

**UNIVERSITY OF KWAZULU-NATAL**  
**SCHOOL OF NURSING AND PUBLIC HEALTH**

**Coping Strategies of Parents with Physically Disabled Children at Disabled Schools in Plateau  
State: A Descriptive Study**

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Nursing)

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## **PREFACE**

From the available literature on the present study, most of the previous related studies focused on exploring the coping strategies utilised by families with a disabled child, rather than describing the effective utilisation of a given strategy for coping with such challenges. Hence, this study seeks to describe the coping strategies adopted by the parents of disabled children. In addition, no research has been conducted on the coping strategies utilised by parents of disabled children from the northern part of the country of Nigeria where the study was conducted.

For the literature review of this study, both old and new references were used because many have studied the area of children with physical disabilities, therefore it is good to look in to both past and resent studies.

## DECLARATION

I, Shilni Jacob Liberty, declare that this dissertation “Coping Strategies of Parents with Physically Disabled Children at Disabled Schools in Plateau State: A Descriptive Study” is my own unaided work. The dissertation has been submitted for the award of a Master’s degree in Community Health Nursing Science at the University of KwaZulu-Natal, Durban.

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## **DEDICATION**

To my husband

## **ACKNOWLEDGEMENTS**

Thank you, God; you are faithful, merciful and gracious.

This dissertation has been one of the most significant academic experiences I have ever had. I am indebted to the following people who contributed to this long journey, and extend my sincere gratitude to the following:

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## ACRYONYMS

UKZN: University of KwaZulu-Natal

PTA: Parent Teacher Association

F-COPES: Family Crisis Orientation Personal Evaluation Scale

ADA: American with Disability Act

CRC: Convention on the Rights of the Child

CRPD: Convention on the Rights of Persons with Disabilities

IHR: International Human Rights

SPSS: Statistical Package for Social Science

ACPF: Respondents in the African Child Policy Forum

## **ABSTRACT**

### **Introduction**

Parenting is no longer accepted merely as an interpersonal bond characterised by love and care. Instead, it has been reframed as a job that must be done well with some level of competence. Parents face different kinds of stress raising a typical child without disabilities. Parents of disabled children cope with the same responsibilities and pressures that other parents face, though with additional stress as reported by some parents. There is therefore a need to devise some workable strategies for such parents concerning how best to cope with the pressures of raising a disabled child.

### **Aim**

This study aimed at describing the coping strategies utilised by parents with a physically disabled child in some selected schools for children with disabilities in Plateau State, Nigeria.

### **Methodology**

A quantitative, non-experimental descriptive design was adopted for this study. A total of 54 parents of children with physical disabilities participated in the study. Data collection was facilitated using the Family Crisis Orientation Personal Evaluation Scale (F-COPES) developed by McCubbin, Olson and Larsen (1981). Data was organised using SPSS, Version 24.0 and was analysed through descriptive statistics. Validity and reliability were tested thus: the research instrument was given to the research supervisor and UKZN statistician for face validity to ensure that study variables were captured and are relevant to measure the constructs. Similarly, a pilot study was undertaken using the research instrument (F-COPES) on 10 volunteer parents with physically disabled children who were not included in the research respondents, to establish validity of the instrument components. To observe ethical consideration, respect to human dignity was upheld by obtaining the informed consent of the respondents. Likewise, for confidentiality and anonymity purpose, neither the participants' names nor any form of identification were used in the data analysis to ensure privacy. The hard and soft copy of the analysed data was protected from the public; only the researcher and research supervisor have access to it.

### **Results**

The descriptive statistics for the sub-scales showed that the most commonly used coping strategy was the social support coping strategy ( $M = 3.87$ ,  $SD = 0.53$ ). The second-ranked coping strategy used by parents was reframing ( $M = 3.43$ ,  $SD = 0.80$ ). The third-ranked coping strategy was mobilising family members to seek and accept help ( $M=3.29$ ,  $SD = 0.73$ ). This was followed by passive appraisal ( $M = 3.11$ ,  $SD = 0.76$ ), and lastly the spiritual coping strategy ( $M = 3.01$ ,  $SD = 0.77$ ).

### **Conclusion**

The results of this study confirmed that there were significant relationships between gender, number of parents in a household, religion and coping strategies (reframing, passive appraisal and acquiring social support). Since the mean usage of acquiring social support coping strategy was higher among parents with a physically disabled child, professionals should encourage parents with children with disabilities to identify and utilise any social coping strategies they may find within their reach, and not to follow the crowd.



## **CHAPTER 1: OVERVIEW**

### **1.1 BACKGROUND TO THE STUDY**

#### **1.1.1 Concept of Parenting**

Parenting is a complicated concept because it is a personal matter that is greatly influenced by so many factors, such as the child, the environment, the culture and the parent. Parenting is no longer accepted merely as an interpersonal bond characterised by love and care. Instead, it has been reframed as a job that must be done well with some level of competence (Gillies, 2008).

According to Storms (2013), Parents are faced with different kinds of stress in raising children, with the everyday tasks of feeding, toileting, travelling and communicating being the most common. Parents with a disabled child cope with the same responsibilities and pressures that other parents face, though with additional stress, as reported by some parents. Raising a young child with a disability, gives a parent a unique set of challenges that impact on their family, including relationships among family members. Most of the literature about parents who have children with disabilities has focused on the mothers. Fathers were reported as being more involved with financial concerns and the traditional provider roles, while the mothers' roles were those of primary caregivers. But as gender roles in the family are becoming increasingly egalitarian, fathers are participating in the daily caregiving tasks of their children (Kwai-Sang Yau & Li-Tsang, 1999).

Single parents face the added stress of assuming the multiple roles of physically, financially and emotionally caring for the child with special needs. Single parents lack emotional support from a spouse, although they may find support from extended friends and family. Older siblings can help take care of the child with special needs and share household responsibilities to reduce stress (Lamb, 2000).

Chu, Farruggia, Sanders and Ralph (2012) and Pritzlaff (2001) outlined the attributes of good parenting to typically include high levels of monitoring and involvement, as well as being warm, accepting and nurturing. Children with disabilities need the same kind of love, support, discipline, and direction as other children; however, caring for a child with a disability may require additional equipment, home modification, time and patience. Pritzlaff (2001) stated that, although children with disabilities may have additional needs, despite their disabilities, they are children first. It is important for every parent to see and treat their children equally.

### **1.1.2 Coping and coping strategies**

Parents develop individual coping strategies that are unique to their family and themselves in parenting a disabled child. Coping involves psychological resources and coping strategies that help to eliminate, modify or manage a stressful event or crisis (Oduburu, 2011; McCubbin & Patterson, 1983). Having a child with a disability creates a crisis event, for which parents have little to no preparation (Rose 1987; Oduburu 2011). How parents respond to the stresses of raising their child with special needs depends on a wide variety of factors influencing their ability to cope, such as their interpretation of the crisis event and the family's sources of support, resources, and family structure. Depending upon which type of strategy is used; one form of coping can be more effective than another (Pritzlaff, 2001; Bailey & Smith, 2000).

### **1.1.3 Prevalence of disability**

With a global population of close to seven billion, estimates suggest that there are approximately one billion people with disabilities in the world today. Children and adolescents constitute 200 million of those with disabilities (about 10 % of the world's youth), and about 80 % of these live in the developing world and experience physical, sensory, intellectual or mental disabilities (United Nations Disability Fact Sheet, 2006, as cited in (Daly, Bray, Bruckauf, Byrne, Margaria, Pecnik, and Samms-Vaughan (2015).

The reported incidence and prevalence of impairment in the population varies significantly from one country to another. Specialists, however, agree on a working approximation giving a minimum benchmark of 2.5 % of children aged 0-14 with self-evident moderate to severe levels of sensory, physical and intellectual impairment. An additional 8 % can be expected to have learning or behavioural difficulties, or both (Daly et. al., 2015).

The Nigerian National Assembly (2013) estimates that there are over 20 million people living with disabilities in the country, 25 % of whom are physically disabled.

### **1.1.4 Definitions of disability**

Disability is difficult to define, because there is no single definition or classification system that is in use. The Americans with Disabilities Act (ADA) (1990) defines disability as "any physical or mental impairment that substantially limits one or more major life activity" (Pitzlaff, 2001; Wellner 1998: 308). Definitions are also influenced by societal and cultural attitudes which create several discrepancies. It is important to note that each type of disability is unique and varies in severity and complications (Fewell, 1986; Pitzlaff, 2001).

Physical disability was defined by the WHO (2000) as a term covering impairment, activity limitations and participation restrictions. When a person has a disability to a part of his or her body which is genetic or results from an injury or hazard in the environment, making him or her unable to perform an activity in a manner or within the range considered normal for a human being of that age, the person is said to be physically disabled. Physically disabled children are those who have problems using their bones, muscles or joints which limit their effectiveness with the academic, social and emotional expectation of the school and community (Okeke, 2000).

### ***1.1.5 Global rights for children with disability***

Stein & Lord (2008) stated that the Convention on Rights of the Child (CRC), adopted in 1989, and the Convention on the Rights of Persons with Disability (CRPD), adopted in 2006 by the International Human Rights (IHR) Network and the African Regional Human Rights Protection (ARHRP) system, apply to the protection of children with disabilities. The Convention contains a specific article recognising and promoting the rights of children with disabilities. Along with the CRC, the Convention on the Rights of Persons with Disabilities (CRPD), adopted by the United Nations General Assembly in December 2006, provides a powerful new impetus to promote the human rights of all children with disabilities.

According to Stein & Lord (2008), the treaties lay out the legal foundation for the rights of children with disabilities where they all embrace a perspective that understands human rights as endowing individuals with rights and responsibilities. According to them, the CRPD highlighted eight principles, among which three are specific to disabled children. These include:

- Non-discrimination
- Respect for the evolving capacities of children with disabilities
- Respect for the right of children with disabilities to preserve their identities

Though it has been observed that, despite the almost universal ratification of the CRC, and the social and political mobilisation that led to adoption of the CRPD, disabled children and their families continue to be confronted with daily challenges that compromise the enjoyment of their rights.

### **1.1.6 International **perspectives** and rights of children with disability**

#### ***1.1.6.1 Disability in America***

In American society, lack of knowledge, education and adequate exposure to people with disabilities prohibits people from making decisions that could bridge the gap between disabled and non-disabled people (Nickson, 2001).

According to Carrie & Lauron (2012), in spite of the efforts of the Americans with Disability Act (ADA) and various activist groups, discrimination, prejudice and stereotyping of people with disabilities is still very much present in the American society. They noted that in 2010, Kessler Foundation/NOD Surveys of Americans with Disabilities, 61 % of Americans with disabilities stated that the passing of the ADA had no effect on their lives, and nearly half of the respondents with somewhat severe disabilities reported others reacting negatively to them.

For example, the ADA allows exceptions to provide appropriate public accommodation if it is too difficult for the owner of the facility to alter the building, and the level of difficulty is left largely open to interpretation (Karger & Rose, 2010). In 1990, a taxi service refused to allow guide-dogs in their taxis, which prevented the access by an individual with visual impairment to the use of this form of public transportation (Carrie & Lauron 2012).

Also, in a national survey, only 21 % of people with disabilities reported being employed, compared to 59 % of people without a disability. Additionally, of those disabled persons who are employed, nearly one third are living below the poverty line (Daly et. al., 2015).

In America, the Americans with Disabilities Act (ADA) (1990) is the main body that regulates the rights of disabled people. The ADA was originally enacted in public law format and was later rearranged and published in the United States Code. Below is the current text of the Americans with Disabilities Act of 1990 (ADA), that is peculiar to children with disability, including changes made by the ADA Amendments Act of 2008 which became effective on January 1, 2009 (ADA, 2009).

- Equal opportunities for individuals with disabilities in employment and public services
- Prohibition against discrimination and other generally applicable provisions
- Public transportation other than by aircraft or certain rail operations
- Public accommodation and services operated by private entities
- Closed-captioning of public service announcements

### ***1.1.6.2 Disability in South Africa***

Disability in South Africa is surrounded by stigma and prejudice. Parents of disabled children often experience ostracism within their communities, and the birth of a disabled child doubles the likelihood of abandonment (Gerison, 2002; Howell, 1996). According to Gerison (2002), the negative attitudes about children with disabilities within communities are reinforced at the household level. Parents themselves often contribute to these children becoming invisible, virtually hidden from society.

In South Africa, significant progress is being made to promote the rights of children with disabilities. *The Law Commission Review of the Child Care Act 1983* recognises the importance of empowering parents to care for their children at home. This requires improved health care services, accessible schools, free or affordable assistive devices and support programmes for parents. It also stresses the need for a more integrated approach to the delivery of services in order to help parents navigate their way through the system more efficiently and receive more coherent and effective provision (Gerison, 2002).

In 1994, the South African President, Nelson Mandela, pledged a commitment to put children first. The UN Convention on the Rights of the Child was ratified by the South African Government in 1995. In so doing, the Government made commitments under international law to recognise disability as grounds for protection against discrimination (Article 2) and to promote the fullest possible social integration of disabled children (Article 23) (Daly et. al., 2015).

Stein and Lord (2008) states that the Bill of Rights in the 1996 Constitution guarantees fundamental rights to all citizens. It includes an equality clause and the right to freedom from discrimination based on several criteria including disability. In addition, the Bill of Rights guarantees that “a child’s best interests are of paramount importance in every matter concerning the child”. The Promotion of Equality and Prevention of Unfair Discrimination (Article 2), 1999, translates the principle of equality into legislation, stressing, for example, the right to education and to supporting and enabling facilities such as Braille, sign language and hearing aids. Social integration (Article 23) also places disability alongside gender and race as requiring explicit attention to overcome discrimination.

### ***1.1.6.3 Disability in Nigeria***

In the past, individuals with disabilities were considered liabilities, suffered inhumane treatment and were often institutionalised and kept away from society (Fewell, 1986; Akhindenor, 2010). A recent study by Omoniyi (2014) points out that prejudice against disabled people is almost universal in Nigeria and affects the social, economic, educational, mental and psychological well-being of such people. People with physical disabilities in Nigeria have a heavy psychological burden due to social deprivations coupled with their struggle for economic survival (Okafor, 2003). In certain communities in Nigeria, traditional attitudes are also negative towards disabled children since they are not even considered an acceptable gift to the gods. They are seen as “a taboo”, an embarrassing spectacle and a disgrace to their families (Omoniyi, 2014).

During the Federal Military Government in Nigeria in 1993, the government passed decrees regarding people with disabilities. The purpose was to provide a clear and comprehensive legal protection and security

for Nigerians with disability, as well as to establish standards for the enforcement of the rights and privileges guaranteed under these decrees and other laws applicable to disabled people in the Federal Republic of Nigeria (Nigerians With Disability Decree, 1993).

The rights of disabled people include:

- Free medical/health services and tax-free purchase of health materials
- Free education at all levels in the government schools and vocational training
- Right to vocational rehabilitation and employment
- Subsidised housing
- Accessibility to facilities in terms of mobility
- Free accessible transportation by bus, rail or other conveyance other than air travel that serves the general public's needs
- Supportive auxiliary social services
- Sport and recreational services
- Telecommunication facilities which include television programmes with Braille, special telephone devices for the hearing-impaired and free postal services for medical materials purchased
- Right to legal services
- Right to vote

Base on the above background, the study was focused on describing coping strategies of Parents with physically disabled children in Plateau state, Nigeria.

## **1.1 PROBLEM STATEMENT**

According to the United Nations, as of 2004, there were about 32 million disabled adults age 18 and above, in addition to 5 million children and youths under age 18 in the world. Nigeria has an estimated population of over 162 million as of July 2011, of which about 20 million are disabled and 25% are physically. Unfortunately, there is currently little or no commitment from the government and non-governmental organisations (NGOs) towards assisting parents of the disabled children with workable coping strategies on how to manage the stress of parenting their disabled children. This could be owing to unavailability of viable information and organised coping guides with a view to address the challenge. There is therefore needed to understand the coping strategies utilized by parents with physically disabled children as the findings could assist organisations (government and NGOs) with information with which they could develop policies, provide aids to affected families and counselling guides for parents and individuals.

In addition, since the parents of the disabled children constitute a significant part of workforce in the society, neglecting them to their fate could pose a setback to national development as their occupational, social and professional productivity may be negatively affected. They need to be provided with means of coping with their disabled children to minimise stress and enhance productivity.

It is on this premise that the researcher was prompted to investigate the coping strategies of parents with physically disabled children at disabled schools in Plateau state, Nigeria.

### **1.3 RESEARCH QUESTIONS**

The research questions for the study were:

- What are the demographic data of parents with a physically disabled child?
- What are the coping strategies used by parents with a physically disabled child?
- What is the relationship and between demographic data and the different coping strategies of parents with disabled child?

### **1.3 PURPOSE OF THE STUDY**

To describe the coping strategies of parents with physically disabled children at disabled schools in Plateau state, Nigeria.

### **1.4 OBJECTIVES**

The objectives of the study were:

- To identify and describe the demographic data of the parents with a physically disabled child.
- To investigate coping strategies utilised by parents with a physically disabled child.
- To describe the relationship of the different coping strategies and the demographic data of parents with disabled child.

### **1.5 DEFINITION OF TERMS**

#### **1.5.1 Coping strategies**

Coping strategies refer to what family members actually do, think and feel about the coping resources available to them (Burr, Klein, Burr & Doxey, 2000; Oduburu, 2011). In this study, coping strategies are defined as the thoughts, feelings, beliefs, actions and plans that help parents to adapt and manage their particular problem.

### **1.5.2 Coping**

Oduburu, (2011) defined coping as utilising psychological resources and strategies that help to eliminate, modify or manage a stressful event or crisis. In this study, coping is defined as the act of adjusting to a stressful situation by modifying environment and seeking help to adapt.

### **1.5.3 Physical disability**

Quinn and Degener (2002) defined physical disability as a condition that exists in diverse forms and has a wide field, including conditions as different as congenital defects of the heart, progressive muscular atrophy, accidental injury and the after-effects of poliomyelitis. In this study, physical disability is defined as impairments in bodily function or structure that limit or make it difficult for the individual to execute a certain task or action, or participate in life activities.

### **1.5.4 Physically disabled children**

Physically disabled children are those who have problems using their bones, muscles or joints, thus limiting their effectiveness within the academic, social and emotional expectations of the school and community (Okeke, 2000). In this study, they are defined as children with difficulty in using bones, muscles and/or joints because of disease, congenital defect or accident, which limits their performance in societal participation.

### **1.5.5 Parent**

A father or mother; one who begets or one who gives birth to or nurtures and raises a child; a relative who play the role of guardian (Advanced English dictionary). In this study, parent is referred to as an individual who takes care of a disabled child either by adoption or birth.

### **1.5.6 Disability**

The condition of being unable to perform as a consequence of physical or mental unfitness (Advanced English dictionary). In this study, disability is referred to the inability of the child to use his or her limb, eyes, and other body part to perform activity of daily living.

## **1.6 SIGNIFICANCE OF THE STUDY**

### **1.6.1 Healthcare providers**

The findings of this study will provide insight into the various coping strategies which will offer nurses and other healthcare providers ideas for counselling and educating their clients.

### **1.6.2 Nurses**

The findings of this study will be of benefit to nurses in evidence-based practice to develop interventions with regard to managing families with disabled children.

### **1.6.3 Healthcare management**

The study will help healthcare administrators/managers in providing initiatives to support parents with disabled children in their organisations, so that they have adequate time for their disabled child, which may serve to motivate staff.

### **1.6.4 Policy-makers**

The study will also provide information and serve as a guide and resource for policy-makers to develop policies which will benefit such parents.

