

A COMPARISON OF WELL-BEING INDICATORS AND AFFECT REGULATION STRATEGIES BETWEEN PARENTS OF CHILDREN WITH DISABILITIES AND PARENTS OF TYPICALLY DEVELOPED CHILDREN

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Abstract: Research to date has shown that the well-being of parents of children with disabilities is lower than that of parents of typically developed children. However, the vast majority of this research has been conducted with this exact purpose in mind, thus placing parents and their children's disability in the spotlight, which may have resulted in a distortion in the participants' answering process. In addition, participants were mostly chosen because they have or do not have a child with disabilities, while other relevant characteristics were poorly matched. The aim of the research described in this paper was to compare parents of children with disabilities to a corresponding group of parents of typically developed children in terms of various well-being indicators and specific sources of life satisfaction. This study was conducted within the framework of the Croatian Longitudinal Study of Well-Being (CRO-WELL) project. The sample used in this study consisted of 41 parents of children with disabilities. Each of these parents was matched to a very similar individual with typically developed children. Consequently, we obtained two samples in which the majority of participants were women, married, living in a large city, and employed, two-thirds of whom had completed secondary school education at least. Differences emerged regarding satisfaction with free time, indicating that parents of children with disabilities were less satisfied than parents of typically developed children. In addition, parents of children with disabilities felt pleasant less frequently. Both groups of parents used active affect regulation strategies more often than passive ones as tools to deal with negative emotions. Proactive strategies were related to higher well-being levels, while passive strategies were related to lower well-being levels, a trend that became particularly evident among parents of children with disabilities.

Keywords: well-being, parents of children with disabilities, life satisfaction, happiness, affect regulation strategies

INTRODUCTION

Disability is still a taboo in some societies, communities and individuals, and parents of children with disabilities are often stereotyped as miserable, helpless, and hopeless. Nowadays, growing evidence is emerging to support the fact that families with children with disabilities can live fulfilling and cheerful lives, while respecting the disabled child's needs and providing sufficient care. This paper will present research on such families in Croatia, conducted as a part of the Croatian Longitudinal Study of Well-Being (CRO-WELL) project, funded by the Croatian Science Foundation.

The Croatian Welfare Act¹ defines a child with developmental disabilities as any child who, due to physical, sensory, communications, or intellectual difficulties, requires extra support for learning and development in order to reach the best possible outcome and attain social inclusion. The Guidelines on Elementary and Secondary School Education and the Education of Pupils with Developmental Difficulties² divide developmental disabilities into seven groups: visual impairment, hearing impairment, speech impairment, organ failure, impaired intellectual function, behavioural and mental disorders, and multiple disorders.

1 Zakon o socijalnoj skrbi, Opće odredbe, čl. 2, točka 8, NN 33/2012

2 Orijentacijska lista vrsta teškoća. Pravilnik o osnovnoškolskom i srednjoškolskom odgoju i obrazovanju učenika s teškoćama u razvoju, NN 24/2015

Children with different disabilities encounter different challenges, while the parents of these children must adjust their private and professional lives in order to meet the children's needs. Earlier research has shown that families with a child with disabilities suffer severe negative impacts, including chronic sorrow (Olshansky, 1962), depression (Quine & Pahl, 1985; Roach, Orsmond & Barratt, 1999; Valentine, McDermott & Anderson, 1998), mental and physical health problems (Witt, Riley & Coiro, 2003; Wolfensberger, 1969), and increased divorce rates (Gath, 1977). Many studies have indicated considerably lower well-being indicators among parents of children with disabilities than among parents of typically developed children (Byrne et al., 2010; Guyard et al., 2011; Ergün & Ertem, 2012). On the other hand, some studies show positive outcomes from parenting a child with a disability through positive coping, which leads to adequate adaptation (e.g. Glidden, 1989; Goodley & Tregaskis, 2006; McKeever & Miller, 2004; Ramey, Krauss & Simeonsson, 1989; Turnbull et al., 1993). Most research on parents of children with disabilities focus on indicators of mental health, such as stress, depression, or sorrow, as these are found to be threats to parental well-being (e.g. Bailey et al., 2008). However, contemporary views on well-being stress the importance of positive emotions and moods that are important for well-being (Seligman & Csikszentmihalyi, 2000). Therefore, in order to get a better insight into how well-being of parents of children with difficulties is different from well-being of parents of typically developed children, it is necessary not only to question the absence of negative indicators, but also to search for the presence of positive ones. The following section shall describe the most prominent approaches to the conceptualisation and research of well-being.

Well-being

Well-being is a broad concept that can be measured both objectively and subjectively. While objective measures of well-being include parameters such as material status, health indicators, and environmental conditions, subjective measures refer to an individual's perception of his/her own life. Objective measures undoubtedly indicate that

parents with typically developed children have higher well-being scores: having a child with a diagnosed disability has been shown to have a significant impact on overall family health ratings as well as other domains such as finances or employment (Seltzer et al., 2001).

However, the present study intends to examine subjective well-being, which is assumed to encompass high levels of positive emotions, low levels of negative emotions, and favourable ratings of life satisfaction (Diener, Suh & Oishi, 1997). Diener et al. (2009) constructed a scale to assess experiences of positive and negative emotions, while either a single-item or single-construct scale was used to measure overall life satisfaction (Diener et al., 1985). Contrary to Diener's approach to well-being, which assesses overall ratings of life satisfaction, Cummins adopts a domain-level representation of global life satisfaction. Viewed in this manner, subjective well-being consists of satisfaction with various aspects of life, such as health and achievement (Cummins, 2013).

A recent concept in well-being research is *flourishing*, describing well-being through developing as a person, being fulfilled, and contributing to the community (Shah & Marks, 2004). Different scholars variously define the concept of flourishing. For instance, Ryan and Deci (2000) contend that it includes relatedness and self-acceptance, while it is described as flow, interest, and engagement by Csikszentmihalyi (1990), and as purpose and meaning by Seligman (2002) and Ryff and Singer (1998). Investigating the elements of flourishing, Brown et al. (2003) and Dunn, Aknin & Norton (2008) found that helping others is more beneficial for well-being than receiving help. This finding may be of interest when studying the well-being of parents of children with disabilities, as they are often challenged to provide help and support to their children.

Comprehensive studies carried out in different countries report that people rate their happiness moderately above the theoretical average. Demographic correlates of subjective well-being have been the subject of a large volume of research. Differences regarding age, sex, and income were found to be small in magnitude (Diener & Suh, 2000), indicating somewhat better well-being in

younger individuals and those with at least moderate incomes, while women seem to experience (and display) more positive and more negative emotions (Diener & Diener, 1996). While the findings regarding the relationship between objectively-measured health and subjective well-being are mixed, subjective health (i.e. subjective evaluations of one's own health) is a strong predictor of well-being. Events such as falling in love, giving birth, or gaining employment are important to most people, and therefore influence their lives and daily routines in various ways, thus affecting their well-being. For most parents, the birth of a child is both a joyful and a stressful experience. For parents of children with disabilities, feelings of joy and happiness are mixed with fear and despair. The first diagnosis is probably the most stressful experience for such parents, and it is followed by reactions similar to those related to bereavement (Marvin & Pianta, 1996). Nevertheless, after the initial shock is absorbed, parents are forced to cope with the various demands arising from their child's disability, from their everyday routine to expectations for the child's future. Because of the demanding living circumstances of such parents, it is important to research their well-being, as well as differences between their well-being and that of parents of typically developed children.

