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# MARITAL RELATIONS AND COPING STRATEGIES IN PARENTS OF CHILDREN WITH CEREBRAL PALSY

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SUMMARY

*Parents of children with cerebral palsy are faced to a variety of challenges in order to answer to the demanding medical procedures, exceeding typical child development needs, and overcoming disappointments related to a child diagnose. Most of the families develop resources and capabilities to overcome and adapt to a new circumstances.*

*The purpose of a study was to examine the quality of interpersonal relationships in families of children with cerebral palsy. The part of this wide study, shown in this paper, refers to marital relations and coping strategies in parents of children with cerebral palsy.*

*Sample included 80 parents (married or single), divided in three groups of 20 parents, based on whether child had a mild, moderate or severe level of impairment, and fourth group of 20 parents, as a control group. Measuring instruments were "Marital adjustment test", "Family environmental scale" and "Coping health inventory for parents".*

*The result indicated that the relations in the marriage subsystem in families with cerebral palsy are different depending on a severity of cerebral palsy. The quality of marital relations does not depend on the intellectual status of the child. Results on Coping health inventory for parents showed that parents usually recourse to the coping pattern 2: maintaining social support, self-esteem, and psychological stability. Results shows significant correlation between "Family environment scale" and "Coping health inventory for parents".*

*Findings have implications for present strategies of health care delivery and for health care professionals' attempts to facilitate family adaptation to the stresses of child disability.*

Key words: parents, family, cerebral palsy, coping, resilience

## INTRODUCTION

### Specifics of the family system of a child with cerebral palsy

Managing the lifetime care of a child with cerebral palsy is challenging both physically and psychosocially. Families are faced with unique stressor and demands in life. The birth of a child with disability, with exceeded typical child development needs and unpredictable prognosis, usually caused a strong quake of family structure and dynamics. Cerebral palsy is a static lesion occurring in the immature brain that leaves children with a permanent motor impairment (Miller, 2005). Depending on a degree and location of a brain injury, these children can also have cognitive impairment, vision and hearing problems, speech and language difficulties, sensory deficits and seizure disorders. Previous concept of family functioning needs a complete revision and

adaptation to a child health condition. This is a long process with uncertain outcome. The way the family faces problems determines the course of development of the child. Consequently, there are many disorders in families taking care of child with disability cited in literature: mental disorders in children, brothers, sisters and parents; divorce, disturbed relations between parent-child (Stanimirović, 2004).

According to a family system theory approach, as a complex and dynamic patterning of individuals and interactions, problems in family functioning caused by a cerebral palsy diagnose, through a circular causal system transfers to all subsystems.

Although literature suggesting that stress, grief, and other factors associated with parenting of a child with disabilities, results in high rates of marital dysfunction, marital dissatisfaction and divorce, this notion is poorly supported by research. Research demonstrates that parents of children with disabilities have marriages that exhibit the full range of function and dysfunction seen in the general population. Most parents of children with disabilities have functional marriages, and the same things that predict healthy and unhealthy marriages in the general population also predict healthy and unhealthy marriages among parents of children with disabilities (Sobsey, 2004). Wiegner and Donders (2000), found that the unequal distribution of roles in the daily care of a child can lead to feeling overburdened by one parent.

Živković (1994), based on study conclusions, generalize that: 1. The father usually leaves the family, 2. family breakups are more common in young parents or where the marital relations already were dysfunctional, and in the families where the child has severe developmental disabilities. Longo and Bond (1984), cited Friedrich's (1979) research about the mechanisms of successful overcoming a consequences of the birth of a child with a disability. He found that marital satisfaction was the most accurate predictor of successful coping and accounted for 79% of the variability in the findings in his study. Mitić (1997) research indicates that spouses almost opposite and different perception of the situation caused by birth of child with disability, is an important indicator of marital and family dysfunction (fathers are perceived family as a unique, while the mother is considered to be divided, on the one side – father, on the other alliance mother-child). In the same study, wife does not have enough support from a partner, doubt his loyalty, and husbands 'escape' from home because he cannot cope with the diagnosis of a child and unhappy wife. Britner et al. (2003) in study compared a group of parents with a child with cerebral palsy and parents with healthy child. Results indicate that there were no overall differences in self-reported family functioning according to presence of severity of the child disability. In both groups of parents, marital quality may have buffered parenting stress. Mothers reported higher levels of marital satisfaction inversely proportional to a less parental distress, regardless of the child's condition. The author states that this information correlates with the results of some previous studies, for example Kazaka (1987, 1989), and Redone (1992). The results of Button et al. (2001) study, showed no relation between maternal stress and partner support; child's level of impairment and the interaction between partner support and child impairment were significant predictors of maternal stress. Florian and Findler (2001), compared 80 mothers of children with cerebral palsy with mothers of healthy child. There were significant differences between the two groups, and indicated that among mothers of children with cerebral palsy, self-esteem, self-mastery, and family network were the

main variables that contributed to mothers' psychological and marital adaptation. The most important and most helpful person according to Ueda and Hirose study (1990) about the relationship between the parents of children with cerebral palsy – is spouse.