## **1.7 RESEARCH METHOD**

A quantitative research approach was used for this study. The quantitative research approach is entrenched in a strong academic belief that puts significant and substantial trust in numbers that represent different opinions and/or concepts. As a result, quantitative research can be conducted through emphasising quantification in the collection and analysis of data. According to Polit & Beck (2005), Creswell (1994) has given a very concise definition of quantitative research as a type of research that explains phenomena by collecting numerical data that is analysed using mathematically-based methods (in particular, statistics). Quantitative research approach was utilised in this study to collect numeric data for the generation of new knowledge using an objective instrument. The present study exploited the number of respondents to describe coping strategies utilize by parents with physically disabled child.

## **1.8 RESEARCH DESIGN**

A descriptive research design was adopted for this study. Oduburu (2011) and Nworgu (1999) stated that a descriptive design is necessary in a situation where the researcher aims at collecting data and describing in a systematic manner the characteristic features or facts about a given population.

A descriptive research design is used to describe the phenomena of this study. The descriptive design lends itself to this study as it provides information on the subject of coping with a disabled child which has not been well addressed in terms of parent utilisation of coping strategies in Nigeria.

## **1.9 VALIDITY AND RELIABILITY OF INSTRUMENT**

The ability to critique quantitative research is an important skill for nurses. Consideration must be given, not only to the results of the study, but also to the rigour of the research. Rigour refers to the extent to which the researchers worked to enhance the quality of the studies. In quantitative research, this is achieved through measurement of the validity and reliability (Pritzlaff, 2001). It is important to consider the validity and reliability of the data collection tools (instruments) when either conducting or critiquing research.

The literature reveals that F-COPES has undergone several validity tests and that the results were good (McCubbin et al., 2000). F-COPES was initially tested on a sample population of 2740 husbands, wives and adolescents who were graduate and undergraduate students. The sample population was split into two halves (Samples 1 and 2) and the researchers used factor analysis to come up with the five subscales. Cronbach's alpha was computed for each subscale, resulting in an overall alpha reliability of .86 for the first half and .87 for the second half (McCubbin et al., 2000). F-COPES has been shown to have high construct validity and reliability (McCubbin et al., 2000).

### **1.9.1 Content validity**

This category looks at whether the instrument adequately covers all the content that it should with respect to the variable (Pritzlaff, 2001). According to the researcher, a subset of content validity is face validity, where experts are asked their opinion about whether an instrument is used to measure the concept intended. In view of this, the research instrument was given to the research supervisor and an official statistician at the School of Nursing and Public Health, UKZN, to confirm face validity, and to ensure that all the study variables are captured and are relevant to measure all the constructs.

### **1.9.2 Construct validity**

Construct validity refers to whether inferences can be drawn about test scores related to the concept being studied (Pritzlaff, 2001). A pilot study was conducted on 10 volunteer parents with a physically disabled child, to establish the content validity of the instrument components after face validity had been approved.

The quality of evidence in a quantitative study is ensured through the maintenance of reliability, and validity refers to the precision and stability of the data collection instrument in its ability to measure the variable or concept of the study (Polit & Beck, 2005). In this study, the F-COPES Likert-scale questionnaire was assessed for internal consistency using the Statistical Package for Social Science (SPSS) Version 24. To determine Cronbach's alpha, a Cronbach alpha coefficient alpha 0.5 was attained for the data collection instrument.

### **1.9.3 Threats to validity**

Threat to internal and external validity was described by Creswell (2009) as the attributes of the participant that may affect the collection of appropriate information from the study population that will help in addressing the study phenomenon. The perceived threat to validity in this study was selection of subjects, and evaluation anxiety.

#### ***1.9.3.1 Threats to Selection of subjects***

This is the biases which may result in selection of comparison groups. Randomization (Random assignment) of group membership is a counter-attack against this threat (Heale and Twycross 2015). The subjects of this study were randomly selected and the same questions were given to answer with the same inclusion criteria apply to all subjects from all the population.

#### ***1.9.3.2 Threat to evaluation anxiety***

The perceived threat to external validity was the evaluation anxiety. Anxiety experienced when one's behavior or accomplishments are being evaluated (Heale and Twycross 2015). This was counter-attacked by using the school meeting where the entire respondents were comfortable with the people around them because they had something in common-the physically disabled child and also use simple English language in the questionnaire.

### **1.9.4 Reliability**

Reliability is the consistency with which instrument measures the attribute (Polit & Beck 2010). A reliable measuring instrument should provide the same results over time, with a minimum error component (Polit

and Beck 2004). In the study, questionnaire was pre-tested (pilot study) to check for understanding by respondents, to ensure reliability. This was carried out on ten respondents possessing the same characteristics as the main study sample.

## **1.10 THEORETICAL FRAMEWORK**

Theoretical framework is the structure that can hold or support a theory of a research study. Theories summarise a body of data; they provide an organised, coherent picture of some part of nature or some aspect of human behaviour (Rose, 2009). While many biological and system theories exist, only one of these theories will be discussed in relation to adaptation and coping: Roy's Adaptation theory.

### **1.10.1 Roy's Adaptation theory**

The theoretical framework underpinning this study has been developed from the reviewed literature and was adapted from the Adaptation theory developed by Roy (1980). The philosophical assumptions are rooted in the general principles of humanism, in what Roy has termed "veritativity and cosmic unity". The cosmic unity stressed in Roy's vision for the future emphasises the principle that people and the earth have common patterns and integral relationships. Rather than the system acting to maintain itself, the emphasis shifts to the purposefulness of human existence in a universe that is creative (Roy & Andrew, 1999; Howard, 2003).

Roy's theory views humans, both individually, and in groups, as holistic adaptive systems, with coping processes acting to maintain adaptation and to promote personal and environmental transformations (Howard, 2003). By implication, a person is a biopsychosocial being who is always in constant interaction with a changing environment. This is based on the premise that an individual respond or adapts to changes or stimuli whether from within the individual or the surrounding environment (Oduburu, 2011).

Per Roy's theory, internal or external stimuli affect people in any or all of these four categories: physiological, self-concept, role function, and interdependence. Processing of the internal and external environment by the coping subsystems will result in human behaviour known as the "adaptive mode". The purpose of nursing is to help people to adapt to stimuli in any of these four categories (Roy, 1980).

The physiological mode involves the maintenance of physical integrity, involving basic human needs such as:

- Nutrition
- Oxygen

- Fluids
- Temperature regulation

The self-concept mode involves the maintenance of psychic integrity, including:

- Perception of one's physical and personal self
- The value of the family and orientation to the family

The role function mode involves the need for social integrity, including:

- Adaptation to role changes in the family

The interdependence mode involves maintaining a balance between the independent and dependent modes in one's relationship with others. Dependent variables include help-seeking and attention-seeking. The interdependence mode includes:

- Mastering obstacles
- Initiative taking
- Interaction of family with neighbours and other community groups, and the support system of the family and significant others.

Below is a diagrammatic presentation of the Roy Adaptation theory

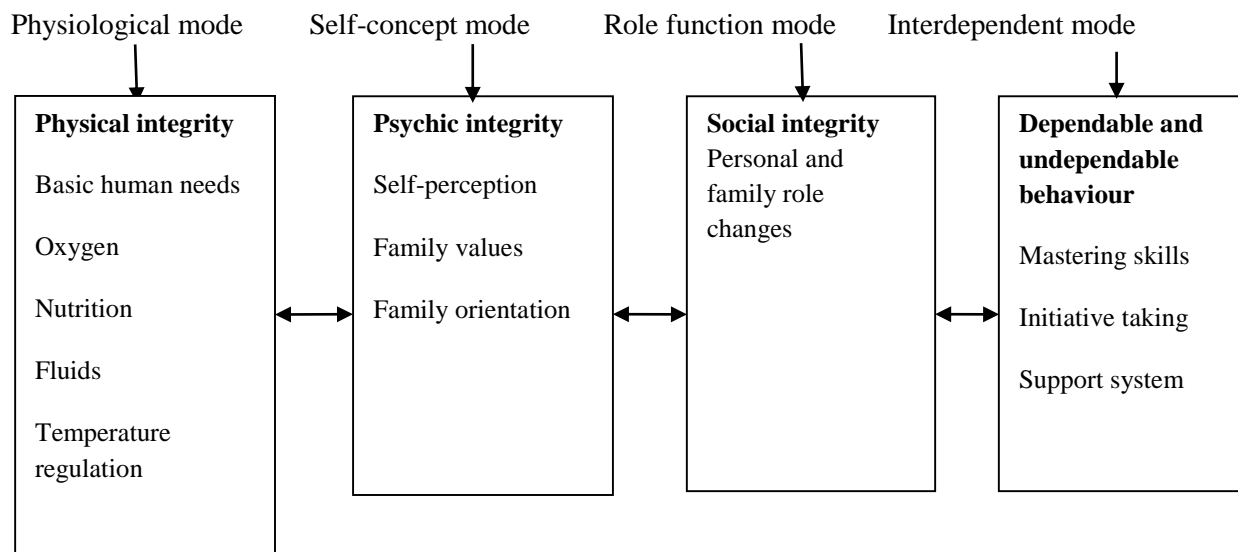


Figure 1: Adaptation model theoretical framework (Roy, 1980)

In conclusion, Roy (1980) suggested that a person is an open, adaptive system who uses coping skills to deal with stressors. To achieve adaptation using her model, she suggests that an assessment process be initiated and a goal statement be made, including the behaviour to be changed and the direction of the change. Also, there should be manipulation of the environment and elements in the client system. Roy's work is based on adaptation and adaptive behaviours which entail altering the environment or situation in order to achieve positive coping.

### 1.10.2 Application to the study

The presence of a physically disabled child in a family brings about stressors to the parents and other family members which could result from either internal or external stimuli. This stressful situation can affect parents in four modes: physiological, self-concept, role function, and interdependence. However, according to Roy (1980), the level of alteration in these four modes depends on a modification of lifestyle.

In the present study, lifestyle includes the following: culture, level of education, spirituality, knowledge and awareness of the condition, financial status and support network. It therefore requires that parents should adjust or adapt to any, or all, of these four modes in order to adapt to the stressor of having a physically disabled child

### 1.11.3 Diagrammatic presentation of Roy's theory as applied to the study

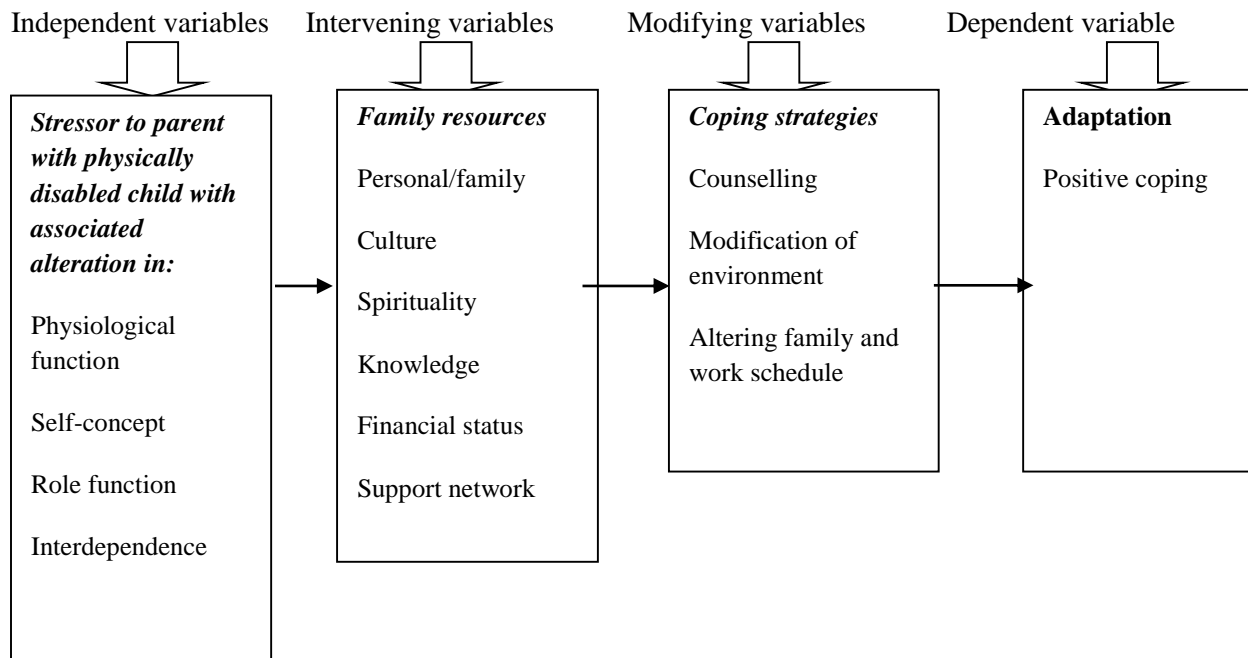


Figure 2: Roy Adaptation theory as it applies to the study (Roy, 1980)

In this study, the independent variable is the stressor to parents with physically disabled children and associated alteration in physiological function, self-concept, role function and interdependence mode. The intervening variable is the personal/family resources, that is, the coping resources which include: culture, spirituality, knowledge, financial status and support networks. Modifying variables are coping strategies including: counselling, modification of environment, and altering family and work schedule and finally, the dependent variable, which is adaptation.

Parents with physically disabled children should be able to assess the situation and make a goal statement signifying their determination to cope with the challenges and the actions to be taken to achieve coping. Such actions include changing the environment in terms of home modification to accommodate the disabled child. Family programmes, and occupational and professional schedules can also be altered, for example, sharing responsibilities among family members to accommodate the child's weaknesses. According to Roy's theory (1980), these changes in behaviour and alteration in the environment will bring about positive coping, which is the dependent variable, but where these modifications are not applied, maladaptive coping will result. of others in the public.

## **1.11 DISSERTATION OUTLINE**

This study is divided into five chapters, covering the following:

### **Chapter 1: Introduction**

This chapter provides an introduction and background to the study. It also presents the problem statement, aim and objectives of the study, research questions, theoretical framework, and operational definition of terms.

### **Chapter 2: Literature review**

This chapter presents reviewed literatures which are organised per themes and presented under the following subheadings: conceptualisation of disability, physical disability, parenting, parenting a child without disability, parenting a disabled child, the role of a partner, sibling and family of the disabled child, coping strategies and coping resources. Empirical studies on coping strategies utilised by parents with disabled children are also discussed.

### **Chapter 3: Research methodology**

This chapter presents the research methodology that was followed in this study. A quantitative research approach was employed, in conjunction with a descriptive research design. An outline of how data was collected and analysed is also presented.

### **Chapter 4: Analysis, interpretation and discussion of data**

This chapter presents quantitative findings which were organised using the SSPS package, Version 24.0, which are presented together with a discussion of the results.

### **Chapter 5: Recommendations, limitations and conclusions**

This chapter presents the discussion and interpretation of research findings, together with recommendations and the limitations of the study.

## **1.12 CONCLUSION**

This chapter introduced the study and highlighted its purpose, objectives and significance. The chapter also defined relevant terms used in the study and explained the theoretical framework underpinning the study, as well as summarising the contents of each chapter. The next chapter (2) will provide the literatures used for the study per topics covered and empirical studies.

## **CHAPTER 2: LITERATURE REVIEW**

### **2.1 INTRODUCTION**

A literature review is an organised written presentation of what has been published on a topic by scholars and includes a presentation of research conducted in the selected field of study (Burns & Grove, 2011; Mdunge, 2012). This chapter presents the review of relevant literatures under the following headings: Conceptual review; Empirical studies; and conclusion.

The review of literature used in this study will provide an overview of

- Disability
- Parenting
- Parenting a physically disabled child
- Coping strategies/resources utilised by families in parenting a disabled child.

An electronic search was conducted at the library of the University of KwaZulu-Natal. EBSCOHOST was utilised, which provided access to the following databases: medical literature analysis and retrieval system online (Medline); Cumulative Index to Nursing and Allied Health (CINAHL); ERIC (nursing and academic edition); Google Scholar and Advanced Google Scholar, and Pub Med.

The following keywords were used in the searches: parenting, disability, physical disability, prevalence of disability, laws and rights of children with disability, adaptation model, coping strategies, coping resources.

### **2.2 DISABILITY**

Disability is difficult to define because there is no single definition or classification system that is used. Americans with Disability Act (ADA) defines disability as “any physical or mental impairment that substantially limit one or more major life activity” (Wellner, 1998: 308). LaPlante, Carlson, Kaye & Bradsher (1996: 2) define a person with disability as “one who is unable to perform his or her major activity or is limited in the amount of activity”.

Definitions are also influenced by societal and cultural attitudes which create several discrepancies. In Africa, children with disabilities and their families face a longstanding history of stigma, discriminations and exclusion from mainstream society. Respondents in the African Child Policy Forum (ACPF) studies across Africa, consistently reported experiencing stigma, prejudice and discrimination (Fewell, 1986).

A study by Omoniyi (2014) points out that prejudice against disabled people is almost universal in Nigeria and affects their social, economic, educational, mental and psychological well-being. People with physical disabilities in Nigeria bear a heavy psychological burden due to social deprivation, coupled with their struggle for economic survival (Okafor, 2003). In certain communities in Nigeria, traditional attitudes are so negative towards disabled children, that they are not even considered an acceptable gift from the gods. Such children are seen as “taboo”, an embarrassing spectacle and a disgrace to their families (Omoniyi, 2014).

Disability in South Africa is still surrounded by stigma and prejudice. Having a disabled child is associated with punishment, curses and failure. Parents of disabled children often experience ostracism within their communities, and the birth of a disabled child doubles the likelihood of abandonment (Howell, 1996).

The most frequently stated causes of disability in some regions of South Africa include: a curse or punishment from God; anger of ancestral spirits; bad omens; reincarnation; heredity; incestuous relationships and the misdemeanors of the mother (Winn and Hay, 2009). These misperceptions not only lead to stigma, but also to a belief that children with disabilities should be demonised and, thus, children may be lashed in an attempt to drive out “evil spirits” causing the disability, or they may be neglected or even killed.

According to Winn and Hay (2009), the negative attitudes about children with disabilities within communities are reinforced at the household level. Parents themselves often contribute to these children becoming invisible and hidden from society. In rural areas, it is common practice for men to leave their wives after the birth of a disabled child. It is the wife who is seen as being to blame for the impairment. Abandonment is not frowned on; indeed, it is largely condoned by local communities. In urban areas, men also leave their wives after a disabled child is born. It seems that men seek to escape the associated pressures of caring for the child, rather than facing the stigma associated with the birth. However, the consequences remain the same for the abandoned child.

## **2.3 PHYSICAL DISABILITY**

Dykens (2000) described physical disability as the lack of ability relative to a personal or group standard or norm, which may involve physical impairment, such as sensory impairment limiting sensory function, or motor impairment limiting mobility. When a person has a disability with a part of his or her body, which is genetic, or results from an injury or hazard in the environment, making him or her unable to perform an activity in a manner, or within the range considered normal for a human being of that age, the person is said to be physically disabled.

The WHO (2000) defines physical disability as a term covering impairment, activity limitations and participation restrictions. Impairment is a problem in body function or structure; activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experienced by an individual in involvement in life situations. Thus, physical disability is a complex phenomenon, reflecting the interaction between features of a person's body and features of the society in which he or she lives.

Demographers agree that world population of individuals with disabilities is very large. In 2004, the WHO estimated a world population of 6.5 billion people, of which nearly 100 million people were estimated to be moderately or severely disabled Stein and Lord (2008). According to the United Nations, as of 2004, there were some 32 million disabled adults (aged 18 and over), plus another 5 million children and youths (under age 18) in the world. In Nigeria, 25 % of the total population are estimated to be physically disabled (Stoneman and Gavidia-Payne, 2006).

