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ASSESSING STRENGTHS IN FAMILIES WHO HAVE CHILDREN WITH DEVELOPMENTAL DISABILITIES

By

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ABSTRACT

ASSESSING STRENGTHS IN FAMILIES WHO HAVE CHILDREN WITH DEVELOPMENTAL DISABILITIES

By

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Family strengths of respondents that have children with developmental disabilities between the ages of six and twelve were assessed to determine if they differed according to the severity of the disability or family demographic variables. The primary caregivers (N= 21) completed the Family Inventory of Resource Management (McCubbin, Comeau, and Harkins, 1981), the Family Strengths Inventory (Stinnett and DeFrain, 1985), and a family information sheet. The following dimensions appear to be attributes of strength as reported by respondents in order: esteem and communication, extended family social support, financial well-being, and mastery and health. The global areas of family strength are reported from highest to lowest: commitment, relationship with child, dealing with crisis, spiritual wellness, expressing appreciation, good communication, spending time together, and spousal relationship. There was no significant relationship between severity of disability and family strengths. Family income, mother's education, and number of years married all appear to be significantly correlated with family strength. The primary caregivers' overall perception of family strength is consistent with family strength as determined the instruments.

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Chapter 1 - Introduction

PURPOSE AND JUSTIFICATION

The purpose of this research project is to assess families' perceived strengths among those families who have children with developmental disabilities. It is believed that, if families' perceive themselves as strong, they act on this presumption. Thus, it is not relevant if families are in "reality" what professionals would determine as strong. Professionals are not as experienced or optimistic in identifying strengths as they are pathologies (Stinnett, Sanders, & DeFrain, 1981).

Most research focusing on families of children with disabilities assumes that the family system is dysfunctional because of the child (Byrne & Cunningham, 1985; Kazak, 1986; Longo & Bond, 1984). Therefore, a pathological model of family functioning is emphasized by researching needs, problems, and stresses (Kazak & Marvin, 1984). Also, most research in this area assumes that families who have children with disabilities are a homogeneous group (Byrne & Cunningham, 1985; Kazak, 1986; Stoneman & Brody, 1982). It is not generally acknowledged in the literature that these families all have different characteristics and that their children have different levels of ability. Additionally,

some research is questionable in its findings as the researcher(s) used inconsistent or inaccurate methodologies, i.e., parental, as opposed to sibling, reports on siblings' attitudes and feelings (Kazak, 1986; Stoneman & Brody, 1982). Researchers must acknowledge that most of these family systems have different but not deviant methods of family functioning (Kazak & Marvin, 1984). Researchers need to focus on assessing strong families (Crnie, Friedrich, & Greenburg, 1983; Kazak & Marvin, 1984; Longo & Bond, 1984; Turnbull, 1988; Wikler, Wasow, & Hatfield, 1983) and what they are doing well that helps them to be successful. In addition, researchers must consider that ALL families and ALL children are unique. To this end, an exploratory study has been developed with the following questions.

RESEARCH QUESTIONS:

1. What are the areas of family strength for families who have children with developmental disabilities as measured by the Family Inventory of Resource Management (FIRM)?

2. What are global areas of family strength for families who have a child with a developmental disability as determined by the Family Strengths Inventory (FSI) instrument?

3. Do areas of family strength as measured by the FIRM differ according to the severity of the child's disability?
If so, how?

4. Do family strengths as measured by the FIRM instrument differ according to the family demographic variables?

5. Do the primary caregivers' perceptions of overall family

strength relate to areas of family strength as measured by the FIRM for the family that has a child with a developmental disability?

6. Do the primary caregivers' perceptions of overall family strength relate to global areas of family strength as measured by the FSI instrument for the family that has a child with a developmental disability?

VARIABLE NAMES AND DEFINITIONS:

Esteem and Communication:

theoretical definition - family esteem, communication, mutual assistance, optimism, problem solving ability, and encouragement of autonomy among family members

operational definition - as measured by items 3, 6, 7, 15, 19, 26, 28, 29, 33, 38, 43, 45, 50, 52, and 54 on the FIRM instrument (Appendix A)

Mastery and Health:

theoretical definition - sense of mastery over family events and outcomes, emotional support, togetherness, cooperation, and physical and emotional health

operational definition - as measured by items 1, 5, 9, 10, 11, 17, 18, 20, 22, 23, 30, 31, 34, 35, 40, 41, 42, 47, 48, and 53 on the FIRM instrument (Appendix A)

Extended Family Social Support:

theoretical definition - mutual help given to and received from relatives

operational definition - as measured by items 13, 24, 36 and 51 on the FIRM instrument (Appendix A)

Financial Well-Being:

theoretical definition - the ability to meet financial commitments, adequacy of financial reserves, ability to help others, and optimism about the family's financial future

operational definition - as measured by items 2, 4, 8, 12, 14, 16, 21, 25, 27, 32, 37, 39, 44, 46, 49, and 55 on the FIRM instrument (Appendix A)

Relationship with Children:

theoretical definition - the quality of the relationship between the respondent and the children including closeness, happiness, and making each other feel good

operational definition - as measured by items 63, 65, 67, and 69 on the FSI instrument (Appendix B)

Relationship with Spouse:

theoretical definition - the quality of the relationship between the respondent and the spouse including closeness, happiness, and making each other feel good

operational definition - as measured by items 62, 64, 66, and 68 on the FSI instrument (Appendix B)

Communication:

theoretical definition - the quality of the family members talking among themselves, listening to one another, and sharing feelings with each other

operational definition - respondent indicates on a scale of one to five the degree to which his/her family possesses good communication, item 58 on FSI instrument (Appendix B)

Commitment:

theoretical definition - the family members' trust and confidence in one another

operational definition - respondent indicates on a scale of one to five the degree to which his/her family possesses commitment to each other, item 57 on the FSI instrument (Appendix B)

Spiritual Well-Being:

theoretical definition - the family's quality of sensitivity or attachment to religious values

operational definition - respondent indicates on a scale of one to five the degree to which his/her family possesses spiritual wellness, item 61 on the FSI instrument (Appendix B)

Spending Time Together:

theoretical definition - family members time together and doing things with one another

operational definition - respondent indicates on a scale of one to five the degree to which his/her family spends time together and does things together, item 56 on the FSI instrument (Appendix B)