**Resources and resilience**

Healthy family forces can be activated in each family in order to accept responsibility for the further development perspective (Arcus, Schvaneveldt, Moss, 1993). Successful family adaptation to stress involves at least two major sets of family resources. First, the family must have or develop such internal resources, as integration and adaptability in order to withstand the social and psychological stresses to which it may be exposed. Second, the family must have or develop a range of coping behaviors directed at strengthening its internal organization and functioning, procuring social supports and reducing or eliminating the sources of stress (McCubbin, 1979). Resources are available characteristics of persons, families and communities, including restrictions that inhibit the use of available resources, in a situation assessed as stressful (Stanimirović, 2004). Resources can be inside and outside the family. Inside family resources, usually cited in the literature are: the cohesiveness, the emotional connection between family members, adaptability, ability to change the family system in the sense of family coherence, understanding of events within the family and finding meaning in family life (Dragojević, 2006). Quality of communication, independence family members and strengthening self-esteem, clear family boundaries, empowerment to seek social support, control stressors and adaptability is important factors for successful functioning of internal family resources (Ružičić, 2005). External resources are located in the wider family, friends and the wider social environment. In theory, between resources and ways of coping stress is the concept of resilience, which has long been associated with individual responses to stress, and since has expanded to the family.According to McCubbin and McCubbin (1993), the Resiliency Model emphasizes the post crisis, adaptation phase. It attempts to explain why some families are "resilient" and recover from crises while others stay vulnerable or deteriorate after crises.Resilience model evolutes from family deficit and pathology – as a "model of damage," to the model of family power and resources in order to overcome and adapt (Krstić, 2013). The basic premise of the family system theory suggested that the process of resilience to severe life challenges, such as health crises and continuing health conditions, have an impact on the whole family, as well as on key processes that affect optimal functioning, adaptation and resilient power of the individual and of the whole family. When families draw on their resources for resilience, they pull together, make the best of their situation, and emerge stronger and better able to meet future challenges. A family resilience practice approach aims to identify and build key relational processes, with the conviction that both individual and family benefits are forged from adversity through collaborative efforts (Pehler, Craft-Rosenberg, 2011). Walsh (2003) family resilient box contains nine key processes in three areas: 1. Belief systems (including make meaning of adversity, positive outlook and transcendence and spirituality; 2. Organizational patterns, (including flexibility in the adaptation, connectedness, and social and economic resources; 3. Communication/

problem solving (including the clarity of information and discussion about the illness, open emotional expression and collaborative problem solving).

Research resilience of families with a child with disability shows us different results. Research of Ungar (2011) and McConnell et al. (2014) suggested that resilience directly correlates with the availability of socio-economic resources and emphasize that most of these families work well with significant social support and low financial difficulties. Greeff and Nolting (2013) research result showed positive correlations between an acceptance of the situation, positive patterns of family communication, commitment to the family unit, a positive attitude toward new experiences and challenges, and family adaptation, whereas incendiary communication and the age of the child were found to be inversely correlated with family adaptation. The quality of family patterns of communication was found to be the most significant predictor of family adaptation. .

The researcher in our region, Krstić (2013) found that high levels of stress in mothers of children with cerebral palsy is a risk factors for mothers' resilience. Resolution status is an essential condition for adaptation to the child's diagnosis. Functional status of the child and maternal depression are important for the prediction of maternal status resolution.

**Coping strategies**

In the literature, we can find different synonyms related to this problem. Styles used to overcome, coping strategies, efforts and ways to overcome the crisis are some of them. Stress management according to a family system theory includes a wide range of variables, classified in two major groups:

- Focus problem strategies, oriented on changing event or situation, which involves the use of problem-solving skills or minimizing its consequences, resolving interpersonal conflicts, seek advice, time management, goal setting and collecting information about what caused the stress,
- Focus emotional expression strategies, oriented on internal resources in order to change the thoughts or feelings about the stressful situation or event. This includes denial of the existence of stressful situations and the free expression of emotions (Sharma, 2011).