Compared to parents of typically developed children, parents of children with disabilities typically show lower levels of well-being indicators, but most research has investigated negative outcomes, such as stress and depression. For example, Mobarak et al. (2000), Ones et al. (2005), and Hamzat & Mordi (2007) all report on the negative outcomes of being a caregiver of a child with a physical disability, such as the high risk of psychiatric morbidity and increased levels of stress and depression. Singer (2006) conducted a meta-analysis showing that mothers of children with developmental disabilities are at elevated risk of depression compared to mothers of typically developing children. On the other hand, Seltzer and Ryff (1994) and Van Riper, Ryff and Pridham (1992) report that many parents of children with disabilities have high well-being at levels comparable to those of similar parents of non-disabled children. It seems that, aside from the type of disability and the child's

behaviour (Baker et al., 2002), parents' coping strategies are crucial, as they face both the normal pressures of family life while also having to accommodate the needs of the child with a disability. The following section shall briefly describe the sources and consequences of stress in families of children with disabilities, and then review coping and affect regulation strategies that can be used to deal with stress and stress-related negative feelings.

Stress in families with a child with disabilities

Stress in everyday life has been found to correlate significantly with both mental and physical illness (Adler & Matthews, 1994; Coyne & Downey, 1991). A great deal of research has confirmed unusually high levels of stress among parents of children with disabilities (Hastings & Beck, 2004; Singer, 2006). Although caregiving is a regular part of parenting, in families with children with disabilities, the level of stress is usually higher, and the child's behaviour often requires additional changes to daily routines. A parent of a child with disabilities usually has to cope with the child's problems while meeting the needs of everyday life. It is not rare for one parent to have to give up his/her job in order to take a permanent caregiver role (Seltzer et al., 2001). Parents of a child with disabilities are not only under stress because of the child's illness itself – it also often triggers difficulties in other life domains (e.g. more frequent absences from work, reduced social life, problems in marital life, and problems related to typically developed siblings). Finally, parents of children with disabilities are additionally troubled by thoughts about the future of their child (Heiman, 2002).

A large body of research has confirmed that one of the most pressing issues in the lives of caretakers is a lack of free time. Families with children with disabilities devote more time to their children than do families of typically developed children, therefore leaving less time for socialising and other entertaining activities (Barnett & Boyce, 1995; Sanders & Morgan, 1997). Time restrictions and time demands have been found to be the most apparent stressor influencing other life domains (Shearn & Todd, 2000; Olsson & Hwang, 2003). Murphy et al. (2007) found that forty percent of caregivers reported that their health had worsened

over the past year, attributing these changes to a lack of time, a lack of control, and decreased psychosocial energy.

People use different strategies to cope with stress, and the most often utilised division of coping strategies refers to the difference between problem-focused coping and emotion-focused coping. While problem-focused coping refers to various behaviours such as planning, taking action, asking for help or support, suppression of competing activities, or restraining from action (until the appropriate moment), emotion-focused coping is oriented towards increasing positive mood or decreasing negative mood through techniques such as reinterpretation, acceptance, or denial (Lazarus & Folkman, 1984).

Affect regulation strategies

Similarly to emotion-focused stress-coping, people consciously and unconsciously use various techniques to improve their emotional states. We refer to these techniques as affect regulation strategies. Similar to coping strategies against stress, affect regulation strategies vary widely from problem-focused to emotion-focused and from cognitive to behavioural, and their purpose is to alter one's current affective state if a sufficient discrepancy is observed between experienced and desired affect.

Therefore, to regulate their emotional states, people do or think different things, sometimes to distance themselves from the problem and sometimes to analyse it, engage with it, and attempt to solve it. To the best of our knowledge, affect regulation strategies have not been investigated among parents of children with disabilities yet, as researchers to date have focused on coping strategies against stress.

Morris and Reilly (1987) classified affect regulation strategies into four categories: management of mood, re-interpretation of the problem, direct action, and affiliation. However, while different studies report different affect regulation strategies, authors most often refer to self-rewarding (by either thinking positive thoughts or doing enjoyable things), actively engaging, seeking social support, making social comparisons, venting, suppressing,

withdrawing, disengaging, and avoiding. Parkinson and Totterdell (1999) differentiate between (1) cognitive vs. behavioural strategies and (2) engagement vs. diversionary strategies. For example, for parents of children with disabilities, thinking about and trying to find ways to solve a central problem (e.g. finding resources for additional therapy) would be a cognitive engagement strategy, while leaving the room when the child is misbehaving would be a behavioural diversionary strategy.

Self-reward strategy implies thinking about nice things like making plans for the future, or taking part in enjoyable activities. This strategy has been found to be efficient in emotion regulation, nearly without exception. However, in its dysfunctional manifestation, this strategy may include excessive drinking, eating, drug use, or other consumption behaviours leading to momentary satisfaction, though their effects do not last long (Larsen & Prizmić, 2004). *Active engagement* with the situation is usually an effective strategy as it provides a feeling of control. *Venting* and *suppression* are two opposing strategies, because venting demands the expression of emotions, while suppression is based on emotional inhibition. Neither of these strategies is found to be successful in the regulation of negative emotions (Larsen & Prizmić, 2004). *Downward social comparison* helps people put a problem into perspective and create positive feelings. *Social contact* itself is beneficial for well-being, and therefore it is a frequently used strategy. As long as the people with whom we socialise are in the desired mood state, this strategy seems to engender positive affect (Larsen & Prizmić, 2004).

Kaliterna Lipovčan, Prizmić, and Franc (2009) analysed affect regulation strategies on a representative sample of Croatian residents and found that active strategies (active distraction, cognitive engagement, and behavioural engagement) were used significantly more than other regulation strategies. All of these strategies can be used by parents of children with disabilities. Since a great deal of research has shown that positive coping strategies against stress lead to adequate adaptation and positive well-being outcomes, we assume that affect regulation strategies function in the same manner.

Positive outcomes in families with children with disabilities

Some studies, including meta-analyses and longitudinal research, indicate that negative outcomes in families with children with disabilities are not as frequent as was previously thought (Seltzer et al., 2001; Risdal & Singer, 2004; Glidden & Jobe, 2006; Singer, 2006). Moreover, Hastings and Taunt (2002) found that many parents of children with disabilities derive benefits and positive contributions from the care and love they give to their child. Research on parents of children with autism reveals many positive outcomes, such as: life-changing experiences resulting in the transformation of their belief and value systems, priorities, and worldview (e.g. King et al., 2006; Hastings & Taunt, 2002), deep spiritual experiences (Gray, 2006; Hastings & Taunt, 2002), and attainment of a sense of coherence and control (King et al, 2006).