Dealing with Crisis:

theoretical definition - the family's ability to respond positively to situations that have reached a critical phase

operational definition - respondent indicates on a scale of one to five the degree to which his/her family possesses the ability to deal with crisis in a positive manner, item 59 the FSI instrument (Appendix B)

Appreciation:

theoretical definition - the family's expression of admiration, approval, or gratitude to one another

operational definition - respondent indicates on a scale of one to five the degree to which his/her family possesses the ability to express appreciation for one another, item 60 on the FSI instrument (Appendix B)

Primary Caregiver's Perception of Family Strength:

theoretical definition - the family's overall quality of functioning together positively

operational definition - respondent indicates on a scale of one to five the degree to which his/her family is strong, item 70 on the FSI instrument (Appendix B)

Child's Overall Level of Functioning:

theoretical definition - the child with a developmental disability's overall IQ score

operational definition - as indicated by the five categories borderline (IQ ranging from 80 to 68), mild (IQ ranging from 67 to 52), moderate (IQ ranging from 51 o 36), severe (IQ ranging from 35 to 20), and profound (IQ ranging of 19 or below) and clustered into high functioning (borderline, mild, and moderate) and low functioning (severe and profound)

Family Income for 1990:

theoretical definition - the total amount of money the family brought in for 1990

operational definition - the actual dollar amount of income reported

Father's Education:

theoretical definition - the highest level of education completed by the father

operational definition - the reported number of years of education completed and clustered into three groups; high school or less, one to four years of college, and five or more years of college

Mother's Education:

theoretical definition - the highest level of education completed by the mother

operational definition - the reported number of years of education completed and clustered into three groups; high school or less, one to four years of college, and five or more years of college

Father's Occupation:

theoretical definition - the vocation of the father

operational definition - the reported occupation of the father, clustered into five groups; skilled position, managerial position, professional position, homemaker, and unemployed

Mother's Occupation:

theoretical definition - the vocation of the mother

operational definition - the reported occupation of the mother, clustered into five groups; skilled position, managerial position, professional position, homemaker, and student

Number of Years Married to Current Partner:

theoretical definition - the total number of years that the two adults in the home have been married

operational definition - the reported number of years married

Child's Sex:

theoretical definition - male or female

operational definition - male or female

SUMMARY

As most research in the area of families that have children with developmental disabilities focuses on the pathologies of the family system, this research has concentrated on assessing areas of strength for such families. In addition to assessing areas of strength in the family, this research assessed the family's perception of strength. Family strength was also assessed as a function of the severity of the child's disability and family demographic variables.

Chapter 2 - Review of Literature

Most research within the context of family functioning and developmental disabilities focuses on dyads within the family, mother-child, father-child, and sibling-child. As a whole, research supports the belief that having a child with a developmental disability has a negative impact on these dyadic relationships. For example, mothers of children with mental retardation (n=60) have a higher correlation with depression ($t= 5.26$, $p<.01$), a lower sense of maternal competence ($t= -2.36$, $p<.01$), and less enjoyment from the maternal role ($t= -5.85$, $p<.01$) than mothers with children not having mental retardation (n=60) (Cumming, Bayley, & Rie, 1966). Research findings have also lead to many inconsistent results. Palfrey, Walker, Butler, and Singer (1989) point out that several studies have reported an increase in depressive symptoms in mothers who have children with a chronic illness. Other studies report no significant differences in personality variables and parental attitudes between mothers who have children with disabilities and mothers who have children without disabilities.

Fathers also displayed negative effects from parenting a child that is developmentally disabled. Fathers with a

child who has mental retardation (n=60) were compared to a control group of fathers (n=60). Most demographic variables between the two groups were comparable. Findings revealed higher correlations of depression ($t= 5.20$, $p<.01$), lower self-acceptance ($t= -1.33$, $p<.10$) and paternal competence ($t= -2.78$, $p<.01$), lower levels of satisfaction with all family members ($t= -8.64$, $p<.01$ for child with MR, $t= -1.77$, $p<.05$ for other children, $t= -1.68$, $p<.05$ for wife), and increased ignoring and rejecting of the child ($t= 1.30$, $p<.10$) (Cummings, 1976).

The sibling relationships are strained as well. Older siblings of children with mental retardation display more sibling conflict and less positive sibling interaction associated with greater childcare demands compared to siblings of children without mental retardation (Stoneman, Brody, Davis, & Crapps, 1988). In addition, sibling pairs, with the younger child having mental retardation, are characterized more by asymmetrical roles with the older sibling assuming more manager and teacher/helper roles (Stoneman, Brody, Davis, & Crapps, 1987). Again, Palfrey et al. (1989) report inconsistencies in research findings. They indicate that children who have a sibling with a chronic illness are more poorly adjusted than a control group of children. Other studies report no difference in adjustment between the two groups.

The research reports inconsistencies regarding marital relationships when a child with a disability is present.

Marriages of couples with a child having Down Syndrome were significantly more likely to be unhappy one year after the birth of the child (Gath & Gumley, 1987). Yura (1987) reports that the initial quality of marriage affects the parental reactions to the child with mental retardation. For families as a whole (n=34), Friedrich and Friedrich (1981) indicate that having a child with motor difficulties and/or mental retardation correlates with decreased amounts of marital satisfaction ($t= -1.70$, $p<.05$), lower levels of psychological well-being ($t= -3.38$, $p<.005$), social support ($t= -1.79$, $p<.05$), and religiosity ($t= -1.69$, $p<.05$), along with high levels of stress.

There have been steady changes in societal policies and attitudes over the past four decades concerning people with developmental disabilities. In the 1950's, parents began to rebel against the policies of forced institutionalization for their children with disabilities. As a result, the 1960's brought about parent groups developing alternatives to institutionalization. In the early 1970's, a large deinstitutionalization movement began throughout the United States (MacMinnon & Marlett, 1984). People with disabilities were moved into smaller homes integrated into the community and were provided with opportunities to grow as human beings. Additionally, the 1970's brought about P.L. 94-142, Education for All Handicapped Children Act. This law required service systems to consider families when providing for children and legally guaranteed families a role in making decisions about

their child (Palfrey et al., 1989). Because of these changes, mental health professionals and human service systems were beginning to encourage families, in the best interest of the developing child, to raise their child at home within the network of the family system. Thus, a new research emphasis came about concentrating on not only what was best for the child with a developmental disability, but what was best for the entire family system. This research also focused on how this child was going to affect all the family members.

