ATTITUDE OF PARENTS TOWARDS THEIR SPECIAL NEEDS CHILDREN: THE ROLES OF CAREGIVERS' BURDEN AND FEELINGS OF GRATITUDE

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CERTIFICATION

This is to certify that this research work was carried out by Miss SUCCESS, ENAI BLESSING with the matriculation number PSY/14/2046 in the department of Psychology, Faculty of Social Sciences, Federal University Oye – Ekiti, under my supervision.

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DEDICATION

I dedicate this work first and foremost to almighty God for all possibilities and also to my wonderful mum Mrs. Rebecca Success and my adopted parents Pastor and Pastor (Mrs.) Jacobs Ajima for their immense support morally and financially. I also dedicate this work to all Special needs children in the World.

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Abstract

The study examined the role of care-givers' burden and feelings of gratitude in attitude of parents who have special needs children. One hundred and ninety six (196) participants were selected using the purposive sampling method among parents whose special needs children are being cared for by some non-governmental organizations in Abuja and Ibadan, Nigeria. Participants were administered the Parental Attitude towards Mental Retardation Scale, the Gratitude Questionnaire, and the Burden Scale for Family Caregiver. Seven hypotheses were tested by means of independent sample t-test, one-way ANOVA and multiple regression. Findings suggests that care-givers' burdens and gratitude jointly predict attitudes towards SN children. However, only feelings of gratitude independently predict attitudes towards SN children. This suggests that an increase in gratitude feelings significantly predict increase in positive attitudes towards SN children. Age, level of disability, birth order and occupation of the parent did not significantly influence parental attitudes towards SN children. Given that feelings of gratitude and care-givers' burden jointly predicted parental attitudes towards SN children; it is recommended that mental health practitioners should aim gratitude intervention and care-giving burden management programs for these parents.

Word count: 196

Keywords: care giver's burden, feelings of gratitude, attitude, special needs, children.

CHAPTER ONE

INTRODUCTION

1.1 Background of the study

The unique feature that distinguishes the human race from other animals is the ability to process complex information (Goswami, 2013). Humans have been blessed and equipped with diverse abilities, in complex information processes, intellect, temperament, attitude, and also in relating with other humans. Some individuals have sadly being found deficient in some of these abilities (Biswas, 1980). According to the World Health Organization (WHO, 2013), more than a billion people, which is about 15% of the world's population, have some form of disability. In Nigeria, the 2006 census put the figure of people with disability at 3,253,169. Of this figure, the total number of women and children with disabilities are 1,544,418 and 1 002 062, respectively. The total number of people with disabilities is approximately 2.32% of the population (140,431,790), with women and children with disabilities being 1.1 and 0.71%, respectively (Federal Republic of Nigeria Official Gazette, 2009; National Population Commission, 2010).

Various studies have focused on stressors associated with caring for children with special needs, and the effects on parents' well-being (Chandramuki, 2012). There is evidence that family attitude contributes to prognosis in these children (Goswami, 2013). Limited financial resources, lack of appropriate services, and insufficient support systems are the family system risk factors that can contribute to poor prognosis (Singer & Powers, 1993).

From the days of Aristotle to this present day, people with special needs have had to go through a lot of challenges in many countries, especially in the developing ones (Haihambo & Lightfoot, 2010) including being denied the right to life (Ingstad, 1990). In certain communities in Nigeria, disabled children are not even considered acceptable gifts to the gods; they are seen as "a taboo",

an embarrassing spectacle and a disgrace to their families (Groce, 1999). Many handicapped children are still abandoned on streets and in bushes because they are considered as liabilities and a source of shame (Bunning, 2017).

Disability conditions such as deafness, blindness, intellectual disability, orthopaedic impairment and so on are mostly attributed to punishment by vengeful gods for what a person has done wrong done in the present or past (Choruma, 2006). In traditional settings, it is also attributed to infidelity of parents, eating prohibited foods, fishing in sacred waters and even disobedience on the part of the expectant mothers who might have exposed certain parts of their bodies or walked in the noon day or in the dark at odd hours (Otte, 2013). There is also a strong belief in witchcraft, evil spirits and demons who parade the streets at night causing havoc in form of disabilities to those who ignore their warnings (Stone-MacDonald & Butera 2012).

Children are expected blessings in families (Gibran, 1986). Parents prepare earnestly and joy for their birth especially after marriage. Most parents expect the child to be born healthy thus there may be little preparations for the birth of a disabled child and this may cause negative attitudes and parenting stress (Bunning et al, 2014). Beliefs about the causes of disabilities tend to condition attitudes and reactions towards the special needs child (Helander, 1993). Often a range of emotions, such as denial, guilt, frustration, anger and despair, affect the parents as they are confronted by their children with disability (Bhan, 1995). Some parents also experience helplessness, feelings of inadequacy, shock and guilt, whereas others go through periods of disbelief, depression and self-blame (Frude, 1992). A number of these parents do not take this easy as they struggle with all the challenges of the disability and/or the daily responsibilities that are associated with the disability (Gona et al, 2010).

Some parents treat their disabled children harshly (Olive 2015). These children are killed at birth and those are that are kept alive are sometimes maltreated by their parents; they are constantly abused physically, verbally and even emotionally (Creswell, 2007). A number of these special needs children are made to hawk in the streets or beg for alms, sometimes walking very long distances and getting expose to sexual abuse and road accidents (Kvam & Braathen 2007). Many parents see it as a waste of time sending these children to school (Shumba, 2011). There are also parents who hide their special needs children as a result of fear of being ridiculed by the society; they keep these children in isolation, hiding them for years even from their neighbors (Hibbard, 2007). These children are often neglected and not allowed to enjoy parental love and bond, they are treated differently from their other siblings and do not partake in family celebrations and outings (Mckenzie et al, 2013).

Caring for a disabled child poses a major cost on the parents of the child as they serve as important advocates and most times the only effective coordinators of care to the child (Jannet Currie & Robert Kahn 2012). In last three decades, care giving has become a growing interest among researchers (Haley, Levine, Brown, & Bartolucci, 1987; Pearlin, Mullan, Semple, & Skaff, 1990; Vitaliano, Russo, Young, Teri, & Maiuro, 1991: Vitaliano, Zhang, & Scanlan, 2003; Zarit, Femia, Kim, & Whitlatch, 2010; Zarit, Reeves, & Bach-Peterson, 1980). Caring for a special needs child causes an increase in financial, physical, and emotional responsibility (Dorfman et al., 1996; Emanuel, Fairclough, Slutsman, & Emanuel, 2000; Ownsworth et al., 2010). In addition to these responsibilities, the parents are also responsible for the use of complex medical equipment, extensive coordination of medical and diagnostic appointments (Keith, 2009) as well as management of all activities of daily living (Emanuel et al., 2000; Keith, 2009; Pearlinetal., 1990). This may cause the parent to become frustrated, depressed, and feel

demoralized because of the demand of the care giving responsibilities (Lim & Zeback, 2004). If they are employed, they may frequently miss time from work, using personal and sick days to provide care; they may even have to quit their jobs or retire early to provide care (Duxbury, Higgins, & Smart, 2011; Emanuel et al., 2000; Pinquart & Sorensen, 2003). Researchers have shown that care giving for individuals with a chronic condition can affect a caregiver's physical, psychological, and social life, resulting in poor physical health, social isolation, and increased stress and burden (Pinquart & Sorensen, 2003; Schulz et al., 1995; Smith, Williamson, Miller, & Schulz, 2011). The multiple aspects of care giving activities also influence a caregiver's quality of life, which, in turn, affects the caregiver's present socioeconomic circumstances, the extent to which the caregiver is able to manage stress, and the extent to which the caregiver is able to create and utilize a social support network (Lim & Zebrack, 2004; Pearlin et al., 1990). Although care giving can be burdensome especially for the parent of a special needs child, some of these parents still do quite well, they have accepted fate, decided to get the best of their situations and focus on being grateful for the blessings the enjoy on a day to day basis irrespective of the challenges they have to deal with regarding the special needs child (MacMilan, et al 2013). Gratitude is a positive emotion that is one of life's most vital ingredients for enhancing mental health (Robert A. Emmons & Robin Stern 2013). More recently, (positive) psychology researchers have started recognizing that being more grateful can lead to increased levels of well-being (Emmons & Crumpler, 2000,Krause et al., 2015). Studies show that grateful people are more agreeable, more open, and less neurotic (McCullough et al., 2002; McCullough, Tsang, &Emmons, 2004; Wood, Maltby, Gillett, Linley, & Joseph, 2008; Wood, Maltby, Stewart, Linley et al., 2008). Furthermore, gratitude is related negatively to depression and positively to life satisfaction thereby leading to wellbeing (Wood, Joseph, & Maltby, 2008).

Perhaps, gratitude may therefore serve as a process in positively affecting the attitude of parents towards their special needs children as they focus on being grateful for the blessings they experience in their everyday life irrespective of the special needs of the child.

This research will thus help us examine the roles that feelings of gratitude plays in helping parents who have special needs children live a better, pleasant, sociable, optimistic, and a more satisfying life despite the challenges of disabilities.

1.2 Statement of Problem

Many times when children are unable to perform a task after many attempts, children and parents may get frustrated and lower the standards for the child. Children with disabilities, however, are automatically given lower standards than those without disabilities (Wathum-Ocama & Rose, 2002). Also, stress and burden among parents who have special needs children have resulted in physical and psychological health challenges stemming from financial insecurity, social isolation, and delaying or completely discontinuing personal and career goals in order to care for ill child (Goode et al., 1998; Pearlin et al., 1990; Pinquart&Sorensen, 2003; Vitaliano et al., 1991; Vitaliano et al., 2003; Zarit et al., 1980). Some families are unable to cope with the emotional implications of the special needs and/or the daily demands that are placed on them as a result of the special needs (Cooke et al., 2001). They are plagued by feelings of pessimism; depression, hostility and shame, denial, projection of blame, guilt, grief, withdrawal, rejection and acceptance (Drew, 2008) and how they deal with this challenge goes a long way in influencing the parental attitude and their treatment of these children (Goswami, 2013). Fundamentally, the parent-child relationship is largely dependent on the parents' attitude. Some parents however treat their special children unfairly, exposing them to many physical barriers in daily life, discriminatory practices, and even direct abuse and violence (Whyte & Ingstad 1998).

For example, children with speech impairments are at five times greater risk of neglect and physical abuse than children without disabilities, and three times greater risk of sexual abuse. Also, mortality in children younger than 5 years with disabilities in some African countries is as high as 80% (Mitra et al, 2011). The relationship between parents and children will be far better when parental attitudes are favorable (Helander, 1993).