It was noted that physical disability comes in diverse forms and has a wide field, including conditions as different as congenital defects of the heart, progressive muscular atrophy, and accidental injury, and the after-effects of poliomyelitis. Okeke (2000) stated that physically disabled children are those who have problems using their bones, muscles or joints which limit the effectiveness with the academic, social and emotional expectations of the school and community. Abba and Aduwo (2007) posited that physically disabled children include those who have a mobility disability, or are physically or emotionally disabled. Therefore, physical disability covers a wide range of disabilities, including deafness and speech disability, blindness, mobility disability, or the malfunctioning of some part of the body which limits the effectiveness with which a child can cope with the academic, social and emotional expectations of the school and community.

## **2.4 PARENTING**

Parenting has been defined by Cojocaru and Cojocaru (2011) as the process of caring for children and helping them to grow and develop. Parenting is a complicated concept because it is seen as a personal matter that is greatly influenced by many factors like the child, the environment, the culture and the parent. Parenting is no longer merely accepted as an interpersonal bond characterised by love and care. Instead, it has been reframed as a job that must be done well with some level of competence (Gillies, 2008).

According to Collins et al. (2000), the quality of parenting that a child receives has a major effect on his/her development. Evidence from behavioural genetics research, as well as from epidemiological, correlation

and experimental studies, indicates that parenting practices have a major influence on children's development, Collins, Maccoby, Steinberg, Hetherington, Bornstein (2000).

Sanders (1999) believed that the lack of a warm, positive relationship with parents; insecure attachment; harsh, inflexible or inconsistent discipline practices; inadequate supervision of and involvement with children; marital conflict and breakdown; and parental psychopathology increase the risk that children will develop major behavioural and emotional problems.

Dekker and Koot (2004) outlined the attributes of good parenting to typically include high levels of monitoring and involvement, as well as being warm, accepting and nurturing. Parents are responsible for protecting their children from physical or psychological harm, as well as protecting them from diseases. Many factors put severe strain on parenting which has restricted parents from performing their parental duties with full attention. Factors such as poverty, societal expectations and focus on careers by parents all affect parenting.

## **2.5 PARENTING A NON-DISABLED CHILD**

Parenting involves providing care, support and love in a way that leads to a child's total development (Hildebrand, 1997; Berger, 2005). Parents are responsible for child's physical needs, while creating a nurturing environment of attention, encouragement, love and meeting the child's physical, mental, emotional and social needs. Parenting is the ability of parents to carry out the responsibilities of raising and relating to a child in such a manner that will prepare the child to realise his or her full potential as a human being. Parenting also entails raising a child in such a way that it increases the chances of the child becoming a capable adult who will live responsibly. It connotes parenting that is supportive, proactive, and responsive and involved (Emerson, 2003).

## **2.6 PARENTING A PHYSICALLY DISABLED CHILD**

According to Storms (2013), raising a young child with a disability presents parents with a unique set of challenges that impact on their family, including relationships among family members. Turnbull et.al. (2007) state that, the family of a child with disability needs supports and services for optimal family functioning. Children with disabilities need the same kind of love, support, discipline and direction as other children; however, caring for a disabled child may require additional equipment, home modification, time and patience. Capper (1996) pointed out that, although children with disabilities may have additional needs, despite their disabilities, they are children first. It is important for every parent to see and treat their children equally.

Parents of children with disability face the same responsibilities and pressures as other parents, though with additional stress, as reported by some parents. The everyday tasks of feeding, toileting, travelling and communicating are much more physically and emotionally demanding for parents with a disabled child (Amber, 1999). Studies have shown that the sense of stress may be associated with the child's characteristics, greater financial and caregiving demands, feelings of being unprepared for the task of parenting, and a sense of loneliness and isolation (Bailey & Simeonsson, 1988). Considering the above demands on the family and parents of the disabled child, it is believed that a working-class parent will have more stress to manage (Amber, 1999).

## **2.7 THE ROLE OF FAMILY MEMBERS**

The quality of family relationships has been found to impact on various aspects of parent well-being and child development (Gupta et al., 2013). Aspects of the family environment, family cohesion in particular, has been predictive of parental stress. The relational aspects of the family environment include the connectedness, expressiveness and degree of conflict among members of the family unit (Cancian and Reed, 2009).

Perceptions of a more positive family climate are expected to predict lower levels of stress among parents with a physically disabled child. Most of the literature about parents who have children with disabilities has focused on mothers. Fathers were reported as being more involved with the financial concerns and the traditional provider role, while the mothers' roles were those of primary caregivers. However, as gender roles in the family are becoming increasingly egalitarian in our society, fathers are participating in the daily caregiving tasks of their children to a greater extent (Kazak & Marvin, 1984; Kwai-Sang Yau & Li-Tsang, 1999; Lamb, 2000).

Single parents face the added stress of assuming the multiple roles of physically, financially and emotionally caring for the child with special needs. Single parents lack the emotional support from a spouse, although they may find support from extended friends and family (Fewell, 1986). The single parent's ability to work depends on the availability of child-care with specialised training, and whether she/he can afford or find it (Fewell, 1986).

The presence of older siblings can help take care of the child with special needs and share household responsibilities to reduce stress (Fewell & Gelb, 1983).

## **2.8 COPING**

McCubbin & Patterson (1983) and Oduburu, (2011) describe coping as utilising psychological resources and strategies that help to eliminate, modify or manage a stressful event or crisis situation. It is the process of managing trying circumstances, expending effort to solve personal and interpersonal problems, and seeking to master, minimise, reduce or tolerate stress or conflict. According to Folkman and Lazarus (2003), coping strategies are cognitions and behaviours used by the individual to evaluate stressors which involve either active or avoidant/denial processes aimed at decreasing the amount of stress.

Coping strategies are what family members actually do, think and feel about the coping resources available to them (Burr, Klein, Burr &, Doxey 2000). The literature on family stress theory and coping behaviour has found that family members do not merely react to stressful events; rather, they actively employ coping strategies (McCubbin, Kelvin & Cauble 2000). The coping process involves virtually every level of human functioning: cognitive, affective, behavioural and physiological.

Judge (1999) and Bailey & Smith (2000) have identified two main types of coping strategies: adaptive or problem-focused, and palliative or emotion-focused coping strategies. In the adaptive or problem-focused type of coping strategy, people try to deal with the cause of their problem. They do this by seeking information on the problem and learning new skills to manage the problem. Adaptive coping strategies are directly aimed at coping with the source of stress. Palliative or emotion-focused coping strategies include efforts to deny, minimise or escape from the stressful situation. Palliative strategies indirectly help reduce a person's awareness of the stress. The goal of coping strategies is to strengthen or maintain family resources, protect the family from the demands of stressful encounters, reduce the sources of stress or negative emotions and achieve a balance in family functioning (Judge, 1999; McCubbin and Peterson 1983).

### **2.8.1 Coping and emotions**

As previously stated, it is difficult to measure the efficacy of coping strategies. One of the ways researchers can assess the effectiveness of coping strategies is by measuring how well coping resources prevent hardships from resulting in emotional stress (McCubbin et al., 1981). In the past, coping was viewed primarily as a response to certain emotions. However, it was found that the relationship between coping and emotions has a bi-directional effect. The way a person feels in stressful situations will affect their form of coping. Some forms of coping are associated with positive feelings, whereas some are associated with increases in negative feelings (Folkman & Lazarus 2003).

Folkman and Lazarus (2011) examined the extent to which eight different types of coping would mediate the emotional responses in a younger (ages 35-45) and older sample (mean age of 68) of white men and women who had recently experienced a stressful encounter. Coping was associated with all four types of emotions: disgust and anger; pleasure and happiness; confidence; and, to a lesser extent, fear and worry (Folkman & Lazarus 2011). Planned problem solving was associated with an improved emotional state, suggesting that people often feel better when they focus on finding solutions to the problem (Folkman & Lazarus, 2003). Positive reappraisal improved emotional states in the younger group, but seemed to contribute to a worsened emotional state in the older group. One explanation for this could be that the older group had difficulty sustaining the positive beliefs when faced with difficult situations.

The results of the study by Folkman & Lazarus (2003) supports the hypothesis that certain coping strategies are related to varying emotional states and one form of coping may be more effective than another in increasing positive emotions. The differences found between the age groups could be due to methodology: different types of stressful situations explained by the different groups or developmental changes in coping efficacy (Folkman & Lazarus, 2003).

### **2.8.2 Gender differences in coping**

Several studies have shown gender differences in coping. Women tend to involve themselves more in the emotional roles of caring for the wellbeing of family members, whereas fathers assume the provider roles (Harris, 1998). According to a study by Burr et al. (2000) on effective coping strategies, women tend to use a wider range of coping strategies, such as reaching out to people, involvement in religious activities and openly expressing their feelings. Men tend to withdraw, keep their feelings inside and use more harmful types of strategies (e.g. alcoholism) (Burr et. al., 2000). Patterson and McCubbin (1983) found that a father's coping patterns could complement a mother's patterns. The parents' ability to effectively adjust to the added demands of taking care of their child also has a positive effect on other family members and society.

### **2.8.3 Functional vs. dysfunctional coping**

A study of 40 families by Bailey and Smith (2000) examined different stages of the family life cycle, the families' healthy and problematic coping strategies through clinical observation and the Beavers Family Assessment Model (1986), which assesses family structure, flexibility and competence. The sample consisted of people of diverse ethnicities and family dynamics. Parents had a high school education or less. Well-functioning families had a positive outlook on life, an acceptance of their responsibilities and an ability to resolve conflicts and take one day at a time (Bailey and Smith, 2000). Well-functioning families

focused on their child's strengths or abilities, rather than their limitations (Abbott & Meredith, 2000). A parent coping with the added stress of raising a child with disabilities found that accepting the situation was the most helpful coping strategy (Burr et al., 2000). Abbott and Meredith (2000) found that successful adaptation to having a child with a disability was accomplished when the parents defined their situation in a positive way.

Unhealthy coping behaviours were often related to the way the families defined their situation (for example, a view of life as unfair and beyond their control, and seeing themselves as victims) (Patterson and McCubbin, 1983). In the above-mentioned study by Bailey and Smith (2000), it was found that unhealthy families focused on negative feelings and denied that their child had a disability or even belonged to the family. The most harmful coping strategies found in parents who had a child with a chronic illness were those, which resulted in expressing less affection and trying to go on as if nothing had happened (Burr et al., 2000). Finally, the results of a McCubbin et al. (2000) study were that high-conflict families faced a pile-up of life changes or stressors with little coping ability.

When examining the efficacy of coping mechanisms, researchers found that having a wide range of responses is more helpful than any single mechanism (Pearlin & Schooler, 2006). In addition, Trute & Hauch (1988) found that families who had positively adjusted to the birth of a child with disability viewed themselves as members of strong families. Research has shown that families who respond to stressful situations more successfully tend to define the situation in a more optimistic, proactive manner and are able to accept the situation (Burr et al., 2000).

## **2.9 COPING RESOURCES**

### **2.9.1 Personal and family resources**

A family's response to stress will involve the various coping mechanisms of individuals and the family as a whole (Pritzlaff, 2011). Personal resources are the broad range of support available to each family member. Personal resources will influence a person's ability to cope effectively in stressful situations. When family members have a sufficient amount of personal resources available to them, they are less likely to view the situation as stressful (McCubbin et al., 1981). There are four basic components of personal resources: financial, educational, health, and psychological resource (Kwai-Sang Yau & Li-Tsang, 1999). Educational resources help facilitate a person's ability to solve problems, psychological resources include personality characteristics and self-esteem, financial resources refer to how well-off the family is financially, and family members' physical health all have an effect on coping.

Pearlin and Schooler (2006) found that self-esteem and sense of mastery over the situation are more efficacious than actual coping behaviours when facing stresses over which an individual has little or no control (McCubbin & Patterson, 1983). However, when it comes to interpersonal relationships, specific coping behaviours are often more effective than psychological resources (Pearlin & Schooler, 2006). One can conclude that specific situations require different types of resources or coping strategies.

The family's resources are the sociological, economical, psychological, emotional, and physical assets that family members can draw upon in response to a stressful event (Burr et al., 2000). A family's structure at the beginning or prior to the crisis event influences the family's ability to cope and the response outcome (McCubbin & Patterson, 1983). Prior experience with stressful situations may help reduce the strain of having a child with special needs and enhance family stability, or it may retard the development of additional coping behaviours directed at the stressful event (McCubbin and Patterson, 1983).

A family raising a child with a disability may have financial problems due to hospital bills and adaptive equipment (Seligman, 1983). Some families may have an advantage when it comes to stressful situations, due to greater income, resulting in greater access to resources and respite or day care. Those who have more education will be better equipped to use problem-solving skills. A family's resources may place an individual at a greater advantage for coping with a child with special needs. Family resources can also include the number of parents in a household (Farran, Metzger and Sparling, 1986; McCubbin Olson, Larsen, 1981). Studies by Abbott & Meredith (2000) documented the importance of having a strong parental coalition. These researchers found that marital satisfaction was the single best predictor of parental adjustment and reduced the amount of stress associated with caring for a child with a disability. The results of these studies indicate that marital strength is critical in predicting adaptation to a stressful situation (Abbott & Meredith, 2000). Researchers have found that single parents who have children with disabilities are at greater risk of increased stress due to the added role demands of a one-parent household. McCubbin (1979) also found that mothers whose coping was directed at maintaining family cohesiveness, and fathers who offered their support and concern, could manage caring for a child with a disability successfully.

Burr et al. (2000) found that maintaining family cohesion is one of the most frequently used and helpful strategies of families experiencing stress. A well-functioning family is having clear, but flexible boundaries between subsystems, flexible role relations, shared power and responsibilities, which promote personal growth and autonomy (Kazak & Marvin 1984; McCubbin et. al. 1981; McCubbin & Patterson, 1983). According to Schaefer and Edgerton (1981), mothers who reported that their husbands shared in housework and child-care roles indicated greater marital satisfaction (Dunst, Trivette & Cross, 1986). The family members work together as a team to establish new rules, roles and responsibilities to achieve stability

(McCubbin & Patterson 1983). One of the major coping strategies depicted by wives who were coping with separation from their significant others was to take on additional role responsibilities and become self-sufficient (McCubbin, 1979). Although certain families may have additional resources to cope with stress, not all families have to be from two-parent households; financially good off or well educated to overcome hardships. Strong families have qualities and guidelines that they live by; they work at being strong (Stinnett & DeFrain, 1985).

Healthy families recognise stress as a means for accentuating family strengths and resources while becoming stronger in the process (Burr et. al 2000). Families who handle stress effectively work together find solutions, share responsibilities, communicate, share their feelings with one another and feel good about them in the end (Burr et. al 2000). The family's ability to communicate and express their thoughts and feelings is also an important component in healthy families (Bennett, Lingerfelt & Nelson 1990). Open and honest communication involves listening to one another and being sensitive to nonverbal communication (Burr et al., 2000). Fostering healthy communication, as well as sharing thoughts and feelings, are vital components in parental adjustment. Even though communication and expressing emotions are helpful to a family's well-being, poor communication and negative emotions are found to be most harmful to families, which emphasises the importance of promoting effective strategies (Burr et al., 2000).

### **2.9.2 Culture and coping**

There is an increasing understanding among disability scholars that disability is a social construct, which is defined variably across cultures (Olkin, 1999). Some studies have shown that families experience different levels of social stigma related to disability depending on their cultural context. For instance, a study conducted by McCabe (2007) discovered that there are many people in China who continue to think that any child who develops in a non-typical fashion to other children is a "*shazi*" – an idiot.

Culture has implications for how families define and experience disability, how families experience their interactions with the formal service system, and how parenting values develop.

Cultural influence can be a foundation of stress or adaptation in families with disabled child. For example, a study conducted by Gardner et al., (2004) to examine the relationship between grandmothers and their disabled grandchildren, indicates less emotional distress in American grandmothers compare to Panamanian grandmothers. Gardner Scherman, Efthimiadis & Schultz (2004) showed that different cultures define disability differently and react differently towards disability. While some see it as a stressful situation as Panamanian grandmother do, others see it as a stress-less situation as the American grandmothers in their

study did. The attitude toward disability determines the way the family can cope with the care of disabled child.

Culture also influences how families, primarily the mothers, seek support and access care. A study conducted by Ow, Tan, & Goh, (2004) to examine Asian and Malay Muslim mothers of children with intellectual disabilities, found some interesting differences that the researchers attribute to differences in culture. The behaviour of Muslim mothers appears to be guided by Islamic *shariah* (laws). The roles of the father and mother are clearly stipulated and support from within the family and community is viewed as sufficient. Conversely, Asian mothers believe they have options for support beyond the family.

### **2.9.3 Spiritual support**

One of the best predictors of emotional adjustment is religion (Atwater, 1999). Spirituality is difficult to define because it means different things to different people (Pargament, 1999). Spirituality can be described in various ways: faith in humanity, ethical behaviour, concern for others, or interaction in relation to a greater Being (Stinnett & DeFrain, 1985). “Spirituality helps people appreciate what they themselves cannot control” (Pargament, 1999). It is a personal way of life in which a person strives to find meaning and significance.

Many people find spiritual support in the form of prayer, literature, participation in religious activities, joining organisations or attending religious services (Pargament, 1999). Faith and religious coping methods are the most frequently reported coping strategies among parents who have children with disabilities (Burr et al., 2000; Pargament, 1999). Others use religious reframing to see things from a new perspective and make the situation more manageable. Religion offers guidelines for living and a sense of stability. Families may view the difficult situation as an opportunity for spiritual growth (Pargament, 1999).

The question has been raised as to whether more people use religion as a coping strategy, compared to other types of strategies, and whether more people turn to religion in times of crisis than at other times of their lives. Research indicates that individuals appear to involve themselves with religion in more stressful situations than in less stressful moments of their life. People will also turn to religion more so than to other resources when religion is more available to them and particularly if it is already a part of their lifestyle (Pargament, 1999). Pargament (1999) looked at three different approaches to control in religious coping: self-directing approach, deferring approach and collaborative approach. The self-directed approach places more coping responsibility on the individual versus God. The deferring approach is described as an individual passively putting responsibility onto God. In the collaborative approach, both the individual and

God are active respondents in the coping process. The collaborative approach has been associated with a greater sense of self-esteem, personal control, and a lower sense of control by chance (Pargament, 1999).

Pargament (1999) has broken religious coping down into different categories in order to determine which types of religious coping are helpful or harmful. Spiritual support, congregational support, prayer and benevolent religious reframing were reported to be helpful, whereas viewing negative events as a punishment from God, and discontentment with God or the congregation were considered harmful.

In Koenig (2005) presents scientific evidence supporting the therapeutic power of religion and faith, as well as examples of individuals who have benefited from having a spiritual life. Studies conducted at Duke University's Center for the Study of Religion/Spirituality and Health have found that people with stronger faith are: less likely to suffer from depression; more likely to live healthier lifestyles; have stronger immune systems; and have a stronger sense of wellbeing and life satisfaction, compared to their non-religious counterparts (Koenig, 2005).

Abbott and Meredith's (2000) comparative study investigated the use of specific coping strategies and found that strong religious beliefs were helpful resources in coping with the challenges of rearing a child with disabilities. Individuals often turn towards their religion or spirituality in attempts to explain certain situations and give meaning to their struggles. Religious parents differed from non-religious parents in the sense that their child with a disability was an opportunity to depend more on God rather than being viewed as a burden (Weisner, Beizer & Stolze, 1991).

Parents who are coping with the diagnosis of the child and the many stressors of raising the child with a disability may find comfort in spirituality. Certain spiritual strategies, such as using religion to explain the event, seeking spiritual support and collaborating with God, were found to be more helpful than other strategies. Helping professionals should be knowledgeable about various religious practices and enquire as to whether spirituality plays a role in the family's lives. It is important to note that much religious coping is measured through self-reports which are potentially biased. Information on the prevalence of religious coping is variable, due to methodological errors (Pargament, 1999).

