

Research Paper

## An Exploration into Dysfunction and Stress in Indian Families with Children having Specific Learning Disabilities

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### ABSTRACT

The prevalence, pattern and severity of dysfunction and parental stress among Indian families with children with specific learning disabilities is observed. The dissertation aims to explore whether there is a significant difference in dysfunctional family including relationship patterns in families and domains of dysfunctionality like communication, organization, support, beliefs about deviant beliefs and cohesion in parents with children with and without specific learning disabilities. The dissertation also observed the difference in stress associated with raising a child with special needs and a child with typical development and family problems and dysfunctions associated with the same. Past literature shows a gap in studies of dysfunction in family with children having specific learning disabilities. Therefore, the following study examines family variables of dysfunctionality and stress of parents. For the same a sample of 100 participants were collected, parents with children having specific learning disabilities (n=50) and parents with children having typical development (n=50). The result showed significant difference in dysfunction and stress in parent with children having specific learning disabilities and parents with children having typical development. Further demographics of age and gender were examined. The present study showed practical and theoretical implications in research on specific learning disabilities.

**Keywords:** *Specific Learning Disability, Family Dysfunction, Parental Stress, Cohesion, Beliefs about family, Deviant Beliefs, Communication, Support, Organization*

**D**ysfunction as a term is defined as any disruption in the specified process of any system. In families, any long-term conflict or disturbance among members which is normalized and accommodated with the day-to-day functioning of a household. Families have their own set of norms that impact how each member thinks and interacts with themselves, others, and the world around them. Children are at the centre of every family and therefore are affected most in these hassles of dysfunction (Masteller et al, 1991)

Parenting is one of the most difficult human responsibilities. Parenthood stress is defined as an emotive reaction to the excessive duties of parenting. Parental stress occurs when the parents' sense of the demands of parenting outweighs their perception of their ability to meet those needs (Deater and Dectard, 2004). Dyson (1996) observed that learning disability, a hidden and unanticipated obstacle in children of normal intellect, causes significant parental

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stress. Researchers have also discovered that having a learning disability might cause problems in the relationship between parents and their children (Amerongers and Mishna, 2004).

It is expected in the present study that there is a significant difference in family dysfunction and parenting stress levels in families with and without children having specific learning disorders. A neurodevelopmental disorder known as specific learning disorder (SLD), includes difficulties with reading (dyslexia), writing (dysgraphia), and mathematics (dyscalculia) (APA, 2013). Families with children with specific learning disabilities (SLD) function differently than families with typical functioning children. (Hastings et al, 2002) This variation in functioning might be functional or dysfunctional in nature.

In the Indian setting, the existence of demanding behaviours in children with SLD, as well as the perceived burden, leads to dysfunctional family functioning. (Karande et al, 2011). Understanding the nature and evolution of such dysfunctional family functioning is crucial for developing successful intervention strategies in these families. (McClellan et al, 2007).

Through the exploratory investigation of this dissertation on 'An exploration into Dysfunction and Stress in Indian Families with Children having Specific Learning Disability', dysfunctionality and stress in familial relationship patterns are explored.

### ***Context of the Study***

The process of identifying and defining the phrase 'learning disorders' in the Western world began in the 1950s and 1960s and saw various developments in advancement and awareness regarding specific learning disabilities. However, the learning disability movement in India is very young (Karande, Mehta and Kulkarni, 2007). A majority of research on the subject of learning difficulties in India has indeed been done, but only in the last two decades. Despite recent increases in studies on learning disabilities, there is lack of clear evidence on the prevalence of this problem in India. Various researches have been conducted in the West regarding prevalence, aetiology, parental awareness and financial factors (Hubert 2010; Wodehouse and McGill 2009). In the behavioural domain, challenging behaviour is said to be associated with a range of family difficulties, including high stress levels (Hastings, 2002) and quality of life restrictions (Emerson, 2001).

There is still a clear need to extend this understanding throughout India's major cities. There are numerous reasons that contribute to the lack of awareness of learning disabilities in our country, as well as the absence of prevalent data. According to Karande and Kulkarni (2005), there is a general dearth of information and understanding about learning impairments in India, resulting in low academic achievement and class detention for the learning impaired child. However, in recent years, much emphasis has been placed on raising awareness among parents and teachers concerning learning difficulties. Furthermore, due to lack of awareness in parents there are numerous challenges to identifying appropriate treatments for children with specific learning disorders, including a lack of in-service training programmes for professionals and insufficient quality criteria for measuring and diagnosing people with mental disability, particularly in developing nations like India (Bhaumik, 2009).