There has been some research on the strengths of families having children with disabilities, although less than on the pathologies of families with children having disabilities. Abbott and Meredith (1986) compared parents with children having mental retardation (n=60) to a control group of parents (n=60). They found that parents of children with mental retardation correlated with being less critical of family members ($t= 2.03$, $p<.04$) and having fewer persistent family problems ($t= 1.88$, $p<.05$). They also found that spousal support (76%), participation in parent groups (58%), and religious beliefs (42%) were positive coping resources. Stoneman and Brody (1982) revealed several positive aspects of sibling interactions with a child who has mental retardation. The interactions allow the child with mental retardation to imitate and practice roles carried out by their sibling. The interactions allow the sibling without mental retardation to expand roles to include caregiver, teacher, and manager. The skill acquisition of the child with mental

retardation may be stronger when the teacher is a sibling closer to the child's age. In another study, when parents (n=27) were asked directly, seventy-five percent of them felt that having a child who is developmentally disabled made them stronger. Forty three percent said that the child made them much stronger (Wikler et al., 1983). A combined questionnaire and family interview assessing competence in families who have a child with mental retardation discovered that most of these families are doing well in family competence. The healthy families were characterized by open and direct communication and the ability to express negative feelings, strong internal support systems, autonomy and responsibility in all members, and few signs of unresolved conflict. Predictors of healthy family adjustment were older female children with mental retardation, two-parent families, and fathers' higher occupational status (Hampson, Hulgus, Beavers, & Beavers, 1988).

Several researchers have assessed strong families to develop predictors for family strength. An assessment of coping in families who have a child with mental retardation (n=40) during four critical periods during life was carried out, preschool (3-5 yrs.), entering school (6-8 yrs.), beginning adolescence (12-14 yrs.), and reaching chronological adulthood (19-21 yrs.). The following characteristics described healthy adaptive families: equal power in two parent coalition, acknowledgement of child's needs and differentness, conscious effort to meet child's needs and family needs,

sibling display of motivation in nurturing and leadership, large amounts of give and take in the family, maintain social contacts, clear diagnosis and information about the disability, experience stress but aware of positive possibilities, accept responsibility, overcome hardships, rise to challenge, focus on small gains, collective pride, more present oriented than future oriented, and negative/frustrating feeling recognized and permitted (Beavers, Hampson, & Hulgus, 1986). In a study of two parent families having a child with mental retardation (n=131), mothers identified the following predictors of positive family relations: marital satisfaction, less maternal depression, more locus of control, having a male child who is disabled, the child living at home, and the disability present at birth (Friedrich, Cohen, & Wilturner, 1987).

McCubbin and Patterson (1981) indicate that family strengths are contingent upon the families' perception of stress, the "pile up" of stressors, and the availability and utilization of social supports. Stinnett and Defrain (1985, 1989) designed a questionnaire to determine qualities of families that perceive themselves as strong. They found that the six major qualities of strong families are commitment, appreciation, communication, time together, spiritual wellness, and ability to cope with stress and crisis.

SUMMARY

In reviewing the literature within the context of family functioning and developmental disabilities, there is a

consistent theme indicating that having a child with a developmental disability has a negative impact on dyadic relationships. This includes mother-child, father-child, sibling-child, and even marital relationships. However, with continued changes over the past four decades in societal attitudes and policies towards people with developmental disabilities, the emphasis on pathological family functioning is beginning to change. Research is now beginning to focus on what is best for the child and the family. Researchers are finding that there are strengths in families that have a child with a developmental disability. Additionally, research has also been carried out assessing qualities of strong families in general. It was the intent of this research to better define the strengths of the family system that has a child with a developmental disability.

Chapter 3 - Methods

SAMPLE

The sample of this study included two populations. The first population included all forty-eight families who currently have children between the ages of six and twelve years old attending Beekman Center. The Marvin A. Beekman Center is a segregated public school in Lansing, Michigan for children with developmental disabilities. This population was chosen with the thought that the responding families would have children with lower levels of ability.

The second population included 220 Board of Directors, Local Association Presidents, and Executive Directors of the Association for Retarded Citizens (ARC) in Michigan. These members were asked to read the cover letter and distribute to families meeting the criteria who they thought would be interested in participating in this research project. The ARC population was chosen with the thought that the responding families would have children with varying degrees of ability.

The initial mailing for both populations included a cover letter briefly describing the research project and requesting participation for families meeting the criteria of having a child with a developmental disability between the ages of six and twelve years old. A copy of the Family

Information Sheet asking family demographic information, a copy of the two part questionnaire, and a postpaid envelope addressed to the primary investigator were also included in the initial mailing. The initial mailing resulted in sixteen respondents after two and a half weeks. A second postcard mailing was sent out to both populations three and a half weeks after the initial mailing. The postcard thanked those families who already responded and reminded those who did not that their participation would be helpful. The second mailing resulted in six more respondents, one of which was not usable as the child with a developmental disability was thirty-seven years old. The total usable respondents were twenty-one. This was a 14.58% return rate from respondents in the Beekman population. The return rate from the undifferentiated ARC population was 6.36%.

DESCRIPTION OF INSTRUMENT

The two instruments used in this study to assess family strengths included the Family Inventory of Resources for Management (FIRM) instrument developed by McCubbin, Comeau, and Harkins (1981) and the Family Strengths Inventory (FSI) developed by Stinnett and DeFrain (1985). The FIRM was used to assess a family's social, psychological, and community resources. The instrument is composed of four subscales: Esteem and Communication (FS), Mastery and Health (RS), Extended Family Social Support (SS), and Financial Well-Being (FWB). The FIRM is composed of fifty-five statements regarding family life, fifteen from subscale FS, twenty from

subscale RS, four from subscale SS, and sixteen from subscale FWB. When completing the FIRM, the primary caregiver in each family was asked to indicate how well the statement described the family situation on a four point Likert scale (1= not at all, 2= minimally, 3= moderately, 4= very well). The overall internal reliability of the FIRM is 0.89 (Cronbach's alpha). The internal reliabilities for the individual subscales are as follows: Esteem and Communication = 0.85 (Cronbach's alpha), Mastery and Health = 0.85 (Cronbach's Alpha), Extended Family Social Support = 0.62 (Cronbach's alpha), and Financial Well-Being 0.85 (Cronbach's alpha) (McCubbin and Comeau, 1987).