According to Weiss, Wingsiong and Lunskey (2014) having a child with a disability creates a crisis event for which parents have little to no preparation. How parents respond to the stresses of raising their child with disability depends on a wide variety of factors influencing their ability to cope. The interpretation of the crisis event and the sources of support, family structure and resources are some of the factors that influence the family's ability to cope. Strong marital relationship and social support also help determine parental adjustment to family stress (Bailey & Smith, 2000; Kwai-Sang, Yau & Li-Tsang, 1999).

Depending on which type of coping strategy is used, one form of coping can be more effective than another. The personality characteristics of the family members, their financial status, educational level, problem-solving skills, and spirituality all influence a family's ability to cope (Bailey & Smith, 2000).

#### **2.9.4 Knowledge and coping**

The knowledge of a person concerning a situation also affects his/her perception of the problem, which will facilitate coping. Educational resources help to facilitate a person's ability to seek, accept and use information in problem solving. Problem-solving skills include the ability to search for information, analyse situations to identify the problem and generate alternative courses of action, weigh alternatives with respect to desired or anticipated outcomes, select, and implement an appropriate plan of action (Oduburu, 2011). A study conducted in Tanzania on families' perceptions in caring for children and adolescents with mental disabilities, found that parents' knowledge of disability differs. Factors mentioned by some parents as the cause of disability included malaria, high fever, side effect of polio vaccine, low birth weight, while others even blamed God. Some were not sure of the cause of their child's disability (Mbwilo, Smide and Aarts 2010).

#### **2.9.5 Financial resources and coping**

Financial resources refer to how well off the individual is financially. Some individuals may have an advantage when it comes to income, resulting in greater access to material resources to aid in their child's care. Therefore, material resources refer to money and the goods and services that money can buy. Monetary resources can greatly increase one's coping options in most stressful situations, especially the care of a disabled child. A study conducted in Enugu urban, revealed that being financially stable enhanced parental coping ability, where seven parents of mentally challenged and six parents of physically challenged children stressed the need for a stable income (Oduburu, 2011).

#### **2.9.6 Acquiring social support**

The study of social support is complex. The vagueness of the term social support has led to some confusion over what types of interventions to employ (Coyne & DeLongis, 1986). Social support can be defined as individuals, groups or institutions that provide assistance to help other individuals overcome stresses that strain a person's resources. Researchers have identified several major areas of social support: financial, emotional, educational, material, formal and informal (Shelton & Stepanek, 1994). Informal sources of support include individuals (e.g. family, friends, neighbours, relatives, co-workers) and groups (e.g. church organisations, parent-groups). Informal supports are available without contact through a professional helper or agency (Bennett et al., 1990). Formal supports include both professional helpers (e.g. physicians, social

workers, counsellors) and agencies (e.g. hospitals, early intervention programmes, day care centres). Research has shown that informal support has more positive effects than formal support (Bennett et al., 1990).

Seeking social support has been positively associated with family strength and greater family confidence in families who have children with disabilities (Judge, 1999). Research indicates that individuals who have access to social support are protected against the emotional and physical effects of stress (Pilisuk & Hillier-Parks, 1983).

Social support increases positive parental attitudes toward their child with a disability (Crnic et al., 1986). Respondents in Abbott and Meredith's (2000) study found that participation in parent support groups and other social services was helpful. Support groups offer parents a study by Peterson (1984) examined the importance of social support and its impact on raising a child with a disability, and found that mothers with high stressors and high support had fewer outcome problems compared to mothers with low support and high stressors (Bailey & Simeonsson, 1988). Social support is helpful because it fills the basic human need for relatedness and connection (Ryan & Solky, 1996). The ability to obtain levels of social support will vary depending upon individual characteristics, the availability of resources and the culture in which one lives (McCubbin et al., 1981).

The capacity to trust others and allow oneself to become dependent upon others is a key variable in establishing social support (Colbe, et al., 1996; Rubin & Quinn-Curran, 1983). Individual family members and the families themselves will vary in the type of social support they need (Shelton & Stepanek, 1994). The opportunity to meet other parents and establish potential childcare for one another (Schilling et al., 1984). Parents' self-help groups are places in which parents can share their feelings, discuss their concerns or problems, exchange information about disabilities or community services, offer advice to one another and focus on positive ways of helping their children (Thompson, 2000). Parent groups help parents feel connected to others, which reduces the feelings of being alienated from the rest of society. Parents express that the common thread or sense of universality that binds them together is the greatest benefit of belonging to a parent group, commenting "the voices of other parents can bring a measure of comfort". In addition to being supportive of their members, mutual self-help groups often focus on changing attitudes and policies, which are beneficial in problem situations (McCubbin et al. 1981).

Social support differs according to the cultural context (Dilworth-Anderson & Marshall, 1996). Where European-Americans value independence, African-Americans, Hispanics, Native Americans, Africans and Asians tend to be more family-centred and have stronger social support networks. Professionals working with families need to be sensitive to the family's cultural heritage. There are also gender differences in

social support. Studies have shown that women rate supportive behaviours as more satisfying than men (Acitelli, 1996). Men and women utilise social support systems differently; men typically isolate themselves under high-stress conditions, while women tend to reach out (Hobfoll, Cameron, Chapman, & Gallagher 1996).

When a couple is married and the quality of the marriage is good, it improves the couple's ability to cope in stressful situations. A strong parental subsystem and utilising the support of family and friendship networks has been shown to be indicative of strong positive family adaptation following the birth of a child with a developmental delay (Trute & Hauch, 1988). Past studies (Kazak & Marvin, 1984; Kazak & Wilcox, 1984) have analysed the characteristics of families that have children with disabilities and have found that the friendship networks were smaller for these families compared to families who do not have children with special needs. However, members of these social networks seemed to know and interact with each other, signifying that they had overlapping friendships. This implies that members of families of children with disabilities are small and highly interconnected. It is important that professionals encourage families to join parent support groups, to extend their social resources and build friendships, as well as offering additional support (Kazak & Marvin, 1984).

## **2.10 COPING STRATEGIES**

### **2.10.1 Counselling**

According to Aron, Loprest, & Steuerle (1996), counselling is providing social and psychological guidance or advice to someone facing difficult situation to resolve problems. Counselling can be valuable for the family of a disabled child, to help parents cope with painful feelings about the child's condition, and access the extra time and patience needed for the care of a special-needs child. Parental counselling deals with the dimension of parent-child interaction and dependence-independence. Most parents are deeply concerned about the well-being of their children hence they become overprotective, which may be resented by the children. Thus, parental counselling is one of the important services that can help to foster a healthy home atmosphere. The focus of counselling depends upon the needs of the disabled child and his/her parents (Hussain & Juyal, 2007).

#### ***2.10.1.1 Aims of counselling***

Counselling is aimed at helping parents become sensitive to the possible adverse effects of their behaviour on their children. It helps the parents achieve acceptance of themselves and their own personalities. According Hussain & Juyal (2007), changing the attitudes of parents is the hallmark of a counselling

programme. Counsellors need to deal with a broad spectrum of issues while counselling parents with a disabled child. The counsellor should be able to remove misconceptions and false beliefs about the child's disability and provide social support to the parents of a physically disabled child at the initial and subsequent counselling stages. Parental adjustment to their disabled children requires a good foundation in basic problem-solving skills. According to Beavers, Hampson and Beavers (1996) counselling should be directed toward the problems of future care.

### ***2.10.1.2 Counselling intervention programmes***

Aron et al., (1996) identified four counselling intervention programmes that can help families with a disabled child to cope. These are:

#### *(i) Skills training*

Skills training, focusing on instructing parents and siblings in the physical and behavioural management of a disabled family member is an important area of involvement for both professionals and parents. Professionals should be able to assess the needs of parents and other family members that will enable them to design individualised education programmes to support them. This requires knowledge of theories and concepts of family functioning and development, and a basic understanding of the family as a complicated and unique system. (Hastings, Allen, McDermott, & Still 2002)

#### *(ii) Parent education*

Many parents, in most parts of Nigeria, are illiterate and consequently need to be given factual information about causes of disability, skills development, how to use existing resources, ways in which they could help and other issues. Parent training can take many different forms depending on the needs of particular families. Parents may require to be taught how to assist their child to master basic academic skills. Most parents are responsible for the teaching and programming for their disabled child and the support professional normally helps them to do this successfully. The training of parents in the organisation of parent groups is a necessary part of programmes for families with disabled children. This can be encouraged at PTA meetings or at social functions. (Hastings et al., 2002).

### *(iii) Counselling practices*

Intervention through counselling arises from the fact that most families with handicapped children have many concerns about both the present and the future and, as indicated in many instances, they may worry about their own competence as parents. They may fear that something they did caused the child's disability. They may be angry or upset that services are not being provided for their child. They may even feel rejected or stigmatised by other parents or people within the community. Group counselling can be organised around specific topics suggested by the parents or by professionals. Such meetings give parents the opportunity to meet other parents of disabled children, thereby making it possible for personal support networks outside the group context. Teachers and others can play active roles by developing or helping locate respite care services, day care programmes for disabled children, and providing the family with necessary information so that services can be easily located (Hastings et al., 2002).

### *(iv) Parental rights and advocacy*

There is a need to understand that parents are the owners of their children, and, apart from having their own rights over their children, they also need to be protected legally against wrong notions. When their children attend school, these rights should be recognised by the school authorities concerned. Parents should fight for the existence of strong regulations and laws protecting them and their children in the Nigerian community (Hastings et al., 2002).

#### **2.10.1.3 Barriers in counselling**

Authors such as Hastings et al (2002) have argued that counselling parents of disabled children takes more effort and time than does counselling parents of children without disability. (There are several reasons for this, including:

- Emotional disturbance of the parents (that is, stress and anxiety)
- Anxiety over speedy recovery
- Religious and cultural beliefs of the parents
- Misconceptions and false beliefs about the disorder
- Personality characteristics of the parents
- Assessment of motivation, attitude and awareness of the parents

#### **2.10.2 Modification of environment**

Home modification refers to converting the living environment to make tasks easier, to reduce accidents and to support independent living. Examples include installing ramps, hand-held showers, grab bars, better

lighting, roll-in showers and stair or chair lifts. Home modifications are adaptations to the living environment intended to increase ease of use, safety, security and independence (Hodgson 1998).

Modifications can include:

1. Changes or additions to the structure (for example, widening doorways, adding a first-floor bathroom or a ramp)
2. Installing special equipment (for example, grab bars and handrails)
3. Adjusting the location of items (for example, moving furniture)

Home modifications overlap with assistive devices (for example, bath benches, walkers) which tend to be more mobile in nature and not attached to the structure of the house. In addition, home modifications are often accompanied by repairs (for example, fixing worn-out stairs) to ensure their usefulness (Hodgson et al., 1998)

According to Hodgson (1998), there is general agreement that an accessible and supportive environment is vital to the quality of life of adults and younger people with disabilities. First, a supportive and accessible environment makes it easier to carry out tasks such as cooking and cleaning, thereby increasing independence, self-confidence and self-esteem. Second, modifications such as ramps or stair lifts can allow people to engage in major life activities and tasks more easily. Third, features such as handrails on the stairs, outside ramps and grab bars in the bathroom help prevent accidents. Fourth, adequate space and access facilitates caregiving by relatives, friends and the formal service system. Fifth, home modifications may minimise the need for costly personal care services. Children with disabilities need home modifications to live in independent housing settings in the community.

### **2.10.3 Altering family and work schedules**

The presence of a disabled child in the family challenges all aspects of family patterns of interaction, creating a sense of vulnerability. The family's ability to master and control remains a critical element in their ability to adapt. Children with disabilities have the potential to create a set of stressors that can disturb the family patterns of living and further compromise the family's well-being. Increased expenses for health care or certain types of professional services can rapidly become overwhelming, even for families with reasonable financial resources. The disrupted daily routines and the additional time demands needed for therapeutic services can also become a constant source of problems for families. The search for respite care becomes a high priority (Gupta and Singhal, 2005).

Most parents display an intrinsic interest in and natural instinct for supporting and promoting their child's development. For optimal results, however, parents must invest considerable and sustained psychological and material resources (Barton 1996). According to Barton (1996), many parents promote their child's social development by encouraging relationships with peers. These interventions often involve significant levels of supervision.

Optimal development also requires parents to invest considerable energy and time in finding experiences that match their child's special interests, talents and needs. Beyond attentiveness to their child's emerging interests or sensitivity to often subtle developmental concerns, parents may require professional assistance and guidance.

## **2.11 EMPIRICAL STUDIES ON COPING STRATEGIES**

Related studies have shown that parents with disabled children experience different types of challenges. Such parents have equally adopted different types of coping styles in order to overcome their burden or minimise the effects.

In a study conducted by Pritzlaff (2001), where she examined the coping strategies of 45 parents who have children with disabilities, a questionnaire developed by McCubbin et al., (1981) called the Family Crisis Personal Evaluation Scales (F-COPES) was used to identify the problem-solving attitudes and behaviours which families develop in response to problematic situations or difficulties. The F-COPES was divided into five subscales: acquiring social support, reframing, seeking support, mobilising family to acquire and accept help, and passive appraisal. Demographic variables were also measured, including gender, age, marital status and number of children, income and the nature of the child's disability.

Pritzlaff's (2001) findings revealed that acquiring social support ( $M = 31$ ) and reframing ( $M = 31$ ) were the most frequently used coping strategies by those parents. The passive appraisal subscale ( $M = 16$ ) was slightly higher compared to mobilising family to accept help ( $M = 15$ ) and seeking spiritual support ( $M = 14$ ). The study found that a majority of the respondents utilised acquiring social support and reframing, which are highly successful strategies.

With regard to demographic variables, significance was found between family income and the reframing and seeking spiritual support subscales; parents with a higher income seemed to utilise reframing and seeking spiritual support more often. Significance was also found between the number of children in the household and passive appraisal; as the number of children increased, passive appraisal seemed to decrease.

Another related study by Hussain and Juyal (2007) on stress and coping ability among parents of physically challenged children, compared the level of stress and coping strategies among parents of physically challenged and parents of children without disability. Sixty (60) parents (either father or mother) of both groups were used for the study, with 30 in each group. Ptacek (1996) stress appraisal measure was used to examine the level of stress, whereas in a similar study by Folkman and Lazarus (2011), a questionnaire was used to assess coping strategies adopted by the two groups of parents. It was found that the level of stress among parents of physically challenged children was much higher and differed significantly from that of their counterparts. The two groups also differed significantly in terms of their coping strategies, with parents of children without disability being found to cope much better than parents of physically challenged children.

Paulo (2002) carried out a study on coping strategies of parents of children with disabilities in three districts in Uganda (Mpigi, Tororo, Iganga). Parents and caregivers of children with disabilities were interviewed. The data collected was analysed qualitatively using the framework approach by Ritchie and Spencer (1994) and then organised, using a software package called Nvivo. Findings revealed that parents used traditional coping strategies such as seeking a cure, physical and social support, family roles, acceptance, spiritual support, knowledge and skills. It was also discovered that the burden of caring for children with disabilities was always on the mothers. However, in some families, grandmothers and siblings took active roles in the caring, thereby relieving mothers of some of the burden of caring. The fathers were not directly involved in the caring. Furthermore, it was discovered that the parents' coping process was inhibited by poverty, lack of information and problem-solving skills, and communication problems (Paulo, 2002).

Oduburu (2011), in her study on coping strategies of parents with physically and mentally challenged children, found that parents used a combination of coping strategies. The data analysis revealed that the most frequently used coping strategies were: spiritual coping strategy ( $M = 4.67$ ), personal/family resources coping strategy ( $M = 3.85$ ) and External Social Support ( $M = 3.49$ ). The coping strategy used least by parents was Denial coping strategy ( $M = 2.98$ ).

Oduburu (2011) also compared the difference in the utilisation of coping strategies among parents of physically challenged and mentally challenged children. She found that parents used a wide range of coping strategies that appeared more helpful to them than any one single strategy. A survey by Billings and Moos (2000) similarly noted that respondents did not use only one style of coping for all events. Burr et al. (2000) agreed, in his studies where he examined the efficacy of coping strategies used by parents.

The same study by Oduburu (2011) found that parents of physically challenged children appear to use external social support significantly more than parents of mentally challenged children. This suggests that

parents of the physically challenged are more connected to others and readier to disclose their problem to people. This agrees with a study by McCubbin & Patterson (1983) which found that coping with the stress of parenting a physically challenged child was easier when family members work together as a team to establish new rules, roles and responsibilities in order to achieve stability (Oduburu, 2011).

A descriptive correlation study was conducted by Van Riper (1982) to explore the resilience of families of children with Down's syndrome. The sample for this study was a volunteer sample of 76 families who had a child with Down's syndrome. The Family Crisis Oriented Personal Evaluation Scale (F-COPES) developed by McCubbin et al., (1981) was used for the study. Findings show the mean F-COPES score as 107.82. The five items from the F-COPES with the highest mean scores were: (a) having faith in God (M = 4.3); (b) knowing that we have the power to solve major problems (M = 4.3); (c) facing problems head on and trying to get solutions right away (M = 4.2); (d) sharing concerns with close friends (M = 4.2); and (e) knowing that we have the strength within our family to solve our problems (M = 4.1). Three of these items were from the reframing subscale—a subscale that assesses the family's capability to redefine stressful events to make them more manageable (McCubbin et al., 1979).

A correlation matrix was generated for major study variables and selected demographic variables (e.g. maternal age, maternal education, family income, number of children, and age of child with Down 's syndrome). Examination of the correlation matrix revealed that none of the demographic variables was significantly associated ( $p > .05$ ) with family adaptation. Another correlation matrix between three family variables (i.e. family demands, family resources, and family problem-solving communication) was significantly associated with family adaptation. There was a significant negative association between family demands and family adaptation ( $r = .35, p < .01$ ). Mothers who reported higher levels of family demands, lifestyle changes and unresolved strains rated their family adaptation lower. Family resources were significantly associated with family adaptation ( $r = .70, p < .01$ ). Mothers who reported greater family resources rated their family adaptation higher. There was a significant positive relationship between problem solving communication and family adaptation ( $r = .53, p < .01$ ). Mothers who reported higher levels of problem-solving communication in their families rated their family adaptation higher.

## **2.12 CONCLUSION**

Several researchers have found that parents who have children with disabilities experience higher amounts of stress and require extra coping ability (Oduburu, 2011; Abbott and Meredith, 2000). Previous research in Nigeria and in the Western world has focused mainly on stress and coping strategies of parents with intellectually challenged children and parents with children with chronic illness, like sickle cell anaemia and *Diabetes Mellitus*, however not much research has been conducted to examine the coping strategies of

parents of physically disabled children. Thus, this study aims to describe coping strategies of families who have physically disabled children within their social environment, such as in the family, school and community, in order to understand how families are coping; what available resources are there for them to cope, and the areas in which the environment may provide support to these families.

This chapter, reviewed current and past literature on disability, parenting and coping strategies utilized by families with a disabled child. Studies on the aspect of coping with a disabled child were reviewed.

The focus of the next chapter, will discuss the step-by-step approach that was used to conduct the study, that is the paradigm, research design, research method and the validity and reliability of the instrument.

## **CHAPTER 3: RESEARCH METHODOLOGY**

### **3.1 INTRODUCTION**

Research methodology is the overall approach to the design process of conducting research including all phases, from the theoretical underpinning to the collection and analysis of data (Creswell, 2009). This chapter presents the research methodology and covers research paradigm, data collection tool, data collection, data analysis, ethics and data management.