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Researchers have also emphasised that the full scope of the concerns and problems associated with learning disabilities is not well recognized in India (Suresh and Sabastian, 2003). According to NCERT 1998 in New Delhi, there has been little systematic collecting of data on learning difficulties, and they rely on the figures commonly provided by foreign organisations. According to figures released by American educators, the figure is between 10% and 12%. (Altrac and Saroha, 2007). In Delhi schools, around three children out of every forty were discovered to have a specific learning disability (Mehta and Pande, 2001). In accordance with the preceding viewpoint, Nair, Paul, and Padma Mohan (2003) observed that, while no countrywide survey on learning difficulties is conducted, about 10 % children are diagnosed with SLD in Indian schools.

With respect to this lack of information and its consequential action in the domain of specific learning disabilities, this study aims at exploring parent-child relationship through family dysfunction and stress in parents with children having specific learning disability.

### ***Statement of Problem***

Families are seen as an essential component of the society and considerable attention is paid to the family in the field of social sciences; thus, it is critical to analyse familial variables and their impact on psychosocial, emotional, and behavioural outcomes & behavioural profile of a learning-disabled child. Previous research has shown that learning difficulties are associated with a variety of psychological, social, and emotional issues. As children are an exceedingly crucial and irreplaceable element of a family, such concerns may be of significant worry to the family and may affect optimal family functioning. The implications of having a kid with learning difficulties in the family are documented in the literature (Reid, 2004).

However, because India is a traditional nation with a joint family system, households might include grandparents and extended family members. When regarded as a system, a family can be defined as an "autonomous collection of persons who have a common sense of history, who feel some degree of emotional attachment, and who desire solutions for addressing the needs of individual family members and the group as a whole."(Anderson and Sabatelli, 2003)

According to empirical research, family members may experience stress as a result of their social interactions, financial resources, or even the physical hardship of having a kid with a developmental disability (Mak and Ho, 2007). It has been observed that families caring for children with developmental delays face more stress than families caring for children without impairments. (Hassall et al., 2005). The parent's attitude toward the child will influence their ability to cope, as will the child's and other family members' reactions to the child's impairment (Callanan, 1990; Kwai-Sang Yau and Li Tsang, 1999). Thus, the literature discussed above demonstrates that family environment is important in the life of a learning challenged child. It also suggests the importance of identifying and comprehending components like family dysfunction and parenting stress.

Poor psychological and physical health of family members is also an outcome of dysfunctional family functioning, therefore, understanding the nature and development of such family dysfunctionality, as well as the resulting stress, is crucial for developing successful intervention strategies in these families.

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Therefore, the question arises is whether there is a significant difference in family dysfunction in parents with and without children with specific learning disabilities (Hypothesis 1). Further parenting stress develops another question of whether there is significant difference in stress levels in parents with and without children with specific learning disabilities (Hypothesis 2). Exploring demographics, it is observed whether there is significant difference family dysfunctionality and stress with respect to the parent's age and gender (Hypothesis 3). Lastly, various domains of family dysfunction and their association with parent with children having specific learning disabilities is also explored (Hypothesis 4).

In order to explore familial correlates of dysfunction and stress with learning disabilities a thorough analysis of the concepts and basic premise must be made, empirical evidence provided by past literature must be analysed and interpreted. A thorough research into the subject matter would help develop a better understanding of the concept and explore that concept further.

### ***Organization of the Dissertation***

The following dissertation is titled “An Exploration into Dysfunction and Stress in Indian Families with Children having Specific Learning Disabilities”.

The study aims to explore significant differences in dysfunctionality and stress levels in parents with and without children with specific learning disabilities. The introduction of the variables of stress and family dysfunctionality were introduced with the research gap providing relevant context of the study. Further statement of problems was identified in Chapter 1. Further empirical evidence provided by past researches and defining the basic constructs of the study were presented in Chapter 2. Theoretical framework including the family systems theory, circumplex model and parent stress model is analysed in Chapter 3. For the present study an exploratory quantitative approach to the sample called using convenience sampling. A 50:50 ratio of families without and with specific learning disabilities (with at least one child pre-diagnosed with SLD) were recruited. Further the measures used, data analysis and results were discussed in Chapter 4. Later, the study was concluded after interpretation and discussion of the results with clinical implications, limitations of the study and scope for future in Chapter 5.