Some parents however may have accepted their fate and decided to see the best in their situation, these parents may be grateful for the goodness in their lives and this may predispose them to improve their attitude towards their special needs children. This is because gratitude is considered to be a positive emotion and grateful individuals tend to be happier, less depressed, less stressed and more satisfied with their lives. (Souza, 2013) Researches have shown that gratitude is a powerful tool for increasing well-being in all sorts of settings including the family (Wood. et al 2008, Elosua 2015). In addition, studies have also shown that more specifically, more grateful people tended to feel positive emotions more frequently; enjoyed life with a higher level of satisfaction and showed a tendency towards less depression, anxiety, and envy in comparison with people who were less grateful (McCullough et al., 2002). Although, many researches have been conducted in the area of understanding the psychological wellbeing of children with disabilities (Bines H & Lei P.2007, Peters ,et al 2008.), less attention is given to attitudes of parents who have special needs children. Thus, it is important to examine and understand psychological factors that may predict parental attitude towards their special needs children.

Considering the foregoing, it is the concern of the present study to investigate the roles that care - givers' burden and the feelings of gratitude play in predicting the attitude of parents towards their special needs children.

1.3 Research Questions

1. Does care-givers' burden influence the attitude of parents towards their special needs children?

2. Do feelings of gratitude influence the attitude of parents towards special needs children?

3. Do care-givers' burden and feelings of gratitude jointly predict parental attitude towards special needs children?

4. Does the severity of disability influence the attitude of parents towards their special needs children?

5. Does age of the special needs child influence the parents' attitude?

6. Does the occupation of the parent influence their attitude towards their special needs child?

7. Does the birth position influence the attitude of the parents towards him/her?

1.4 Objective of Study

1. To examine the influence of care-givers' burden on parental attitude towards special needs children.

2. To determine the influence of the feelings of gratitude on the attitude of parents towards their special needs children.

3. To examine if care-givers' burden and feelings of gratitude will jointly predict parental attitude.

4. To investigate the influence of the severity of the disability on the attitude of parents towards their special needs children.

5. To examine whether age of special needs child influences parental attitude

6. To investigate the role occupation of the parents plays in influencing the parents' attitude.

7. To determine whether birth position of special needs child influences the attitude of their parents.

1.5 Significance of study

The aim of the study is geared towards increasing the existing body of knowledge on the influence of care-givers' burden and roles of gratitude on the attitude of parents towards their special needs children. It is also important to mental health institutions because it will promote creation of more coping styles and proper adjustment for parents in dealing with the difficulties of parenting a special needs child by helping psychotherapists get a deeper understanding. In addition, this study will inform psychotherapists and experts that their intervention program should not be limited to children alone but also to the parents of these children.

CHAPTER TWO

LITERATURE REVIEW

2.1 Theories of Attitude

2.2 Attitude Formation

Attitude is a combination of affective, behavioral and cognitive reactions to an objective (Eiser, 1986). According to this tri-component approach an attitude is:

a) A positive, negative or mixed response comprising of our emotions, moods and feelings regarding a n object or actions;

b) A behavioral disposition to act in a certain manner towards something; and

c) A cognitive response as our evaluation of the object is based on relevant beliefs, images and memories. Schulman as cited in Schewarts *et al* (1995), however differs with this tri-component view and instead defines attitude as simply a positive or negative evaluation of an object. When people use such words as like, dislike, love, hate, good and bad, they are usually describing their attitudes. This means that evaluation of the attitude object centers solely on its utility for the person and not on its relation to longstanding values. The importance that one attaches to a particular value largely determines whether or not it will influence attitudes. For example, one's attitude towards persons with disability is probably based on what he/she thinks about the value the disabled can add to him/her and to the society. According to theories of reasoned action and planned behavior (Fisbein & Ajzen), specific attitudes combined with social factors produce behavior. Wanjohi, 1990 observes that strong attitudes are rooted in our genetic makeup. Davidson *et al,* as cited in (Oyugi, 1992) suggests that people tend to behave in ways that are consistent with their attitudes when they are well informed and the manner in which the information was received in the first place.

According to Bandura (1989), the learning of attitudes is an integral part of the socialization process which may occur through direct experience and interactions with others or as a product of cognitive process. Most of the attitude people hold are the product of direct experience with the attitude object. The attitude formed eventually influences an individual's behavior. The extent of the influence is generally believed to be moderated by personal characteristics. Attitudes do not necessarily correlate with behavior but under certain conditions they may. According to (Fanzoi, 1996), attitudes should be regarded as a learned association between a given object and a given evaluation. People are assumed to behave the way they do because of meanings they assign to their environment and events and objects within it. Different theories have been put forward to indicate how attitudes are formed.

Two major theories are as follows:

Mere Exposure Effect (Fechner, 1876): According to this theory, the more we are exposed to an object or behavior, the higher the tendency to develop more positive feelings. Merely exposing people to a particular object repeatedly will make them develop an attitude towards it. Overall the significance of the mere exposure effect regarding attitude illustrates how affect can become associated with an object independent of any knowledge about it. As human beings we seem to naturally develop a liking for those things that are repeatedly presented to us. For example, exposing the society to special needs children who showcase their talents frequently is likely to influence the kind of attitude one will develop towards the children.

Classical Conditioning: Through these methods, a previously neutral attitude object can come to evoke an attitude response simply by being paired with some other object. This is also called learning by association. When a neutral or conditioned stimulus is paired with unconditioned

stimulus, it naturally produces an emotional response. Exposing a special needs child to a neutral stimulus, like educational opportunities, will result into unconditioned stimulus in form of emotional response which is the attitude. Learners with disability will then form positive or negative attitude due to the classical conditioning. Classical conditioning is a more powerful determinant of attitude formation when people possess little knowledge about the attitude object (Caciappo, 1992).

Theories of Gratitude

The Broaden and Build Theory of Positive Emotions

There have been several studies that look at the impact of positive emotions, but have not fully captured the unique effects that they have on our emotional and physical well-being and functioning. In light of this, Fredrickson (2004) developed an alternative model that was designed to capture the significant impact that these positive emotions have on our daily lives, called the Broaden-and-Build theory of positive emotions.

Positive emotions build an individual's long-term psychological, intellectual, social and physical well-being and resources (Fredrickson, 2004). Positive emotions enable us to achieve higher functioning. Fredrickson proposed that happiness is not only the result of hard work and success, but it is also present before we experience our greatest achievements or moments of higher functioning. Positive emotions are the building blocks for people to become the best version of themselves, helping them to learn, grow, thrive and hold a higher level of life satisfaction. To help support and understand the effect positive emotions have in a person's life, Barbara Fredrickson developed a theory which explains how people's minds are broadened through experiencing positive emotions. The Broaden-and-Build Theory of Positive Emotions suggests that positive emotions broaden a person's awareness and encourage exploratory thoughts and

actions. It has been proven that positive emotions broaden people's momentary thought-action repertoires and build their enduring personal resources (Fredrickson, 1998, 2001). The Broaden-and-Build Theory describes the form and function of a subset of positive emotions such as joy, interest, contentment and love. These positive emotions have a complementary effect and are related to neutral states and widen the variety of thoughts and actions that come to a person's mind. For example, when someone is feeling joyful, this creates the urge for them to play, push their comfort zones, be impulsive and creative not only in their social and physical behavior but also intellectually, in their intimate relationships and artistically too (Fredrickson, 2004). Similarly, when a person is feeling interested this can create the urge to explore, retrieve and take in new information and experiences and expand their sense of self amidst the process of developing and adopting these new interests. Contentment is the third most distinct positive emotion, which elicits the urge to sit back and appreciate current life circumstances and combine this appreciative nature into new views of the self and beliefs surrounding the world (Fredrickson, 2004). Finally, love, which is viewed as the combination of all the distinct positive emotions mentioned, is experienced within a person's safe, intimate relationships and nurtures a person into creating a recurring cycle of all the urges created by joy, interest, and contentment. The Broaden-and-Build theory of positive emotions can help a person cultivate these positive emotions like gratitude and use them to help in coping with their negative emotions or other challenges (the challenges of disability) they may experience in their everyday lives. People who are optimistic are able to deal with the problem at hand and move forward and away from the negative emotions that may be holding them back. This broadening effect increases the probability of being able to see the good in future events rather than continuously looking at the possible setbacks. Fredrick further posited that, people who express a high amount of positive

emotions also have higher levels of psychological resilience, which assists them in building resources which will in turn help them cope with negative experiences. The Broaden-and-Build theory focuses on how positive emotions allow a person to create and build resources which can be drawn upon to improve their life satisfaction for extended period of time rather than just in the moment.

Fredrickson theory explains the unique effect that a positive emotion has on our well-being and self-growth. She has demonstrated through several studies that positive emotions are not just a sign of simply surviving in life but rather they are a sign of flourishing, thriving and expanding in life and they can also help create and maintain this growth in the present and in the future. Research has found correlations between reports of positive emotional well-being and increased life expectancy. A longitudinal study conducted in the 1930 investigated the emotional well-being of Catholic nuns. The research found that participants who reported the most positive emotions lived up to 10 years longer than those who did not experience as many positive emotions (Fredrickson, 2003). Furthermore, recent research has found supporting results, also finding that people who feel good live longer. Naturally, there are questions that arise from this discovery like what defines positive well-being and happiness and also the reason why people live longer if they feel good.

A person that experiences optimal daily functioning is generally in an environment where they can learn, thrive, flourish and reach higher ground. They exercise positive thoughts, mindfulness and deal with negative thoughts and feelings about themselves or the world around them by being aware, addressing the effects these thoughts may have on their mind and body and even the people around them. Positive emotions and people who function highly and are happy and balanced are hard to come by, therefore making the positive emotions they experience a little

harder to study. In contrast, there is a natural tendency to study something that burdens or troubles the well-being of humanity and unfortunately, the expression and experience of negative emotions are responsible for much of what ails the world (Fredrickson, 2003).

Happiness is a combination of life satisfaction, coping resources and positive emotions and feelings of gratitude can therefore serve as a coping mechanism and also a trigger for positive emotion. As stated by Fredrickson (2011) positive emotions open us and literally change the boundaries of our minds and hearts and our outlook on the world surrounding us. By feeling good, being happy, and experiencing emotions such as joy, gratitude and love, our visual perspective opens up, we can see our common humanity with others, and we are open to new experiences and build on our knowledge and urge to explore the world around us. Fredrickson (2011) has conducted a number of studies looking at how positive emotions affect our lives. In one of the studies, it was found that if people are induced with positive emotions they are more likely to step back and see the big picture and similarities in life or their current situation. Evidence has also uncovered that people who experience and express positive emotions widen the scope of what they scan for in their environments and relationships. These characteristics and behaviors are expressed by people who lead more positive lives and contribute to reducing stress, negative emotions and unstable relationships or mental health and increase chances of a happy and invigorating life. Thus when an individual, in this case, the parent of a special needs child tends to be express gratitude, he sees more positivity in spite of the situation and this in turn influences his attitude towards the special needs child.