Olsson and Hwang (2003) described the following positive outcomes related to having a child with disabilities: joy and happiness, increased sense of purpose and priorities, expanded personal and social networks and community involvement, increased spirituality, family unity and closeness, increased tolerance and understanding, personal growth and strength, positive impacts on others and on the community, and more conscious behaviour towards other children.

The purpose of the research and the research problem

Most of the research so far has shown that the well-being of parents of children with disabilities (usually assessed using "negative" indicators such as stress, sorrow, depression) is lower than the well-being of parents of typically developed children. However, some authors have also reported on positive outcomes. Although much research has examined anti-stress coping strategies in relation to parenting children with disabilities, affect regulation strategies have not yet been explored. Moreover, most research uses levels of sorrow, stress, and depression as well-being indicators, but only a single instrument for measuring happiness or life satisfaction. We believe that research that takes more indicators of well-being into account and uses measures of experienced positive and negative emo-

tions, satisfaction with various life-domains, and flourishing would contribute to existing knowledge regarding the specific outcomes of raising a child with disabilities. Gupta and Singhal (2004) argue that research should be structured to include the positive feelings of parents of children with disabilities, something current research frequently fails to do.

Research goals

The goal of this research was to analyse various indicators of well-being among parents of children with disabilities and to compare these indicators to those collected from a similar group of parents of typically developed children. In addition, we will explore how specific affect regulation strategies are related to well-being in each group. The following goals were formulated:

1. Explore differences in well-being indicators between parents of children with disabilities and parents of typically developed children. Based on most previous research, we hypothesise that parents of children with disabilities will report higher levels of experienced negative emotions (Olshansky, 1962; Quine & Pahl, 1985). However, since results from previous research have been controversial, it is not possible to make clear hypotheses about differences between parents of children with disabilities and the control group regarding overall happiness, experienced positive emotions, or flourishing. Regarding general life satisfaction and satisfaction with various life domains, we expect that parents of children with disabilities are less satisfied with most of the domains than the control group, since raising children with disabilities triggers difficulties in other life domains, which we assume will reflect on their general life satisfaction as well.
2. Identify affect regulation strategies used by parents of children with disabilities and parents of typically developed children, and assess correlations between affect regulation strategies and various well-being indicators in both groups. On the basis of the results of previous research (e.g. Kaliterna Lipovčan, Prizmić & Franc, 2009), we expect that both groups will use more proactive than passive strategies. Furthermore, we expect that in both groups, proactive regula-

tion strategies will be related to higher levels of well-being, and passive strategies to lower levels of well-being. Since affect regulation strategies have not yet been studied among parents of children with disabilities, we cannot make clear hypotheses about differences in the use of various strategies between the two groups.

METHOD

Participants

This study was conducted as part of the CRO-WELL project, a longitudinal well-being study in Croatia. An initial sample of participants ($N=1432$) yielded a subsample of 41 individuals who reported being a parent of a child with a developmental disability. Due to the large sample size, we were able to match each of these individuals to a very similar parent of a typically developed child. Matching criteria were age, gender, education level, employment status, monthly income per family member, population in the place of residence, and number and age group of children. These criteria were selected based on previous research that has indicated that these demographic variables are relevant in well-being research (Diener, Lucas & Oishi, 2002; Seligman & Darling, 2007). We thus formed two groups of participants³: parents of children with disabilities (CWD; $N=41$) and parents of typically developed children (TDC; $N=41$).

Table 1. Socio-demographic characteristics of parents of children with disabilities and parents of typically developed children.

| Feature | | Parents of | |
|------------------------|-------------------|------------|-----|
| | | CWD | TDC |
| Gender (female) | | 80% | 80% |
| Married | | 88% | 90% |
| Employed | | 85% | 80% |
| Education | ≤ high school | 44% | 49% |
| | > high school | 56% | 51% |
| Income* | < 2,000 HRK | 26% | 27% |
| | 2,000 - 5,000 HRK | 66% | 65% |
| | ≥ 5,000 HRK | 9% | 8% |

Notes: CWD – children with disabilities, TDC – typically developed children; * per person in the household

The two sample groups consisted of mostly women, and in fact contained all the female participants in the CRO-WELL project. The average age was around 42 years. The majority of participants in both groups were employed and almost all were married, while two-thirds of the participants had an income of between 2,000 and 5,000 Croatian kuna per family member (*Table 1*). We also gathered information on disability type, which is displayed in *Table 2*.

Table 2. Number of reported developmental disabilities in the sample.

| Child disability | N |
|----------------------------------|----|
| Visual impairment | 1 |
| Hearing impairment | 3 |
| Speech impairment | 3 |
| Organ failure | 8 |
| Impaired intellectual function | 3 |
| Behavioural and mental disorders | 3 |
| Multiple disorders | 20 |
| Total | 41 |

Procedure

Participants used an on-line application to complete an on-line survey, which consisted of a comprehensive battery of questionnaires. The survey was advertised in print media, on various on-line forums, on social networks, and on websites. Every adult person in Croatia interested in completing the survey was able to access the study using the link provided (www.sreca.hr). Participation in the study was voluntary and anonymous, which resulted in a self-selected convenience sample favouring female, young, educated participants. No special effort was invested into attracting a larger sample of parents of children with disabilities.

Instruments

Demographic information

The personal socio-demographic information of subjects was recorded, such as age, gender, and family income. They were also assessed on whether they were parents of children with disabilities.

³ Cases were matched based on the indicated criteria using Microsoft Excel. First, the program searched for a perfect match for all eight criteria. Then, the formula was reduced by one criteria at a time, starting with the age group of other children and moving towards the age of the participant. If a certain participant was not perfectly matched, we searched for similar ones and then manually chose the closest match.

On the basis of this demographic information, we formed a "control" group that corresponded to the group of parents of children with disabilities.

Well-being indicators

The measure of life satisfaction as a global cognitive judgment of satisfaction with one's life was used to assess the cognitive component of subjective well-being. We used a single-item measure that is typically used for this purpose, such as in the World Values Survey (2007). The subjects were asked "All things considered, how satisfied are you with your life as a whole?". They rated their satisfaction with their life using an 11-point scale, where 0 means "not satisfied at all" and 10 means "extremely satisfied".

The Happiness Measure Scale (Fordyce, 1988) was used to examine the affective component of subjective well-being. The question "In general, how happy do you usually feel?" was rated on an 11-point scale ranging from 0 "not happy at all" to 10 "extremely happy". Correlation between life satisfaction and the Happiness Scale was $r = .819$ ($p < .01$) for the initial sample.