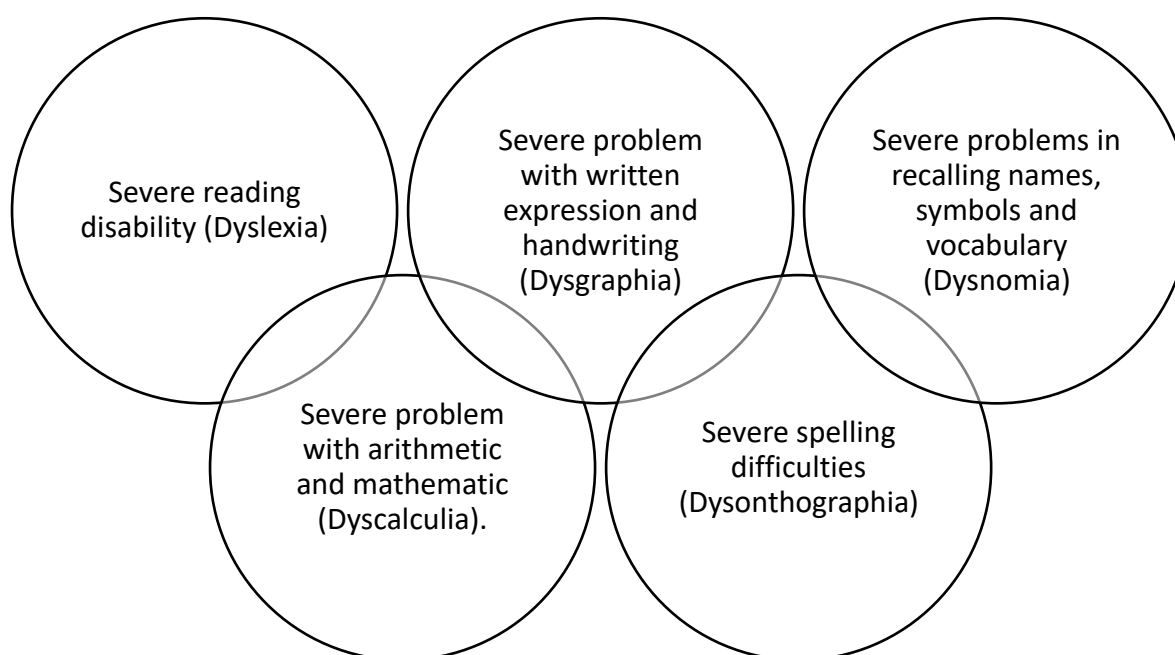
## **REVIEW OF LITERATURE**

### ***Specific Learning Disabilities***

Neurodevelopmental disorders are types of disorder that appears throughout the developmental period that is 0-18 years. The disorders are differentiated by developmental impairments that affect interpersonal, social, academic, or occupational functioning and frequently appear early stages of development, much before the child enters elementary school. The range of developmental disorders extends from very narrow limits in acquisition or executive function control to universal deficits in social skills or IQ. Individuals with autism spectrum disorder, for example, often have an intellectual developmental impairment, and many children with attention deficit/hyperactivity disorder (ADHD) also have a particular learning disorder. For some disorders, the clinical manifestations include exaggerated symptoms and deficits, as well as delays in completing expected milestones. (DSM, 5th ed., 2013, p. 31)

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*Figure 2.1 Types of Specific Learning Disability*