### **3.2 RESEARCH DESIGN**

A quantitative, descriptive design was adopted for the study. A research design is the set of methods and procedures used in collecting and analyzing measures of the variables specified in the research. Descriptive research involves gathering data that describe events and then organizes, tabulates, depicts, and describes the data collection (Glass & Hopkins, 1984). In this study data is presented in visual aids such as graphs and charts to aid the reader in understanding the data distribution

### **3.3 RESEARCH PARADIGM**

Research paradigm is the theoretical, political and philosophical backgrounds to social research and their implications for research practice and for the use of particular research methods (Robson, 2002)). This study is underpinned by the positivist paradigm. The positivist paradigm is the worldview or research belief that reality exists in the world and that reality can be investigated objectively by researchers to produce knowledge or to validate existing knowledge (Polit & Beck, 2012).

The researcher chose this paradigm because in positivist research paradigm the researcher and what being researched has no relationship. The researcher remains distant and independent from that which is being researched, therefore, being objective in assessing the situation Creswell (2006)

### **3.4 RESEARCH SETTING**

The study was conducted in Jos, the capital city of Plateau State, Nigeria. Jos is an urban settlement located in North Central Nigeria, which occupies 30,913 square kilometres. Plateau State shares borders with Kaduna State to the North, Kaduna and Nassarawa States to the East, Benue to the South and Taraba State to the East. Plateau State is located between latitude 80°24'N and longitude 80°32' and 100°38' east. Plateau

State gets its name from the Jos Plateau, a mountainous area in the north of the state with impressive rock formations. Bare rocks are scattered across the grasslands which cover the plateau. The altitude ranges from around 1,200 metres (about 4,000 feet) to a peak of 1,829 metres above sea level in the Shere Hills range near Jos (Plateau State Ministry of Health 2009).

The study covered three selected schools for disabled children in Jos. These schools are purely for disabled children, all the schools operate only during the day. The schools are approximately ten kilometers apart and they all admit children with physical disabilities from all over the country.

### **3.5 STUDY POPULATION**

A population is the entire aggregation of cases in which a researcher is interested (Polit & Beck, 2005). For this study, the research population was parents with physically disabled children from the three schools (Special Education Model Teaching, Open Doors Special Education Centre and Otana Integrated School) for disabled children in Jos selected for the study. English language was used as official means of communication in the study location, hence the researcher needed no interpreter.

### **3.6 SAMPLE AND SAMPLING TECHNIQUES**

A sample refers to the people selected to participate in a study, that is, the people among whom data was collected (Burns & Grove, 2011). In the study, the sample was parents with physically disabled children who are attending the three schools selected for the study.

Polit and Beck, (2005) narrate that; sampling is the process of selecting a portion of the population to represent the entire population. Sampling process depends on the type of research design and the attributes of the prospective respondents (Creswell 2009). The researcher assumed that the respondents have knowledge of the phenomenon under study, which was coping strategies, and as such, they could provide the research with information pertaining to coping strategies. Polit and Beck (2012) categorise this type of sampling as purposive sampling, which fall under non-probability sampling technique, the authors describe purposive sampling as the strategy of targeting specific kind of respondents, who are allegedly knowledgeable about the issue to be researched. In this study, the researcher used non-probability purposive sampling to recruit 54 parents with physically disabled child in the selected schools as the study sample. The estimated target of parents was 20 from each selected school. The inclusion criteria were as follows:

- Must be a parent to physically disabled child
- The child must be staying with him/her in the same home for not less than 3 months
- Must have children currently enrolled in either of the selected schools

- Must be available at a parent teacher association (PTA) meeting

Table 3.1 presents the actual number and distribution of the selected respondents to participate in the study.

Table 1: Distribution of parents with physically disabled child per school

Name of school	Number of respondent	Percentage of respondents (%)
A	15	27.8
B	19	35.2
C	20	37.0
<b>Total</b>	<b>54</b>	<b>100</b>

### 3.7 DATA COLLECTION INSTRUMENT

The Family Crisis Oriented Personal Evaluation Scale (F-COPES) developed by McCubbin et al., (1981) was adopted and incorporated into the data collection instrument Section B. This five-point Likert self-report scale was designed to record problem-solving attitudes and behaviours that parents develop in response to problems or difficulties (McCubbin et al., 1979). In this study, the five-point Likert self-report scale measured the coping strategies utilize by parents with disabled child. The scale indicates the degree to which a person agrees or disagrees with each statement (1 = strongly disagree and 5 = strongly agree).

The data collection tool comprises two sections (refer to Appendix F). Section A measured the parents with disable child' demographic characteristics and had nine questions; the demographic characteristics that were included in the questionnaire were gender, age, income, number of children in a household, number of parents in a household, position of the disabled child, occupation and religion. Section B comprises thirty questions using a Likert scale. According to Polit and Beck (2004), a Likert scale is a merged measure of attitude that involves the addition of scores obtained in the rating by respondents of the extent to which they either agree or disagree with a certain statement. Section B of the questionnaire (had Likert-scale statements that determined the coping strategies utilised by parents with a physically disabled child. Nine statements assessed the utilisation of the acquiring social support coping strategy, six statements assessed the reframing coping strategy, four assessed the spiritual support coping strategy, five assessed mobilising family members to seek and accept help, and six assessed utilisation of the passive appraisal coping strategy.

### **3.8 DATA COLLECTION PROCEDURE**

According to Polit and Beck (2005), the phenomena in which researchers are interested must be translated into data that can be analysed and this can only be actualised by using a high-quality data collection method. After clearance from the UKZN Ethical Committee, the researcher and a trained research assistant went to the schools on an agreed date (Otana Integrated School 28 November 2016, Open Doors Special Learners 28 November 2016 and Special model school 30 November 2016) and time to administer the questionnaires and collect data. Researcher and research assistant visited each school on a different day, questionnaires were administered (in a classroom) and collected same day in each visit.

On the day of data collection time was given to the researcher to give a short introduction on the research to the respondents and attend to questions, which was successfully done. An information sheet and declaration of consent form, together with the questionnaire, was given to each participant, which they responded and returned to the researcher and her assistant. Data collection was done over a period of one day at each school.

#### **3.8.1 PILOT STUDY**

Prior to data collection, the data collection tool was pre-tested to determine its validity and reliability. A pilot study is a small-scale replication of the actual study, targeting a small number of people with characteristics similar to those of the target group of respondents (Polit and Beck 2012).

The purpose of the pilot study is to determine the feasibility of the study; to test the reliability and validity of the instrument and trustworthiness of respondents for data collection in the main study; to establish how appropriate, understandable and practical the instrument is; to address any problems prior to the main study; and to check the time required for the completion of the questionnaire (Polit and Beck 2012).

The pilot sample consisted of 10 volunteer respondents who are parents with physically disabled children and were not included in the main study. The questionnaire was administered to these volunteers individually on an agreed date and time. Some took it home completed it and return to researcher while some completed it on the spot and return it to the researcher. The result of the pilot study showed that most of the respondents understood the questions and responded accordingly and result was similar to some study reviewed in the literature of the study.

### **3.9 DATA ANALYSIS**

The data collected were captured and subsequently analysed using SPSS Version 24. Descriptive statistics, such as frequencies and percentages, were used to summarise the data. Descriptive statistics facilitate the

organisation of data so that meaning can be obtained from the data Burns and Grove, (2011). Results were presented on pie charts, tables and clustered bar charts.

Data analysis was done by the researcher after receiving SPSS Version 24 from the Information and Communication Centre of the School of Nursing and Public Health, UKZN. Assistance was offered by the school statistician during the early phase of the proposal. Services rendered included aligning objectives and questions, assessment of the data collection tool and determining the applicable data analysis method.

The first phase of data analysis entailed coding of data, populating it in SPSS Version 24 on the computer, and examining respondents' demographic characteristics. The second phase included transforming the variables into new variables that represented disagreement and agreement with the statement. Respondents were categorised under "disagreed", "agreed" and "neutral".

### **3.10 DATA MANAGEMENT**

The analysed data were stored in a computer system protected by a password to which only the researcher and the supervisor have access. The hard copy and soft copy (copied on a CD) data were stored in a locked system to which only the researcher and the research supervisor have access. The data will be kept for a minimum of five years, after which they will be permanently removed from the computer hard drives and CD.

### **3.11 DATA DISSEMINATION**

The completed research work will be deposited in the UKZN library, the three institutions for the disabled children where research data was collected. A soft copy of the completed research project will also be submitted to the UKZN library and the research supervisor. In addition, this study will be published in accredited journals.

### **3.12 ETHICAL CONSIDERATIONS**

Scientific research work, as are all human activities, is governed by individual, community and social values. Research ethics involve requirements on daily work, the protection of dignity of subjects and the publication of the information in the research. In concert with the above statements, it follows that in planning a study the researcher took the consideration, and protect the feelings, welfare, and rights of the respondents (Pritzlaff, 2001).

Hence, in concert with the rules and regulations of the university with regard to conducting research using human subjects, the following ethical considerations was taken into account during the course of this research (refer to appendix A, D and E).

### **3.12.1 Favourable risk-benefit ratio**

According to Pritzlaff (2001), the principle of beneficence encourages the researcher to ensure the respondents' right to protection, by securing the respondents from harm and discomfort in any aspect of life. In this proposed study, descriptive design was adopted which is a non-experimental research design; therefore, the researcher only observed the phenomenon and did not manipulate any variables thereby preventing harm. The information provided by the respondents was not disclose or use against them in any way during and after the study.

### **3.12.2 Informed consent**

It is ideal for the researcher to obtain an informed consent from the prospective respondents prior to commencement of the study. In view of the above statements, in the present study, the principle of respect to human dignity was upheld by obtaining the informed consent of the participant. Respondents were informed about the purpose of the study and that their participation was voluntary and without risk of penalty. They were free to ask questions at any stage should they need clarification and to withdraw at any point when they felt threatened. Similarly, permission to undertake the study was obtained from all the schools under study as shown in appendix B.

### **3.12.3 Confidentiality and anonymity**

Pritzlaff (2001) proposed that a procedure to maintain the confidentiality of the collected data should be put in place in research work. In concurrence with this, in this study, neither the respondents' names nor any form of identification were used in the data analysis to ensure privacy. The hard copy of the analysed data will be stored in the care of the supervisor under lock and key, while the soft copy is stored in a computer system with a password that only the supervisor and the researcher have access to.

## **3.13 CONCLUSION**

Chapter 3 presented the research methodology and research paradigm adopted for the study. A descriptive research design was adopted and the data collection method used, whereby questionnaires were administered by the researcher and completed by the respondents. The schools for the disabled children were selected based on the purpose of the study. The completed questionnaires were analysed and saved

onto a CD and computer system. Data analysis was done using SPSS, Version 24, after the data had been coded and entered onto a computer. Data management was also discussed in depth.

The next chapter (4) presents the analysis and results and discussion of the study per the research questions. Results for demographic characteristics which is the first research question are presented on graph (pie chart). Followed by the different coping strategies utilize by the respondents, question two, which are presented on tables and lastly the relationship(s) between the demographic characteristics and the coping strategies, question three, on bar chart.

## **CHAPTER 4: RESULTS AND DISCUSSIONS**

### **4.1 INTRODUCTION**

This chapter presents the statistical results of the research, data analysis and discussion of the findings. The purpose of this study was to describe the coping strategies of parents with a physically disabled child. The researcher utilised the F-COPES scale of measurement to assess coping behaviours and attitudes. Of the 54 parents who were administered questionnaires, 54 parents responded (100 % response rate). The data were collected and analysed using descriptive statistics.

Frequencies and percentages of the demographic variables are presented in tables. Descriptive statistics are reported on each of the five subscales. Mean and standard deviations are also reported for the various coping strategies. In addition, this section discusses the significance found between demographic variables and coping strategies.

Out of the 54 questionnaires administered to the parents of a physically disabled child in three selected schools for the disabled in Plateau State, 54 of the surveys were returned, giving a response rate of 100 %. The data was analysed using Statistical Package for Social Scientists (SPSS) Version 24; coded data were entered the computer system. Frequency counts and percentages were calculated for the demographic variables pertaining to the respondent's gender, age, religion, number of parents in the household, number of children in the family, position of the disabled child in the family, and annual income, occupation and level of education of respondents.

Mean and standard deviation of the various coping strategies utilised by the respondents was analysed and presented in tables and graphs. There was a total of 30 variables to determine the respondent's coping strategies. The 30 questions were distributed on a five-point Likert scale to determine the coping strategies of the respondents. Lastly, the relationships between the demographic variables of the respondents and the five coping strategies were analysed and represented in graphs.

## 4.2 RESEARCH RESULTS

The results of this study are discussed in two sections, A and B according to the data collection instrument. Section A Section A includes frequency and percentage distribution of respondents' demographics which include gender, age, annual income, religion, number of children that the parent has and others.

### 4.2.1 Section A: Demographic variables of respondents

#### 4.2.1.1 Frequency and percentage distribution of respondents' gender

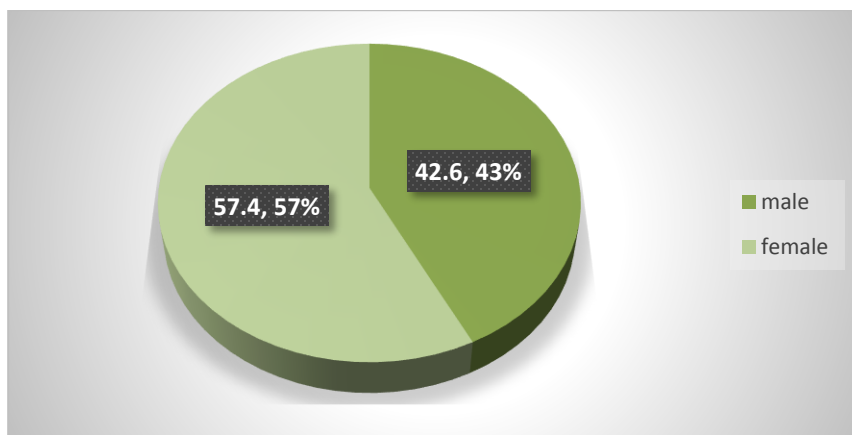


Figure 3: Gender of respondents

Figure 3 above shows the distribution by gender of the respondents in frequency and percentage 23 (42.6 %) represents the male and 31 (57.4 %) represents the female respondents. The figure shows that there are more female respondents than male respondents.

#### 4.2.1.2 Frequency and percentage distribution of respondent's age

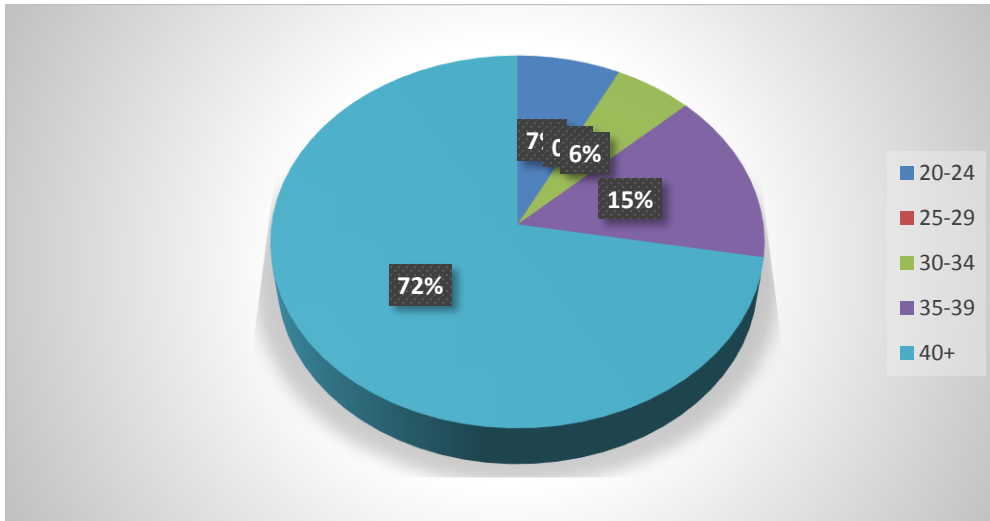


Figure 4: Age of respondents

Figure 4 shows that the age range of the respondents was 4 (7.4 %) ranging from 20-24 years of age. There were no respondents 0 (0%) for age 25-29 years however 3 (5.6 %) of the respondents were aged 30-34 years, 8 (14.8 %) were 35-39 years, and lastly, 39 (72.2 %) were aged 40 and above.

#### 4.2.1.3 Frequency and percentage distribution of respondents' annual income

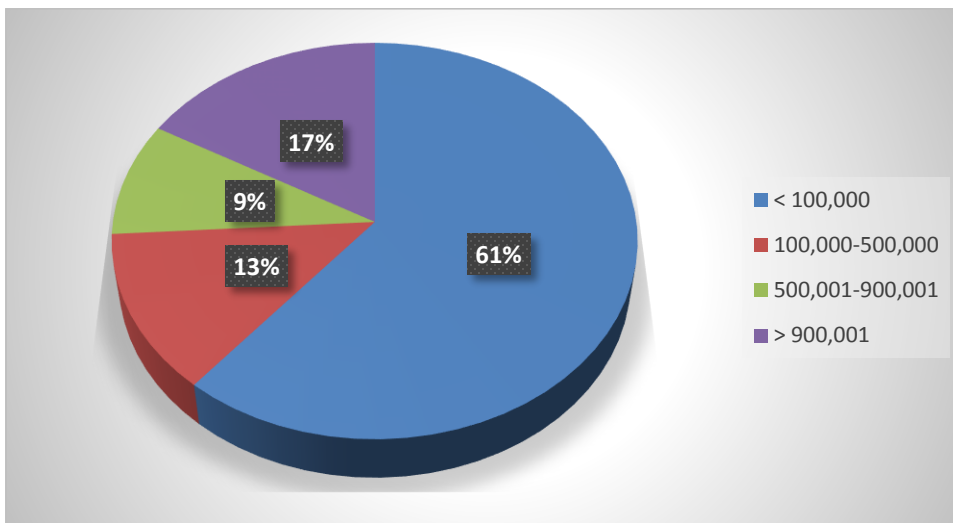


Figure 5: Annual income of respondents

Figure 5 above presents the annual income of the respondents. The annual income ranged from below 100,000 naira to above 900,001, with the majority 33(61.1 %) having an annual income below 100,000

naira. Data showed that seven (13.0 %) of the respondents had an annual income of 100,000-500,000, 5(9.3 %) 500,001-900,000 annual income, and 6(16.7 %) above 900,001 annual income.

#### 4.2.1.4 Frequency and percentage distribution of respondents' religion

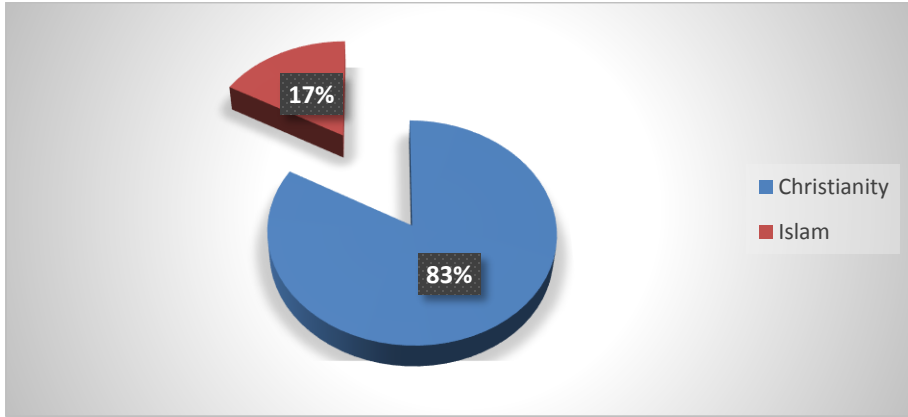


Figure 6: Religion of respondents

Figure 6 above presents the religion of the respondents. The figure shows that a majority of the respondents practice Christianity [4 (83.3 %)], while relatively few practice Islam [9 (16.7 %)].