In family systems theory, we can find many other categories as a coping concept. Ružičić (2004) lists three sub-categories:

1. Overcome resources, general attitudes and skills, which include attitudes towards themselves (self-esteem and ego-strength); attitudes towards the world (the feeling of coherence and belief in the ability to control external events) and intellectual skills (cognitive strength and cognitive flexibility);
2. Overcoming styles – generalized coping strategies defined as a typical learned preferences in the way of approaching problems (withdrawal tendencies – approaching, activity – passivity, etc.);
3. Overcoming attempts – the specific actions taken in specific situations in order to reduce stress or problems (cognitive assessment of the problem, or inhibition of the emotional expression, solicitation or refusal of assistance, etc.).

Lazarus and Folkman (1984), defined coping strategies as a process, not as an isolated attempt for overcoming stress. That fact was crucial in establishing of modern theory stress concept. Lazarus and Folkman coping model present eight strategies for coping with stress: confrontation, distancing, self-control, seeking social support, acceptance of responsibility, escape – defense, scheduled problem solving and positive reevaluation.

Because of the unknown outcomes and prognosis of cerebral palsy, parents may need to develop several different strategies for coping. Lack of coping mechanisms in parents cause reduced quality of life and prolonged effects of stress. It is important to point at families strengths and abilities as soon as possible (Retinck et al., 2006). Many parents use religion and faith as a method of coping, and spirituality has been shown to be a source of strength and purpose for both the family members of disabled people and children with disability (Poston & Turnbull, 2004).

Study which purpose was to examine the critical family strength in families with child with cerebral palsy (McCubbin, Huang, 1989), emphasize the importance of family resource assessment and communication, as a key factor for overcoming stress and adaptation.

## METHOD

### Sample

The sample included 80 families with child with cerebral palsy: 20 families with child with mild form, 20 families with child with moderate form and 20 families with child with severe form or child with multiple disability. Control group included 20 families with healthy child.

The sample included the parental couple or single parents with cerebral palsy child, aged up to 14 years. Severity of a child's disability was evaluated on a 3-point scale: mild, moderate and severe. The Gross Motor Function Classification System (GMFCS) measures severity of cerebral palsy and rates outcome of motor function in a scale ranging from I to V, and was completed by a physician. Cerebral palsy was graded as mild when the child was rated as I/II level, moderate if child was rated as level III, and severe when the child was wheelchair dependent-IV/V level. Sample was dichotomy divided according to intellectual status as the criterion variables in children with and without intellectual disabilities. Patient case histories were the source of data of the intellectual status and were completed by psychologists.

### Instruments and procedures

Locke-Wallace Short Marital-Adjustment Test (LWS – MAT, 1959), is one of the most frequently used instruments for the measurement of marital adjustmentand measures marital satisfaction, which is realized when the mates feel satisfied with the marriage and each other, develop common interests and activities and feel that marriage is fulfilling their expectations. The MAT is the gold-standard of public domain marital satisfaction measures. The scale focuses on issues such as involvement in joint activities,

demonstration of affection, frequency of marital complaints, level of loneliness and well-being, and partner agreement on significant issues. A score of 100 is the dividing point between distressed and non-distressed individuals. The average score for distressed couples is 72 and the average score for non-distressed individuals is 136. Instrument is reliable and frequently used for evaluating marital relations. It is easy to administer, a higher score is directly proportional to greater satisfaction in marriage. Reliability of the test recently checked several times with a variety of research, arguing over the issue. Recent research has confirmed the reliability of the test examining the quality of marital relations (Freeston, 1997; Jiang et al, 2013).

Coping health inventory for parents; McCubbin et al. (1983), is a research and clinical instrument specifically designed to assess parent's perception of their response to the management of family life when they have a child member who is seriously and/or chronically ill. Inventory is valid and reliable, standardized and widely used in researches, shows useful for finding the right strategy to overcome health problems in the family. Coping health inventory is a 45-item, self report measure of the parent's coping activities in response to this general question: How helpful do you find each one of the activities below in handling the problems due to your child illness? Each item has four response categories on a Likert scale ranging from 0 to 3 (0 – not helpful, 1 – minimally helpful, 2- moderately helpful, 3 – extremely helpful) across behavior items within each pattern. Each of these statements and behavior patterns has an option – "I do not want" and "it was not possible". The scale includes 45 items, divided into three subscales:

1. Coping pattern I – Maintaining of family integrity, cooperation and optimistic definition of the situation (19 items);
2. Coping pattern II – Maintaining social support, self-esteem, and psychological stability (18 items);
3. Coping pattern III – Understanding of the information related to the child's health care through communication with other parents and consultation with the health care teams (8 items).