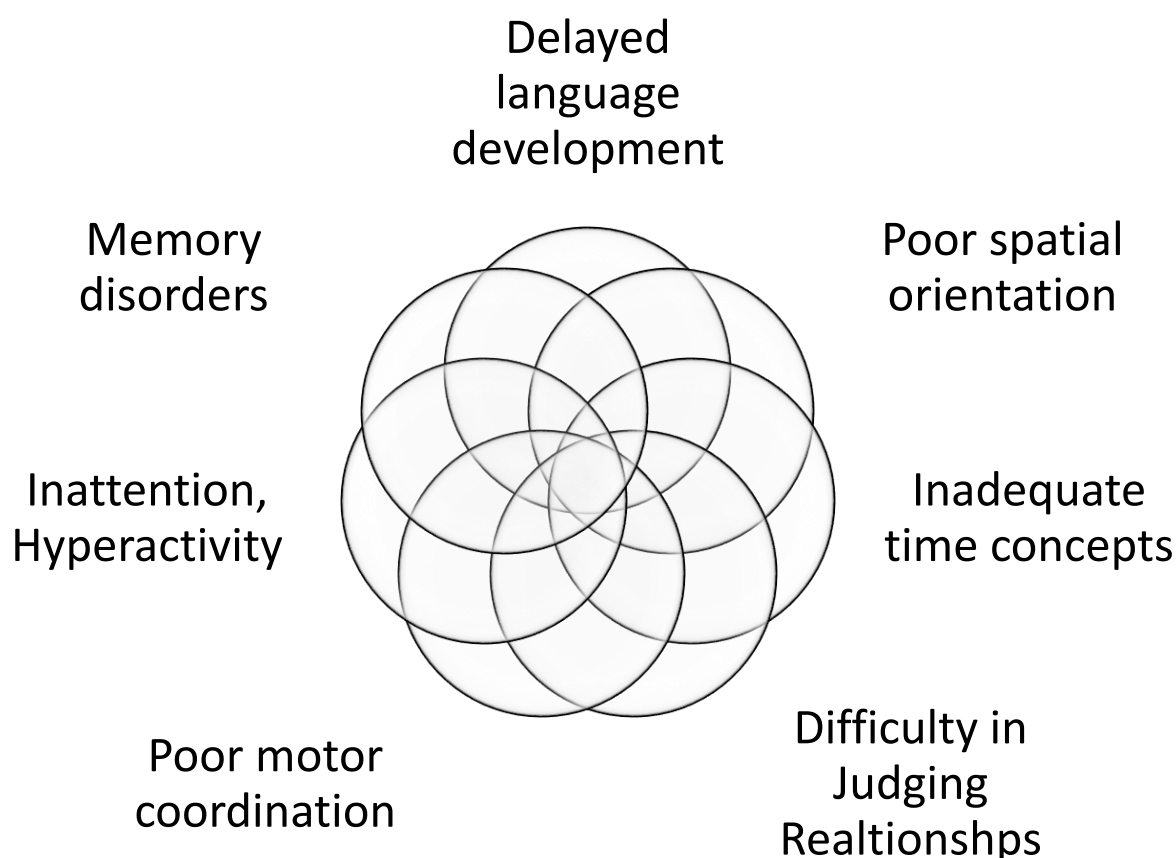


"A specific learning disability is identified when there are specific weaknesses in an individual's capacity to recognise or process information effectively and properly," as the name implies. This neurodevelopmental disorder manifests itself during the years of secondary education and is marked by chronic and detrimental difficulties with essential academic learning abilities such as reading, writing, and/or math. Academic performance of the afflicted individual skills is significantly below the age standard, or adequate level of performance can only be reached via extraordinary effort. Specific learning disorders can develop in intellectually gifted individuals and appear only when the cognitive demands or assessment procedures (e.g., tests) create hurdles that their inherent intelligence and compensating mechanisms cannot overcome." A specific learning disability can have long-term effects for all persons, such as vocational performance. (Blook, 2003)

Specific learning disorders are developmental conditions that are typically diagnosed in preschool-aged children but may not be discovered until adulthood. They are characterised by persistent impairments in at least one of these three key areas: reading, writing, and/or math. Some of the specific skills that may be compromised include reading comprehension accuracy, spelling, grammar, and math. Reading and math fluency may also be noticed. Difficulties with these skills typically produce problems in academic subjects such as history, mathematics, physics, and social studies, as well as in daily tasks and social interactions. (Cunningham, 2011)

Many children's academic challenges have been caused by certain developmental impairments of scholastic ability. Various titles, such as dyslexia and perceptual impairment, have been assigned to them over the years in an attempt to describe them. Congenital word blindness, neurological abnormality, minor brain dysfunction, developmental aphasia, congenital aphasia, learning disabilities, and so on (Mehta, 2011).