The FSI instrument was used to assess more global areas of family strength. The FSI instrument is made up of fourteen quality descriptions of families. The primary caregivers were asked to indicate on a five point Likert scale the degree to which they felt their family possessed each quality, (1) representing the least degree and (5) representing the greatest degree. The split-half reliability of the FSI is 0.94 (N. Stinnett, personal communication, February 5, 1991). For this study, an additional question (Question 70) was added to the FSI. The respondents were asked to indicate on the same five point Likert scale the degree to which they felt their family was strong.

In addition to the two part questionnaire on family strengths, respondents were also asked to complete the Family Information Sheet for family demographics. The following information was obtained on each family: names, ages, and

relationships of all people living in the household, names and ages of all children not living in the household, parental occupations, parental education, family income for 1990, numbers of years married if currently married, child's date of birth, child's diagnosis, age of child at diagnosis, sex of child, and child's overall level of functioning based on IQ.

DESCRIPTION OF STATISTICAL ANALYSIS

1. The means, standard deviations, and minimum and maximum values were calculated for each question on the FIRM, each subscale of the FIRM, the total FIRM, each question on the FSI, question 70, the total FSI, and all demographic variables. Additionally, the means, standard deviations, and minimum and maximum totals were calculated for the total scores on each subscale of the FIRM, the total FIRM, and the total FSI.

The means for each FIRM subscale were calculated to determine which subscales were high in family strength. The means and standard deviations of the total FIRM subscale scores were calculated to compare to the means and standard deviations of a normative sample, previously calculated by McCubbin and Comeau (1987).

2. Cronbach's alpha reliability was calculated for each subscale on the FIRM and the total FIRM. These values were calculated to compare to the Cronbach's alpha values determined by the authors of the FIRM instrument. The split-half reliability of the FSI was calculated to compare with the split-half reliability determined by the author of the FSI

instrument.

3. Pearson R correlations were calculated between the following items: question 70 and each subscale on the FIRM, question 70 and total FIRM, question 70 and each question on the FSI, and question 70 and total FSI. The correlations were calculated to determine the relationship between the primary caregiver's perception of family strength and the family strength as determined by each instrument.

4. One-way ANOVA was calculated with the child's level of functioning and each subscale on the FIRM and the total FSI. ANOVA was calculated to determine if there was variability between families with high functioning children (borderline, mild, and moderate) and low functioning children (severe and profound) in areas of family strength as determined by the FIRM subscales and the FSI.

5. The frequencies of family demographic variables were calculated. The frequencies are used to describe the overall sample. Additionally, the frequencies allowed each demographic variable to be divided into groups.

6. The frequencies of each subscale on the FIRM and the total FSI were calculated. The mean test was used to divide each subscale on the FIRM and the total FSI into two groups each.

7. The frequencies of each question on the FIRM and each question on the FSI including question 70 were calculated. The frequencies of each question are used to describe the percentage of respondents to each question.

8. Pearson R correlations were used on the following

information to determine if there was a statistically significant relationship between each subscale of the FIRM (esteem and communication, mastery and health, extended family social support, and financial well-being) and family income, mother's education, father's education, and number of years married to current partner.

SUMMARY

This study included two populations of families with children who have developmental disabilities between the ages of six and twelve years old in an attempt to get varying levels of children's ability. Of the 268 questionnaires sent out to families, twenty-one were returned in usable form. The primary caregiver in the family completed a two part, seventy item self-report instrument focusing on four specific areas of family strength and global areas of family strength. In addition, they completed a form on family demographics. In analyzing the information gathered statistically, the following statistical tests were used: means, standard deviations, reliabilities, Pearson R correlations, ANOVA, and frequencies.

Chapter 4 - Results

Reliability of Instrument

Cronbach's alpha was calculated for internal reliability of FIRM instrument. The overall reliability of the fifty-five item FIRM was 0.9517. The reliability of Esteem and Communication subscale, fifteen items, was 0.8601. The reliability of Mastery and Health subscale, twenty items, was 0.9134. The reliability of Extended Family Social Support subscale, four items, was 0.5518. The reliability for the Financial Well-Being subscale, sixteen items, was 0.9296. A split-half reliability of 0.8848 was calculated for the fourteen item FSI instrument. All reliabilities for the FIRM instrument were higher than the reliabilities reported by the authors of the instrument, except the four item Extended Family Social Support subscale. The reliability for the FSI instrument was slightly lower that the reliability reported by the author of the instrument.

Demographics of Sample

The overall family demographics of the sample are described in Table 1. The range of incomes for twenty families was $7000 to $150,000. The mean of the sample was $38,855 and the median was $31,500. Over half of all the families' incomes were between $24,000 and $40,000. The

majority of the families had only siblings older than the child with a developmental disability. Nearly forty percent of all fathers held professional positions, with another quarter having skilled positions. Of mother's occupations, nearly half were homemakers and about twenty percent held professional positions. Just over half of all fathers attended one to four years of college, with the mean being 14.65 years of school and the median 14 years of school. Just under half of all mothers attended one to four years of college, with the mean being 13.7 years of school and the median being 13.5 years of school. One third of all respondents were not married and another third of all respondents were married between 11 and 20 years. The mean number of years married was 12.75 years and the median was 12 years. Two thirds of all children with developmental disabilities were male and the other one third were female. About half of the children were in the high range of overall functioning and half were in the low range of overall functioning.

Of the sample of twenty-one, the respondents indicated that their children had the following diagnoses: nine with Down's syndrome, seven with severe multiple impairments (SXI), two with mental retardation, one with a chromosome abnormality, one with mucopolysaccaridosis-sanfilippo, and one with cerebral palsy. The distribution of ages at which the child received a diagnosis are the following: twelve at birth, six between six weeks and one year, and two between

fourteen and twenty-four months. The sample did include one family with two children, ages six and nine, who both had developmental disabilities. For purposes of the questionnaire, information was given only on the older child. There was also one family whose child with a developmental disability did not live in the home. The child was currently in foster care. Although the initial cover letter requested families who had a child with a developmental disability between the ages of six and twelve, one respondent had a son fifteen years old who was developmentally disabled. This respondent was included in the sample.