The Scale of Positive and Negative Experiences (SPANE) is a 12-item questionnaire that includes six items to assess positive feelings and six items to assess negative feelings (Diener et al., 2009). For both the positive and negative subcategories, three items are general (e.g., positive, negative), while three are more specific (e.g., joyful, sad). Participants reported how often they experienced each of these emotions over the past month using a seven-point scale with a range from 1 "almost never" to 7 "almost always". Results can be presented for each emotion separately or as a linear combination of positive and negative emotions. According to Diener et al. (2009), the scale shows good psychometric properties, with a Cronbach's α of over 0.90. Factor analysis showed one strong factor for both positive and negative items. The Cronbach's α for the initial sample of this study was 0.94, and factor analysis showed the same structure as in the original validation of the scale.

To assess satisfaction with various life domains, we used an adapted Personal Well-being Index (PWI, Cummins, 1996). The PWI scale contains

seven items rated for satisfaction on an 11-point (0-10) choice scale. The items correspond to different personal life domains: standard of living, health, achievement in life, relationships, safety, community connectedness, and future security. We adapted this scale by dividing "relationships" into two categories (family and friends) and also examined four additional domains – free time, work, physical appearance, and love life. Ratings of satisfaction on 11-point scales optimise respondent discriminative capacity and are simple to understand (Cummins, 2013). PWI shows good reliability $\alpha = .83$ (Ganglmair-Wooliscroft & Lawson, 2008) with a single-factor structure. In the initial sample of this study, the Cronbach's α of the adapted personal well-being index was 0.88.

To assess flourishing, we used the Flourishing Scale (Diener et al., 2009), an 8-item summary measure of the respondent's self-perceived success in important areas, such as relationships, self-esteem, purpose, and optimism. Participants rated their agreement with statements on a 7-point scale ranging from "totally disagree" to "totally agree". The score is calculated as a linear combination and transformed into a range of 1-7 for clarity of presentation. The scale shows good psychometric characteristics, with single-factor structure and a Cronbach's α of 0.87 (Diener et al., 2009). The Cronbach's α of the initial sample of this study was 0.88.

To assess affect regulation strategies, we used an adapted version of the Measure of Affect Regulation Styles (MARS; Larsen & Prizmić, 2004; Prizmić & Larsen, 2012). Strategies were classified into six items describing: *behavioural distraction*, *cognitive distraction*, *situation-focused strategies*, *affect-focused strategies*, *disengagement*, and *avoidance*. Four items describing various maladaptive consumption behaviours (eating, drinking alcohol, illicit drug use, and prescription drug use) were added to the instrument. Subjects reported how frequently they used a specific behaviour to change their negative feelings on a 7-point scale ranging from "not at all" to "almost always". The adapted version used in the CROWELL study had a two-factor structure including active and passive strategies. The Cronbach's α of

Table 3. Results of testing differences in overall life satisfaction and happiness between parents of CWD and parents of TDC.

| Well-being indicator | Parents of | Mode | Mdn | Mean rank | Mann-Whitney U | Wilcoxon W | z value | p |
|----------------------|------------|------|-----|-----------|----------------|------------|---------|-------|
| Life satisfaction | CWD | 8 | 7 | 37.67 | 683.5 | 1544.5 | -1.478 | 0.140 |
| | TDC | 7 | 7 | 45.33 | | | | |
| Happiness | CWD | 8 | 7 | 37.43 | 673.5 | 1534.5 | -1.566 | 0.117 |
| | TDC | 8 | 7 | 45.57 | | | | |

Notes: CWD- children with disability, TDC- typically developed children

the initial sample of this study (N= 1432) was 0.73 for active strategies and 0.58 for passive strategies.

RESULTS

Before performing the analyses, we conducted a Kolmogorov-Smirnov test and a test for homogeneity of variance across all well-being indicators. The results showed that our data did not meet the assumptions for parametric statistics. Therefore, all analyses were conducted using non-parametric statistics. A Bonferroni correction was applied due to the multiple comparisons throughout the analyses. All analyses were conducted using SPSS 24 (IBM, Chicago, IL, USA).

Comparison of well-being indices between parents of children with disabilities and parents of typically developed children

a. Overall life satisfaction and happiness

We examined overall life satisfaction and happiness as two general indicators of well-being. The results indicated that both groups of parents were moderately happy and satisfied with their lives, similar to previous research on a representative sample of Croatian residents (Pilar's Barometer of Croatian Society, 2016). Spearman correlation between happiness and life satisfaction was 0.915 ($p = 0.000$). No significant difference in well-being was found between the studied groups (Table 3).

b. Positive and negative emotions

Table 4 shows mean ranks of positive and negative affect experienced in the past month, as well as cumulative results for positive and negative emotions. To correct for multiple comparisons, we

performed a Bonferroni correction, which lowered the critical p value to $p = 0.003$. The results showed that there was no difference in the experience of positive and negative emotions between the two groups. When analysing each emotion separately, parents of children with disabilities felt *pleasant* on fewer occasions than parents of typically developed children.

A Wilcoxon signed-rank test indicated that parents of children with disabilities experienced more positive emotions ($Mdn = 29$) than negative ones ($Mdn = 23$), $Z = -2.064$, $p = 0.039$,⁴ $r = 0.82$. Similarly, parents of typically developed children also felt more positive emotions ($Mdn = 32$) than negative ones ($Mdn = 20$) in the past month, $Z = -4.174$, $p = 0.000$, $r = 0.86$.

c. Flourishing

There was no statistically significant difference in flourishing, as both groups of parents reported a similar, moderately high level of flourishing (Table 5).

d. Satisfaction with various life domains

Both groups seemed to be quite satisfied with each of the various examined life domains (Table 6). A Bonferroni correction was used to adjust the p value for multiple comparisons. Satisfaction with *free time* was found to be lower ($p < 0.004$) among parents of CWD than among parents of TDC.

In all comparisons, mode values were similar between the two groups of participants, except in satisfaction with future security. Parents of children with difficulties mostly said they were *not at all satisfied* with future security, while the predominant answer for parents of typically developed children was *very satisfied* (Table 7).