#### 4.2.1.5 Frequency and percentage distribution of number of children in household

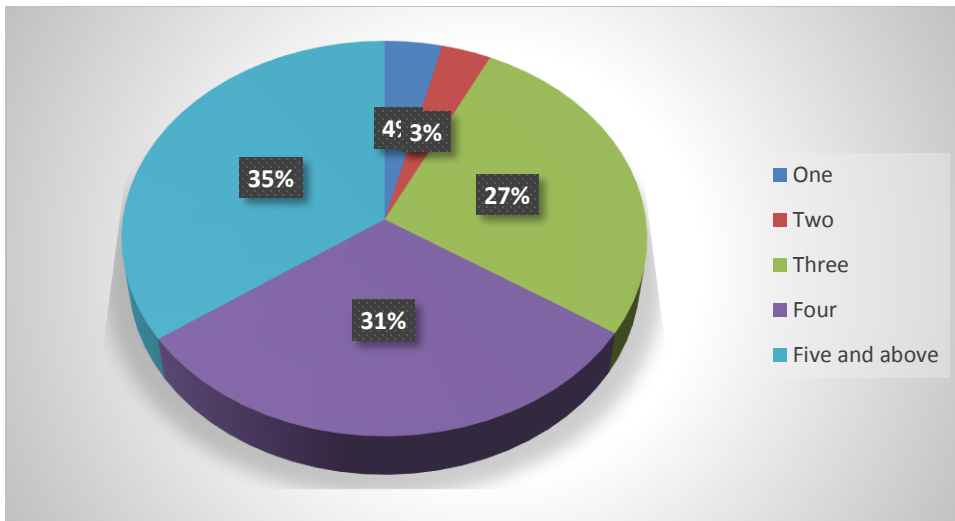


Figure 7: Number of children in household

Figure 7 above presents the number of children in a household. The range representing the number of children in a household was from one to five and above. Only 2 (3.7 %) of respondents had only 1 child, 4

(7.4 %) had 2 children, 14 (25.9 %) had 3 children, 18 (29.6 %) had 4 children, and 18 (33.3 %) had 5 or more children.

**4.2.1.6 Frequency and percentage distribution of position of disabled child in family**

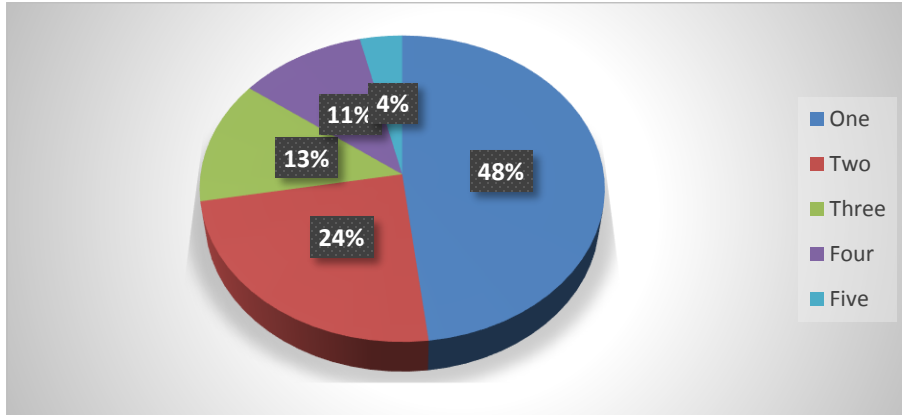


Figure 8: Position of disabled child in family

Figure 8 above presents the position of the disabled child in the family. The majority families, 26, (48.1 %) had the disabled child as the first child, followed by 13 (24.1 %), 7 (13.0 %), 6 (11.1 %), and 2 (3.7 %) for child two, three, four and five respectively.

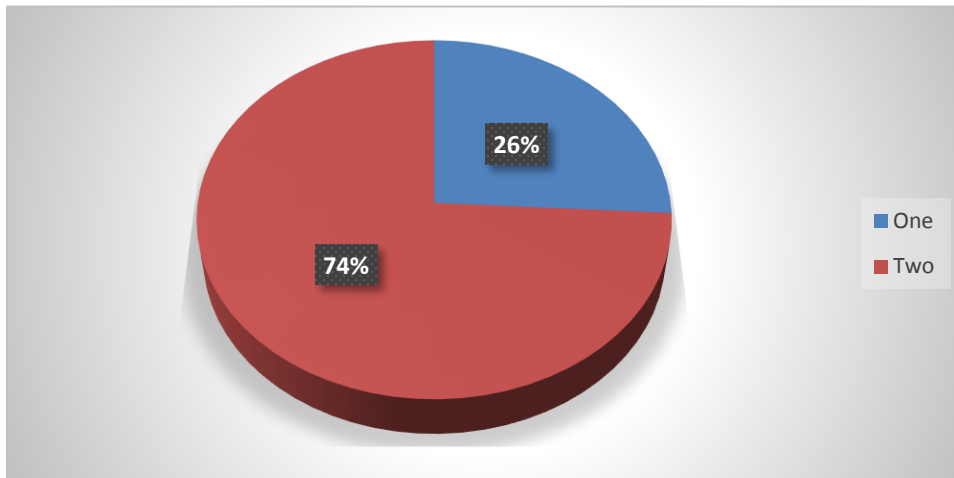


Figure 9: Number of parents in household

Figure 9 above shows that the majority of the respondents had 2 parents in the house, 40, (74.1 %), that is, the father and mother, while the remaining 14 (25.9 %) had only 1 parent (either father or mother).

#### 4.2.1.8 Frequency and percentage distribution of respondents' level of education

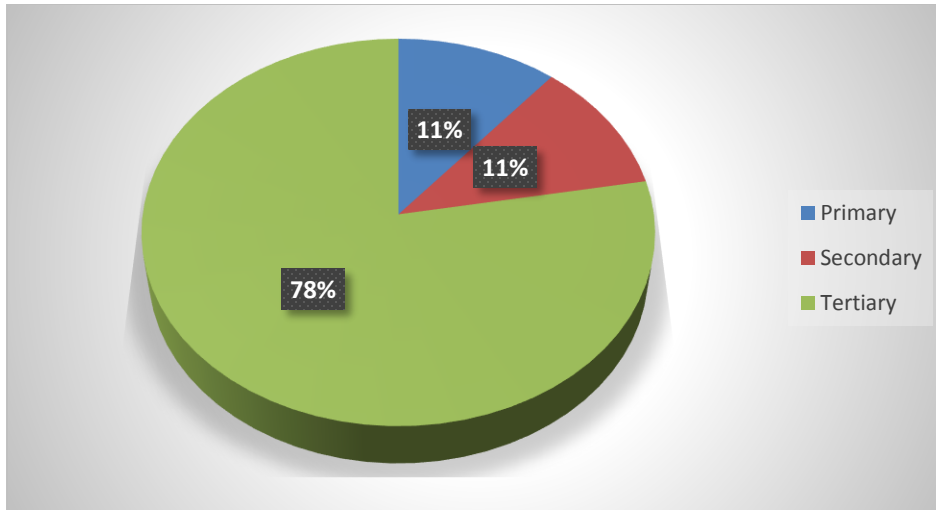


Figure 10: Level of education of respondents

Figure 10 above reveals that all the respondents have attained a level of education, with the majority attaining tertiary education, and 42 (77.8 %) and 6 (11.1 %) primary and secondary of education respectively.

#### 4.2.1.9 Frequency and percentage distribution of respondents' occupation

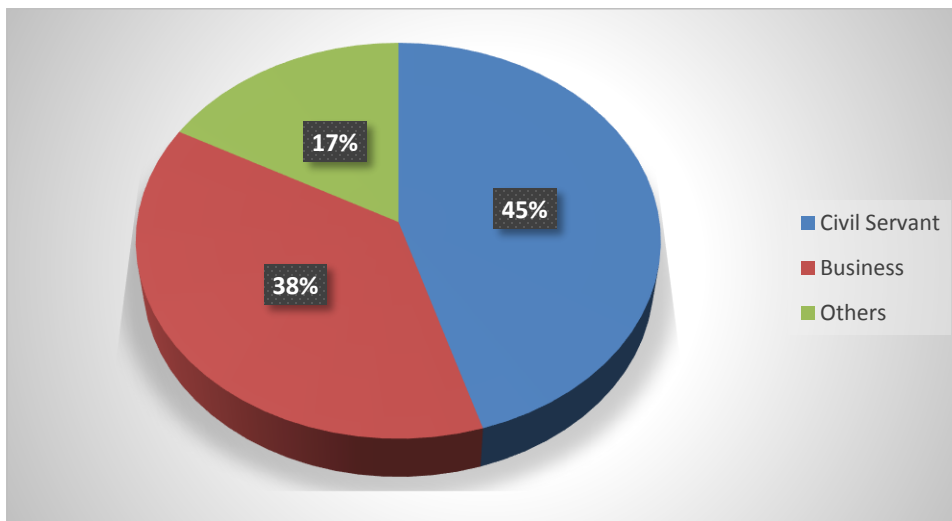


Figure 11: Occupation of respondents

Figure 11 above presents the occupation of the respondents, of whom 24 (44.4 %) were civil servants, 20 (38.0 %) were business people, and 10 (16.7 %) were doing another form of work for a living.

#### **4.2.2 Section B1: The five coping strategies as utilised by respondents**

The tables below (Tables 4.1 to 4.5) present the results of the five coping strategies according to McCubbin et al. (1981) five-point Likert scale. The results were attained by coding respondents' answers to the 30 questions under: "When we face problems or difficulties in our family, we respond by:" Respondents answered by selecting option 5-1 with a score of 5 (strongly disagree) as the highest, and 1 (strongly agree) as the lowest. Each response was analysed using SPSS, Version 24, to determine the mean and standard deviation for each question.

The descriptive statistics for the sub-scales show that the most used coping strategy was the social support coping strategy ( $M = 3.87$ ,  $SD = 0.53$ ). The second ranked coping strategy used by parents was reframing ( $M = 3.43$ ,  $SD = 0.80$ ). The third ranked coping strategy was mobilising family members to seek and accept help ( $M = 3.29$ ,  $SD = 0.73$ ). This was followed by passive appraisal ( $M = 3.11$ ,  $SD = 0.76$ ), and lastly, the spiritual coping strategy ( $M = 3.01$ ,  $SD = 0.77$ ).

#### 4.2.2.1 Social support coping strategy

Table 2: Mean and standard deviation for acquiring social support strategy

<b>Strategies</b>	<b>Mean</b>	<b>Std. Deviation</b>
Sharing our difficulties with relatives	3.41	1.52
Seeking encouragement and support from friends	3.35	1.53
Seeking information and advice from persons in other families who have faced the same or a similar problem	3.50	1.53
Seeking advice from relatives (grandparents, etc.)	3.65	1.46
Receiving gifts and favours from neighbors (food taking in mail, etc.)	4.56	0.93
Exercising with friends to stay fit and reduce tension	4.22	1.06
Doing things with relatives (get-togethers, dinners, etc.)	4.35	1.05
Asking relatives how they feel about problems we face	2.98	1.45
Sharing problems with neighbors	4.78	0.86
<b>Acquiring social support strategy</b>	<b>3.87</b>	<b>0.53</b>

Social support as a coping strategy was determined by nine out of the thirty questions asked as shown in Table 2 above. The result revealed a mean ( $M = 3.87$ ) and standard deviation ( $SD = 0.53$ ).

#### 4.2.2.2 Reframing coping strategy

Table 3: Mean and standard deviation for reframing coping strategy

<b>Strategies</b>	<b>Mean</b>	<b>Std. Deviation</b>
Knowing we have the power to solve major problems	3.81	1.30
Knowing that we have the strength within our family to solve our problems	2.26	1.44
Facing the problems “head-on” and trying to get solution right away	2.69	1.59
Showing that we are strong	4.22	1.25
Accepting stressful events as a fact of life	3.57	1.34
Believing we can handle our own problems	4.02	1.35
<b>Reframing</b>	<b>3.43</b>	<b>0.80</b>

Table 3: Above presents, the six questions representing reframing as a coping strategy with its mean and standard deviation. The mean and standard deviation for reframing as a coping strategy were ( $M = 3.43$ ) and ( $SD = 0.80$ ) respectively.

#### 4.2.2.3 Spiritual support coping strategy

Table 4: Mean and standard deviation for spiritual support coping strategy

<b>Strategies</b>	<b>Mean</b>	<b>Std. Deviation</b>
Attending religious services	3.72	1.45
Participating in religious or spiritual activities	4.19	1.25
Seeking advice from a minister or spiritual leader	2.22	1.62
Having faith in God or a higher power	1.93	0.82
<b>Spiritual support strategy</b>	<b>3.01</b>	<b>0.77</b>

Table 4 above presents the questions asked to determine the spiritual coping strategy with the mean and standard deviation, the mean was (M = 3.01) and standard deviation was (SD = 0.77).

#### 4.2.2.4 Mobilising family to seek and accept help coping strategy

Table 5: Mean and standard deviation for mobilising family to seek and accept help

<b>Strategies</b>	<b>Mean</b>	<b>Std. Deviation</b>
Seeking assistance from community agencies and programmes designed to help families in situation	3.70	1.40
Seeking information and advice from the family doctor	2.06	1.50
Asking neighbors for favours and assistance	3.96	1.49
Sharing concerns with close friends	3.07	1.32
Seeking professional counselling and help for family	3.63	1.36
<b>Mobilising family to seek and accept help</b>	<b>3.29</b>	<b>0.73</b>

Table 5: Above presents mobilising family to seek and accept help, which is the fourth coping strategy that was measured. There were five questions asked to determine the use of it as a coping strategy. The result was mean (M = 3.29) and standard deviation (SD = 0.73).

#### 4.2.2.5 *Passive appraisal coping strategy*

Table 6: Mean and standard deviation for passive appraisal

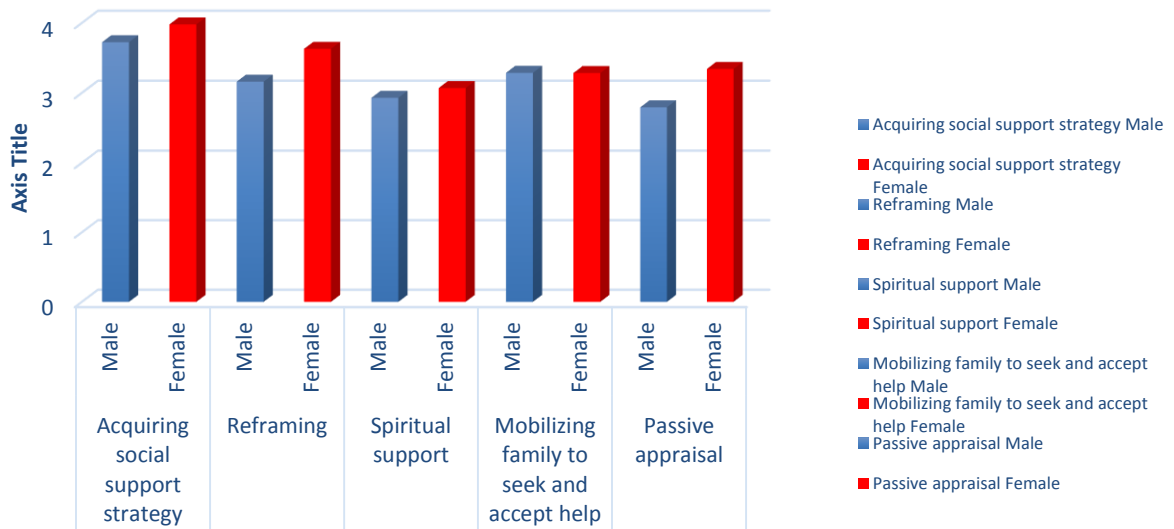
<b>Strategies</b>	<b>Mean</b>	<b>Std. Deviation</b>
Watching television	3.09	1.65
Knowing luck plays a big part in how well we are able to solve family problems	3.50	1.46
Accepting that difficulties occur unexpectedly	3.37	1.62
Defining the family problem in a more positive way so that we do not become too discouraged	2.50	1.58
Feeling that no matter what we do to prepare, we will have difficulty handling problems	3.85	1.37
Believing if we wait long enough, the problem will go away	2.31	1.53
<b>Passive appraisal</b>	<b>3.11</b>	<b>0.76</b>

Table 6 above presents the results for the passive appraisal coping strategy. The mean is ( $M = 3.11$ ) and the standard deviation is ( $SD = 0.76$ ).

#### 4.2.3 **Section B2: Relationship between respondents' demographic variables and coping strategies**

The respondents' demographic variables were compared with the five coping strategies to determine whether there is any relationship between demographic data and coping strategy as revealed by other literature. The Statistical Package for Social Scientist (SPSS), Version 24, was used to analyse the data. Figures 4.10 to 4.17 below present the results showing the relationship between the respondents' demographic data and utilisation of the five coping strategies. The results with P values less than 0.05 indicate a significant relationship ( $P < 0.05 = S = \text{Significant}$ ), while results with P values greater than 0.05 indicate a relationship that is not significant ( $P > 0.05 = NS = \text{Not Significant}$ ). The results show that there is a significant relationship ( $S = \text{Significant at } P < 0.05$ ) between gender (male and female), number of parents in a household (one and two) and religion (Christianity and Islam) with the respondents' coping strategies.

### 4.2.3.1 Relationship between gender and coping strategies



**Figure 12: Relationship between gender and coping strategies**

The above table shows that there is a relationship between reframing and passive appraisal and gender.

### 4.2.3.2 Relationship between age and coping strategies

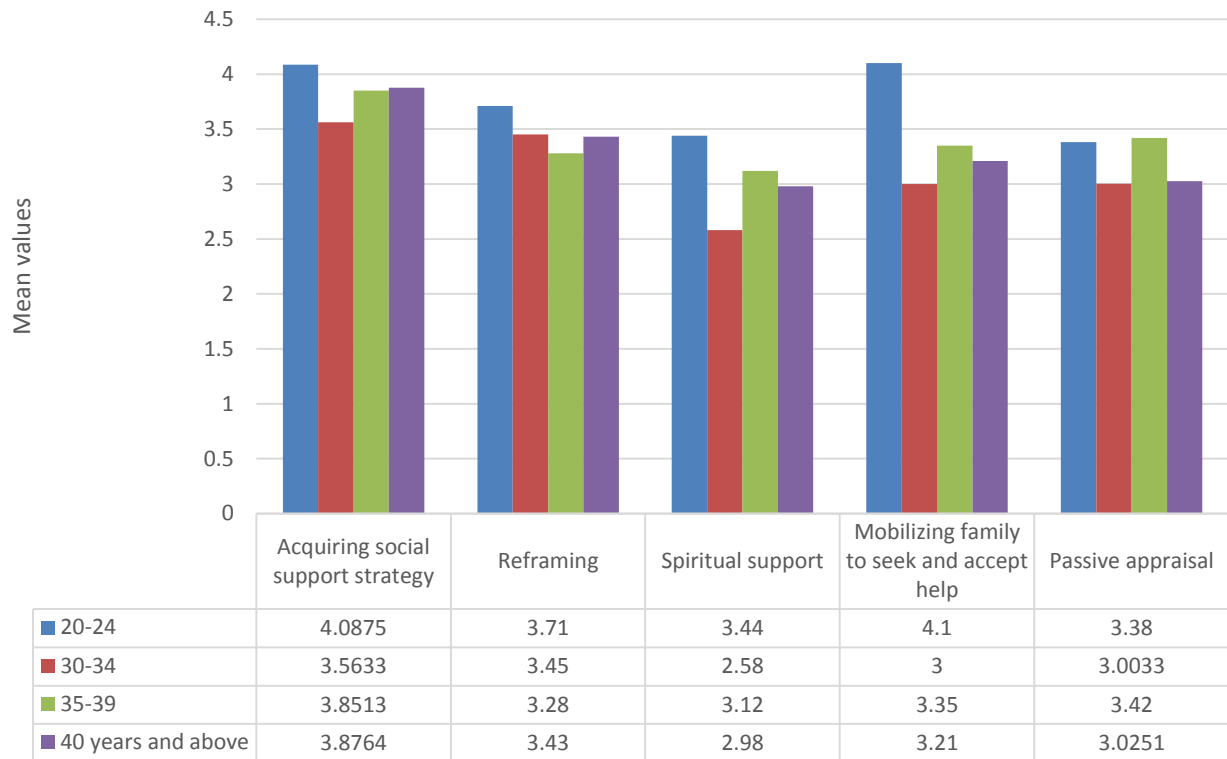


Figure 13: Relationship between age and coping strategies

The above table shows that there is no significant relationship between age and the five coping strategies.