Family environmental scale (FES, Moos, Insel & Humphrey, 1974) comprises 90 true-false items and was designed to evaluating social climate of all types of families. This self report questionnaire is used to measure perceived family interactions by assessing three dimensions of the family and its social environment: the Relationships – the degree to which family members are perceived to be involved with each other and how openly positive and negative feelings are expressed, the Personal growth – the family of origin's goal orientation or ways the family of origin encourages or inhibits an individual's personal growth, and the System maintenance dimension – the degree to which the family emphasizes clear organization, control, structure, rules and procedures in running family life. The scale has been used to access family environment from the perspective of different informants within the family, as well as from from single family members' perspective (Kokkinos & Panayiotou, 2013)**.** Family interpersonal relationship cluster, contains 3 subscales : a) cohesion, b) expressiveness and c) conflict. Family personal growth cluster contains 5 subscales: a) independence, b) achievement, c) intellectual-cultural orientation, d) active-recreational orientation,

e) moral – religious emphasis. Family system maintenance cluster contains 2 subscales: a) organization and b) control.

**Data processing**

The data were analyzed by the following statistical procedures and methods: Measures frequency, Measures of central tendency (mean and standard deviation). When testing the significance of differences between the two groups on the numeric variables, the t-test for independent samples, and to distinguish between multiple groups analysis of variance. Statistical analysis was performed in the statistical package SPSS 20.0 for Windows.

## RESULTS

The results of researching marital relations and coping mechanisms in families with children with cerebral palsy.

Table 1 *Quality of marital relations variable associated with the severity of cerebral palsy*

| GMFCS | N | M | SD |
|---|---|---|---|
| GMFCS 1 | 17 | 90,94 | 31,154 |
| GMFCS 2 | 15 | 84,73 | 25,886 |
| GMFCS 3 | 15 | 58,33 | 26,340 |
| Total | 47 | 78,55 | 30,906 |

The results of ANOVA showed that marital relation variable were found significantly associated with the severity of cerebral palsy ($F=5.91$, $df1=2$, $df=44$, $p=0.05$, $\eta^2=.21$).

Table 2 *Quality of marital relation variable associated to the degree of severity of cerebral palsy*

| (I) GMFCS | | Mean difference (I-J) | SDe | **Sig.** | Confidence interval | |
|---|---|---|---|---|---|---|
| | | | | | Lower | Upper |
| Mild form of Cerebral palsy | Moderate | 6,21 | 9,937 | ,823 | -18,97 | 31,38 |
| | Severe | 32,61* | 9,937 | **,008** | 7,43 | 57,78 |
| Moderate form Of cerebral palsy | Mild | -6,21 | 9,937 | ,823 | -31,38 | 18,97 |
| | Severe | 26,40* | 10,243 | **,045** | ,45 | 52,35 |
| Severe form of Cerebral palsy | Mild | -32,61* | 9,937 | ,008 | -57,78 | -7,43 |
| | Moderate | -26,40* | 10,243 | ,045 | -52,35 | -,45 |

Group of parents of children with mild form of cerebral palsy (M=32.6, SD=9.9) has a significant better marital relations than a group of parents of children with severe cerebral palsy (M=26.4, SD=10.2), the level of sig. ($p <.01$). Group of parents of children with moderate cerebral palsy (M=6.21, SD=9.9) shows the significant better marital relations than a group of parents with severe cerebral palsy ($p <.05$).

Table 3 *Quality of marital relations variable associated with intellectual abilities of a child with cerebral palsy*

| Intellectual abilities | N | M | SD |
|---|---|---|---|
| Average | 23 | 80,35 | 33,762 |
| Mental disability | 24 | 76,83 | 28,526 |
| Total | 47 | 78,55 | 30,906 |

There is no significant difference between these two variables (F=.149, p=.701).

Table 4 *Marital relation variable comparing experimental and control group*

| Group | | N | M | SD | SeM |
|---|---|---|---|---|---|
| MAT | Control | 15 | 85,13 | 30,727 | 7,934 |
| | Experimental | 47 | 78,55 | 30,906 | 4,508 |

Results indicates no significant difference between control and experimental group in marital relations variable (t=.719, df=60, p=.475).