Theory of Learned Optimism

Learned optimism is a theory in positive psychology that postulates that positive thoughts and feelings can be exhibited consciously by challenging any negative self-talk that a person

experiences. Learned optimism was defined by Martin Seligman and published in his 1990 book, Learned Optimism. Seligman states that optimism has several benefits; optimists are higher achievers and have better overall health. Pessimistic people are more likely to suffer from depression and poor physical health. Similar to Fredrickson, Seligman invites and encourages people to learn to be optimists by thinking about their reactions to challenges and daily stressors in a new, alternative way. This new way and shift of thinking from pessimism is what Seligman defines as learned optimism.

This theory suggests that over time the positive emotions and novel experiences accumulate into significant resources that can change people's lives. For example, curiosity can evolve into someone having expert knowledge or affection and shared interests can become lifelong supportive relationship. Positive emotion predicts valued outcomes like health, wealth and longevity because they help build the foundation and harness the resources to get there (Cohn et al., 2009).

The learned optimism theory and the broaden-and-build theory are similar in their views and how they can be applied in everyday situations. They both highlight the importance of positive thinking and managing negative thoughts, views and behavior so that an individual even one who has to deal with the challenges of disability can ensure that daily functioning and overall life satisfaction are joyful, content and of positive moments. The theories listed above suggests that being grateful triggers positive emotions in an individual and this can help in positively influencing the attitude of parents of special needs children as it helps deal with negative thoughts and emotions by focusing more on positivity.

Care-Givers' Burden Theory

Lazarus and Folkman's Transactional Stress Theory

Lazarus and Folkman's Transactional Stress Theory has been used extensively in stress, burden, and coping research. The Transactional Stress Theory suggested that the individual and environment interact in a dynamic and mutually shared relationship. Stress occurs when the interaction between the person and the environment taxes the person's coping resources and threatens his or her physical and psychological well-being. Subsequent research and application of Lazarus and Folkman's theory by (Pearlin et al, 1990) provided a framework for conceptualizing stress and burden among informal caregivers. Building on Lazarus and Folkman's Transactional Stress Theory, Pearlin provided a care-givers' stress theory for conceptualizing stress within the context of care giving. This theory has been the framework by which stress among care-givers has been examined across various chronic conditions (e.g., Alzheimer's disease, cancer, stroke, multiple sclerosis, Parkinson's disease). There are individual differences among care-givers in responses to stress and how the individual care-giver performs under stressful conditions. These stress reactions will ultimately affect the individual caregivers' quality of life. Therefore, according to Lazarus and Folkman, psychological stress occurs when the individual encounters a specific situation that is determined to be demanding beyond the individual's resources thereby creating a risk to the person's physical, mental, or emotional well-being. The Transactional Stress Theory suggested that a stress reaction occurs under situations where the demands of the environment exceed the individual's resources. In the presence of threat, the individual will engage in both primary and secondary appraisals of the perceived threat. Primary appraisal is set into action when the individual appraises the encounter as harmful, a threat, or a challenge (Lazarus & Folkman, 1984). The person makes a secondary

appraisal or judgment regarding his or her available coping resources for managing the potential threat. For example a parent with a special needs child may view the care has being a burden. Stress is the interaction between the person and the environment that is burdening to the person's coping resources or taxing to the extent that it threatens his or her physical and psychological well-being. The individual makes a cognitive assessment of his or her ability to cope with the situation. In turn, the individual copes with the stress by engaging in cognitive and behavioral efforts to manage the physical and emotional demands that are beyond the individual's resources to manage the stressful event (Lazarus & Folkman, 1984). The more negative or threatening the individual perceives the stressful situation; the more unfavorable the stress reaction. For example, the demands of care-giving can create stress that involves an increased number of care-giving activities that conflict with other responsibilities. The care-giving demands can cause a loss of opportunity to regenerate from care giving activities, obtain adequate rest, or engage in social activities. The care-givers' stress may be aggravated by inadequate care-giving skills to care for the patient and inadequate coping strategies to manage the care-giving burden (Lazarus & Folkman, 1984: Pearlin et al., 1990). Therefore, stress will become a negative self-reinforcing process (Lazarus & Folkman, 1984; Pearlin et al., 1990).

Vitaliano et al. (1991) provided a theoretical model of distress to predict burden among spouses of individuals with Alzheimer's disease. The model was based on a formula that states: "Distress = Exposure to Stressors +Vulnerability /Psychological, Social Resources". This model indicated that care-givers' distress was a response to the responsibilities of care giving that led to feelings of burden (Vitaliano et al., 1991). Exposure to stress is the caregiver's response to the care recipient's physical, emotional, or cognitive impairments (Vitaliano et al., 1991). Care-givers' vulnerability is the physical, mental, and emotional experiences to the demands of care-giving.

Care-giver resources are the coping mechanisms, social supports, and outlooks on life. Therefore, the model suggested that caregiver burden was related to whether the care-giving responsibilities were deemed a negative or a positive experience (Vitaliano et al., 1991).

In summary, based on Lazarus and Folkman's (1984) Transactional Stress theory, researchers have formulated theories on the nature, cause, and management of stress among informal caregivers. (Haley et al., 1987; Pearlin et al., 1990; Vitaliano et al., 2003; Zarit et al., 1980). The Zarit Burden Interview identified specific care giving characteristics that may have contributed to caregivers' perceived burden (Zarit et al., 1980). Care-givers with a high vulnerability to stress and fewer coping resources might experience an increase in burden and stress over time (Vitaliano et al., 1991). The caregivers' level of stress will depend on the pattern of stress, the caregiver's appraisal of his or her ability to cope, and the caregivers' perceived level of social support (Haley et al., 1987; Pearlin et al., 1990)

2.3 Related Empirical Studies

Societal Attitudes towards Persons with Disabilities

Historically, Framption and Gall as cited in (Mbiti, 1969) have summarized the stages of development of attitudes towards the handicapped to include: First, during the pre-Christian era the handicapped persons were persecuted, neglected and mistreated. Second, during the spread of Christianity era they were protected and pitied. Third, in very recent years there has been a movement towards accepting the handicapped and integrating them into society to the fullest extent.

Early Greek and Roman civilization viewed the persons with disabilities with a mixture of superstitions and ruthlessness. For instance in Rome, Athens and Sparta, blind children were put to death in a legally approved manner, and fathers had a right to abandon their newborn infants if

they were deformed. Those learners with disabilities who survived were seen as inferior and were given severe punishment as it was believed that they possessed evil spirits (Gellman, 1973). In other societies, children who exhibited disabilities were isolated from society and some were even taken to the forest and left to die. Children manifesting mental disabilities have probably been the most mistreated of all learners with disabilities. In earlier civilizations some were used as court jesters to entertain royal families simply because of their submissiveness and lack of social discernment (Ndurumo, 1990). In India, disability is still viewed in terms of tragedy with a "better dead than disabled" approach, the idea being that it is not possible for persons with disabilities to be happy or enjoy a good quality life.

Cultural beliefs about disability play an important role in determining the way in which the family perceives disability and the kind of measures it takes for prevention, treatment and rehabilitation. Studies report that parental expectations from their learners with disabilities are mostly negative and unrealistic.

(Dalal & Pande 1999) investigated cultural beliefs and attitudes towards physical disability. The results revealed fatalistic attitudes and external dependence in families with learners with disabilities. Most of the respondents felt that the disabled member in a family could not do anything and just needed help and sympathy.

In most African families, the handicapped were seen as a curse and were separated from the main stream society. In some cases even the birth of twins and triplets were seen as an event out of the ordinary. Some societies used to kill such children while others killed both the mother and the children (Mbiti, 1969: 117). The practice of viewing the disabled as incapable of gainful employment is embedded in the original Kiswahili term "*Wasiojiweza*" used in Eastern Africa to refer to the disabled. The literal translation of the term means "those incapable of performing".

According to Kalugula *et al* (1984), the term has a wider meaning for it was additionally used to refer to all disabled persons, including the deaf. The hearing impaired were in the past called "*Bubu*" (deaf and dumb) and later on "*Viziwi*" (deaf), but are now referred to as "*Wasiosikia*" (those who cannot hear). These are some of the stigmatizing Kiswahili terms referring to persons with disabilities. These words refer to persons with disabilities negatively, are reserved things and carry the third person singular and plural respectively. Thus, persons with disabilities are referred to as non-human beings (Ndurumo, 1990). Many people in Nigeria do not accept disability. Many children with disabilities are hidden at home due to the shame that they bring to their family. They are considered "cursed and a blemish to the reputation of the family and the community". For example, a case has been cited of a mentally disabled child in Kenya who has been tethered to a seat for years because the parents are ashamed (NjaGih, 2005). In Southeast Nigeria, a father was chased out of the village for having three children with disabilities (McFerran, 2005).

Parental Attitudes towards Education of their Children with Disabilities

(Rangaswami, 1995) asserts that often parents have a negative attitude towards their learners with disabilities. These parents experiences feelings of pessimism, hostility, shame, denial, projection of blame, guilt, grief, withdrawal, helplessness, depression, feelings of inadequacy, anger, rejection and even go through periods of disbelief and acceptance. These reactions lead to the formation of negative attitudes towards the learners with disabilities. (UNESCO, 1974) expressed the view that parents of learners with disabilities tend to feel ashamed so that such children are hidden away from the rest of the society. From this statement from UNESCO, it is quite evident that this lack of concern starts with the parents of such children. The stigma from disability makes parents reluctant to send their children outside the home thus denying them

education and training in vocational skills. In Bhutan in Southern Asia, 279,500 children under the age of 14 years are disabled. However, most of these learners with disabilities are still locked after at home by their families and do not attend school (Miller, 2003). Likewise, in Kenya learners with disabilities are hidden away from society. For example, a girl was kept hiding her disabilities from the rest of the world for 13 years (Oyaro, 2004). However in the recent years, people are now accepting that a child with disability is a normal child faced with some shortcomings. This new attitude that is developing is also due to the developing of modern techniques and discoveries that have shown that a child with disability can be rehabilitated into a useful member of society if provided with special skills and education.