### 4.2.3.3 Relationship between annual income and coping strategies

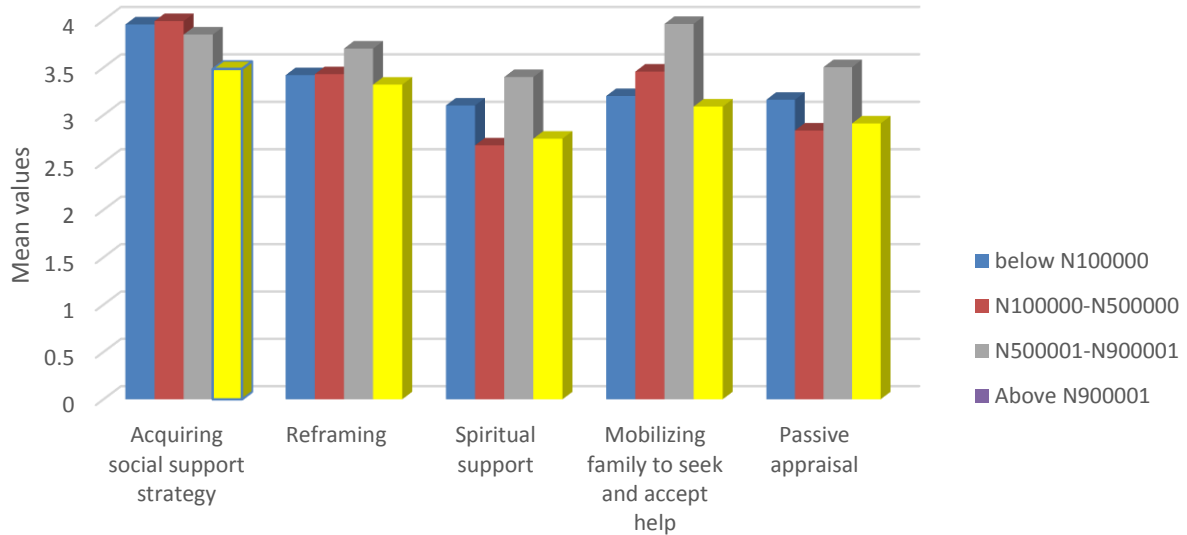


Figure 14: Relationship between annual income and coping strategies

The above table shows that there is no significant relationship between income and the five coping strategies.

### 4.2.3.4 Relationship between religion and coping strategies

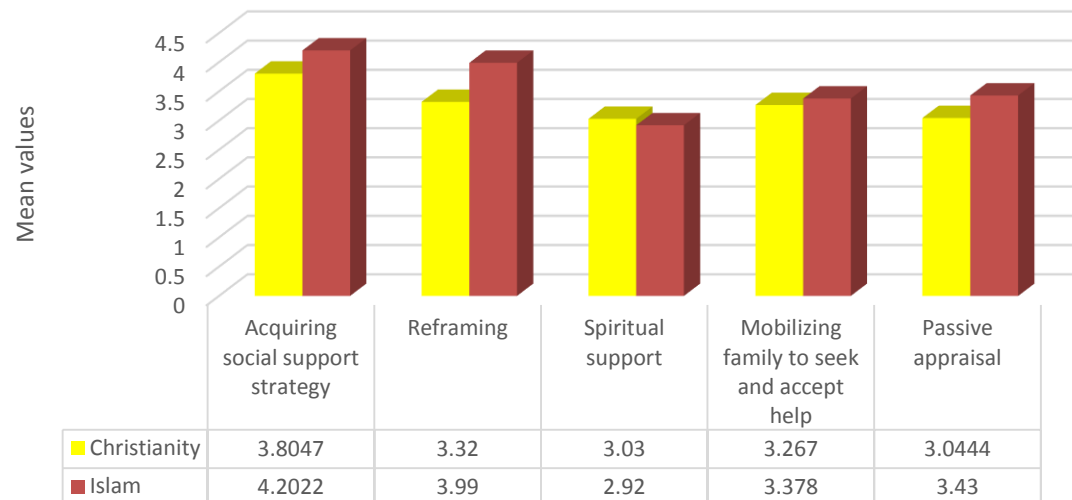


Figure 15: Relationship between religion and coping strategies

The above table indicates that there is a significant relationship between acquiring social support and reframing coping strategies and the religion of the parents with a physically disabled child.

**4.2.3.5 Relationship between number of children in household and coping strategies**

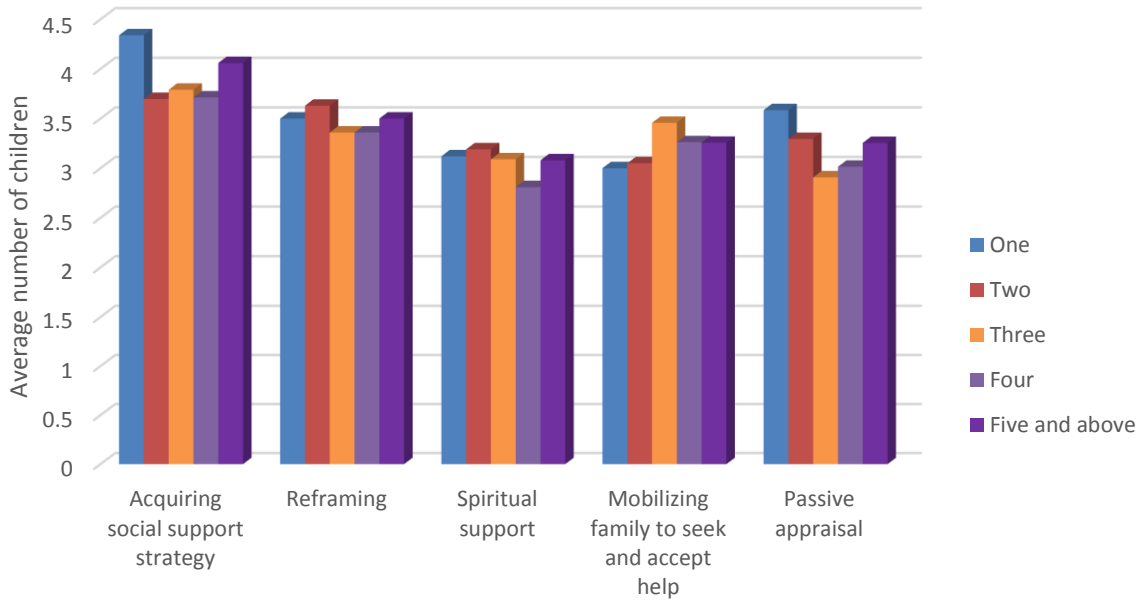


Figure 16: Relationship between number of children in household and coping strategies

The above table indicates no significant relationship between the number of children in a household and the five coping strategies.

#### 4.2.3.6 Relationship between position of disabled child and coping strategies

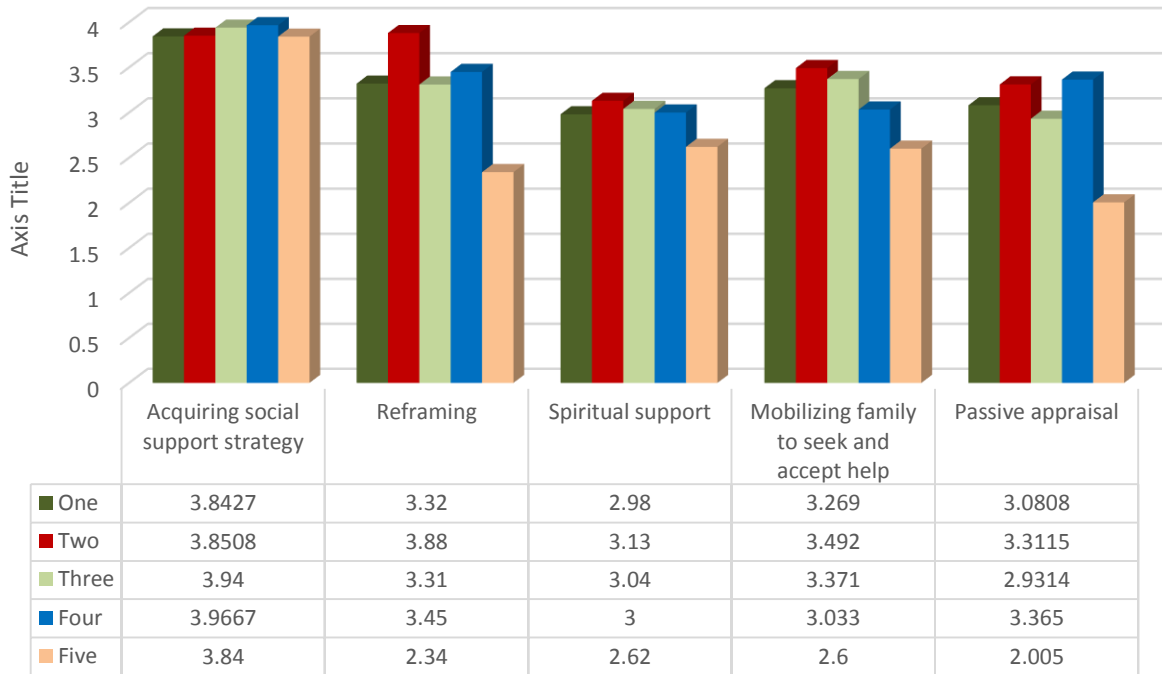


Figure 17: Relationship between position of disabled child and coping strategies

The above table shows that there no significant relationship was found between the position of the disabled child in the family and the coping strategy utilised by the parents.

**4.2.3.7 Relationship between number of parents in household and coping strategies**

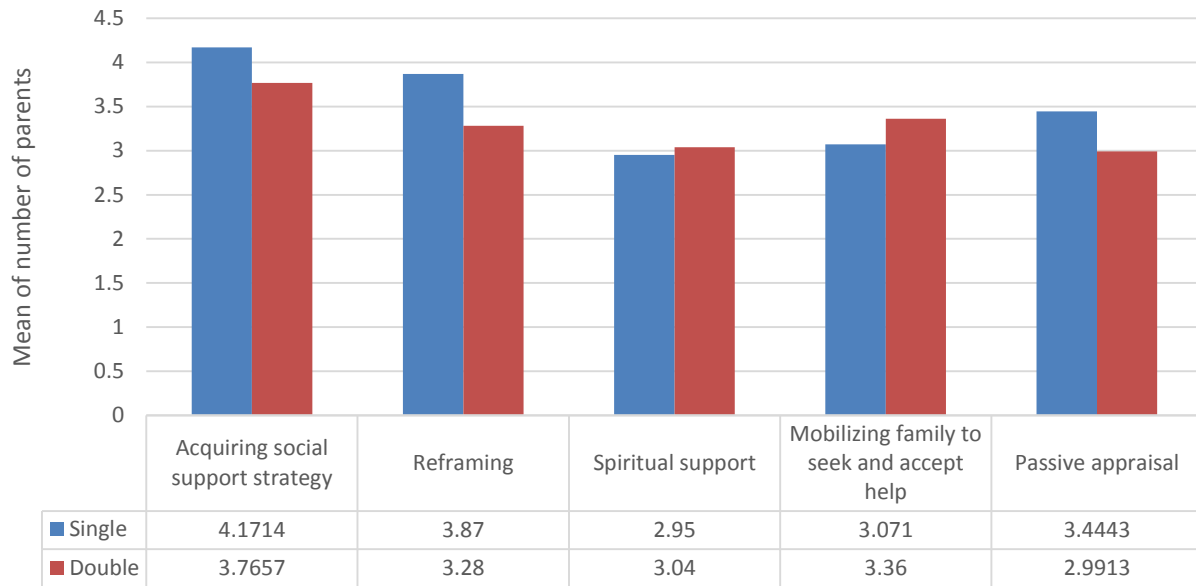


Figure 18: Relationship between number of parents in household and coping strategies

The above table shows that there is a relationship between acquiring social support, reframing and passive appraisal with the number of parents in a household. Single parents in a household tend to use the acquiring social support (M = 4.17; SD = 0.46), reframing (M = 3.87; SD = 0.77) and passive appraisal (M = 3.44; SD = 0.80) coping strategies.

**4.2.3.8 Relationship between occupation and coping strategies**



Figure 19: Relationship between occupation and coping strategies

The above table shows no significant relationship between occupation and the five coping strategies.

## **4.3 DISCUSSIONS**

Discussion of the findings of this study is based on the objectives and research questions and will be discussed in the context of the relevant literature and the theoretical framework of the study.

### **4.3.1 Demographic characteristics of parents with a physically disabled child**

The demographic characteristics of an individual determine the personality of the person. Previous studies relating to coping strategies have shown the influence of demographic characteristics on the coping strategies used. A study conducted by McCubbin et al. (2000), found that the ability to obtain support varies, depending upon individual characteristics, the availability of resources and the culture in which one lives. The present study found that the individual characteristics (gender, religion and number of parent in a household) determine their coping and utilization of coping strategies.

The female (31%) utilize various coping strategies (reframing and passive appraisal). This agreed with a study conducted by Burr et al. (2000) on effective coping strategies, where he found that women tend to use a wider range of coping strategies than men. According to this study passive appraisal and reframing coping strategies shows ones believe in self strength to adapt or cope with stressful situations. Believe in striving to accommodate a stressful situation rather than depending on others or denying reality. The female parents in the present study indicate that they mostly believe in their inner strength to cope with the care of their physically disabled child.

The number of parents in a household, (74. %) was also found to affect the type of coping strategy used by the respondents. The study found that households with double parent (father and mother) utilizes varying coping strategies (acquiring social support, Reframing and Passive appraisal). This may be because the presence of both parents develops confidence in each other to explore sources of help in addition to their personal resilience in a stressful situation, such as having a disabled child, and that this will influence the rest of the family. The study agreed with a study by Pritzlaff (2001) which highlighted that the quality of family relationships has been found to impact various aspects of parent well-being and child development. The aspect of family environment, family cohesion has predictive of parental adaptation to stressful condition.

Religion (45%) was also found to influence utilisation of coping strategy (Acquiring social support and Reframing). This agreed with Pargament, (1999) study where he highlighted that Religion reframing is viewed to see things from a new perspective and make the situation more manageable. Religion offers guidelines for living and a sense of stability. Families may view the difficult situation as an opportunity for change and become more religions observing all religious activities (Pargament, 1999).

The above findings indicate that individual characteristics or demographic data is vital to a person's ability to utilise a coping strategy.

### **4.3.2 Coping strategies utilised by parents with a physically disabled child**

As previously mentioned, it is difficult to assess the outcomes of coping due to the many variables involved. The literature review (90%) suggests that there are certain strategies that are more adaptive or more effective ways of coping than others. The present study found that acquiring social support (65%), reframing (39%), and passive appraisal (35%) is mostly use. The goal of coping strategies is to strengthen or maintain family resources, reduce the source of stress or negative emotions and achieve a balance in family functioning. A family's ability to adapt to stressful situations depends upon several variables, including an individual's psychological strengths, individual and family resources and the type of coping strategies utilised (Oduburu, 2011; Abbott & Meredith, 1986). F-COPES measured parenting coping strategies in the respondents of this study based on five subscales: social support, reframing, spiritual support, mobilising family members to acquire and accept help, and passive appraisal.

#### **4.3.2.1 Acquiring social support as coping strategy**

Acquiring social support is the act of seeking and accepting help from the society, either from a group, an organisation or individuals. According to Schilling et al. (1984) and Pitzlaff (2001), social support can be defined as individuals, groups or institutions which provide assistance to other individuals to overcome stresses on their resources. The results of this study indicated that acquiring social support was highest with mean  $M = 3.87$ ; (65%), this agreed with a study conducted by Pritzlaff (2001), where she found acquiring social support to be a commonly used coping strategy that is highly successful

Social support can be in the form of information or/and material obtained outside the conference of the family (Oduburu 2011). Acquiring social support was found to be determined by individual demographic characteristics, such as the number of parents in a household 35 out of 54 (65%). This is possible, considering the level of emotional and physical support parents can render to each other to access support in addition to the support they already have.

#### **4.3.2.2 Spiritual support as coping strategy**

The spiritual coping strategy is the least common strategy used by the respondents in the present study 12 out of 54 (22%). This contrasts with Oduburu's (2011) study of coping strategies used by parents with physically and mentally challenged children, where she found that the spiritual coping strategy was mostly used. She concluded that the respondents use the spiritual coping strategy because they are Christians and they believe God is supreme and has a reason for everything. The present study speculation (based on the

participant's utilization of reframing and passive appraisal) is that respondents use the spiritual coping strategy less because some individuals believe in keeping their relationship with God personal and unconditional, so they don't believe He will allow evil or any bad situation to befall them. This made them decide to believe "when we hold on the situation will pass" or respond inaccurately to the questions posed by the researcher.

#### **4.3.2.3 Mobilising family to seek and accept help as coping strategy**

Mobilising family members to seek and accept help was also seen to be used by few respondents 13 out of 54 (24%). This agrees with studies by Oduburu (2011). In their studies on coping strategies of parents with disabled children, they found that coping with the stress of parenting a physically challenged child is easier when family members work together as a team to establish new rules, roles and responsibilities to achieve stability. The family of a disabled child can adapt positively by mobilising resources such as time, money, information or knowledge and strength, to positively handle the challenge. When a family is faced with a difficult or challenging situation it is important for them to organise themselves toward positive adaptation.

#### **4.3.2.4 Reframing as coping strategy**

Reframing was another important coping strategy used by parents of physically disabled children. The present study reveals that reframing is the second most used coping strategy by respondents of the study 21 out of 54 (38%). Reframing entails believing in one's strength and ability. The researcher found that respondents responded to statements such as "knowing that we have strength in ourselves to solve our problems; showing that we are strong". This indicates the respondents have faith in themselves, that is, reframing coping strategy. This finding agreed with that of Oduburu (2011), who highlighted that parents' personal attributes, like patience, problem-solving skills, emotional strength, faith in oneself and ability to seek information, were an essential aspect of parents' coping process. These personal attributes helped some of these parents to see themselves as not being the only people with such problems, thereby developing the ability to hold on.

#### **4.3.2.5 Passive appraisal as coping strategy**

Passive appraisal means accepting stressful events as a fact of life, or believing that luck plays a big part in problem-solving. The present study found that parents of physically disabled children, especially female parents and households with two parents, utilised the passive appraisal coping strategy, 19 out of 54 (35%). This form of coping predisposes one not to seek solutions to stressful situations. Such individuals rather stay and allow the situation to determine their life. According to Pritzlaff (2001), though passive appraisal can be beneficial, professionals should discourage its long-term use.