Table 5 *Result distribution on Coping health inventory for parents variable associated to a severity of cerebral palsy*

| | TOTAL | (n=60) | GMFCS 1 | (n=20) | GMFCS 2 | (n=20) | GMFCS 3 | (n=20) | |
|---|---|---|---|---|---|---|---|---|---|
| CHIP | M | SD | M | SD | M | SD | M | SD | p |
| Coping pattern 1 | 1,5398 | .33843 | 1,4887 | ,25292 | 2,0611 | ,36083 | 1,8580 | ,63008 | .554 |
| Coping pattern 2 | 2,0235 | .42688 | 1,5264 | ,30641 | 1,9779 | ,36187 | 1,9393 | ,53988 | .827 |
| Coping pattern 3 | 1,9427 | .57409 | 1,6042 | ,43646 | 2,0316 | ,54860 | 2,0307 | ,56502 | .644 |

There is no significant difference among groups of parents in experimental group on the Coping health inventory for parents variable.

Table 6 *Result distribution on Coping health inventory for parents variable associated to a intellectual abilities of a child*

| CHIP | Intellectual abilities | N | M | SD | SeM |
|---|---|---|---|---|---|
| Coping Pattern 1 | Average | 27 | 1,49 | ,252 | ,048 |
| | Mental dis. | 33 | 1,57 | ,394 | ,068 |
| Coping Pattern 2 | Average | 27 | 1,97 | ,389 | ,075 |
| | Mental dis. | 33 | 2,06 | ,457 | ,079 |
| Coping Pattern 3 | Average | 27 | 1,85 | ,607 | ,116 |
| | Mental dis. | 33 | 2,01 | ,545 | ,094 |

There is no significant difference in Coping health inventory for parents variable and intellectual status of a child with cerebral palsy.

Table 7 *Parental coping patterns and indices of family environment*

| Indices of family environment | Interpersonal relationship | | | | Personal growth | | | | System maintenance | |
|---|---|---|---|---|---|---|---|---|---|---|
| Parental coping patterns | Cohesivness | Expressiveness | Conflict | Independence | Achievement | Intell.-cult orientatio | Recreational | Moral | Organizaton | Control |
| Coping Pattern 1 | -,130 | -,248 | ,119 | ,195 | **,401**** | -,252 | **-,387**** | -,180 | **-,351**** | **,278*** |
| | ,322 | ,056 | ,364 | ,135 | ,002 | ,052 | ,002 | ,170 | ,006 | ,032 |
| Coping Pattern 2 | ,067 | -,143 | ,200 | ,130 | ,018 | ,061 | **-,310*** | -,054 | -,063 | -,222 |
| | ,612 | ,277 | ,126 | ,322 | ,890 | ,641 | ,016 | ,681 | ,635 | ,089 |
| Coping Pattern 3 | -,044 | -,107 | -,049 | ,229 | **-,409**** | -,114 | **-,254*** | -,163 | **-,392**** | **,314*** |
| | ,737 | ,418 | ,709 | ,078 | ,001 | ,385 | ,050 | ,214 | ,002 | ,015 |

*p<.05. , **p<.01.

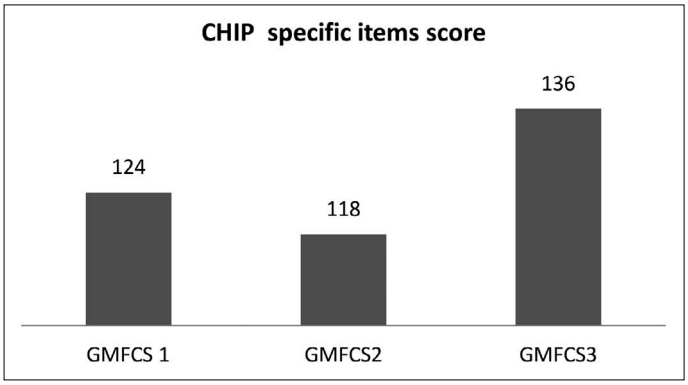
Parental coping patterns are associated with four indices of family environment. All three coping patterns are associated with dimension Active-Recreational in Personal growth cluster, coping pattern 1 (r=-.387, p<.01), coping pattern 2 (r=-.310, p<.05) and coping pattern 3 (r=-.254, p<.05). Copping pattern 1 is associated with Personal growth cluster, dimension Achievement (r=-.401, p<.01), as well as coping pattern 3 (r=-.409, p<.01).

Coping pattern 1 and coping pattern 3 are significantly associated with System maintenance cluster, both dimension on System maintenance – Organization and Control.