However, some parents no longer confine learners with disabilities. They have accepted them as they are (Maingi, 2004). Some parents are now seeing learners with disabilities as a blessing and not as a curse as before (Ombara, 2003). Some parents are positive and enthusiastic towards education of their children (Browers, 1985). This study seeks to investigate the attitude of parents towards the education of their learners with disabilities in Nakuru District.

Socio-Economic Status of Parents of Learners with disabilities

Learners with disabilities are in themselves a cost to their parents. These children, irrespective of age, usually need permanent attention, care and treatment. All these needs have an innate socio-economic cost to the parent and the family involved. In Russia, examinations of the socio-economic characteristics of families with learners with disabilities show that most of them are employed in less demanding jobs. When children are born or become invalids, forty percent of the mothers break their labor force participation while thirteen percent change their place of work. Mass involvement of mothers in caring for children is caused by insufficient development of the sphere of special services for people with disabilities including provision of personal

services, nursing and teaching at home, special education for the disabled. Treatment, care, education and rehabilitation of learners with disabilities require direct participation of parents and much time (Elena, 2018). Learners with disabilities often make heavy demands on the family's time, resources and energy by demanding constant supervision and stimulation. (McConachie, 1986) in a study of six to fourteen year old severely mentally disabled learners, revealed that mothers spent an average of over seven hours daily on care, supervision and training of their children. Another persistent problem for parents of learners with disabilities involves stigma, an attribute that is deeply discrediting. Parents of learners with disabilities suffer from stigmatization by society. Some parents of learners with disabilities are rejected by relatives and friends due to the fear that they too may share the stigma (Shea & Baver, 1991). The problems facing parents with learners with disabilities including poverty, are negatively affecting the decisions concerning education of the children. Parents decide to lock them after in the houses thus denying them education.

Gender and Education of Disabled Children

Even among persons with disabilities, discrimination has also been portrayed in terms of their gender differences. Women with disabilities suffer the most. Many women are discriminated against merely because they are women. Having a disability compounds this prejudice, particularly for women in developing countries. This double prejudice is the root cause of the inferior status of women with disabilities, making them the world's most disadvantaged group. It is the cause of hostility and negative attitudes that are often more debilitating for disabled women than the disability itself (Boylan, 2011). In Asia, 66 percent of all women are illiterate, and in Africa, the proportion is 85 percent (Boylan, 1991). With such high rates of illiteracy among women in general in developing countries, the chances for a girl with disability getting

education are slim. Research has shown that in an average Asian home, especially in rural areas, girls with disabilities are just left to exist in confined areas of the house and very few, if any have the chance to go to school. Child gender is anticipated to be associated with parental attitudes in a variety of ways that would limit education opportunities for disabled girls.

In African traditional culture, expectations for each sex were different and depended on the role one was expected to play in society. Men were expected to play economic roles while women were expected to play domestic and other feminine roles. As a result of this, when formal schooling was introduced in Africa, there was much emphasis on education of the boy because he was seen as the potential head of the family and a bread winner while the girls were prepared for feminine roles and successful marriage (Muola, 2000). This emphasis is still held by some people in Nigeria. The country is faced with regional gender disparities in education especially at the primary school level. The disparities differ from region to region. (Vitaliano et al. 1991) examined the longitudinal effects of burden among 95 caregivers providing long-term care to individuals with Alzheimer's disease at the beginning of the research study, and 15 to 18-months afterward. Between 15 to 18 months, there was a significant decline in the care recipients' functioning and a concurrent increase in the caregiver's assistance with activities of daily living (Vitaliano et al., 1991). Approximately one-third of the caregivers reported mild to moderate levels of depression or anxiety. Variables that measured caregivers' physical health and coping abilities did not change. However, the mean scores decreased for the outlook on life measures (Vitaliano et al., 1991). The findings suggested that the distress model is useful in predicting burden and stress in care-givers (Vitaliano et al., 1991). Therefore, caregiver burden is the response to the exposure to stress, the level of influence of the vulnerability factors, and the extent to which the care-giver assess the available resources as useful (Vitaliano et al., 1991).

They concluded that care-giver burden is a response to stress overtime. They also concluded that care-givers differentially respond to the task of care giving (Vitaliano et al., 1991).

In another research, (Butler et al., 2005) found that among a sample of 62 rural informal caregivers, caregivers showed a small relationship between care-giver burden and age at the bivariate level. Perceived support and knowledge about the care giving task were most prevalent among middle aged women. However, younger care givers felt more depressed than their older counterparts (Butler et al., 2005). (Williams, 2005) also found a correlation between age of caregiver and outcome. Among a sample of 295 Black and 425 White care-givers for individuals with dementia, younger Whites and African Americans reported greater symptoms of emotional distress compared to their older counterparts who were likely to experience more age-related health problems (Williams, 2005). Other factors that influenced background and context (Pearlin et al., 1990) included caregiver history, patient needs, socioeconomic status (SES), family and network composition, and social support program availability (Pearlin et al., 1990).

(Smith et al. 2005) conducted a longitudinal investigation of stress among caregivers of individuals diagnosed with Alzheimer's disease. The sample consisted of 310 care givers' baseline stress levels at the beginning of the research investigation and a sample of 213 care givers' stress levels after a one-year follow-up. As the care recipients' needs increased over time, care-givers experienced a concomitant increase in stress, and a decrease in quality of life (Smith et al., 2011). (Aronson, 1997) examined the quality of life among a sample of 345 care-givers for individuals with multiple sclerosis (MS). They found that a decline in quality of life was related to providing care for longer durations of time. (McCullough et al., 2002) examined the correlations between the gratitude disposition and other personality dimensions. These authors developed a Gratitude Questionnaire and found that the gratitude disposition was related to

positive emotions, psychological and physical well-being, social relationships, and religiosity/spirituality. More specifically, more grateful people tended to feel positive emotions more frequently; enjoyed life with a higher level of satisfaction and hope and showed a tendency towards less depression, anxiety, and envy in comparison with people who were less grateful. They also observed that people with high scores in the gratitude trait tended to be more empathic; forgave, helped, and supported others more; and were also less materialistic, in comparison with people with lower scores in the gratitude trait. Finally, more grateful people tended to be more religious and more spiritually oriented; more specifically, they tended to have higher scores in conventional religiosity measurements (e.g., church going or reading the Bible) and also in spiritual sensitivity measurements (e.g., feeling in contact with a divine force, the belief that all living beings have a connection).

Gratitude and Neuroscience

Aside from psychological investigations into gratitude in athletics, research into gratitude is being further modernized by incorporating research methods from neuroscience. One such study measured the brain's response to feelings of gratitude with functional Magnetic Resonance Imaging (fMRI) (Fox et al., 2015).

These researchers elicited feelings of gratitude in their participants and found that gratitude was associated with activity in areas of the brain that deal with morality, reward, and value judgment. The researchers also claim that their findings show that gratitude is a social emotion. These neural findings are interesting for a few reasons. For one, the fact that gratitude is associated with morality and value judgment helps explain why philosophical and religious thinkers have been (and continue to be) so interested in gratitude for millennia.

The idea that gratitude is an important social emotion also validates the above-mentioned idea by Robert Roberts (1991) that gratitude forges an important bond between followers of Christianity, as well as the ancient philosophical idea that gratitude is a foundational emotion for the success of the society.

This collection of research directions indicates that gratitude is as interesting to modern psychologists as it has been to philosophers and religious thinkers in the past. On top of that, compared to how long gratitude has historically been discussed by intellectuals, these psychological investigations are still in their infancy. It will be interesting to see what is in store for future psychological investigations into gratitude.

In a study by (McCraty et al 1998), 45 adults were taught to "cultivate appreciation and other positive emotions". The results of this study showed that there was a mean 23% reduction in the stress hormone cortisol after the intervention period. Moreover, during the use of the techniques, 80% of the participants exhibited an increased coherence in heart rate variability patterns, indicating reduced stress. In other words, these findings suggest that people with an "attitude of gratitude" experience lower levels of stress.

Gratitude in Relationships

In a romantic relationship, both partners take actions to please the other one. This can elicit several emotions such as gratitude and indebtedness. (Algoe et al. 2010) looked into these two emotions that are characterized as an emotional response to a costly and intentionally provided benefit. Also, gratitude and indebtedness are associated with the intention to repay for the received benefit. Gratitude leads to an internal motivation, and indebtedness to an external motivation to reciprocate.

Thoughtful actions: (Algoe et al. 2010) asked sixty-seven couples to keep a diary for two weeks. The participants had to record their own and their partner's thoughtful actions, their emotions, and their relationship well-being. By coupling the data of the two partners, they were able to see whether a thoughtful action of the participant was recognized by the partner and if he or she acknowledged the action accordingly.

(Algoe, et al. 2010) found that a partner's thoughtful action predicted an increase in feelings of gratitude and indebtedness. However, only feeling gratitude, not indebtedness, on one day predicted an increase in relationship well-being of the participant the next day. When these feelings of gratitude are noticed by the partner, the relationship well-being of the partner also increases.

Historically, philosophers have suggested that gratitude is one of the most important human emotions for the success of the society, and religious and spiritual thinkers have suggested that it is a crucial aspect of religious and spiritual life. Modern psychology research confirms that gratitude is an important social emotion that can benefit the lives of religious people who practice gratitude, and that practicing gratitude can also benefit non-religious people.

For the specific purposes of positive psychology, gratitude is a powerful tool for increasing well-being in all sorts of settings including the family. The benefits of practicing gratitude are also not tied to any sort of specific pathology, which is also in line with the values of positive psychology research. Investigations into the power of gratitude should continue being an important part of research directions in psychology.