Figure 2.2 Characteristics of Children Having Specific Learning Disabilities



### *Historical Origins of Specific Learning Disorder*

The origins of Learning Disability (LD) may be traced back to the year. Franz Joseph Gall, a German anatomist and physiologist who explored the localisation of mental activities in the brain and is credited with being involved with the first reported case of learning impairments, was born in 1802. However, the naming of LD, which was previously known as mental retardation, began towards the end of the nineteenth century with a German scientist Adolf Kassmaul, who coined the phrase "word blindness" to characterize such a disorder in 1877. Learning difficulty has been named a variety of labels over the years, ranging from mental handicap or mental retardation to word blindness, cerebral dominance, brain wounded, Strauss syndrome, minimum brain dysfunction, perceptual problem, and so on. Dr. Samuel Kirk, speaking at a conference in Chicago in 1963, used the phrase "learning disability" for the first time to characterize youngsters with a learning issue. "Recently, I have adopted the term "learning disability" to designate a group of youngsters who have a difficulty in development, language, speaking, reading, and associated communication skills required for social engagement," Kirk explained. "I now include children with sensory impairments such as blindness or deafness in this group since we have strategies for controlling and training the deaf and blind. I also eliminate children with widespread mental impairment from this category" (Kirk, 1963).

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***Table – 2.1 Important Milestones in Development of Specific learning disorders***

<b>Time Period</b>	<b>Milestones</b>
<b>1807-96</b>	Various cases around learning impairment were found. Morgan, a general physician published the first case of a 14-year-old girl with “difficulties with words”
<b>1950-60</b>	Learning Disabilities are characterised as deficits in general learning processes that focus primarily on what we now call distractibility, impulsivity, and visual-perceptual and sensory disorders, all of which arose in the Western world.
<b>1960</b>	Dr. William Cruickshank founded one of the earliest public-school programmes for students with learning difficulties at Syracuse University in New York.
<b>1963</b>	At the Palmer House in Chicago, the phrase "learning disability" was coined. Dr. Samuel A. Kirk, known as the "Father of Learning Disabilities," coined the name. The meeting resulted in the formation of the Association for Children with Learning Disabilities.
<b>1970-80</b>	The primary breakthroughs in the LD movement during this time period centred on children who appeared normal in many academic capabilities but also displayed a variety of cognitive impairments that seemed to hamper their ability to read, write, and learn in the school.
<b>1980</b>	There was a renewed emphasis on the relationship between language problems and Learning Disabilities, and it was accepted that LD is a language-based disorder
<b>Present</b>	There are several types of specific learning disabilities that have been identified: Specific Learning Disabilities include dyslexia (difficulty reading), dysgraphia (difficulty writing), dyscalculia (difficulty with numbers and mathematical ideas), and dyssomnia (difficulty naming) as described in DSM, 5th edition.

***Defining Learning Disabilities***

Since Dr. Samuel Kirk first established the term "Learning Disability," there has been a lack of agreement on the precise description of learning disorders. According to Rotatori and Wahlberg (2004), characterizing learning impairments has been an ongoing and contentious effort since its inception. Skues and Cunningham (2011) concluded that there is a sense of disagreement and little clarity pertaining to the definition of learning disabilities due to a lack of agreement on the exact definition of learning disabilities; however, it is clear that even when students with learning disabilities have average intelligence and show problem specifically in learning.