Table 8 *Parental and family demographic information and parental coping patterns*

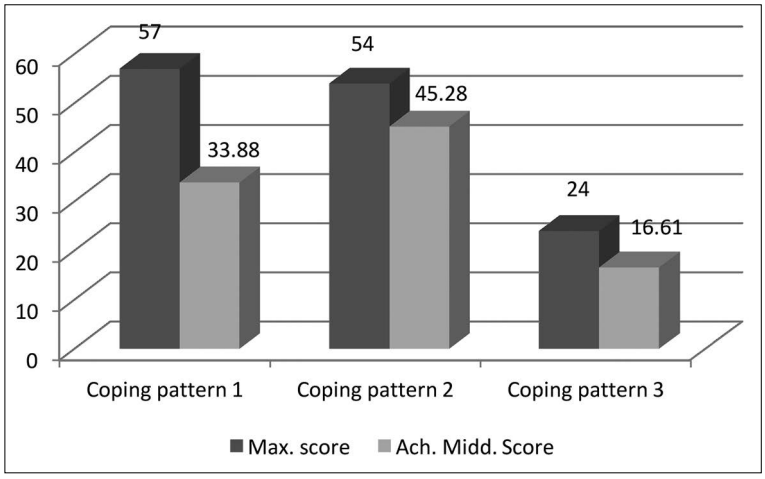
| | Parental coping patterns | | |
|---|---|---|---|
| Demographic characteristics | Coping pattern 1 | Coping pattern 2 | Coping pattern 3 |
| Parental marital status | -,071<br>,589 | -,085<br>,520 | -,154<br>,239 |
| Father's age | ,146<br>,266 | ,097<br>,459 | ,074<br>,575 |
| Mother's age | ,188<br>,150 | ,168<br>,201 | ,063<br>,635 |
| Number of children | -,032<br>,808 | ,114<br>,387 | -,095<br>,470 |
| Father's education | ,110<br>,403 | ,196<br>,134 | ,191<br>,143 |
| Mother's education | ,103<br>,433 | ,108<br>,412 | ,087<br>,511 |
| Father's employment | -,072<br>,584 | ,224<br>,086 | -,013<br>,921 |
| Mother's employment | ,083<br>,530 | ,143<br>,277 | ,128<br>,331 |

Result showed no significant association between parental demographic characteristics and parental coping patterns.




*Graph 1 Results distribution on some specific items on Coping health inventory for parents variable*

Results showed no significant association between four specific items on Coping health inventory related to making closer and stronger bond with spouse, as a part of coping pattern 1 (F=2,06, df=2, p=.137). The graph 1. shows the most interesting outcome – the highest score on these items showed parents of child with severe cerebral palsy. This fact has practical implication and open field for intervention of professionals.




*Graph 2 Maximal and achieved middle score on Coping health inventory for parents*

The graph 2. shows achieved middle scores in the Coping health inventory for parents. Coping pattern 2, maintaining social support, self-esteem and psychological stability, shows highest score uses in our sample as a way to overcome stress and adapt. Right behind it is Coping pattern 3, where parents choose understanding medical situation through communication with other parents and consultation with medical stuff. Coping pattern 1, maintaining family integration, cooperation and an optimistic definition of a situation, shows the lowest middle score.

## DISCUSSION

The results suggested that marital relations are most vulnerable and dysfunctional in families of children with the severe cerebral palsy. Increasing demands of caring, nurturing, complicated medical procedures from birth are the reason for this. Family strength resources are empting fast and if existing marital relations were not on a healthy basis, new circumstances easily lead to dysfunctions and to crisis. Results indicated no significant difference of marital relation quality associated with intellectual status of the child. There is also no significant difference in marriage satisfaction between the experimental and control groups. This fact confirms the premise of theorists that dysfunctional marital relations can be in the families with healthy child, as well as in families of children with cerebral palsy.