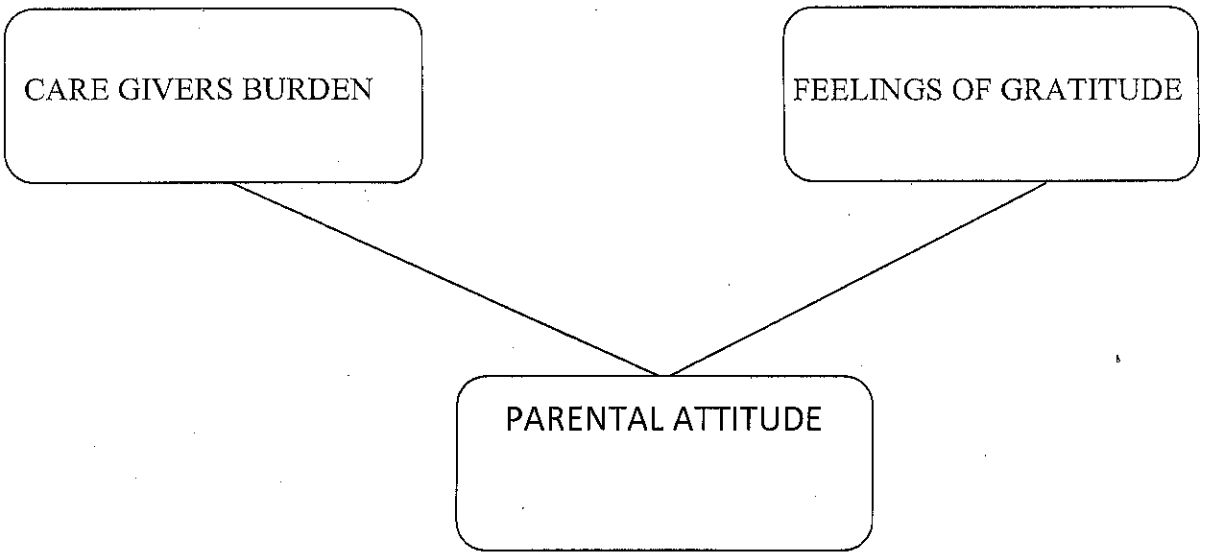
Parental attitudes and the special needs child

The view that having a child with an intellectual or developmental disability creates negative family outcomes including added stress and parental depression has underpinned much of the

research of the past three decades (Baxter, Cummins, & Yiolitis, 2000; Hayden & Goldman, 1996). Yet, research on this subject has suggested varying outcomes for families. In support of the view that disability leads to negative outcomes, a couple of comparative studies have noted greater stress in parents of children with disabilities than parents of children without disabilities (Baker-Ericzen, Brookman-Frazee, & Stahmer, 2005; Dyson, 1997). Likewise, two studies, focusing specifically on mothers, have found that mothers of children with mental retardation experience more depression than those of typically developing children when compared using the Beck Depression Inventory (Olsson & Hwang, 2001) and the Center for Epidemiologic Studies Depression Scales (Blacher, Shapiro, & Fusco, 1997). Although these studies suggest a relationship between childhood disability and parent stress or depression, it is important to note that they did not control for variations related to the diagnosis or care demands associated with the disability.

When the parental experience has been examined across diagnoses, some differences have been noted. Parents of children with Down syndrome have been found to experience less stress (Ricci & Hodapp, 2003), depression (Abbeduto, Seltzer, Shattuck, Krauss, Orsmond, & Murphy, 2004), and pessimism (Lewis, Abbeduto, Murphy, Richmond, Giles, Bruno, et. al., 2006) than parents of children with other diagnoses, particularly autism. In addition, childhood disability may not be as stressful for families as childhood illness. A comparative study of families of children with physical disabilities versus families of children with cancer found higher stress levels in the families dealing with cancer (Hung, Wu, & Yeh, 2004).

2.4 Theoretical Framework



2.5 Hypotheses

1. There will be a significant influence of care givers' burden on attitude of parents towards their special needs children.

2. There will be a significant influence of feelings of gratitude on attitude of parents with special needs children.

3. Care-givers' burden and feelings of gratitude will jointly predict parental attitude towards special needs children.

4. Level of disability will significantly influence the attitude of parents towards their special needs children.

5. There will be a significant influence of the age of the special needs child on parents' attitude.

6. The occupation of parents will significantly influence the attitude of the parents towards special needs child.

7. Birth orders will significantly influence parental attitude.

2.6 Operational Definition of Terms

Gratitude: It is defined as an emotional response of thankfulness that causes an individual to acknowledge and appreciate the goodness that he experiences in his everyday life. It is measured by the gratitude questionnaire item Form GQ-6 (McCullough et al, 2002). High scores show that the parent has high level of gratitude while low scores depict low levels of gratitude.

Care givers' Burden: It is defined as the emotional, social, financial, physical strain that an individual who cares for a sick person experiences as a result of the care he gives. It is measured using Burden Scale for Family Caregivers BSFC-s (Graessel et al, 2014). High score reveals high level of burden while low score reveals low level of burden.

Parental Attitude: It is defined as the way an individual who gives birth to, nurtures, cares for or is culturally or legally responsible for the upbringing of a child feels about the child in question that causes him to respond positively or negatively to the child and it is measured using the scale measuring attitude of Parents Towards Mentally Retarded Children (Goswami, 2013). High score indicates positive attitude while low score indicates negative attitude.

Special needs children: It can be defined as persons who have not yet reached adulthood, whether naturally [puberty], culturally or legally and need special help or care as a result of physical or mental impairment for example deafness, cerebral palsy, autism, blindness and so on. Special need is sometimes expressed as SN in this study.

Birth Position: It is defined as the placement of the child in the family according to the time he or she was born. It could be elder, middle or younger

CHAPTER THREE

METHOD

3.1 Research Design

The researcher adopted the use of ex-post facto research design to examine the influence of care givers' burden, feelings of gratitude, birth position, parent's occupation and age on attitude of parents towards their special needs children. None of the variables of study was subjected to active manipulation; rather they were measured as occurred. Purposive sampling method was used in the research to select nongovernmental organizations in Ibadan and Abuja. The choice of special needs children is purposive hence, only special needs children were used. The independent variables are care givers' burden, feelings of gratitude, birth position, age and parental occupation. The dependent variable is parental attitude towards their special needs children.

3.2 Setting and Participants

The study was carried out among parents of special needs children from nongovernmental organizations in Ibadan and Abuja. These nongovernmental organizations include: The Engraced Ones, Abuja, Jesus kids Orphanage, Abuja and Ibadan branch, Centre for Deaf Rights and Empowerment, Abuja and Pearls International, Abuja. The participants were 196 (92 (46.9%) mothers, 80 (40.8%) fathers and 24 (12.2) care-givers of the special needs children). Sixty-three (26.0%) of the participants were singles, 165 (68.2%) were married and only 14(5.8%) were divorced. Regarding religious affiliation, 192 (79.3%) were Christian 45 (18.6%) were Muslims and 5 (2.1%) was Traditional. Sex of SN children was almost evenly distributed for males (49%) and females (51%). Most of the SN children had moderate disability (57%) with 18.9% having severe disability. The birth order of SN children were almost evenly distributed for the eldest

(35.7%), middle (33.2%) and younger positions (31.1%). Most are care-givers care for one SN child (91.8%)

3.3 Research Instrument

Validated self-report instruments were used to gather relevant information from the participants. The questionnaire was divided into four different sections. They are:

Section A: This section consists of items measuring socio-demographic information of the parents and their special needs children, such as sex, age, religion, marital status, ethnic group, educational qualification, severity of disability, and birth position.

Section B: This section measures parental attitude of mentally retarded children using a 35 – items scale by (Goswani, 2013). The scale covers the important structural and functional features of parental attitude towards special needs children and it referred directly to the attitude object in question. The scale has a 5 – point Likert response format ranging from strongly disagree (1) to strongly agree (5). Higher score indicates a positive attitude towards the special needs child and lower scores indicates a negative attitude towards the child. The participants' attitudes score is the sum of the positive responses which they answered. Information received from the parents was analyzed using Statistical Package for Social Sciences (SPSS) 20.0.

Construction of the Scale: The 36 items scale interview schedule was prepared from 53 items expressing parental attitude towards Mentally Retarded Children. While constructing the items care was taken on the following points:

1. The items covered the important structural and functional features of parental attitude towards MR Children.
2. They expressed an opinion rather than a matter of fact
3. They referred directly to the attitude object in question.

4. They were simple and unambiguous.

5. They covered the entire continuum of attitude towards religion from extreme favorableness to extreme negative attitude.

Scoring: The subjects 'attitude score is the sum of the positive responses which they answered. After percentage (%) of the responses are taken out.

Information received from the parents (target group) were critically examined, cleaned, quantified as far as possible and tabulated systematically. The reliability coefficient alpha of the scale as obtained in the present study is .73.

Section C: This section contains the Burden Scale for Family Care givers. It measures care givers' burden using the burden scale for family caregiver (Graessel et al, 2014). The burden experienced by family caregivers is the most important caregiver-related variable in the home care of a chronically-ill person. The extent of subjective burden has significant impact on the emotional and physical health of the family caregiver, and even influences the mortality of spouse caregivers. It affects the way the family caregiver deals with the care-receiver and determines the time of institutionalization.

Scoring Details

a) If the BSFC score ranges from 0 to 41, the extent of overall physical symptoms (Gießen Symptom List GBB-24) corresponds to the expected value in the "normal population", that is, 50% of those caregivers have a percentile rank (PR) of physical symptoms < 50 and the other 50% a PR > 50.

b) If the BSFC score ranges from 42 to 55, 74% of those caregivers have an above average extent of physical symptoms (PR > 50).

c) If the BSFC score ranges from 56 to 84, 90% of those caregivers have an above average extent of physical symptoms (PR > 50). Parents' care giving burden was assessed using the likert format ranging from strongly disagree (1) to strongly agree (5). High score indicates high level of care-giving burden and low score indicates low level of care-giving burden. The reliability coefficient alpha is .80 was obtained for the scale in the present study.

Section D: This section contains 6 –item Gratitude Scale developed by (McCulolough et al., 2002) to measure feelings of gratitude using. The scoring includes adding up items 1, 2, 4, and 5, reversing the scores for items 3 and 6 then adding the reversed scores for items 3 and 6 to the total from step 1. The number should be between 6 and 42. High score is interpreted as high level of gratitude and low scores interpreted as low level of gratitude.

Interpretation: Based on a sample of 1,224 adults who took the GQ-6 as part of a feature on the Spirituality and Health Web Site, there are some benchmarks for making sense of the scores obtained. 25% Percentile: Someone who scored 35 out of 42 on the GQ-6 scored higher than 25% of the people who took it. If he scored below a 35, then he is in the bottom 1/4th of the sample of Spirituality and Health Visitors in terms of gratitude.

50th Percentile: Someone who scored 38 out of 42 on the GQ-6 scored higher than 50% of the people who took it. If he scored below a 38, then he is in the bottom one-half of people who took the survey.

75th Percentile: Someone who scored a 41 out of 42 on the GQ-6 scored higher than 75% of the 1, 224 individuals who took the GQ-6 on the Spirituality and Health web site one year ago. If he scored 42 or higher, then he scored among the top 13% of our Spirituality and Health Sample. A coefficient alpha of .57 was obtained for the scale in the present study.

