب النصيحة من الأقارب (الجد أو الجدة،....)	1	2	3	4	5
6. طلب الإعانة من مؤسسات إجتماعية أوبرامج مصممة خصيصاً لمساعدة العائلات في مواجهة هذه الصعوبات.	1	2	3	4	5
7. معرفة أننا لدينا القدرة اللازمة لمعالجة هذه المشاكل ضمن العائلة.	1	2	3	4	5
8. تلقي هدايا أو خدمات من قبل الجيران(كاستلام البريد أو...)	1	2	3	4	5
9. البحث عن معلومات و نصيحة من طبيب العائلة.	1	2	3	4	5
10. الطلب من الجيران مساعدة أو عون .	1	2	3	4	5
11. مواجهة المشاكل وجهاً لوجه ومحاولة إيجاد الحل السريع لها.	1	2	3	4	5

12. مشاهدة التلفزيون.	1	2	3	4	5
13. الظهور بأننا أقوياء.	1	2	3	4	5
14. حضور الشعائر الدينية.	1	2	3	4	5
15. تقبل الأحداث الضاغطة على أنها من واقع الحياة.	1	2	3	4	5
16. تقاسم الهموم مع أصدقاء مقربين قادرين على حل المشاكل العائلية.	1	2	3	4	5
17. معرفة أن الحظ يلعب دوراً كبيراً في مدى مقدرتنا على حل المشاكل العائلية.	1	2	3	4	5
18. ممارسة الرياضة مع الأصدقاء للمحافظة على اللياقة الجسدية والتخفيف من حدّة التوتر.	1	2	3	4	5
19. القبول بأن الصعوبات تحدث بشكل غير متوقع.	1	2	3	4	5
20. القيام ببعض النشاطات مع الأقارب (اللقاءات، العشاوات،إلخ...)	1	2	3	4	5
21. البحث عن المشورة المهنية والمساعدة للعائلة.	1	2	3	4	5
22. الاعتقاد بأننا يمكننا التعامل مع مشاكلنا الخاصة.	1	2	3	4	5
23. المشاركة في نشاطات دينية أو روحية.	1	2	3	4	5
24. تحديد المشكلة العائلية بطريقة أكثر إيجابية لكي لا نشعر بخيبة أمل.	1	2	3	4	5
25. سؤال الأقارب كيف يشعرون حيال المشاكل التي نواجهها.	1	2	3	4	5
26. الشعور أنه بغض النظر عمّا نقوم به للتحضّر، سيكون لدينا مشاكل في التعامل مع الصعوبات.	1	2	3	4	5
27. طلب المشورة من كاهن أو من زعيم روحي.	1	2	3	4	5
28. الإعتقاد بأنه إذا انتظرنا طويلاً بما فيه الكفاية، فإن المشكلة سوف تختفي.	1	2	3	4	5
29. تقاسم المشاكل مع الجيران .	1	2	3	4	5
30. وجود الإيمان بالله أو بقوة عليا.	1	2	3	4	5

بشكل عام، ما الوسيلة التي كانت أكثر إفادة لك في تعاطيك مع **الحاجات الخاصة أو الصعوبات التعليمية** لطفلك ؟

(الحصول على الدعم الروحي، الحفاظ على موقف إيجابي، العائلة، الأصدقاء، الموارد المجتمعية، إلخ...)؟

.....

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Appendix L

Wellbeing Assessment Too (Arabic Version)

تقييم الصحة النفسية

الغرض من هذا الفحص هو التعرّف الصحة الجسدية، الإجتماعية، العاطفية، الروحية والفكرية للعائلات التي لديها أطفال ذوي الحاجات الخاصة أو ذوي الصعوبات التعليمية.

الرجاء وضع دائرة حول الرقم (1-2-3- أو 4) لتتوافق الإجابة مع كل حالة.

الصحة البدنية	نادراً ما لم يكن أبداً	أحياناً	معظم الأوقات	دائماً
1- أحافظ على الوزن المرغوب فيه.	1	2	3	4
2- أواظب على التمارين القوية كالمشي السريع.	1	2	3	4
3- أمارس بعض التدريبات الخاصة بتقوية العضلات والمفاصل.	1	2	3	4
4- أقوم بتحمئة وتبريد جسدي بواسطة التمديدات الجسدية قبل وبعد التمارين الرياضية القوية.	1	2	3	4
5- أشعر بالرضى عن حالة جسدي.	1	2	3	4
6- أحصل على سبع الى ثمان ساعات من النوم كل ليلة.	1	2	3	4
7- جهاز المناعة عندي قوي، وأنا قادر على تجنب معظم الأمراض المعدية.	1	2	3	4
8- جسدي يشفي نفسه بسرعة حين أمرض أو أتعرّض لإصابة.	1	2	3	4
9- لدي الكثير من الطاقة ويمكن أن أمضي نهاري من دون أن أكون مرهقاً للغاية.	1	2	3	4
10- أستمع إلى نداء جسمي، وعندما يكون هنالك أمراً على غير ما يرام أطلب المشورة المهنية.	1	2	3	4