We have already stated that the essence of the family system is marriage. There is a reasonable assumption that child with disability has a devastating effect on the quality and stability of marital relations. There are number of various studies of parents of children with different types of disabilities, with same goal – make some practical implications. According to data from the early studies, in the seventies, percentage of divorce or separation of parents with disabled child, were three times higher than among parents of healthy children (Ferrari & Sussman, 2016). However, studies between the 80s and 90s of the last century, shows that the percentage of divorce is not higher than in a typical population (Starr, 1981; Waisbren, 1980). The focus of recent research has moved from the research point of marriages breakup to marital adjustment and efforts to overcome the problems caused by the birth of a child with disability. Kersh et al., (2006) in his study on 67 families, emphasizes the importance of the quality of marital relations for the overall well-being and prosperity of both parents and children with disabilities. Murphy's research of marital relations (2007), implicates that only 10% of the sample of 40 parent's marriage crisis ended by divorce. However, Cheshire et al. (2010), study on 70 parents of children with cerebral palsy, emphasize an important practical implications. Group of parents with cerebral palsy child in compare with group of parents with healthy children, has significantly poorer psychosocial stability, life satisfaction, and there is a high level of depression and anxiety. We believe that this information is more important than the number of divorces. Parents of children with cerebral palsy,were in marriage or not, have poor quality of life and reduced capacity for change. This fact should be a long-term priority in the efforts of all available resources to provide adequate assistance to families.

Marital adjustment scale test does not contain items related to children; so we tried to highlight the results of the specific items on Coping health inventory for parents. Four items of inventory refer to the rapprochement with spouse, as a strategy for coping with stress and crisis: 1. Talk with spouse about personal feelings and concerns; 2. Confidence in the spouse to help in caring for a child with cerebral palsy; 3. Regular outs with a spouse; 4. Bonding more with their spouse. Results of the comparison between the groups were not statistically significant, but the scores say more than that. The highest score on these items (136) showed parents of children with severe cerebral palsy. When we compare the results that we get one, it seems to us that they are in conflict. However, this opens the field for the intervention of family therapists. Although

the study results suggest dysfunctional marriage relation in families of children with severe cerebral palsy, the parents choose to become closer with spouse as a coping strategies and way to overcome crises.

Results on Coping health inventory for parents are not significant between the three groups of parents with mild, moderate and severe cerebral palsy. Results are no statistically significant between the parents of children who are functioning intellectually average and parents of children with intellectual disability.

We assumed that the coping patterns correlate with the indices of family environment scale. Coping patterns 1, 2 and 3 are associated with dimension Active-Recreational in Personal growth cluster, coping pattern 1 ($r=-.387$, $p<.01$), coping pattern 2 ($r=-.310$, $p<.05$) and coping pattern 3 ($r=-.254$, $p<.05$). Copping pattern 1 is associated with Personal growth cluster, dimension Achievement ($r=-.401$, $p<.01$), as well as coping pattern 3 ($r=-.409$, $p<.01$).

Coping pattern 1 and coping pattern 3 are significantly associated with System maintenance cluster, both dimension – Organization – coping pattern 1 ($r=-.351$, $p<.01$) and coping pattern 3 ($r=-392$, $p<.01$) and Control – coping pattern 1 ($r=-.278$, $p<.01$) and coping pattern 3 ($r=-.314$, $p<.01$).

The McCubbin et al., (1983) study explored ways of coping with stress in families of children with chronic disease, such as cystic fibrosis. The authors cited significant correlation results on the dimensions Cohesion ($p<.01$), Expression ($p<.05$) and Conflicts ($p<.05$), all within the cluster Interpersonal relationships, also on dimension Organization ($p<.01$) and the Control ($p<.05$), as part of the cluster System maintenance, while the cluster of Personal growth, showed no significant correlation.

There is no significant correlation between certain forms of coping and the demographic characteristic. In the similar study McCubbin et al. (1983), the authors state that there are significant correlation between the coping pattern 1 and coping pattern 3 and data concerning family income, and between coping pattern 3 and child's age.

As there is no statistically significant correlation between the parents of the three groups according to the severity of cerebral palsy on Coping health inventory for parents, so we have analyzed data according to the achieved scores. Scores are high and inclined to a maximum, which indicates an increased effort and commitment of the family system to overcome the crisis and maintain the balance.

Coping refers to a person's cognitive or behavioral efforts to manage the demands of a stressful situation (Lazarus, Folkman, 1984). Copping pattern 1, refers to a family integration, cooperation and optimistic definition of the situation. This pattern leads the family's progress in overcoming stress or crisis, but carries with it the threat of closure of the family. Families can stay close in the system, using the old models of functioning, not taking the crisis as an opportunity to redefine relationships and develop new relationships. Although changes are leading to a loss of balance within the system, it also leads to a progress in adaptation and new patterns of behavior, which should be applied to family system in order to carry on with life. Medium score noted on the Coping pattern 1 is the lowest in all three groups, which means that parents in our sample, least frequently resort to this way of coping with stress.