3.4 Procedures

The researcher began the research process by seeking approval from the Department of Psychology, Federal University, Oye- Ekiti, Ekiti State to carry out the study. After the approval, the researcher proceeded to selected nongovernmental located at Ibadan, Oyo State and Federal Capital Territory, Abuja, Nigeria. The letter was shown to the management authority of the nongovernmental organization and the researcher was invited about three weeks later with a warm welcome to begin the data collection. In order to get a large number of participants, the researcher was available at various events held by the nongovernmental organizations at different times, contributing financially, emotionally and physically in the activities to get data from them and the questionnaires were collected after the participants responded to the tests items. Over 350 questionnaires were administered but only 220 were returned. Of this number, only 196 were found properly filled and were taken for data analysis in this study.

3.5 Statistical Method

Statistical Package for Social Sciences 20.0 was utilized for running data analyses. The demographic data collected was analyzed using descriptive statistics such as mean, range, standard deviation, frequency distribution and percentages. Hypotheses one, two, five and six stated were analyzed using independent sample t-test, hypotheses three using multiple regression while hypothesis four and seven were analyzed using one –way ANOVA.

CHAPTER FOUR

RESULTS

Table 1: Distribution of Social-demographics

N = 196	n	%		n	%
Marital status			**Relationship with SN child**		
Single	30	15.3	Mother	92	46.9
Married	142	72.4	Father	80	40.8
Separated	24	12.2	Other	24	12.2
Religious Affiliation			**Level of disability**		
Christianity	132	67.3	Mild	47	24.0
Islam	62	31.6	Moderate	113	57.1
Traditional	2	1.00	Severe	37	18.9
Family type			**Birth order of SN child**		
Joint	32	16.3	Elder	70	35.7
Nuclear	137	69.9	Middle	65	33.2
Extended	27	13.8	Younger	61	31.1
Education			**Age of SN child**		
Secondary	22	11.2	1-10	113	57.7
Graduate	123	62.8	11-20	72	36.7
Postgraduate	47	24.0	21-30	11	5.6
None	4	2.0	**Number of children**		
Occupation			1-4	175	89.3
Civil servant	99	50.5	> 4	21	10.7
Self-employed	74	37.8	**Number of Special Need (SN) children**		
Unemployed	7	3.6	1	180	91.8
Others	16	8.2	2	12	6.1
Sex of SN Child			3	2	1.0
Male	96	49.0	5	1	.5
Female	100	51	6	1	.5

The socio-demographic distributions of participants are displayed in table 1. Majority of care-givers are mothers (46.9%), Christians (67.3%), married (72.4%), civil servants (50.5%) and are from nuclear families (69.9%). Sex of SN children was almost evenly distributed for males (49%) and females (51%). Most of the SN children had moderate disability (57%) with 18.9% having severe disability. The birth order of SN children were almost evenly distributed for the eldest (35.7%), middle (33.2%) and younger positions (31.1%). Most care-givers care for one SN child (91.8%).*SN means special needs

Table 2: Means (M) and Standard Deviations (SD) and bivariate correlations

Variable	A	M	SD	3	4
1. Age of SN children		10.43	6.07		
2. Age of care-giver		42.94	8.79		
3. Parental attitude towards SN child	.73	84.31	11.55	-	
4. Care-giver burden	.80	27.27	7.47	-.05	
5. Gratitude	.57	11.95	3.22	-.19**	-.27**

***p < .01 (2-tailed)*

The result of correlation analyses among study variables are presented in Table 2. Parental attitudes towards SN child was significantly and positively related to feelings of gratitude [r (194) = .19, p = .009] but not care-givers' burden [r (194) = -.05, p = .52]. Gratitude and care-givers' burden were significantly and negatively related [r (194) = -.27, p < .001].

Hypothesis 1

There will be a significant influence of care giver's burden on the attitudes towards SN children.

Table 3: Independent sample t-test – care-givers' burden on attitude towards SN children

	Burden					
	Low (n = 102)		High (n = 94)			
	M	SD	M	SD	$t_{(194)}$	95%CI
Attitude towards SN children	84.62	12.49	83.98	10.49	.39	[-2.63, 3.90]

An independent sample t-test (table 3) showed that the difference in attitude towards SN children between participants low (M = 84.62, SD = 12.49) and high (M = 83.98, SD = 10.49) on care-giver burden scores were not statistically significant, t (194) = .39, p = .70. Therefore hypothesis one is not supported.

Hypothesis 2

There will be a significant influence of feelings of gratitude on attitudes towards SN children.

Table 4: Independent sample t-test – care-givers' burden on attitude towards SN children

	Gratitude					
	Low (n = 95)		High (101)			
	M	SD	M	SD	$t_{(194)}$	95%CI
Attitude towards SN children	83.69	11.50	84.89	11.62	-.72	[-4.46, 2.06]

An independent sample t-test (table 4) showed that the difference in attitude towards SN children between participants low (M = 83.69, SD = 11.50) and high (M = 84.89, SD = 11.62) on gratitude scores were not statistically significant, t (194) = -.72, p = .47. Therefore hypothesis two is not supported.

Hypothesis 3

Care-givers' burden and feelings of gratitude will jointly predict attitude towards SN children.

Table 5: Multiple regression- care-givers' burden and gratitude on attitude towards SN children

Variable	β	**T**	$\mathbf{R^2}$	**F**
Care-givers' burden	.004	.05		
Gratitude	.19*	2.55	.04	3.45*

Dependent variable: Attitude towards SN children

*p < .05

Table 5 showed that care-givers' burdens and gratitude jointly predicted attitudes towards SN children [F (2, 193) = 3.45, p = .03, R^2 = .04]. Independently, only feelings of gratitude significantly predict attitudes towards SN children [β = .19, p = .01] while care-givers' burdens [β = .004, p = .96] did not. This showed that an increase in gratitude feelings significantly predict increase in positive attitudes towards SN children. Therefore, hypothesis three is supported.

Hypothesis 4

Level of disability will significantly influence attitudes towards SN children

Table 6: One-way ANOVA- level of disability on attitudes towards SN children

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	497.70	2	248.85	1.88	.16
Within Groups	25512.32	193	132.19		
Total	26010.02	195			

Table 6 showed that the level of disability among SN children did not significantly influence care-givers' attitudes, F (2, 193) = 1.88, p = .16]. Therefore hypothesis four is not supported.

Hypothesis 5

There will be a significant influence of age of SN children on caregiver attitudes.

Table 7: Independent sample t-test – age on attitude towards SN children

	Age					
	1-10 (n = 113)		> 10 (n = 83)			
	M	SD	M	SD	$t_{(194)}$	95%CI
Attitude towards SN children	84.86	12.05	83.57	10.86	.77	[-2.00, 4.56]

An independent sample t-test (table 7) showed that the difference in attitude towards SN children scores between participants who care for 1-10 years (M = 84.86, SD = 12.05) and more than 10 years old SN children (M = 83.57, SD = 10.86) were not statistically significant, t (194) = .77, *p* = .44. Therefore hypothesis five is not supported.

Hypothesis 6

The occupation of care-givers will significantly influence attitudes towards SN children

Table 8: Independent sample t-test – occupation on attitude towards SN children

	Occupation					
	Civil servants		Self-employed			
	M	SD	M	SD	$t_{(171)}$	95%CI
Attitude towards SN children	83.97	11.91	84.74	10.91	-.44	[-4.26, 2.71]

An independent sample t-test (table 8) showed that the difference in attitude towards SN children scores between civil servants (M = 83.97, SD = 11.91) and the self-employed (M = 84.74, SD =

10.91) were not statistically significant, t (171) = -.44, p = .66. Therefore hypothesis six is not supported.

Hypothesis 7

Birth order will significantly influence attitudes towards SN children.

Table 10: One-way ANOVA- birth order on attitudes towards SN children

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	311.77	2	155.88	1.17	.31
Within Groups	25698.25	193	133.15		
Total	26010.02	195			

Table 10 showed that birth order of SN children did not significantly influence caregivers' attitudes [F (2, 193) = 1.17, p = .31]. Therefore hypothesis seven is not supported.

CHAPTER FIVE

DISCUSSION, CONCULSION, LIMITATION AND RECOMMENDATION

5.1: Discussion

In this study, the researcher investigated the attitude of parents towards their special needs children: the roles of caregivers' burden and feelings of gratitude. Seven hypotheses were tested, of which one hypothesis was supported and the rest were not supported.

The investigation of the role of care givers' burden and feelings of gratitude on the attitude of parents towards their children with special needs concluded that there is no significant influence of care-givers' burden and gratitude on the attitude of parents towards special needs children.

Hypothesis one states that there would be a there will be a significant influence of care giver's burden on the attitude of parents towards their SN child. The findings showed that the difference in attitude towards SN children between participants on care-giver burden scores were not statistically significant. Therefore, the hypothesis was rejected. This simply implies that care givers' burden does not have any influence on attitude towards SN children. This finding however conflicts with literature which showed attitude and burden of parents with schizophrenia in a middle income economy. (Caqueo - Urizar et al, 2011) argued that parents, especially mothers who experience the burden of care giving tend to express negative attitude. A rationale for this finding could be that the participants might be disciplined, dutiful and culture bound. Studies have supported this, showing that culture can have an influence on the care giving attitude of parents. (Im et al, 2007). Culture has a significant influence in determining the attitude of people towards different scenarios especially in Africa where culture is strictly respected (Angi & Gretchen, 2014). Parents may therefore, be indifferent about the burden of

care giving to avoid judgments from the society about their parental abilities; this may influence their perspective and attitudes about care giving.

Also, psycho-social interventions which include psycho-education, support and counselling, multi-component and psychological interventions have been proven to aid care-givers deal with the task of caregiving (Valzolgher, 2018). This may tend to influence the attitude of parents towards caregiving in this study as they were associated with nongovernmental organisations that provided counselling.

Hypothesis two states that feelings of gratitude will significantly influence the attitude of parents with special needs children. The analysis shows that that the difference in attitude towards SN children between participants on gratitude scores were not statistically significant. Therefore hypothesis two wasn't accepted. This means that feelings of gratitude doesn't influence attitude towards SN children. This is also not in tandem with literature as previous findings revealed that gratitude influences parental attitude. For example, McCullough et al, 2002 found that gratitude creates a positive emotion that influences social relationships. A possible explanation why no significant influence of gratitude on parental attitude could be because even though some parents go through challenges with the disability, they still manage to find other positive coping mechanisms to deal with the disabilities especially with the evolution of technology and insurance policies. For example, it was discovered that social support, good communication with spouse and locating programs to aid the disabled child can assist parents in coping with child's disability (Mcgrail & Rieger, 2010). This may account for the reason why there is no difference between feelings of gratitude and parental attitude as parents of these children were being educated at these nongovernmental organizations and intervention programs were also made available to them.