⁴ A measure of effect size, calculated by dividing Z by the square root of N (Rosenthal, 1994)

Table 4. Results of testing differences in experienced positive and negative affect during the past month between parents of children with disabilities and parents of typically developed children.

| Emotion | Parents of | Mode | Mdn | Mean ranks | Mann-Whitney U | Wilcoxon W | z value | p |
|-------------------|------------|------|-------|------------|----------------|------------|---------|-------|
| positive | CWD | 6 | 5.00 | 37.51 | 677.00 | 1538.00 | -1.56 | 0.118 |
| | TDC | 5 | 5.00 | 45.49 | | | | |
| good | CWD | 4 | 5.00 | 36.00 | 615.00 | 1476.00 | -2.16 | 0.031 |
| | TDC | 5 | 5.00 | 47.00 | | | | |
| pleasant | CWD | 5 | 5.00 | 33.70 | 520.20* | 1381.50 | -3.06 | 0.002 |
| | TDC | 6 | 6.00 | 49.30 | | | | |
| happy | CWD | 6 | 5.00 | 37.56 | 679.00 | 1540.00 | -1.54 | 0.123 |
| | TDC | 6 | 5.00 | 45.44 | | | | |
| joyful | CWD | 5 | 5.00 | 38.33 | 710.50 | 1571.50 | -1.24 | 0.214 |
| | TDC | 6 | 5.00 | 44.67 | | | | |
| pleased | CWD | 5 | 5.00 | 36.65 | 641.50 | 1502.50 | -1.88 | 0.060 |
| | TDC | 6 | 5.00 | 46.35 | | | | |
| negative | CWD | 4 | 4.00 | 46.65 | 629.50 | 1490.50 | -2.01 | 0.045 |
| | TDC | 3 | 3.00 | 36.35 | | | | |
| bad | CWD | 4 | 4.00 | 47.51 | 593.50 | 1454.50 | -2.36 | 0.018 |
| | TDC | 2 | 3.00 | 35.48 | | | | |
| unpleasant | CWD | 4 | 4.00 | 45.98 | 657.00 | 1518.00 | -1.76 | 0.079 |
| | TDC | 2 | 3.00 | 37.02 | | | | |
| sad | CWD | 4 | 4.00 | 46.43 | 638.50 | 1499.50 | -1.93 | 0.054 |
| | TDC | 4 | 4.00 | 36.57 | | | | |
| scared | CWD | 1 | 3.00 | 45.02 | 696.00 | 1557.00 | -1.38 | 0.168 |
| | TDC | 1 | 2.00 | 37.98 | | | | |
| angry | CWD | 5 | 4.00 | 44.48 | 718.50 | 1579.50 | -1.17 | 0.242 |
| | TDC | 4 | 4.00 | 38.52 | | | | |
| positive emotions | CWD | 19 | 29.00 | 35.99 | 614.50 | 1475.50 | -2.10 | 0.036 |
| | TDC | 29 | 32.00 | 47.01 | | | | |
| negative emotions | CWD | 22 | 23.00 | 47.43 | 597.50 | 1458.50 | -2.26 | 0.024 |
| | TDC | 12 | 20.00 | 35.57 | | | | |

Notes: CWD- children with disability, TDC- typically developed children; Bonferroni's corrected * $p < .004$

Table 5. Results of testing differences on the flourishing scale between parents of children with disabilities and parents of typically developed children.

| Well-being indicator | Parents of | Mode | Mdn | Mean ranks | Mann-Whitney U | Wilcoxon W | z value | p |
|----------------------|------------|------|------|------------|----------------|------------|---------|-------|
| flourishing | CWD | 5.5 | 5.63 | 36.40 | 631.5 | 1492.5 | -1.942 | 0.052 |
| | TDC | 6.13 | 6 | 46.60 | | | | |

Notes: CWD- children with disability, TDC- typically developed children

Comparison of affect regulation strategies

a. Affect regulation strategies used by parents of children with disabilities and parents of typically developed children

The affect regulations strategies used most by parents in both groups were *situation-foc-*

cused strategies, affect-focused strategies, and cognitive distraction, while strategies related to alcohol, prescription drugs, and illicit drugs were used least (Table 8). We found no statistically significant differences in the use of regulation strategies between the two groups. A Wilcoxon signed-rank test indicated that parents of chil-

Table 6. Results of testing for differences in satisfaction with various life domains between parents of children with disabilities and parents of typically developed children.

| Satisfaction with | Parents of | Mode | Mdn | Mean ranks | Mann-Whitney U | Wilcoxon W | z value | p |
|----------------------------|------------|------|------|------------|----------------|------------|---------|-------|
| standard of living | CWD | 6 | 6.00 | 38.77 | 728.50 | 1589.50 | -1.05 | 0.295 |
| | TDC | 5 | 6.00 | 44.23 | | | | |
| health | CWD | 7 | 7.00 | 34.30 | 545.50 | 1406.50 | -2.77 | 0.006 |
| | TDC | 9 | 8.00 | 48.70 | | | | |
| achieving in life | CWD | 8 | 7.00 | 40.44 | 797.00 | 1658.00 | -0.11 | 0.683 |
| | TDC | 8 | 7.00 | 42.56 | | | | |
| relationships with family | CWD | 9 | 7.00 | 35.93 | 612.00 | 1473.00 | -2.15 | 0.031 |
| | TDC | 9 | 9.00 | 47.07 | | | | |
| relationships with friends | CWD | 9 | 7.00 | 38.57 | 720.50 | 1581.50 | -1.13 | 0.259 |
| | TDC | 10 | 8.00 | 44.43 | | | | |
| safety | CWD | 8 | 8.00 | 39.10 | 742.00 | 1603.00 | -0.92 | 0.356 |
| | TDC | 8 | 7.00 | 43.90 | | | | |
| community connectedness | CWD | 8 | 7.00 | 38.06 | 699.50 | 1560.50 | -1.32 | 0.188 |
| | TDC | 9 | 7.00 | 44.94 | | | | |
| future security | CWD | 1 | 4.00 | 36.70 | 643.50 | 1504.50 | -1.84 | 0.066 |
| | TDC | 8 | 5.00 | 46.30 | | | | |
| free time | CWD | 5 | 5.00 | 33.29 | 504.00* | 1365.00 | -3.14 | 0.002 |
| | TDC | 8 | 7.00 | 49.71 | | | | |
| work | CWD | 6 | 7.00 | 45.15 | 691.00 | 1552.00 | -1.40 | 0.162 |
| | TDC | 5 | 5.00 | 37.85 | | | | |
| physical appearance | CWD | 8 | 7.00 | 39.82 | 771.50 | 1632.50 | -0.65 | 0.516 |
| | TDC | 8 | 7.00 | 43.18 | | | | |
| love life | CWD | 8 | 8.00 | 39.99 | 778.50 | 1639.50 | -0.58 | 0.561 |
| | TDC | 10 | 8.00 | 43.01 | | | | |

Notes: CWD- children with disability, TDC- typically developed children; Bonferroni's corrected * $p < .004$

Table 7. Frequency of responses and means of central tendency for the item on Future security

| Future security | Parents of | |
|-----------------|-------------|-------------|
| | CWD | TDC |
| 0 | 5 | 4 |
| 1 | 7 | 3 |
| 2 | 2 | 1 |
| 3 | 5 | 3 |
| 4 | 5 | 3 |
| 5 | 4 | 7 |
| 6 | 1 | 4 |
| 7 | 4 | 3 |
| 8 | 5 | 8 |
| 9 | 3 | 2 |
| 10 | 0 | 3 |
| N | 41 | 41 |
| M (SD) | 5.07 (2.98) | 6.32 (3.01) |
| Mode | 2 | 9 |
| Median | 5 | 6 |