الصحة الإجتماعية	نادراً ما لم يكن أبداً	أحياناً	معظم الأوقات	دائماً
1- حين أقابل الناس أشعر بالرضى عن الإنطباع الذي أتركه لديهم.	1	2	3	4
2- أنا منفتح، نزيه، وأتفق جيداً مع الناس.	1	2	3	4
3- أشارك في مجموعة واسعة من الأنشطة الإجتماعية، وأستمتع بالتواجد مع اشخاص مختلفين عني.	1	2	3	4
4- أحاول أن أكون " شخصاً أفضل" وأعمل على السلوكيات التي تسببت لي بمشاكل في تفاعلي مع الآخرين.	1	2	3	4

5- أتفق جيداً مع أفراد أسرتي.	1	2	3	4
6- أنا مستمع جيّد.	1	2	3	4
7- أنا منفتح ويمكنني الوصول إلى علاقة مُحبّة ومسؤولية.	1	2	3	4
8- لديّ أحدٌ ما أستطيع التحدث معه عن مشاعري الخاصة.	1	2	3	4
9- أراعي مشاعر الآخرين ولا أتصرف بطرق مؤذية أو أنانية.	1	2	3	4
10- أتنبّه إلى ما سأقوله وكيف قد يُفهم من قبل الآخرين قبل أن أنطق به.	1	2	3	4

الصحة العاطفية	نادراً ما لم يكن أبداً	أحياناً	معظم الأوقات	دائماً
1- من السهل عليّ أن أضحك على بعض الأمور التي تحصل في حياتي.	1	2	3	4
2- أتجنب استعمال الكحول كوسيلة تساعدني على نسيان مشاكلي.	1	2	3	4
3- أستطيع أن أعبّر عن مشاعري من دون أن أشعر بأنني سخيف.	1	2	3	4
4- عندما أكون غاضباً، أحاول أن أدع الآخرين يعرفون ذلك بطرق غير تصادمية و مؤذية.	1	2	3	4
5- أنا شخص أعاني من قلق مزمن.	1	2	3	4
6- إنني أدرك عندما أكون مضغوطاً، فأقوم بخطوات للإسترخاء عن طريق التمارين الرياضية أو اللجوء إلى الوقت الهادئ أو غيرها من الأنشطة.	1	2	3	4
7- أشعر بالرضا عن نفسي وأعتقد أن الآخرين يحبونني لما أنا عليه.	1	2	3	4
8- عندما أشعر بالضيق، أتحدث إلى الآخرين وأحاول العمل جاهداً العمل على حل مشاكلي.	1	2	3	4
9- أنا مرن وأتأقلم أو أتكيف مع التغيير بطريقة إيجابية.	1	2	3	4
10- أصدقائي ينظرون لي كشخص مستقر ومتزن عاطفياً.	1	2	3	4

الصحة الروحية	نادراً ما لم يكن أبداً	أحياناً	معظم الأوقات	دائماً
1- أعتقد أن الحياة هي هدية ثمينة ينبغي أن نرعاها.	1	2	3	4
2- أكرّس وقتاً للإستمتاع بالطبيعة وبالجمال الذي يحيط بي.	1	2	3	4
3- أمضي وقتاً لوحدي أفكّر بما هو الشيء المهم في الحياة- من أنا، ما أقدّره، أين هو مكاني المناسب وإلى أين سأذهب.	1	2	3	4

4- أؤمن بأهمية الأشياء التي تتخطى حدود نفسي.	1	2	3	4
5- أنخرط في رعاية الآخرين بطيبة خاطر من دون أن أتوقع شيئاً في المقابل.	1	2	3	4
6- أشعر بالحزن تجاه الأشخاص الذين يتعذبون وأحاول مساعدتهم في أوقاتهم الصعبة.	1	2	3	4
7- أنا واثق من أنني لمست حياة الآخرين بطريقة إيجابية.	1	2	3	4
8- أنا أعمل من أجل السلام في علاقاتي الشخصية، في مجتمعي وفي العالم بأسره.	1	2	3	4
9- أنا راضٍ عن نفسي.	1	2	3	4
10- أميل إلى الاستمتاع واختبار الحياة إلى أقصى حد.	1	2	3	4

الصحة الفكرية	نادراً إن لم يكن أبداً	أحياناً	معظم الأوقات	دائماً
1- أميل إلى التصرف باندفاع من دون أن أفكر بالعواقب.	1	2	3	4
2- أتعلّم من أخطائي وأحاول التصرف بطريقة مختلفة في المرّة القادمة.	1	2	3	4
3- أتّبع الإرشادات والتوجيهات الموصى بها وأتصرّف بطريقة تؤمّن سلامتي وسلامة الآخرين.	1	2	3	4
4- أنظر في الخيارات قبل اتخاذ القرارات.	1	2	3	4
5- أنا في حالة تيقظ واستعداد للرد على تحديات الحياة بطرق تعكس تفكيراً صائباً وحسن تقدير.	1	2	3	4
6- أميل إلى ترك مشاعري تأخذ أفضل ما لدي وأتصرّف من دون تفكير.	1	2	3	4
7- أحاول بكل نشاط أن أتعلم كل ما يمكنني القيام به حول موضوع معين قبل اتخاذ القرارات.	1	2	3	4
8- أدير وقتي بشكل جيد، بدلاً من أن يديرني هو.	1	2	3	4
9- أصدقائي وعائلتي يثقون بتقديراتي .	1	2	3	4
10- أفكر بما يخالجني من أفكار(الأمور التي أقولها لنفسي) وبعدها أتفحص الدلائل التي أبني عليها رؤيتي للأمور وشعوري بها.	1	2	3	4

شكراً لوقتكم وتعاونكم.