Hypothesis three states that caregivers' burden and gratitude will jointly predict parental attitudes towards SN children. The analysis showed that care-givers' burdens and gratitude jointly predicted attitudes towards SN children. Independently, only feelings of gratitude significantly predict attitudes towards SN children. This showed that an increase in gratitude feelings significantly predict increase in positive attitudes towards SN children. Therefore, hypothesis three is supported. There is however no past empirical research relating to the joint relationship of care-givers' burden and feelings of gratitude.

Hypothesis four states that severity of disability will significantly influence the attitude of parents towards their children with special needs. This hypothesis was not supported because the findings showed severity of disability doesn't influence attitudes towards SN children. This is not in agreement with literature as past studies have revealed that the level of a child's disability affects parental attitude. This is seen in a research by (Kendel & Merrick, 2007) which indicates that family reaction to the birth of a disabled child changes according to the type of disability and the child's diagnostic category.

Hypothesis five states that there will be a significant influence of the age of the special needs child on parents' attitude. The finding however, showed no significant difference. This implies that age of SN children in no way influences the attitude of caregiver. Therefore, the hypothesis was not supported. This finding is not in alliance with literature which often shows age of the SN child negatively influencing parental attitude. According to findings of (Oyaro, 2004) who opined that parents who have older SN children feel more frustrated, stressed and hopeless, hence he found a negative influence of SN child's age on parental attitude. (Boylan, 1998) also added that parents with older SN children have less hope for their child's future. Being a member

of a nongovernmental organisation may have an influence too as different events were organized to educate and encourage the parents.

The sixth hypothesis states that the occupation of parents will significantly influence the attitude of the parents to the child with special needs. The findings revealed that the difference in attitude towards SN children scores between civil servants were not statistically significant, Therefore, hypothesis six was rejected; this simply implies that the occupation of parents doesn't influence their attitudes towards SN children. This is not in harmony with previous findings, which showed that socio–economic status significantly influences parental attitude (McConachie, 1986; Elena, 2018). The previous findings could be interpreted that disabilities often make heavy demands on the family's time, energy and resources therefore it increases the tendencies for occupational stress thereby influencing parental attitude. Having a support group can encourage a parent despite their occupation as the government makes effort to not only support these parents who are members of the nongovernmental organizations but also make life easier for the child by making financial provisions from time to time.

The seventh hypothesis stated birth position will significantly influence parental attitude. This hypothesis was not supported because the findings showed that birth order of SN children did not significantly influence caregivers' attitude. This outcome is in consonance with literature as studies shows that gender and not birth position has an influence on parental attitude. For example, (Boylan, 2011) explained that child gender is associated with parental attitude hence women with disabilities suffer the most and birth position does not influence parental attitude.

5:2. Conclusion

Based on the findings in the study the following are the conclusions made:

The results of the study revealed the following;

1. There is no significant difference in care giver's burden on the attitude of parents towards their special needs children.

2. There is no significant difference in feelings of gratitude on attitude of parents with special needs children.

3. Care-givers' burden and gratitude jointly predicts attitude towards their special needs children.

4. There is no difference in severity of disability on attitude of parents towards their special needs children.

5. There is no significant difference in age of the special needs child on parents' attitude.

6. There is no significant difference in occupation of parents on attitude of the parents to the special needs child.

7. There is no significant difference in Birth position on parental attitude towards special needs children.

5:3. Recommendation:

Considering the findings of this research it is recommended that psychotherapist and other experts adopt mechanism to encourage a more positive approach to dealing with the challenges of disabilities. More coping mechanism should be created to encourage parents have a wider

variety to choose from with the help of psychotherapists and other experts. Based on the findings of this study, there are several avenues for continued research on attitude of parents towards their special needs children.

It is recommended that psychotherapists and other experts pay closer attention to the care givers' burden and feelings of gratitude on attitude of the parents of these children to encourage them live better and more fulfilling lives in spite of the disability. The challenges of the disability can greatly influence the lives of these parents sometimes for a lifetime so it is recommended that parents are encouraged to seek for ways to cope well. Every parent of these special needs children should be encouraged to seek professional help in dealing with the disability as this will help them deal with the situation better and be more informed about changes that come with giving care to a special needs child. The findings from this study implicated that mental health practitioners should aim gratitude intervention and care-giving burden management programs for these parents.

5.4: Limitation of study:

Like a lot of other study researches, this study is subject to several limitations. A few limitations in this study have been identified.

Firstly, is the use of non-random sampling techniques adopted for selecting samples for the study, study made use of convenient sampling techniques which leads to bias selection of the sample from the population.

Secondly, no attempt was made to verify the accuracy of data reported by participants. It is possible that participants responded in a manner that is socially acceptable. The study analyses attitudes and does not make attempt to verify that these self-reported attitudes are consistent with the behaviour of subjects. Participants would have responded in a way that put them in a desirable light, therefore, social desirability response bias would have occurred. This limitation could however be controlled by laying emphasis on the true responses from respondents. However, participants can decide to heed or not.

The small sample size used in the study may not be representative enough to characterize the whole population of interest. Due to the cross sectional nature of data used in the study, drawing causal, inferences among constructs may not be appropriate. For researchers who might want to replicate this study it is suggested that they use a larger sample, to have more viable findings and be able to generalize findings.

In addition, the fear of unveiling confidential information that could cause the society to doubt their parental abilities and thereby expose them to more stigmatization was expressed by these parents at different occasions also posed a limitation in this study. Although, the researcher promised confidentiality of information provided, this fear probably still influenced the information provided.

Also, the participants were all gotten from nongovernmental organisations that provide social support and psycho-education to the participants. This may have influenced the result of this research.

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FEDERAL UNIVERSITY, OYE EKITI, EKITI STATE
DEPARTMENT OF PSYCHOLOGY
FACULTY OF SOCIAL SCIENCES

Dear Respondent,

As a final year student of psychology, I request that you give your immediate impressions as response to the following questions. The answer to this questionnaire is strictly for a research on behavior and psychology. There is no right or wrong answer. Please note that every response will be treated with confidentiality.

Please express your interest for participation by ticking either a yes or no below

I AGREE TO PARTICIPATE: YES [ ] NO [ ]

SECTION A

Please read and respond to each question. All responses will be kept confidential

1. Sex - M [ ] F [ ]
2. Age:____
3. Marital Status- Single [ ] Married [ ] Separated [ ]
4. Religion - Muslim [ ] Christian [ ] Traditional worshiper [ ]
5. Type of Family - Joint [ ] Nuclear [ ] Extended
6. Educational Qualification -Secondary [ ] Graduate [ ] Post Graduate [ ] None [ ]
7. Occupation of the Father of the SN Child _____

Civil Servant [ ] Self Employed [ ] Unemployed [ ] Others [ ]

8. Relationship with the SN Child of the Respondent _____

Mother [ ] Father [ ] Other [ ]

9. Age of the Child ____
10. Sex of the Child - M [ ] F [ ]
11. How many SN children do you have_____
12. How many children do you have in total_____
13. Level of Disability of the SN child - Mild [ ] Moderate [ ] Severe [ ]
14. Cause of Disability - Genetic [ ] others [mention]
15. Age in which disability was first recognized ____
16. Community from which the SN Child is coming -Rural [ ] Urban [ ]

17. Position of the Special Needs Child within the family – Elder Child [ ] Middle Child [ ] Younger Child [ ]

SECTION B

Please tick the appropriate column that best describe your answer to the statement using the following code, 1-Strongly agree 2-Agree 3-Undecided 4-Disagree 5-Strongly disagree.

Kindly note that SPECIAL NEEDS is represented as SN in this research

S/N	ITEMS	SA	A	U	D	SD
1.	Upbringing of a SN Child is affected by family's Economical condition.					
2.	A SN Child should be sent to a special school.					
3.	Learning from a special school is helpful for a SN child					
4.	A SN Child should be treated more specially than his/her siblings.					
5.	A SN Child is discriminated more than other siblings.					
6.	A SN Child's birth is considered as a curse for his/her Parents.					
7.	A SN Child should not be confined at home.					
8.	My SN Child should get similar benefits as other children.					
9.	My SN Child should get proper entertainment as others.					
10	A SN Child's parents should become overprotective about their child.					
11.	A SN Child's mother should get more support from her husband.					
12.	A SN Child is considered as a burden for his/her parent.					
13.	I often feel hopeless as a SN child's parent.					
14.	A SN Child's parent sometime wishes to die.					
15.	Parents often experience unpleasant comments about their children from outsider.					
16.	A SN Child can function independently sometime.					
17.	A SN Child always needs parent's support.					

18.	As an SN Child's parent I often get worried about the future of my child.					
19.	A SN Child's parents should plan some special savings for their child's future.					
20.	A SN Child should attend festivals or social occasion.					
21.	A SN Child can have other caregivers.					
22.	A SN Child is often dominated by his/her parents.					
23.	A SN Child parent's ambitions are not fulfilled about their child.					
24.	A SN Child's parents wishes their child will get Economic independency in future.					
25.	A SN Child's parents hopes their child will get proper establishment in his/her life.					
26.	A SN Child shares a healthy bonding with his parents.					
27.	Parents of these children are happy with their parenthood.					
28.	A SN Child's parent has differences with her spouse Regarding her child.					
29.	A SN Child should get proper medical facilities.					
30.	A SN Child's parents should express their love properly.					
31.	If informed about retardation or disorder the prenatal should be aborted in pregnancy.					
32.	It is irritating for parents when all other parents can talk about their normal children.					
33.	A SN Child's parents should be consistent in their treatment with the children.					
34.	A noisy home is bad for an SN Child.					
35.	A SN child's parents want their children to socialize with Peers.					

SECTION C

In this section, the following statements refer to your assistance and support to your special needs child. Please answer every question accordingly.