Notes: CWD- children with disability, TDC- typically developed children

dren with disabilities use active strategies ($Mdn = 4.5$) more often than passive ones ($Mdn = 2.0$), $Z = -5.26$, $p = 0.000$, $r = 0.82$. Similarly, parents of typically developed children use active affect regulation strategies ($Mdn = 4.75$) more frequently than passive ones ($Mdn = 2.33$), $Z = -5.56$, $p = 0.000$, $r = 0.86$.

b. Correlation between positive and negative strategies and various well-being indicators in both groups

A Spearman's rank correlation was conducted in order to gain better insight into differences in affect regulation strategies used by the two groups of parents and how this affects well-being. The tables below display the Spearman's rho between various affect regulation strategies and well-being indicators between parents of children with disabilities (Table 9) and parents of typically developed children (Table 10). At first glance, it is obvious that

Table 8. Results of testing for differences in affect regulation strategies used by parents of children with disabilities and parents of typically developed children.

| Affect regulation strategy | Parents of | Mode | Mdn | Mean rank | Mann-Whitney U | Wilcoxon W | z value | p |
|------------------------------|------------|------|------|-----------|----------------|------------|---------|-------|
| behavioural distraction | CWD | 4 | 4 | 40.16 | 785.50 | 1646.50 | -0.53 | 0.598 |
| | TDC | 4 | 4 | 42.84 | | | | |
| cognitive distraction | CWD | 4 | 5 | 40.96 | 818.50 | 1679.50 | -0.21 | 0.834 |
| | TDC | 5 | 5 | 42.04 | | | | |
| situation-focused strategies | CWD | 5 | 5 | 43.70 | 750.50 | 1611.50 | -0.86 | 0.391 |
| | TDC | 4 | 5 | 39.30 | | | | |
| affect-focused strategies | CWD | 6 | 5 | 42.20 | 812.00 | 1673.00 | -0.27 | 0.786 |
| | TDC | 6 | 5 | 40.80 | | | | |
| disengagement | CWD | 1 | 2 | 38.24 | 707.00 | 1568.00 | -1.27 | 0.203 |
| | TDC | 2 | 3 | 44.76 | | | | |
| avoidance | CWD | 1 | 2 | 37.48 | 675.50 | 1536.50 | -1.57 | 0.116 |
| | TDC | 4 | 4 | 45.52 | | | | |
| eating | CWD | 2 | 3 | 44.41 | 721.00 | 1582.00 | -1.13 | 0.257 |
| | TDC | 1 | 2 | 38.59 | | | | |
| alcohol use | CWD | 1 | 1 | 37.21 | 664.50 | 1525.50 | -1.98 | 0.048 |
| | TDC | 1 | 1 | 45.79 | | | | |
| prescription drugs | CWD | 1 | 1 | 40.79 | 811.50 | 1672.50 | -0.38 | 0.704 |
| | TDC | 1 | 1 | 42.21 | | | | |
| illicit drug use | CWD | 1 | 1 | 42.50 | 799.50 | 1660.50 | -1.42 | 0.155 |
| | TDC | 1 | 1 | 40.50 | | | | |
| active strategies | CWD | 4.25 | 4.5 | 41.06 | 822.50 | 1683.50 | -0.17 | 0.867 |
| | TDC | 5 | 4.75 | 41.94 | | | | |
| passive strategies | CWD | 2.5 | 2 | 38.72 | 726.50 | 1587.50 | -1.06 | 0.289 |
| | TDC | 2.33 | 2.33 | 44.28 | | | | |

Notes: CWD- children with disability, TDC- typically developed children

correlations between affect regulation strategies and well-being indicators were stronger among parents of children with disabilities, and that more of them were significant (22 significant correlations in the sample of parents of disabled children, compared to only 6 in the sample of parents of typically developed children).

In the group of parents of children with disabilities, correlations were small to medium in magnitude, but in general, proactive affect strategies positively correlated with higher levels of well-being, while passive strategies correlated with lower levels of well-being (Table 9). *Situation-focused strategies* correlated significantly with all well-being indicators. *Cognitive distraction* correlated with all well-being indicators, except negative emotions. *Affect-focused strategies* correlated with overall happiness, life satisfaction, and positive emotions, while *behavioural distraction* correlated only with life satisfaction.

On the other hand, *use of prescription drugs* (such as anti-depressants) was related to lower levels of all well-being indicators, except negative feelings, where no significant correlation was found. Of the other passive strategies, *avoidance* was related to lower levels of life satisfaction and positive emotions and higher levels of negative emotions, while *disengagement* was related to lower levels of positive emotions and higher levels of negative emotions. *Eating*, *alcohol use* and *illicit drug use* did not correlate with any well-being indicators, likely in part because of a lack of variability.

In the group of parents of typically developed children, only a few correlations were significant, and this was mainly in the domain of passive strategies, which proved to correlate with lower levels of well-being (Table 10). *Situation-focused strategies* positively correlated with flourishing, and this was the only significant correlation between active

Table 9. Correlations between positive and negative strategies and various well-being indicators in a sample of parents of children with disabilities.

| Parents of CWD | Happiness | Life satisfaction | Positive emotions | Negative emotions | Flourishing |
|------------------------------|-----------|-------------------|-------------------|-------------------|-------------|
| behavioural distraction | 0.28 | 0.31* | 0.26 | 0.02 | 0.24 |
| cognitive distraction | 0.43** | 0.51** | 0.38* | -0.17 | 0.36* |
| situation-focused strategies | 0.39* | 0.50** | 0.45** | -0.37* | 0.45** |
| affect-focused strategies | 0.32* | 0.31* | 0.41** | -0.15 | 0.29 |
| disengagement | -0.29 | -0.31 | -0.48** | 0.50** | -0.29 |
| avoidance | -0.30 | -0.34* | -0.34* | 0.36* | -0.20 |
| eating | -0.21 | -0.06 | -0.20 | 0.22 | -0.23 |
| alcohol use | 0.06 | -0.03 | -0.08 | 0.22 | -0.09 |
| prescription drug use | -0.50** | -0.44** | -0.37* | 0.22 | -0.52** |
| illicit drug use | -0.21 | -0.13 | 0.01 | -0.03 | -0.23 |

Notes: CWD children with disabilities; * $p < .05$ ** $p < .01$

Table 10. Correlations between positive and negative strategies and various well-being indicators in a sample of parents of typically developed children.