Table 1 RESPONDENT DEMOGRAPHIC VARIABLES

Demographic Variable:	Percentage of Respondents:	N:
FAMILY INCOME		
$7,000 to $15,000	19.0%	4
$24,000 to $40,000	52.4%	11
$43,715 to $150,000	23.8%	5
no response	0.48%	1
FAMILY TYPE		
no siblings	9.5%	2
younger siblings only	14.3%	3
mixed siblings	23.8%	5
older siblings only	52.4%	11
FATHER'S OCCUPATION		
skilled position	23.8%	5
managerial position	14.3%	3
professional position	38.1%	3
homemaker	4.8%	1
unemployed	9.5%	2
no response	9.5%	2
MOTHER'S OCCUPATION		
skilled position	23.8%	5
managerial position	4.8%	1
professional position	19.0%	4
homemaker	47.6%	10
student	9.5%	2
no response	9.5%	2
FATHER'S EDUCATION		
high school or less	28.6%	6
1 to 4 years of college	52.4%	11
5 or more years of college	14.4%	3
no response	4.8%	1
MOTHER'S EDUCATION		
high school or less	38.1%	8
1 to 4 years of college	47.5%	10
45 or more years of college	9.6%	2
no response	4.8%	1
NUMBER OF YEARS MARRIED		
not married	33.3%	7
1 to 10 years	14.4%	3
11 to 20 years	33.3%	7
21 to 34 years	19.2%	4
CHILD'S SEX		
male	67.7%	14
female	33.3%	7
CHILD'S OVERALL LEVEL OF FUNCTIONING		
high	52.4%	11
low	46.6%	9

RESEARCH QUESTIONS, HYPOTHESES, AND RESULTS

1. What are the areas of family strength for families who have children with developmental disabilities as measured by the FIRM?

The following dimensions appear to be attributes of strength as reported by respondents in order: esteem and communication, extended family social support, financial well-being, and mastery and health (Table 2).

Table 2 MEANS AND STANDARD DEVIATIONS FOR FIRM

variable	number of items	mean	std dev	N
esteem & comm.	15	3.22	.44	21
extended family social support	4	3.00	.59	21
financial well being	16	2.78	.75	21
mastery & health	20	2.58	.60	21
total FIRM	55	2.84	.50	21

2. What are global areas of family strength for families who have a child with a developmental disability as determined by the Family Strengths Inventory (FSI) instrument?

The global areas of strength for families with children who have developmental disabilities are reported to be the following from highest to lowest according to respondents: commitment, closeness with child(ren), happiness with child(ren), making child(ren) feel good, dealing with crisis, spiritual wellness, expressing appreciation, child(ren) making you feel good, good communication,
spending time together, closeness with spouse, making spouse

feel good, spouse making you feel good, and happiness with spouse (Table 3).

Table 3 MEANS AND STANDARD DEVIATIONS FOR FSI

variable	mean	std dev	N
Commitment	4.38	1.02	21
Closeness with child(ren)	4.24	1.00	21
Happiness with child	4.10	.89	21
You make child(ren) feel good	4.05	1.02	21
Dealing with crisis	3.71	.90	21
Spiritual wellness	3.57	1.25	21
Expressing appreciation	3.52	.81	21
Child(ren) make you feel good	3.52	1.12	21
Good communication	3.48	1.08	21
Spending time together	3.43	1.03	21
Closeness with spouse	3.26	1.41	19
You make spouse feel good	3.21	1.27	19
Spouse makes you feel good	3.16	1.38	19
Happiness with spouse	3.11	1.41	19
Total FSI	3.66	.82	21

3. Do areas of family strength as measured by the FIRM differ according to the severity of the child's disability? If so, how?

HYPOTHESIS: Family strengths as measured by the subscales on the FIRM instrument (esteem and communication, mastery and health, extended family social support, and financial well-being) do not differ according to the severity of the child's disability (high or low functioning).

Oneway ANOVA was calculated with the child's overall level of functioning, either high functioning or low functioning, and each subscale on the FIRM instrument. There

is no statistical significance between severity of disability and family strengths according to the FIRM. The null hypothesis for the question is accepted (Table 4).

Table 4 ANOVA FOR FIRM AND LEVEL OF FUNCTIONING

variable:
by variable Child's Overall Level of Functioning

	D.F.	F Probability
Extended Family Social Support	(1, 18)	.3102
Financial Well Being	(1, 18)	.3324
Esteem & Communication	(1, 18)	.7501
Mastery & Health	(1, 18)	.7567
Total FSI	(1, 18)	.4549

4. Do family strengths as measured by the FIRM instrument differ according to the family demographic variables?

HYPOTHESIS: Family strengths as measured by the FIRM instrument do not differ according to family demographic variables.

Pearson R correlations were calculated with each subscale on the FIRM instrument and the following demographic variables: family income, father's education, mother's education, and number of years married to current partner. There was a significant correlation between esteem and communication and financial well-being as well as between financial well-being and family income. Additionally, there was a significant correlation between financial well-being and mother's education. Mastery and health had a significant correlation with the number of years married , and financial well-being had a significant correlation with the number of

years married (Table 5).

The null hypothesis is rejected for the following items at the .05 level of significance: mother's education and financial well-being, number of years married and mastery and health , number of years married and financial well-being, and family income and esteem and communication. The null hypothesis is rejected at the .001 level of significance for family income and financial well-being.

Table 5 CORRELATION OF FIRM AND DEMOGRAPHIC VARIABLES

subscale/variable	Pearson r	p<.05	p<.001
esteem & communication/ family income		.0477	
financial well-being/ mother's education		.0346	
financial well-being/ number of years married		.0177	
mastery & health/ number of years married		.0151	
financial well-being/ family income			.0006

5. Do the primary caregivers' perceptions of overall family strength relate to areas of family strength as measured by the FIRM for the family that has a child with a developmental disability?

HYPOTHESIS: The primary caregivers' perceptions of overall family strength positively relate to the subscales of family strength on the FIRM instrument.

All four subscales on the FIRM, esteem and communication, mastery and health, extended family social support, and financial well-being are significantly related to the primary

caregiver's perception of overall family strength (Table 6). The null hypothesis is rejected at the .001 level of significance for caregiver's perception of strength and esteem and communication as well as caregiver's perception of strength and the total FIRM. The null hypothesis was rejected at the .01 level of significance for the following: caregiver's perception of strength and mastery and health, caregiver's perception of strength and extended family social support, and caregiver's perception of strength and financial well-being.