### **4.3.3 Relationship between demographic data and coping strategies**

Researchers have discovered that different relationships exist between demographic variables and coping strategies. The present study also revealed some relationships which agree with the fact that the demographic status of an individual may have effect on the coping strategy that an individual or a family adopts. The results were obtained from the computation of P-values of the coping strategies against demographic characteristics as used in the study.

#### **4.3.3.1 Relationship between number of parents in a household and coping strategies**

The quality of family relationships impacts on various aspects of parent well-being and child development Amy (2001). The present study showed a significant relationship between the number of parents in a household (74%) and utilization of coping strategies. Household with double parents (father and mother) influences the utilization of coping strategy (acquiring social support). This agrees with studies by Schilling et al. (1994) and Pritzlaff (2001), where it was found that having a strong parental coalition of two parents is a high predictor of parental adjustment and reduced amounts of stress associated with caring for a child with a disability. This implies that single parents are at a higher risk of experiencing stress in caring for a disabled child.

There is the need for both parents to become involved in the effective parenting of a disabled child for maximum success. The role of the mother cannot easily be handled by the father and vice versa. Each parent has his or her special impact on the child's development. The single parent finds it difficult to effectively parent a physically disabled child owing to the demands of looking for resources to take care of the child. The single parent's ability to parent well depends on the availability of a child-care service and whether s/he can afford or find it.

#### **4.3.3.2 Relationship between number of children in a household and coping strategies**

The present study showed no relationship between the number of children and any of the coping strategies. This may be because the parents in this study have the disabled child as the first child, making him or her older than the other siblings.

#### **4.3.3.3 Relationship between gender and coping strategies**

Several studies have shown gender differences in coping. The present study found that female parents (31%) used passive appraisal and reframing coping strategies more than help seeking or spiritual support. This suggests that female parents use a variety of coping strategies and that there is no unique form of coping which they hold on to. According to a Burr et al. (2000) study on effective coping strategies, women

tend to use a wider range of coping strategies such as reaching out to people, involvement in religious activities and openly expressing their feelings. Men tend to withdraw, keep their feelings inside and use more harmful types of strategies for example, alcoholism.

The ability of female parents to use different forms of coping strategies empower them to cope with the care of their physically disabled child.

#### **4.3.3.4 Relationship between age, income, and level of education and coping strategies**

The researcher did not find any significant difference between coping strategies with age, level of education and annual income of the respondents. Religion was also not found to influence the choice of coping strategies in the present study. This is presumably because the respondents seem to use the passive appraisal (accepting a stressful event as a fact of life) and reframing (knowing we have the power to solve our problem) coping strategies.

#### **4.4 CONCLUSION**

This chapter presented the data results and discussion of the study. The researcher discussed the demographic data, the coping strategies and the relationship(s) between each demographic characteristics and coping strategy. The number of questionnaires that were fully completed and returned to the researcher for analysis consisted of 54. The total number of questionnaires distributed was 54. The response rate of parents to demographic data was 54 (100 %). The response to the coping strategies was 54 (100 %) and likewise for utilisation of coping strategies.

Firstly, the baseline demographic characteristics of the study respondents were presented: gender, age, income, religion, number of children in a household, number of parents in a household, position of the disabled child in the family, and occupation. The demographic variables gave characteristics of the respondents of the study. Analysis of the data gathered was done to determine the frequency and percentage of each demographic characteristic and results were presented in Tables 2 to 6.

Secondly, the coping strategies of the respondents were measured using the Family Crisis Orientation Personal Evaluation Scale (F-COPES), a five-point Likert scale. Descriptive statistics (mean and standard deviation) were determined and presented in figures. In addition, the 30 questions on the Likert scale were distributed under the 5 sub-headings to determine the 5 coping strategies, and were then analysed. The results were also presented in bar charts, see Figures 12 to 19 and interpretation of the results was given under each figure. The next chapter (5) presents the limitations of the study with recommendations and the conclusion of the entire study.

## **CHAPTER 5: RECOMMENDATIONS, LIMITATIONS AND CONCLUSIONS**

### **5.1 RECOMMENDATIONS**

The recommendations from this study are directed at the nursing profession, policy-makers and nursing research.

#### **5.1.1 Nursing profession**

Nurse counsellors should therefore encourage parents with disabled children to identify and utilise any social coping strategies they may find within their reach but not to keep their problems to themselves.

Passive appraisal was found to be utilised by several parents, especially mothers and single parents. It is important to note that, though passive appraisal may be helpful, it can only work on a short-term basis, therefore nurses/nurse counsellors should encourage and promote the use of more effective strategies, such as finding support and developing positive attitudes.

#### **5.1.2 Policy-makers**

Acquiring social support coping strategies was found to be most commonly used. Policy-makers should make avenues available to families, for example, funded associations to facilitate social support. Associations should be formed who can assist parents with information, basic amenities and also encourage parents to seek assistance and share their problems with such association.

#### **5.1.2 Nursing research**

Future research is needed in the family burden of disabled children and adopting a qualitative research approach to obtain in-depth information on the experiences of individual family members. A comparative study is recommended to look at the differences and commonalities in the burden perceived by family members in terms of disabled children.

Further study can be conducted aimed at to developing a template for use by parents with disabled children on how to cope with such children.

### **5.2 LIMITATIONS**

As with any other research, the present study has limitations.

1. One of the limitations of this study was the sample size. According to Creswell (2006) the purpose of quantitative research is to generalize from a sample to a population so that inferences can be made about

some characteristic, attitude, or behavior of this population. In the present study, only 54 parents with physically disabled child participated because only 54 respondents showed up on the data collection day, therefore, the use of larger sample will be of importance for similar study in the future.

2. Another limitation in this study was funding, though the researcher got funding from the university, it was insufficient for the study. Because the researcher collected data outside the country and had to spend much on transport.

3. Lastly, time constraints were another limitation. Heale and Twycross (2015) noted that studies that are subject to time constraints are problematic in that possible respondents who struggle with real or perceived time constraints are less likely to respond to surveys because they feel overworked and do not have the time to complete the survey. In this study, the questionnaires had to be administered and collected the same day in each school to meet up with time stipulated for the study therefore not giving the respondents much time.

### **5.3 CONCLUSIONS**

The purpose of the study was to describe the coping strategies utilised by parents of a physically disabled child in some selected schools for the disabled children in Plateau State, Nigeria.

Based on the findings of this study, the following conclusions were made:

The results of the study confirmed that families use different coping strategies to adapt to the burden of caring for a disabled child with little or no government aid.

Among all the strategies utilised by parents, the mean was the highest for acquiring social support, followed by reframing, mobilising family members to seek and accept help, passive appraisal and lastly, spiritual coping strategy.

There were significant relationships between gender, number of parents in household and coping strategies (reframing, passive appraisal and acquiring social support).

It is pertinent to note that utilisation of coping strategy can be determined by the characteristics of an individual.

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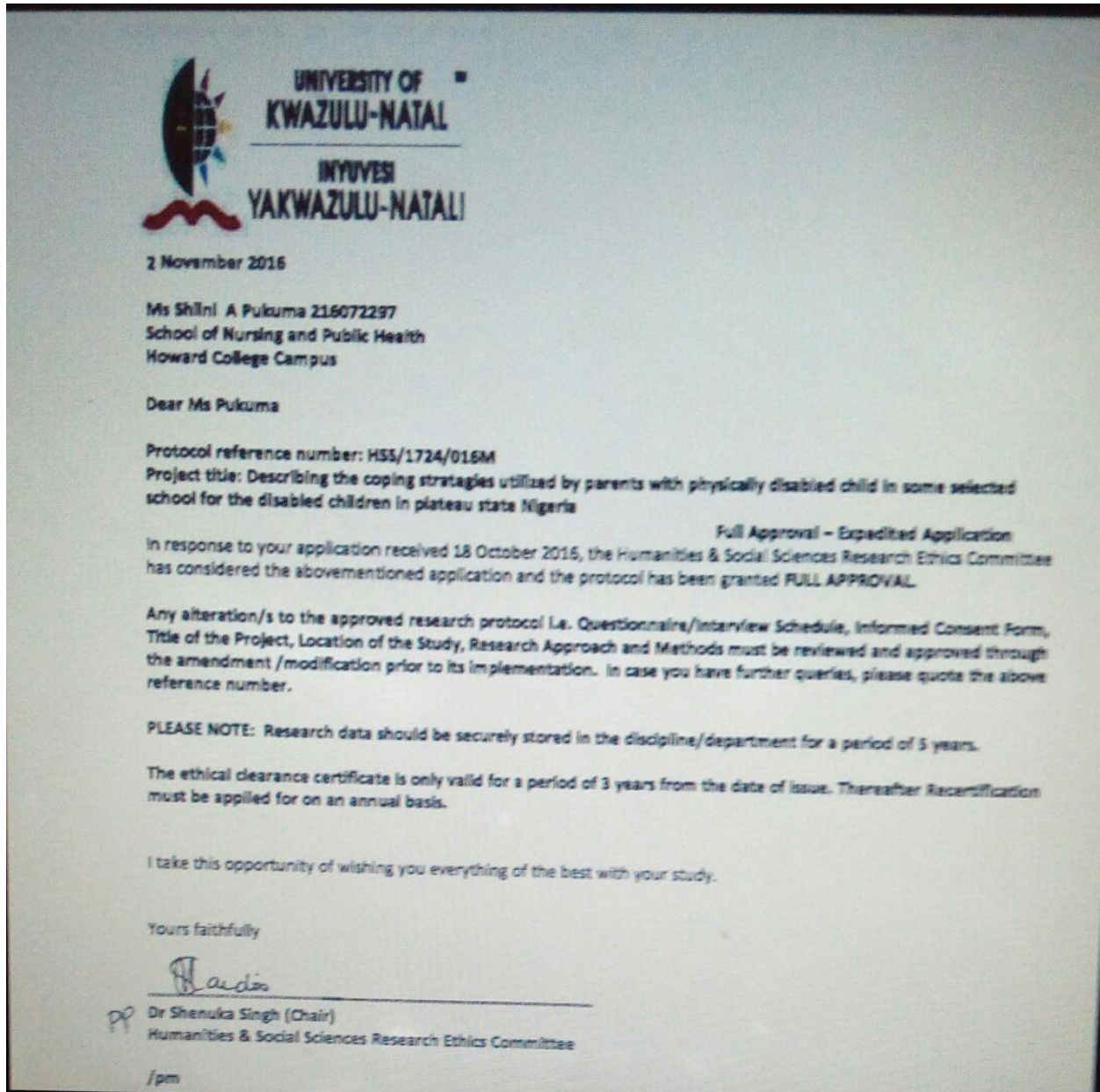
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## APPENDICES

### APPENDIX A: ETHICAL CLEARANCE LETTER



**APPENDIX B: GATE KEEPER LETTERS**

**SPECIAL EDUCATION MODEL TEACHING  
CENTRE, ABATTOIR, JOS  
DEPARTMENT OF SPECIAL EDUCATION AND REHABILITATION  
SCIENCES, UNIVERSITY OF JOS NIGERIA.**

5<sup>th</sup> October, 2016

Shilin Alfred Pukuma,  
College of Health Sciences, School of Nursing,  
Department of Community Health Nursing,  
University of Kwazulunatal, Durban, South Africa.

Dear Madam,

**RE: PERMISSION TO UNDERTAKE A RESEARCH STUDY**

With reference to your letter dated September 27<sup>th</sup> 2016 on the above subject matter, the management of this Centre will grant you access to the special needs children in the Centre for your study. At the moment, the Centre has children with hearing impairment and learning disabilities.

Be assured of our maximum co-operation

Thank you



ONOJA PETER OJO

A handwritten signature in black ink, appearing to read "Peter Ojo", written over a horizontal line.

FOR: MANAGEMENT



*Open Doors for Special Learners*  
**OPEN DOORS**  
**SPECIAL EDUCATION CENTRE**

---

Shilni Alfred Pukuma  
Collage of health sciences,  
school of nursing  
Department of community health nursing  
University of kwazulu-Natal Durban  
Durban South Africa

4 October 2016

**Permission to conduct research at Open Doors Special Education Centre**

I am pleased to inform you that you have permission to conduct research on coping strategies of parents with physically disabled children in some selected disable children schools in Plateau state Nigeria at Open Doors Special Education Centre, Jos, Plateau State, Nigeria .

Sincerely,

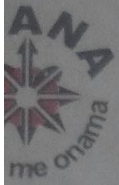
Open Doors  
Special Education Centre  
*Joanne J. Umolu*

Prof. (Mrs.) Joanne Umolu  
Director

---

OPEN DOORS SPECIAL EDUCATION CENTRE

Joanne J. Umolu, Ph.D, Director.  
Off Liberty Blvd, Jos P. O. Box 6417, Jos, Plateau State, Nigeria  
Tel. 0803 453 4990 [opendoorsng@gmail.com](mailto:opendoorsng@gmail.com) [www.opendoorsnigeria.org](http://www.opendoorsnigeria.org)  
Facebook Page: Open Doors for Special Learners



# Otana Integrated School

9 Richard Road, (Behind Leventis Motors) P. O. Box 8383, Jos, Nigeria

Email: otanajos@yahoo.com

et.....

Your Ref:.....

Date: 30/09/2016.

Shilni Alfred Pukama,  
College of Health Sciences,  
School of Nursing,  
Department of Community Health Nursing  
University of Kwazulunatal Durban,  
Durban, South Africa.

Dear ma,

## RE-APPLICATION FOR PERMISSION TO UNDERTAKE A RESEARCH STUDY

You are highly welcomed as your study with the topic, "Describing the coping strategies of parents with physically disabled children in some selected disabled children schools in Nigeria" is in line with the philosophy of inclusive education and most especially persons living with disabilities and the challenges faced by their parents.

We look forward to having a cordial working relationship with you. Thank you.

Yours faithfully,  
  
ADMINISTRATOR  
30 SEP 2016  
9 9 SEP 2016  
RICHARD ROAD, JOS NIGERIA  
Administrator

## **APPENDIX D: INFORMED CONSENT FORM**

**Project title:** Coping Strategies of Parents with Physically Disabled Children at Disabled Schools in Plateau State. A Descriptive study.

Dear Sir/Madam

I am Shilni Alfred Pukuma, a registered nurse with the Nursing and Midwifery Council of Nigeria, currently registered with the University of KwaZulu-Natal for the Master's Programme in Community Health Nursing. I am inviting you to participate in this research study.

### **What is the purpose of the study?**

The purpose of this study is to describe how parents cope with the demanding challenges of parenting a physically disabled child considering the little or no help coming from the government.

### **Why have you been selected?**

You have been selected to participate in my study because you are the parents of a disabled child and you know best how you cope in taking care of him/her. You have used some strategies that ease your situation in one way or the other. Therefore, I would like you to participate in the study.

### **Do you have to take part?**

Participation in this study is voluntary.

### **What will happen to you if you take part?**

You need to fill in a questionnaire that will help to collect information needed for this study.

### **What if there is a problem?**

Should you have any problems or inquiries please contact the following:

Researcher: Shilni Jacob Liberty

216072297@stu.ukzn.ac.za or shilnipukuma@gmail.com. Tel. +27(0)781015185

Research supervisor: Dr Gumede Zandile

gumedez@ukzn.ac.za. Tel. +27(0) 722605376

Thank you for your time and cooperation.

Yours faithfully

Shilni Jacob Liberty

## APPENDIX E: DECLARATION OF CONSENT

By signing, I..... (full name of participant) agree to take part in this research study titled:

**Describing the coping strategies of parents with physically disabled children in some selected schools for disabled children in Plateau State, Nigeria.**

I confirm and declare that:

- I understand the contents of this document and the nature of the research project.
- I agree to participate voluntarily in this research project.
- I understand that I'm at liberty to withdraw from the project at any time should I so desire.
- I hereby freely consent to take part in the research project.

Signed at (place).....

Signature of participant.....

Date.....

Signature of witness.....

Date.....

Declaration by the Researcher

I, Shilni A. Pukuma, declare that:

- I have explained the information in this document to the participant by means of the information document.
- I was available to answer questions directly.

Researcher:

Supervisor:

Ethics

Mrs. Shilni J. Liberty

Gumede Zandile

HSSREC Research

44 Bowen Avenue Glenmore

4<sup>th</sup> Floor, School of Nursing Office

Durban.

Howard College Campus (UKZN) Tel. 0312608350

Tel. +27(0)781015185

Tel. +27(0)722605376

Email: shilnipukuma@gmail.com

## APPENDIX F: QUESTIONNAIRE

Dear Parent

The researcher is a post-graduate student at the School of Nursing and Public Health, College of Health Sciences, University of KwaZulu-Natal, Durban, South Africa. She is carrying out research on coping strategies of parents with physically disabled children in Plateau State, Nigeria. This research is for academic purposes. Your participation is completely voluntary and your answers will remain entirely confidential and anonymous.

### SECTION A

Socio-demographic data

(Please tick ✓ the appropriate answer.)

1. Gender:

Male

Female

2. What is your age?

20-24

25-29

30-34

35-39

40+

3. What is your annual income?

50,000–100,000

150,000–500,000

550,000–1,000,000

Above 1,000,000

4. What is your religion?

Christianity

Islam

Traditional

Other

5. How many children do you have?

1

2

3

4

5+

6. What is the position of the disabled child in the family?

1

2

3

4

5 and above

7. What is the number of parents at home?

1

2

8. What is your level of education?

Primary

Secondary

Tertiary

9. What is your occupation/profession?

Civil servant

Business

Other

## SECTION B

**Instructions:** First read the list of response choices one at a time. Secondly, decide how well each statement describes the coping strategies you utilise in response to your child’s situation. 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 the number 2, 3 or 4 to indicate how much you agree or disagree with the statement about your response.

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	2	3	4	5
1	Sharing our difficulties with relatives					
2	Seeking encouragement and support from friends					
3	Knowing we have the power to solve major problems					
4	Seeking information and advice from persons in other families who have faced the same or a similar problem					
5	Seeking advice from relatives (grandparents, etc.)					
6	Seeking assistance from community agencies and programmes designed to help families in situation					
7	Knowing that we have the strength within our family to solve our problems					
8	Receiving gifts and favours from neighbours (e.g. food taking in mail, etc.)					
9	Seeking information and advice from the family doctor					
10	Asking neighbours for favours and assistance					
11	Facing the problems “head-on” and trying to get a solution right away					
12	Watching television					
13	Showing that we are strong					
14	Attending religious services					
15	Accepting stressful events as a fact of life					

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

## APPENDIX G: PROOF OF EDITING



7 Woodlands Rd  
GLENWOOD  
DURBAN  
4001  
083 415 2531  
30 December 2016

**Reg. No. 2006/156780/23**

Shilni A. Pukuma

### **EDITING OF RESEARCH DISSERTATION OF SHILNI A. PUKUMA**

I have an MA in English from University of Natal (now UKZN) and have been performing editing services through my company for eleven years. My company regularly edits the research dissertations, articles and theses of the School of Nursing, Environmental Studies and various other schools and disciplines at the University of KwaZulu-Natal and other institutions, as well as editing for publishing firms and private individuals on contract.

I hereby confirm that Shirley Moon edited the dissertation of **Shilni Pukuma** titled “Describing the coping strategies utilised by parents with a physically disabled child in some selected schools for disabled children in Plateau State, Nigeria” on behalf of WordWeavers cc and commented on the anomalies she was unable to rectify in the MS Word Track Changes and review mode by insertion of comment balloons prior to returning the document to the author. Corrections were made in respect of grammar, punctuation, spelling, syntax, tense and language usage as well as to sense and flow. An editing guideline and additional comments were provided to assist with corrections.

I trust that the document will prove acceptable in terms of editing criteria.

Yours faithfully

**C Eberle**  
**Catherine P. Eberle (MA: University of Natal)**

**APPENDIX H: MAP OF NIGERIA SHOWING THE STUDY LOCATION-PLATEAU STATE**