| Parents of TDC | Happiness | Life satisfaction | Positive emotions | Negative emotions | Flourishing |
|------------------------------|-----------|-------------------|-------------------|-------------------|-------------|
| behavioural distraction | -0.02 | 0.04 | 0.11 | -0.12 | 0.23 |
| cognitive distraction | -0.11 | -0.01 | -0.02 | 0.04 | 0.10 |
| situation-focused strategies | 0.23 | 0.26 | 0.30 | -0.29 | 0.35* |
| affect-focused strategies | 0.15 | 0.18 | 0.25 | -0.10 | 0.02 |
| disengagement | -0.34* | -0.29 | -0.35* | 0.26 | -0.36* |
| avoidance | -0.21 | -0.15 | -0.22 | 0.33* | -0.25 |
| eating | -0.11 | -0.07 | -0.03 | 0.34* | -0.12 |
| alcohol use | -0.20 | -0.23 | -0.08 | 0.21 | -0.23 |
| prescription drug use | -0.24 | -0.18 | -0.15 | 0.27 | -0.14 |
| illicit drug use | . | . | . | . | . |

Notes: TDC typically developed children; * $p < .05$ ** $p < .01$

strategies and well-being indices. *Disengagement* correlated with lower levels of happiness, positive emotions, and flourishing, while *avoidance* and *eating* both correlated with higher levels of negative emotions. Alcohol and prescription drug use were not significant, and there was no variability for illicit drug use in this group, as none of the participants used this strategy.

DISCUSSION

The results of our research indicate that the level of well-being of parents of children with disabilities was quite similar to the level of well-being of parents of typically developed children. No differences were found in levels of happiness or overall life satisfaction. Moreover, the levels of

happiness and life satisfaction in both groups of parents are similar to the national average found in a representative sample of Croatian residents in 2016 ($M(h)=6.88$; $M(ls)=6.52$; Pilar's Barometer of Croatian Society, 2016). The observed similarities in emotions experienced during the past month are somewhat inconsistent with previous research. Research so far has shown that parents of children with disabilities are more vulnerable to stress, experience a higher level of parental depression, and feel sad, angry, or lonely more often (Ergün & Ertem, 2012; Quine & Pahl, 1985; Roach, Orsmond & Barratt, 1999; Valentine, McDermott & Anderson, 1998). However, this research found differences only in reports of feeling *pleasant*, while both groups of parents equally experienced other emotions such as *happiness*, *sadness*, or

anger. These results are not in line with our original assumption, as it was expected that differences would emerge regarding negative emotions and not positive ones. The finding that parents of children with disabilities feel pleasant less often than parents of typically developed children suggests that raising a child with disabilities is related to experiences of positive emotions.

Although one can assume that parenting a child with disabilities might lower one's feeling of fulfillment or slow down one's personal development due to stress and providing for the child's needs, we found that the two groups of parents did not differ regarding flourishing. These results correspond with research indicating that some outcomes of experiencing trauma can be a new perception of one's self and additional growth and development (Tedeschi & Calhoun, 2004; Tedeschi, et al., 1998). Although we have no knowledge of how long the parents in our sample have been taking care of a child with a disability⁵ or whether or not positive adaptation or personal growth had already taken place, the literature justifies taking into consideration the idea that parents of children with disabilities can revise their personal goals and benchmarks and thereby achieve levels of flourishing similar to those of parents with typically developed children (Affleck, Tennen & Gershman, 1985; Abbott & Meredith, 1986; Scorgie & Sobsey, 2000).

Regarding satisfaction with life as a whole and satisfaction with various life domains, the only significant difference between parents of children with disabilities and parents of typically developed children appeared in their satisfaction with free time. Parents of children with disabilities have many tasks that parents of typically developed children do not. Their everyday routine forces them to push their limits, and it is both exhausting and time-consuming. It is only logical to assume that finding personal time is difficult, if not impossible, which would explain the lower level of satisfaction in the domain of free time. Our results are consistent with previous research, which stresses the lack of free time among parents of children with disabilities. Barnett and Boyce (1995) and Sanders

and Morgan (1997) found that many families with children with intellectual disabilities devoted more time to child care, and therefore spent less time engaging in social activities and enjoyed less active free time. In addition, Murphy et al. (2007) showed that caregivers attributed worsened health to a lack of time, control, and decreased psychosocial energy, while Shearn and Todd (2000) found that exceptional time demands were a major threat to mothers' equal opportunity to take part in paid work. Similarly, Olsson and Hwang (2003) found that a restricted social life and time restrictions seemed to be the two most evident and problematic stressors for Swedish families with children with an intellectual disability. Our initial assumption was not confirmed, as we expected to find differences in satisfaction with various life domains and overall life satisfaction. Our finding is consistent with research that suggests that a lack of (free) time is a higher-order stressor that affects many other domains (e.g. social activities, work, health). If lack of time is a prime stressor, it is logical that differences are most apparent in this domain. As free time proved to be the only source of lessened satisfaction for parents of children with disabilities, these parents should be encouraged to take time for themselves, and proper services should be arranged for this purpose, as it is known that parents reap benefits from free time only if they are confident that their child is being well taken care of (Olsen & Hwang, 2003).

Regarding satisfaction with various life domains, one result stood out as striking: The dominant value for satisfaction with future safety was "1" in the sample of parents of children with disabilities (almost one-third of the participants in this group chose "0" or "1" on this scale), while the dominant value in the group of parents of typically developed children was "8". Further inspection showed that the answers of parents of children with disabilities were mostly equally distributed across the scale (although the value of "10" was absent), with a tendency towards lower values, while the answers of parents of typically developed children were slightly higher, generally between 5 and 8 (*Table 7*).

⁵ Results on the scale of life events in the CRO-WELL study showed that none of our participants had become a parent of a child with a disability during the past year. This scale was used in the present study only to obtain this information.

The lack of significant differences in various well-being indicators can likely be partially attributed to the convenient and small sample and strict Bonferroni correction for multiple comparisons. Still, it is interesting that the differences reached significance for feeling pleasant, something the hypothesis did not predict. This suggests that differences can emerge in positive emotions, and not only negative emotions.

The initial hypothesis regarding affect regulation strategies was confirmed: both groups were more likely to use proactive tools to improve their emotional states, and proactive strategies in both groups were related to higher levels of well-being, while passive strategies were related to lower levels of well-being. Moreover, there was no difference between groups in frequency of affect regulation strategies used. These results are consistent with the findings of Kaliterna Lipovčan, Prizmić & Franc (2009) on a representative sample of Croatian residents.

It is interesting to note that correlations between the reported use of affect regulation strategies and well-being indicators differed so greatly between the two studied groups. Affect regulation strategies seem to be closely related to the level of well-being of parents of children with disabilities, a fact that was not so apparent in the group of parents of typically developed children. Among parents of typically developed children, there was only one significant correlation between active strategies and well-being (*situation-focused strategies* were positively correlated with flourishing), while *disengagement* was the only passive strategy to show a reasonably stable negative correlation with well-being. It is possible that parents of children with disabilities face more challenging situations on a daily basis and that use of affect regulation strategies is crucial to "getting through the day" and maintaining a certain level of well-being, although they use these strategies as often as parents of typically developed children do.