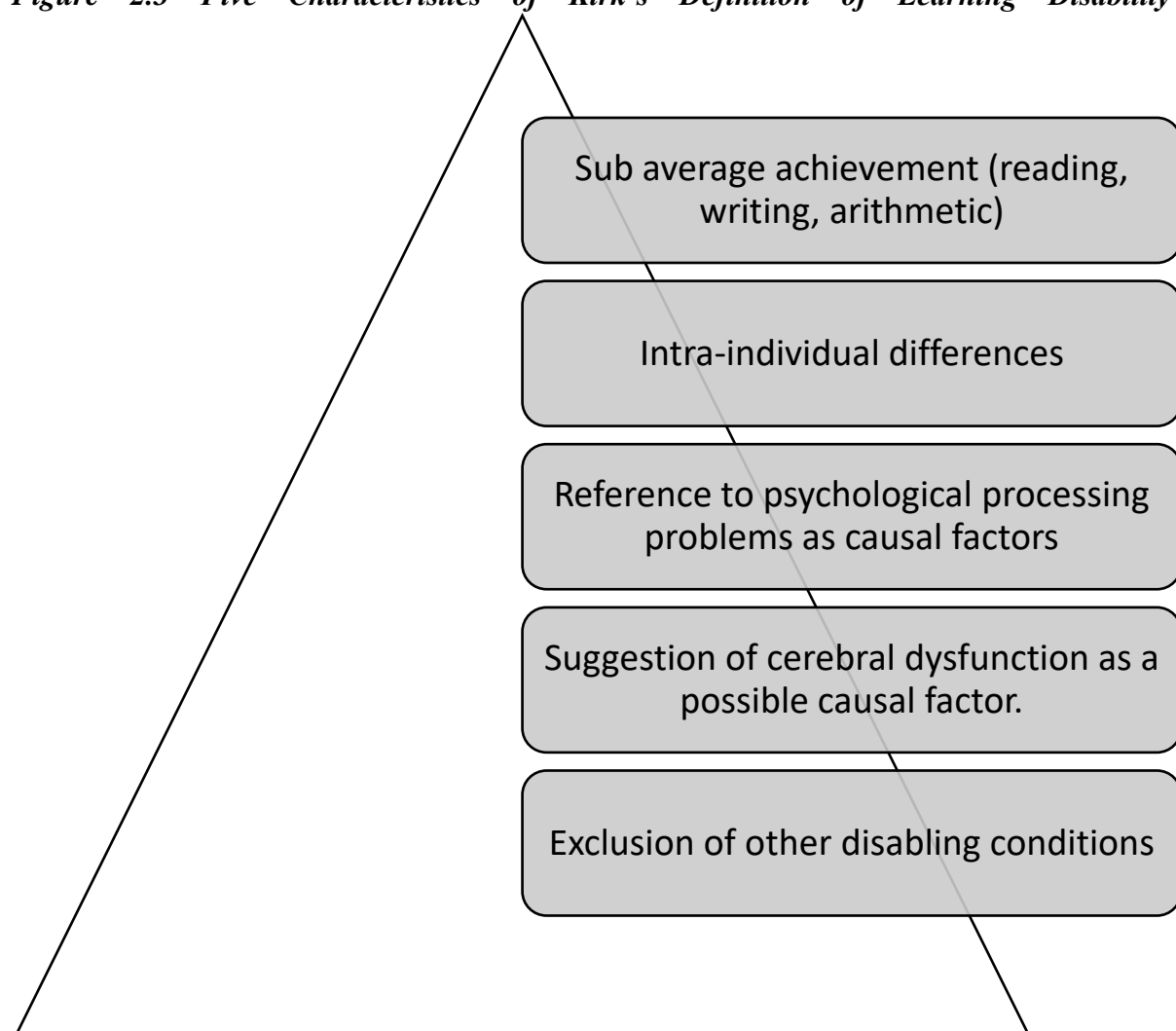
Despite the fact that the term "learning disabilities" has been in use since 1962, no single globally agreed definition of the disease exists. Current learning descriptions and meanings. Disabilities are mentioned in the World Health Organization's document on disabilities, as well as in law and court decisions, education, disability concerns, psychology, medicine, and

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human rights policy. Furthermore, organizations such as the Learning Disabilities Associations and the National Joint Commission, the Committee on Learning Disabilities proposed their own definitions. These definitions share some characteristics, although they are not consistent or expressed in a consistent manner. Language that is easily understood and utilized by people with learning difficulties and their families as well as individuals who operate in relevant aiding professions. The absence of a unified definition constitutes a significant impediment for those who have learning disabilities.

According to Kirk, a learning disability is characterized by “retardation, disorder, or delayed development in one or more of the processes of speech, language, reading, writing, arithmetic, or other school subject as a result of a psychological handicap caused by possible cerebral dysfunction and/or emotional or behavioural disturbances. It is not due to mental impairment, sensory deprivation, or cultural or educational issues”. (Kirk,1962)

*Figure 2.3 Five Characteristics of Kirk's Definition of Learning Disability*



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dysfunction and/or emotional or behavioural disturbances. It is not due to mental impairment, sensory deprivation, or cultural or educational issues". (Hallahan et al., 2005)

According to Bateman (1965), "Children with learning disorders have an educationally significant gap between their estimated intellectual potential and actual level of performance due to basic learning disorders that may or may not be associated by demonstrable central nervous system impairment and are not secondary to generalized mental retardation, academic or cultural deprivation, severe emotional disruption, or sensory disturbances."