Coping pattern 2 refers to seeking social support, in terms of helping friends, and society as a whole, as well as strengthening individual psychological strength and stability. Achieved medium score showed that this coping pattern is the first choice in our sample. Based on the results, we conclude that parents have reduced individual capacity to overcome and adapt and for seeking social support. We have already emphasizes that the family, because of shame and sadness, close and do not have the strength nor the will to seek help from a friend or the relevant social institutions. On the other hand, the institutions must invest maximum effort to adequately informed parents about the possibilities it offers. Often, parents do not have any information where to go and whom to turn.

Coping pattern 3, which refers to information and cooperation with health services as well as close cooperation with families that have the same or similar problem, also shows high scores. This pattern requires the active involvement in the process of habilitation, to investigate ways the health care services can facilitate the daily care and child health care, in cooperation with professionals in the health sector. Our sample high scores on this subscale indicate a desire to be actively involved in medical care process and not transferring all responsibility on health care system, which often happens.

We have already mentioned the results of some studies that used this measuring instrument. Because of its reliability, it is often used in research. McCubbin, Huang (1989) conducted similar research. The purpose of this investigation was to examine the critical family strengths which contribute to the overall healthstatus and health improvement of children who have mild, moderate and severe cerebral palsy. The results are significant associate between coping pattern 1 and coping pattern 3 and parents of children with mild form of cerebral palsy. In the group of parents of children with severe cerebral palsy, there were no significance in using specific coping pattern, while in the group of parents with children with severe cerebral palsy significance was recorded on coping pattern 2. Badr & Azar (2010), examine parents of children with intellectual disabilities. Primary coping pattern was 1 (family integration and cooperation), then coping pattern 2 (individual psychological strength and stability), and at the end coping pattern 3 (health professionals). Interesting research of Cavallo et al., (2008) demonstrated the correlation between level of child disability and parents coping patterns. Most parents in this study used a coping pattern 2, as well as in our sample, while only parents of children with severe disability rated as the most useful coping pattern 3.

Brittner et al. (2003), reported a significant difference in the amount and type of stress between the group of parents of children with cerebral palsy and a group of parents with healthy children. The functioning of the family, in general, did not depend on the child's diagnosis. Parents of children with cerebral palsy declare need for individual professional experts support, considering it as insufficient or inadequate. Between the two groups of parents, found more similarities than differences in family functioning. Professional support in the wider social level is refer as an important factor of functioning between the child and maternal depression in the study of Manuel et al. (2003). It is important to emphasize that we should not underestimate the coping mechanisms that family already has. Signs of family stress can be reduced with

productive mechanisms of coping, with permanent social and family support, a good self-assessment and the various services support (Brehaut et al. 2004). In the research of Lin (2000), coping strategies that parents of children with cerebral palsy state in more than 65% of the sample, are family and friends support, spiritual orientation, personal growth and transmission of positive social interaction.

The practical implications of this research are clear in terms of the attitude that expert help is needed in communication between family members, strengthen the power of individual family members, which contributes to the strengthening of family resources and wider, general progress of the child. In order to optimize the efforts of parents in their coping strategies, it is necessary to organize trainings for parents to improve communication skills, especially if we consider parental education and social framework from which some parents come. It is necessary to organize longitudinal studies to identify the pattern that provides the best results.

## CONCLUSION

Marital relations in parents of child with cerebral palsy are significant different depends on severity of cerebral palsy. Parents of a child with mild cerebral palsy have better relations and better overcome a crisis. Results suggested significant difference in marital relations between parents of children with mild cerebral palsy and parents of children with severe cerebral palsy ($p < .01$), as well as parents of children with moderate cerebral palsy compared to parents of children with a severe cerebral palsy ($p < .05$). There is no significant difference between parents according to child intellectual status.

Results on Coping health inventory for parents indicates that parents often resort to coping pattern 2, which refers to maintaining social support, self-esteem, and psychological stability, then the coping pattern 3, related to communication with health care professionals, as well as addressing other families with similar problems. Coping pattern 1 relating to family integration, cooperation and optimistic definition of the situation, shows the lowest middle score. Results on Coping health inventory correlates with four indices of Family environment scale.

The quality of interpersonal relationships and a strong support system plays a key role in the quality of life of children with cerebral palsy. To provide support to children, various professional experts have to provide support to family members and encourage them to be strong, because of the children who need help. Advocacy in family and friends' interaction, family involvement in the planning and encouraging socialization, can significantly improve the emotional and social well- being of families with children with cerebral palsy (Davis et al., 2008).

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