It is crucial to point out that, because of the nature of the correlation in this study, it is impossible to interpret the results causally. For example, it may be possible that an earlier diagnosed case of depression or another similar disorder led to both lower levels of well-being and the use of

prescription drugs, or that a lack of social support affected well-being and also manifested in reduced opportunities for venting and expressing affect. Therefore we cannot argue a causal relationship between them, although it is apparent that certain affect regulation strategies are related to higher/lower levels of well-being.

Advantages and limitations of this study

The vast majority of research on the well-being of parents of children with developmental disabilities has been conducted on small samples, either focusing on possible negative outcomes such as depression, stress, and chronic sorrow, or using limited measures of well-being, or both. Approaching participants simply because they have a desirable characteristic might lead to distortions in their responses, causing them to answer from a particular point of view. Additionally, a survey of the literature shows that parents of children with disabilities are typically compared to others based on the fact that they have a child with or without typical development, while other demographic characteristics are rarely taken into account. The greatest advantage of the current study lies in the fact that targeted participants (i.e. parents of children with disabilities) were gathered through a larger project measuring the well-being of all residents, as well as in the fact that all parents of children with disabilities were matched to similar participants who are parents of typically developed children according to many demographic factors.

The greatest limitation of this study lies in its relatively small sample, and in the fact that it consists mostly of younger, educated, middle-class individuals. It is possible that the lack of differences in well-being indicators comes because of this self-selected sample. Although we tried to gain some control by selecting a very similar sample of parents of typically developed children, results are not to be generalised. A larger sample will hopefully be gathered within this project in the future, giving us the possibility to gain further insight into the well-being of parents of children with disabilities. Another limitation lies in the fact that two-thirds of participants in our research were women. Most studies indicate that mothers raising a child with disabilities typically show higher levels of stress

(Herring et al., 2006) and depression (Olsson & Hwang, 2003) than fathers. These discrepancies are probably due to care-taking duties that usually fall on mothers. Although some studies have reported similar levels of well-being between mothers and fathers when child-raising duties are equally shared (Hastings, 2003; Keller & Honig, 2004), this is likely not the case in Croatian society, where traditional gender roles often hold. Therefore, we assume that differences might appear between mothers and fathers, but the very small proportion of fathers in our sample did not allow testing for gender differences. We believe that the on-line nature of our study is more appropriate than a traditional pen-and-pencil survey or the interview method for a sample of parents of children with disabilities. As time management is of extreme importance in raising children with disabilities, the on-line method enabled respondents to decide when and where to fill out the questionnaire. However, the on-line method required our participants to be computer users, and this biased the sample in favour of young, city-dwelling, and educated individuals.

Recommendations for further research and practice

In the future, researchers should try to eliminate or lessen the limitations of this study. A larger, more heterogeneous sample with more male participants should be obtained. In addition, future research should consider a longitudinal design and the inclusion of some other variables such as quality of marriage, social support, locus of control, and self-efficacy. It is known that all these variables are positively connected to well-being, but how large and significant their influence is in the long run has yet to be discovered. Longitudinal studies incorporating a broader range of variables could glean information that may be useful in planning and providing psychosocial support. Also, a qualitative approach could provide a better understanding of the well-being of parents of children with disabilities. A larger sample would also enable the comparison of differences between parents of children with different types of disabilities. Future research should also take the characteristics of children and the severity of their disabilities into consideration.

CONCLUSION

This study compared the well-being of parents of children with disabilities and a matched group of parents of typically developed children. The two groups in this study did not differ in overall happiness, general life satisfaction, or flourishing, showing similar values. Regarding the frequency of various positive and negative emotions experienced during the past month, both groups of parents experienced more positive than negative emotions. The two groups differed only regarding feeling pleasant, as parents of children with disabilities reported feeling pleasant less often than parents of typically developed children. Concerning satisfaction with various life domains, a significant difference was found only regarding free time, with which parents of children with disabilities were less satisfied. Therefore, the initial assumption that differences between the two groups would emerge when negative feelings and satisfaction with various life-domains and overall life satisfaction were taken into account was not confirmed. In fact, the only result in line with this hypothesis was a difference in satisfaction with free time.

Both groups of parents used more proactive affect regulation strategies than passive affect regulation strategies, which confirmed our initial hypothesis. Furthermore, in accordance with the initial hypothesis, the use of proactive strategies was related to higher levels of well-being, while the use of passive strategies was related to lower levels of well-being. The relationship between the affect regulation strategies used and well-being indicators was more apparent among parents of children with disabilities.

Although the obtained results must be interpreted in light of the characteristics and convenience of the sample, this study provides valuable implications for practice. Helping parents of children with disabilities unburden their schedule in order to enjoy more free time might lead to higher levels of well-being.

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USPOREDBA INDIKATORA DOBROBITI I STRATEGIJA REGULACIJE EMOCIJA IZMEĐU RODITELJA DJECE S TEŠKOĆAMA I RODITELJA DJECE UREDNOG RAZVOJA

Sažetak: *Dosadašnja istraživanja pokazala su da je dobrobit roditelja djece s teškoćama niža u odnosu na roditelje djece urednog razvoja. No, većina tih istraživanja provedena je upravo s tom svrhom, stavljajući roditelja i teškoću djeteta u prvi plan, što je moglo dovesti do distorzije u odgovorima. Dodatno, ispitanicima se pristupalo s obzirom na činjenicu da li imaju ili nemaju dijete s teškoćama, dok su druge relevantne karakteristike zanemarene. Cilj ovog istraživanja je usporediti roditelje djece s teškoćama i slične roditelje djece urednog razvoja, s obzirom na različite indikatore dobrobiti i specifične izvore zadovoljstva životom. Ova studija provedena je u sklopu projekta CRO-WELL: hrvatsko longitudinalno istraživanje dobrobiti. Uzorak koji je korišten za potrebe ovog istraživanja sastoji se od 41 roditelja djece s teškoćama. Svaki od tih roditelja uparen je s roditeljem djeteta urednog razvoja prema nekim karakteristikama. Posljedično, u ovom istraživanju koristili smo dva uzorka, u kojima je većina sudionika ženskoga spola, u braku, iz velikih gradova, zaposleni, a dvije trećine završile su barem srednju školu. Ispitanici se razlikuju s obzirom na zadovoljstvo slobodnim vremenom, a niži stupanj zadovoljstva u ovom području pokazuju roditelji djece s teškoćama. Dodatno, roditelji djece s teškoćama rjeđe se osjećaju ugodno. Obje skupine roditelja češće koriste aktivne nego pasivne strategije regulacije emocija, kao strategije suočavanja s negativnim emocijama. Proaktivne strategije povezane su s višim, a pasivne s nižim stupnjevima dobrobiti, što naročito dolazi do izražaja kod roditelja djece s teškoćama.*

Ključne riječi: *dobrobit, roditelji djece s teškoćama, zadovoljstvo životom, sreća, strategije regulacije raspoloženja*