According to the National Joint Committee of Learning Disabilities (1988), the term learning disabilities refers to a "diverse collection of conditions characterized by severe difficulty in the acquisition and application of listening, speaking, reading, writing, thinking, or mathematical abilities. These illnesses are personal to the individual and are thought to be caused by central nervous system dysfunction. A learning disability may coexist with other handicapping conditions (e.g., sensory impairment, mental retardation, social and emotional disturbance) or environmental influences (e.g., cultural differences, insufficient-inappropriate instruction, psychogenic factors), but it is not the direct result of those conditions or influences". (NJCLD, 1988)

Specific learning disabilities (1986) are defined by the Learning Disabilities Association (LDA) as a chronic condition of presumed neurological origin that selectively interferes with the development, integration, and/or demonstration of verbal and/or nonverbal abilities. Throughout one's life, the illness might have an impact on one's self-esteem, education, career, socialization, and/or everyday living activities (Hallahan et al., 2005).

The Individuals with Disabilities Education Act Amendments Of 1997 (IDEA) gave a definition for SLD. The term "specific learning disability" refers to a "disorder in one or more of the basic psychological processes involved in understanding or using spoken or written language, which may manifest itself as an imperfect ability to listen, think, speak, read, write, spell, or perform mathematical calculations. Perceptual difficulties, brain damage, minimum brain malfunction, dyslexia, and developing aphasia are examples of such conditions". A learning problem that is mostly focused caused as the result of visual, hearing, or movement disability, mental retardation, emotional disturbance, or environmental, cultural, or economic disadvantage is not included in this definition.

India has adopted the Federal definition of learning disabilities given by US Government Public Law. "Specific Learning Disabilities means a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, which may manifest itself in an imperfect ability to listen, speak, read, spell or to do mathematical calculations. The term includes such conditions as perceptual handicaps, brain injury, minimal brain dysfunction, dyslexia and developmental aphasia. The term does not include children who have learning problems which are primarily the result of visual, hearing or motor handicaps, or mental retardation, emotional disturbance or environmental, cultural or economic disadvantages." (Federal Register, 1977, p. 65083) (Karanth, 2002).

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**Table 2.2 Various sub-types of Specific Learning Disabilities**

<b>Sub – Type of SLD</b>	<b>Domain of Difficulty</b>	<b>Problems associated with</b>	<b>Instances</b>
Dyslexia	Processing Language	Reading, writing and spellings in language comprehension	Backward writing or pronunciation of letters like b and d
Dyscalculia	Mathematical abilities	Understanding, remembering and computation of numbers and concept of time and money	Difficulty is counting 2, 3 ,4
Dysgraphia	Writing Language	Writing, spelling and composition of language	Illegible handwriting
Dyspraxia	Motor Skills	Coordination of the body and dexterity of movements	Difficulty in shoe laces and buttons

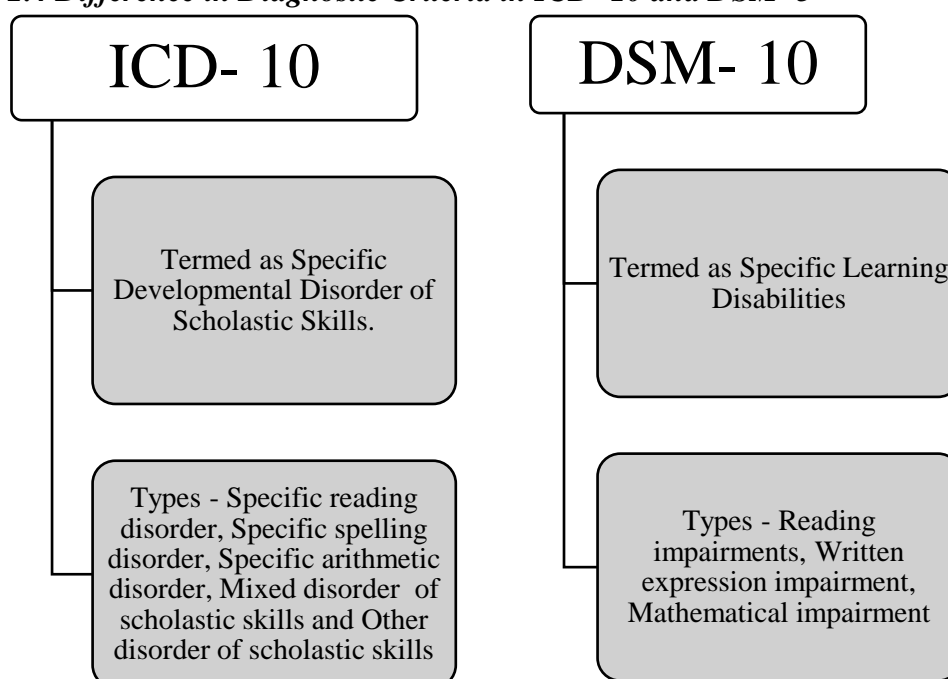
*Note: SLD – specific learning disability*