Table 6 CORRELATION OF FIRM AND PERCEPTION OF STRENGTH

subscale	Pearson R	p<.01	p<.001
extended family social support		.5503	
financial well-being		.5836	
mastery & health		.5945	
esteem & communication			.6987
total FIRM			.7315

6. Do the primary caregivers' perceptions of overall family strength relate to global areas of family strength as measured by the FSI instrument for the family that has a child with a developmental disability ?

HYPOTHESIS: The primary caregivers' perceptions of overall family strength positively do not relate to the global areas of family strength as determined by the FSI instrument.

All global areas of family strength as determined by the FSI instrument, except dealing with crisis, are significant in relationship to the primary caregivers' perceptions of overall

family strength (Table 7). The null hypothesis is accepted for caregivers' perceptions of strength and dealing with crisis. The hypothesis is rejected at the .01 level of significance for caregivers' perceptions of family strength and the following: commitment, good communication, closeness with spouse, and making spouse feel good. The hypothesis is rejected at the .001 level of significance for caregivers' perceptions of family strength and the following: spending time together, expressing appreciation, spiritual wellness, closeness with child(ren), happiness with spouse, happiness with child, spouse makes you feel good, child(ren) make you feel good, and making child(ren) feel good.

Table 7 CORRELATION OF FSI AND PERCEPTION OF STRENGTH

subscale	Pearson R	p<.01	p<.001
Dealing with crisis	.4865		
You make spouse feel good		.5706	
Closeness with spouse		.6081	
Commitment		.6290	
Good communication		.6326	
Happiness with child			.6649
Expressing appreciation			.6727
Spending time together			.6746
Spiritual wellness			.6754
Closeness with child(ren)			.6822
Child(ren) make you feel good			.7060
You make child(ren) feel good			.7091
Happiness with spouse			.7687
Spouse makes you feel good			.7774
Total FSI			.7315

SUMMARY

The reliability scores of the instruments used in this study were, for the most part, higher than the reliability scores reported by the authors of the instrument. Demographically, the families that participated in this study can be described in the following manner: most family incomes ranged from $24,000 to $40,000 annually, most families had only older siblings, fathers primarily held professional positions while most of the mothers were homemakers. Educationally, about half of all the parents had one to four years of college. About a third of the respondents were married and the same portion was not married. More participating families had boys than girls with developmental disabilities. The majority of the children with developmental disabilities had Down syndrome, and most were diagnosed with their disability at birth.

The respondents indicate that attributes of family strength include the following in order: esteem and communication, extended family social support, financial well-being, and mastery and health. Global attributes of family strength are reported respectively: commitment, relationship with child(ren), dealing with crisis, spiritual wellness, expressing appreciation, communication, spending time together, and relationship with spouse. Family strengths do not appear to differ according to the severity of a child's disability. Family income, mother's education, and number of years married to current partner appear to be significantly

correlated with family strength. Additionally, the primary caregivers' perceptions of family strength are consistent with family strength as determined by the two part instrument.

Chapter 5 - Discussion

SUMMARY

As most research in the area of families that have children with developmental disabilities focuses on the pathologies of the family system, this research has concentrated on assessing areas of strength for such families. In addition to assessing areas of strength in the family, this research assessed the family's perception of strength. Family strength was also assessed in relationship to the severity of the child's disability and family demographic variables.

In reviewing the literature within the context of family functioning and developmental disabilities, there is a consistent theme indicating that having a child with a developmental disability has a negative impact on dyadic relationships. This includes mother-child, father-child, sibling-child, and even marital relationships. However, with continued changes over the past four decades in societal attitudes and policies towards people with developmental disabilities, the emphasis on pathological family functioning is beginning to change. Research is now beginning to focus on what is best for the child and the family. Researchers are finding that there are strengths in families that have a child with a developmental disability. Additionally, research has

also been carried out assessing qualities of strong families in general. It was the intent of this research to better define the strengths of the family system that has a child with a developmental disability.

This study included two populations of families with children who have developmental disabilities between the ages of six and twelve years old in an attempt to get varying levels of children's ability. Of the 268 questionnaires sent out to families, twenty-one were returned in usable form. The primary caregiver in the family completed a two part, seventy item self-report instrument focusing on four specific areas of family strength and global areas of family strength. In addition, they completed a form on family demographics. In analyzing the information gathered statistically, the following statistics were used: means, standard deviations, reliabilities, Pearson R correlations, ANOVA, and frequencies.

The reliability scores of the instruments used in this study were, for the most part, higher than the reliability scores reported by the authors of the instrument.

Demographically, the families that participated in this study can be described in the following manner: most family incomes ranged from $24,000 to $40,000 annually, most families had only older siblings, fathers primarily held professional positions while most of the mothers were homemakers. Educationally, about half of all the parents had one to four years of college. About a third of the respondents were not married and another third were married eleven to twenty years.

About two thirds of the children with disabilities were boys, and the other third were girls. The majority of the children with developmental disabilities had Down syndrome, and most were diagnosed with their disability at birth.

The respondents indicated that attributes of family strength include the following in order: esteem and communication, extended family social support, financial well-being, and mastery and health. Global attributes of family strength are reported respectively: commitment, relationship with child(ren), dealing with crisis, spiritual wellness, expressing appreciation, communication, spending time together, and relationship with spouse. Family strengths do not appear to differ according to the severity of a child's disability. Family income, mother's education, and number of years married to current partner all appear to be significantly correlated with family strength. Additionally, the primary caregivers' perceptions of family strength are consistent with family strength as determined by the two part instrument.

DISCUSSION

The results of this study suggest that families with children who have developmental disabilities are able to identify their own strengths. Furthermore, their perception of family strength is consistent with the family strengths identified by self-report instruments. Families identified the subscale Esteem and Communication to be their area of greatest strength on the FIRM. Esteem and Communication

includes such areas as family esteem, communication, mutual assistance, optimism, problem solving ability, and encouragement of autonomy among family members. They have identified Extended Family Social Support as their second greatest area of strength, indicating there is much giving to and receiving from relatives. The third area of strength for these families was Financial Well-Being. And, finally Mastery and Health was identified as the fourth greatest area of strength. Mastery and Health includes areas of sense of mastery over family events and outcomes, emotional support, togetherness, cooperation, and physical and emotional health. It is understandable that families who have a child with a developmental disability would not consider mastery and health as their area of greatest strength. These families have a child that probably has a number of ongoing physical and/or emotional problems.