S/N	ITEMS	SA	A	U	D	SD
1.	My life satisfaction has suffered because of the care.					
2.	I often feel physically exhausted.					
3.	From time to time I wish I could "run away" from the situation I am in.					
4.	Sometimes I don't really feel like "myself" as before.					
5.	Since I have been a caregiver my financial situation has decreased.					
6.	My health is affected by the care situation					
7.	The care takes a lot of my own strength					
8.	I feel torn between the demands of my environment [such as family]					
9.	I am worried about my future because of the care I give					
10.	My relationships with other family members, relatives, friends and acquaintances are suffering as a result of the care					

SECTION D

Please tick the option that best express how much you agree with the statements below

S/N	ITEMS	SA	A	U	D	SD
1.	I have so much in life to be thankful for					
2.	If I had to list everything that I felt grateful for, it would be a very long list					
3.	When I look at the world, I don't see much to be grateful for.					
4.	I am grateful to a wide range of people					
5.	As I get older I find myself more able to appreciate the people, events, and situations that have be part of my life history					
6.	Long amounts of time can go by before I feel grateful to something or someone					

APPENDIX

MARITAL

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Single	30	15.3	15.3	15.3
	Married	142	72.4	72.4	87.8
	Separated	24	12.2	12.2	100.0
	Total	196	100.0	100.0	

RELIGIOUS

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Islam	62	31.6	31.6	31.6
	Christianity	132	67.3	67.3	99.0
	Traditional	2	1.0	1.0	100.0
	Total	196	100.0	100.0	

Familly type

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Joint	32	16.3	16.3	16.3
	Nuclear	137	69.9	69.9	86.2
	Extended	27	13.8	13.8	100.0
	Total	196	100.0	100.0	

EDUCATION

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Secondary	22	11.2	11.2	11.2
	Graduates	123	62.8	62.8	74.0
	Postgraduate	47	24.0	24.0	98.0
	None	4	2.0	2.0	100.0
	Total	196	100.0	100.0	

OCCUPATION

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Civil servant	99	50.5	50.5	50.5
	Self-employed	74	37.8	37.8	88.3
	Unemployed	7	3.6	3.6	91.8
	Others	16	8.2	8.2	100.0
	Total	196	100.0	100.0	

Relationship with the SN child

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Mother	92	46.9	46.9	46.9
	Father	80	40.8	40.8	87.8
	Other	24	12.2	12.2	100.0
	Total	196	100.0	100.0	

Sex of the SN child

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	96	49.0	49.0	49.0
	Female	100	51.0	51.0	100.0
	Total	196	100.0	100.0	

Number of SN children

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	180	91.8	91.8	91.8
	2	12	6.1	6.1	98.0
	3	2	1.0	1.0	99.0
	5	1	.5	.5	99.5
	6	1	.5	.5	100.0
	Total	196	100.0	100.0	

Level of disability

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Mild	47	24.0	24.0	24.0
	Moderate	112	57.1	57.1	81.1
	Severe	37	18.9	18.9	100.0
	Total	196	100.0	100.0	

Community

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Rural	55	28.1	28.1	28.1
	Urban	141	71.9	71.9	100.0
	Total	196	100.0	100.0	

Birth order

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Elder child	70	35.7	35.7	35.7
	Middle child	65	33.2	33.2	68.9
	Younger child	61	31.1	31.1	100.0
	Total	196	100.0	100.0	

Age of SN child

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1-10	113	57.7	57.7	57.7
	11-20	72	36.7	36.7	94.4
	21-30	11	5.6	5.6	100.0
	Total	196	100.0	100.0	

Number of children

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1-4	175	89.3	89.3	89.3
	> 4	21	10.7	10.7	100.0
	Total	196	100.0	100.0	

```
CORRELATIONS
  /VARIABLES=Attitude Burden Gratitude
  /PRINT=TWOTAIL NOSIG
  /STATISTICS DESCRIPTIVES
  /MISSING=PAIRWISE.
```

Correlations

Descriptive Statistics

	Mean	Std. Deviation	N
Attitude	84.31	11.549	196
Burden	27.2653	7.46623	196
Gratitude	11.9490	3.21972	196

Correlations

		Attitude	Burden	Gratitude
Attitude	Pearson Correlation	1	-.046	.186**
	Sig. (2-tailed)		.521	.009
	N	196	196	196
Burden	Pearson Correlation	-.046	1	-.267**
	Sig. (2-tailed)	.521		.000
	N	196	196	196
Gratitude	Pearson Correlation	.186**	-.267**	1
	Sig. (2-tailed)	.009	.000	
	N	196	196	196

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

```
REGRESSION
  /MISSING LISTWISE
  /STATISTICS COEFF OUTS R ANOVA
  /CRITERIA=PIN(.05) POUT(.10)
  /NOORIGIN
  /DEPENDENT Attitude
  /METHOD=ENTER Burden Gratitude.
```

Regression

Variables Entered/Removed[a]

Model	Variables Entered	Variables Removed	Method
1	Gratitude, Burden[b]		Enter

a. Dependent Variable: Attitude

b. All requested variables entered.

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.186[a]	.035	.025	11.407

a. Predictors: (Constant), Gratitude, Burden

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	898.047	2	449.024	3.451	.034[b]
	Residual	25111.968	193	130.114		
	Total	26010.015	195			

a. Dependent Variable: Attitude

b. Predictors: (Constant), Gratitude, Burden

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	76.148	5.034		15.125	.000
	Burden	.006	.114	.004	.051	.959
	Gratitude	.670	.263	.187	2.545	.012

a. Dependent Variable: Attitude

```
ONEWAY Attitude BY LEVELSN
  /STATISTICS DESCRIPTIVES HOMOGENEITY
  /MISSING ANALYSIS.
```

Oneway

Descriptives

Attitude

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
Mild	47	85.23	10.825	1.579	82.06	88.41	63	116
Moderate	112	83.03	11.961	1.130	80.79	85.27	61	126
Severe	37	87.03	10.854	1.784	83.41	90.65	67	113
Total	196	84.31	11.549	.825	82.68	85.94	61	126

Test of Homogeneity of Variances

Attitude

Levene Statistic	df1	df2	Sig.
.307	2	193	.736

ANOVA

Attitude

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	497.697	2	248.849	1.883	.155
Within Groups	25512.318	193	132.188		
Total	26010.015	195			

```
T-TEST GROUPS=AGECHILDCAT1(1 2)
  /MISSING=ANALYSIS
  /VARIABLES=Attitude
  /CRITERIA=CI(.95).
```

T-Test

Group Statistics

	Age of SN child	N	Mean	Std. Deviation	Std. Error Mean
Attitude	1-10	113	84.86	12.050	1.134
	> 10	83	83.57	10.859	1.192

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
Attitude	Equal variances assumed	1.976	.161	.773	194	.440	1.292	1.671	-2.004	4.588
	Equal variances not assumed			.786	186.008	.433	1.292	1.645	-1.953	4.537

```
T-TEST GROUPS=OCCUPATION(1 2)
  /MISSING=ANALYSIS
  /VARIABLES=Attitude
  /CRITERIA=CI(.95).
```

T-Test

Group Statistics

	OCCUPATION	N	Mean	Std. Deviation	Std. Error Mean
Attitude	Civil servant	99	83.97	11.912	1.197
	Self-employed	74	84.74	10.913	1.269

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
Attitude	Equal variances assumed	.294	.588	-.438	171	.662	-.774	1.767	-4.261	2.714
	Equal variances not assumed			-.443	164.022	.658	-.774	1.744	-4.218	2.671

```
ONEWAY Attitude BY POSTIONSN
  /STATISTICS DESCRIPTIVES HOMOGENEITY
  /MISSING ANALYSIS.
```

Oneway

Descriptives

Attitude

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
Elder child	70	83.24	12.141	1.451	80.35	86.14	61	113
Middle child	65	83.72	10.174	1.262	81.20	86.24	63	115
Younger child	61	86.16	12.181	1.560	83.04	89.28	61	126
Total	196	84.31	11.549	.825	82.68	85.94	61	126

Test of Homogeneity of Variances

Attitude

Levene Statistic	df1	df2	Sig.
1.960	2	193	.144

ANOVA

Attitude

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	311.768	2	155.884	1.171	.312
Within Groups	25698.247	193	133.152		
Total	26010.015	195			

```
T-TEST GROUPS=BurdenCAT(1 2)
  /MISSING=ANALYSIS
  /VARIABLES=Attitude
  /CRITERIA=CI(.95).
```

T-Test

Group Statistics

	BurdenCAT	N	Mean	Std. Deviation	Std. Error Mean
Attitude	Low	102	84.62	12.493	1.237
	High	94	83.98	10.486	1.082

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
Attitude	Equal variances assumed	4.046	.046	.386	194	.700	.639	1.655	-2.625	3.903
	Equal variances not assumed			.389	192.360	.698	.639	1.643	-2.602	3.880

```
T-TEST GROUPS=GratitudeCAT(1 2)
  /MISSING=ANALYSIS
  /VARIABLES=Attitude
  /CRITERIA=CI(.95).
```

T-Test

Group Statistics

	GratitudeCAT	N	Mean	Std. Deviation	Std. Error Mean
Attitude	Low	95	83.69	11.503	1.180
	High	101	84.89	11.620	1.156

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
Attitude	Equal variances assumed	.074	.786	-.724	194	.470	-1.196	1.653	-4.456	2.063
	Equal variances not assumed			-.724	193.487	.470	-1.196	1.652	-4.455	2.062

```
DESCRIPTIVES VARIABLES=AGE AGECHILD
  /STATISTICS=MEAN STDDEV MIN MAX.
```

Descriptives

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
AGE	196	20	67	42.94	8.788
Age of SN child	196	1	28	10.43	6.074
Valid N (listwise)	196				

```
RELIABILITY
  /VARIABLES=SN1 SN2 SN3 SN4 SN5 SN6 SN7 SN8 SN9 SN10 SN11 SN12 SN13 SN14 SN15 SN16 SN17 SN18 SN19
SN20 SN21 SN22 SN23 SN24 SN25 SN26 SN27 SN28 SN29 SN30 SN31 SN32 SN33 SN34 SN35
  /SCALE('Care-giver attitude') ALL
  /MODEL=ALPHA.
```

Reliability

Scale: Care-giver attitude

Case Processing Summary

		N	%
Cases	Valid	196	100.0
	Excluded[a]	0	.0
	Total	196	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.730	35

```
RELIABILITY
  /VARIABLES=BURDEN1 BURDEN2 BURDEN3 BURDEN4 BURDEN5 BURDEN6 BURDEN7 BURDEN8 BURDEN9 BURDEN10
  /SCALE('Care-giver burden') ALL
  /MODEL=ALPHA.
```

Reliability

Scale: Care-giver burden

Case Processing Summary

		N	%
Cases	Valid	196	100.0
	Excluded[a]	0	.0
	Total	196	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.803	10

```
RELIABILITY
  /VARIABLES=GRATEFUL1 GRATEFUL2 GRATEFUL3 GRATEFUL4 GRATEFUL5 GRATEFUL6
  /SCALE('Gratitude') ALL
  /MODEL=ALPHA.
```

Reliability

Scale: Gratitude

Case Processing Summary

		N	%
Cases	Valid	196	100.0
	Excluded[a]	0	.0
	Total	196	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.571	6