The FSI instrument included seven global areas of family strength. The families in this sample indicated that their strengths were in the following order: commitment, relationship with child(ren), dealing with crisis, spiritual wellness, expressing appreciation, communication, spending time together and relationship with spouse. Thirty-three percent of all respondents were not married. However, nineteen of the twenty-one respondents answered the questions on the FSI related to spousal relationship. Therefore, it is believed that the respondents' answers reflected their current relationship with their ex-spouse (the parent of the child

with a disability). Only two respondents indicated otherwise. One female respondent indicated that her children were adopted, and she was not married. Therefore, she responded to spousal questions by marking a one on the scale of one to five. Another female respondent indicated that she was living with the father of her children. Although they were not married, it is assumed that she was referring to her partner in answering the spousal questions.

As expected, the severity of the child's disability does not affect family strength. Three family demographic variables do positively correlate to areas of family strength as indicated by the FIRM instrument. There is a significant difference in esteem and communication based on family income, suggesting that families with higher income have a higher esteem. As one would suspect, there is a significant difference in financial well-being based on family income. There is also a significant difference in financial well-being based mother's education. Eight mothers had a high school education or less, ten mothers had one to four years of college, one mother had five or more years of college, and one was not reported. The relationship between financial well-being and mother's education suggests that those mothers with a higher education are earning more money than those mothers with a lower education. Of twenty-one respondents, ten reported that the mother is currently a homemaker, seven mothers are employed, two mothers are students, and two were not reported. There is a significant difference in mastery

and health based number of years married to current partner. There is a greater sense of mastery over family outcomes and events, more emotional support, togetherness, cooperation, and better physical and emotional health in families where the parents have been married longer. A significant difference in financial well-being based on number of years married was also found.

The total means scores of the sample in this study are slightly lower in all four areas of family strength as determined by the FIRM instrument compared to a normative sample of families (Table 8). However, the standard deviation for all four areas of strength are slightly larger with the families who have children with developmental disabilities. The total mean scores of the sample in this study are lower than the normative group. This may mean that in families who have children with developmental disabilities, some strengths are suppressed. However, slight differences in scores does not equate to a pathological family.

Table 8 COMPARISON OF NORMATIVE AND RESEARCH SAMPLES

variable	number of items	mean	std dev	N
esteem & comm.				
families	15	33.33	6.57	21
normative	15	35	6	
mastery & health				
families	20	31.48	11.85	21
normative	20	39	9	
extended family social support				
families	4	8.00	2.35	21
normative	4	9	2	
financial well being				
families	16	28.43	12.04	21
normative	16	29	9	
total FIRM				
families	55	101.24	27.31	21
normative	55	110	18	

Contrary to most other research done in this area, respondents in this study indicate that families who have children with developmental disabilities do have strengths. There is one similar theme in predictors of family strength. Hampson et al. (1988) indicated that two-parent families were predictors of healthy family adjustment. Friedrich et al. (1987) found in their study that marital satisfaction was a predictor of positive family relations. Respondents in this study indicate that the number of years married is a predictor of family strength, specifically in the area of mastery and health. All three studies suggest that marital relations do have an impact on family functioning. In regards to the sex of the child with a developmental disability having an impact on family strengths, the results are inconclusive and inconsistent. In their 1988 study, Hampson et al. indicate that an older female child with mental retardation is a predictor of healthy family adjustment. On the other hand, Friedrich et al. (1987) suggest that a male child who is disabled is a predictor of positive family relations. The respondents in this research suggest that there is no difference between male and female children in regards to predicting family strength.

ABOUT LIMITATIONS

It should be noted here that the very small sample size in this study has a number of ramifications. First, the small sample size limits the generalizability of the findings. Additionally, the small sample size could mean that a

selection factor has occurred in this study. Specifically, families that perceived themselves as not strong may have chosen not to respond to the questionnaire. Therefore the diversity of the sample that was desired may not have been achieved.

Also in regards to the small sample size, the ARC sample was an undifferentiated group of families. Unlike the Beekman sample where all families that were contacted had children between the ages of six and twelve with developmental disabilities, the ARC population included only individuals that were members of the Association for Retarded Citizens. Their membership in this organization did not necessarily mean that they met qualifications for participation in this study. All individuals contacted not meeting the study's qualifications may have been the reason why the response rate for the ARC population was only 6.38%.

IMPLICATIONS FOR THE PRACTITIONER

The most significant finding in this research is the indication that families who have children with developmental disabilities are able to accurately identify their own strengths as well as their areas of need. Practically, this suggests that some families with children who have developmental disabilities are functioning well by utilizing their strengths. Furthermore, not all families who have children with developmental disabilities are dysfunctional. In providing services to those families in need, this research would suggest that service begins by assisting the family to

identify their strengths, define their strengths, and build upon their strengths. Then, family strengths can be seen as a beginning step of an intervention plan instead of being seen only as a consequence of intervention. It is important that families have full input into their individualized service plans as the best know their strengths and needs.

IMPLICATIONS FOR FUTURE RESEARCH

Research implications suggest that, first and foremost, additional research should begin to focus on family strengths. What are families doing right? How? Why? In concentrating on family strength, much consideration should be given to perceived family strengths. It would be beneficial to look at perceived family strengths from the part of all family members individually. Then perceptions among individual members could be compared and contrasted. This particular study focused on families of children between the ages of six and twelve. A comparative study might be carried out to determine differences and similarities in family strength with varying aged children. Additionally, when choosing a sample for a future study, the sample should be age specific to the group that is being studied.

APPENDICES

Appendix A

FREQUENCIES OF EACH QUESTION ON THE FIRM

Responses:
1= not at all
2= minimally
3= moderately
4= very well

QUESTION	1	2	3	4	mean
1. Being physically tired	9.5%	38.1%	47.6%	4.8%	2.476
2. Financially able to help relatives	38.1%	33.3%	19.0%	9.5%	2.000
3. Friends enjoy visiting	9.5%	14.3%	33.3%	42.9%	3.095
4. Good retirement income program	33.3%	14.3%	33.3%	19.0%	2.381
5. Nag each other to get things done	4.8%	28.6%	52.4%	9.5%	2.571
6. Understand help expected from each other	4.8%	9.5%	47.6%	38.1%	3.190
7. Ability to make plans work	0%	14.3%	57.1%	28.6%	3.143
8. No problem paying bills	19.0%	23.8%	28.6%	28.6%	2.667
9. Events as a matter of good or bad luck	4.8%	33.3%	23.8%	38.1%	2.952
10. One person earning money a problem	23.8%	14.3%	38.1%	19.0%	2.429
11. Take each other for granted	4.8%	33.3%	38.1%	23.8%	2.810
12. No problem getting a loan	23.8%	14.3%	19.0%	42.9%	2.810
13. Relatives take but give little	0%	23.8%	28.6%	47.6%	3.238

14. Money for unexpected expenses	23.8%	4.8%	19.0%	52.4%	3.000
15. Look at good and bad of solutions	0%	4.8%	66.7%	28.6%	3.238
16. Good income benefits	19.0%	4.8%	38.1%	38.1%	2.952
17. Don't have enough control over life	23.8%	38.1%	23.8%	14.3%	2.286
18. Some do the giving others do the taking	4.8%	47.6%	19.0%	28.6%	2.714
19. Look on the bright side	0%	28.6%	38.1%	33.3%	3.048
20. Put off decision making	4.8%	23.8%	42.9%	28.6%	2.952
21. Can afford dinner out	4.8%	19.0%	47.6%	28.6%	3.000
22. Under much emotional stress	38.1%	38.1%	14.3%	9.5%	1.952
23. Interferences in sharing time	19.0%	23.8%	42.9%	14.3%	2.524
24. Keep in touch with relatives	4.8%	14.3%	42.9%	38.1%	3.143
25. Need more life insurance	14.3%	38.1%	23.8%	23.8%	2.571
26. "Okay" to show positive feelings	0%	4.8%	33.3%	61.9%	3.571
27. Able to make contributions	19.0%	14.3%	42.9%	23.8%	2.714
28. Happier than most	0%	28.6%	47.6%	23.8%	2.952
29. "Okay" to cry	0%	19.0%	14.3%	66.7%	3.476
30. Money decisions made by one person	38.1%	19.0%	14.3%	28.6%	2.333
31. More illness than most	9.5%	23.8%	23.8%	42.9%	3.000

32. Money in savings for needs	28.6%	19.0%	23.8%	28.6%	2.524
33. Discuss decisions with family first	14.3%	19.0%	23.8%	42.9%	2.952
34. Some members have all responsibility	19.0%	42.9%	19.0%	19.0%	2.381
35. Upsetting when plans don't work	9.5%	61.9%	23.8%	4.8%	2.238
36. Relatives willing to listen	9.5%	38.1%	23.8%	28.6%	2.714
37. Worry about paying unexpected bills	23.8%	33.3%	9.5%	33.3%	2.524
38. Satisfaction from helping one another	0%	9.5%	52.4%	38.1%	3.286
39. Saving for the future important	4.8%	14.3%	19.0%	61.9%	3.381
40. Being sad is a problem	19.0%	19.0%	42.9%	19.0%	2.619
41. Hard to get family to cooperate	14.3%	23.8%	38.1%	23.8%	2.714
42. Little influence over events	19.0%	42.9%	23.8%	14.3%	2.333
43. Working members respected by coworkers	0%	9.5%	33.3%	51.7%	3.476
44. Made checks knowing there isn't enough	0%	9.5%	19.0%	71.4%	3.619
45. Members respect one another	0%	19.0%	42.9%	38.1%	3.190
46. Have spending money for special things	23.8%	28.6%	28.6%	19.0%	2.429
47. Same problem over and over	4.8%	19.0%	28.6%	47.6%	3.190
48. Things need to get done that don't	23.8%	38.1%	38.1%	0%	2.143
49. If lost job, could find another	9.5%	19.0%	23.8%	47.6%	3.095

50. Family encouraged to have own interests	0%	9.5%	57.1%	33.3%	3.238
51. Relatives make us feel appreciated	4.8%	28.6%	38.1%	28.6%	2.905
52. Members good neighbors and citizens	0%	4.8%	33.3%	61.9%	3.571
53. Don't spend enough time together	4.8%	28.6%	52.5%	14.3%	2.762
54. Make an effort to help relatives	0%	28.6%	52.4%	19.0%	2.905
55. Financially better off than 5 years ago	19.0%	19.0%	28.6%	33.3%	2.762

Appendix B

FREQUENCIES OF EACH QUESTION ON THE FSI

scale: 1 to 5
1= least
5= most

QUESTION	1	2	3	4	5	mean
56. Spending time together	9.5%	0%	38.1%	42.9%	9.5%	3.429
57. Commitment	0%	9.5%	9.5%	14.3%	66.7%	4.381
58. Good communication	4.8%	14.3%	23.8%	42.9%	14.3%	3.476
59. Dealing with crisis positively	0%	9.5%	28.6%	42.9%	19.0%	3.714
60. Expressing appreciation	0%	4.8%	52.4%	28.6%	14.3%	3.524
61. Spiritual wellness	0%	28.6%	19.0%	19.0%	33.3%	3.571
62. Closeness with spouse	14.3%	9.5%	28.5%	14.3%	23.8%	3.263
63. Closeness with child(ren)	0%	9.5%	9.5%	28.6%	52.4%	4.238
64. Happiness with spouse	14.3%	19.0%	19.0%	19.0%	19.0%	3.105
65. Happiness with child(ren)	0%	4.8%	19.0%	38.1%	38.1%	4.095
66. Spouse makes you feel good about self	9.5%	23.8%	23.8%	9.5%	23.8%	3.158
67. Children make you feel good about self	4.8%	14.3%	23.8%	38.1%	19.0%	3.524
68. Make spouse feel good about him/ herself	9.5%	19.0%	19.0%	28.6%	14.3%	3.211

69. Make children feel good	4.8%	0%	19.0%	38.1%	38.1%	4.048
70. Degree to your family is strong	0%	0%	23.8%	33.3%	42.9%	4.190

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