***Causes of Learning Disabilities***

Genetic, neurological, and environmental variables have all been proposed as possible causes of various learning disorders. This area of genetic research is very difficult. Learning disabilities clearly run-in families, as evidenced by extensive family and twin studies (e.g., Christopher et al., 2013). However, examinations of the genes implicated reveal that many of the effects are not specific, implying that there are no separate genes responsible for reading disorders and mathematics disorders. Instead, there are genes that influence learning and may lead to issues in multiple domains (reading, mathematics, and writing) (Petrill, 2013; Plomin & Kovas, 2005). The various issues linked with learning stem from a variety of sources. For example, children (and adults) frequently experience a wide range of reading difficulties. (Demonent, Tylor and Chaix, 2004).

Many studies have described learning disorders, and a review of those definitions reveals the presence of two distinct techniques that might be used to identify the causes of learning disabilities. As a result, these two approaches are known as cause-oriented and effect-oriented. The first approach advocates attempting to find the source of etiology of observable actions, whereas the second opinion advocates focusing on the behaviour rather than the causes that underpin that behaviour. To support the cause-oriented viewpoint, Clements (1966) defined children with learning problems as having "minimum brain malfunction syndrome." This may include children with average or above-average general intellect but specific learning or behavioural challenges.

Figure 2.4 Difference in Diagnostic Criteria in ICD- 10 and DSM- 5



### Prevalence in India

According to Arun et al. (2013), the challenges of identifying specific learning impairment situations in the Indian setting are maybe more complex than in western nations. As class settings are far from ideal, socioeconomic issues, bilingualism, and inadequate competency in medium of teaching are all variables specific to our subcontinent that play an important part in the Indian educational system. Other researchers suggest that class sizes are large, and that a lack of screening tools for identification by instructors is another key factor impeding the identification of learning challenged children in India (Karanth, 2003)

According to recent study, learning problems affect 13 to 14 percent of all school-aged youngsters (Sadaket, 2009). A prevalence survey of school students in a city in southern India found that the prevalence of LD was 15.17 percent in the sampled children. The same study found 11.2 percent dyslexia, 12.5 percent dysgraphia, and 10.5 percent dyscalculia (Mogasale et al (2011). The findings cited above confirm our contention that there is a desperate need in our country to raise awareness and have a system set up where such children can be identified and remedied.

### Family Environment and Specific Learning Disabilities

A child with learning impairments can increase a family's stress in a variety of ways. Inadequate information processing skills, which are common in children with learning impairments, may affect how a parent interacts with a kid with learning difficulties or a generally developing youngster (Kalsow and Cooper, 1978). The increased involvement with school officials that parents of learning impaired children face may also be distressing (Waggoner and Wilgosh, 1990.) The effects of having a child with learning difficulties and their impact on the family have also been studied (Falik, 1995; Fish and Jain, 1985; Margalit and Almougy, 1991).

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According to empirical research, having a child is full of duties and stressors for the parent, but raising a child with neurodevelopmental disorders, such as learning difficulties, can be considerably more difficult. In other words, the stress levels of parents whose children have developmental problems are much higher than those of parents whose children are typically developing (Dyson, 1997; Hassall, Rose, & McDonald, 2005; Minnes, 1998; Solomon, Ono, Timmers Goodling - Jones, 2008). The additional stress could be a result of parental expectations and disappointment with the child's performance in comparison to classmates (Kaslow and Cooper, 1978). According to research, families of children with learning disabilities experience higher levels of anxiety than parents of generally functioning children (Margalit and Heiman, 1986).

There is a good amount of empirical evidence that suggests a causal relationship between damaged parent-child bonding and the consequent issues with family relationships (Fite, Greening and Stoppelbein, 2008; Vacca, 2008). As a result of the complex psychosocial, emotional, and behavioural issues that accompany learning difficulties, raising a child with learning difficulties may cause anxiety in families. According to studies, this may result in lower levels of coherence, less priority being placed on family members' personal growth, and a higher need for control within the family (Torro, Weissberg, Guare and Liebenstein, 1990; Margalit, Raviv and Ankonina, 1992).

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There is no doubt that both parents are stressed by having a kid with learning difficulties, but women who are more active in the child's day-to-day activities are more aware of the psycho-social and emotional deregulations. It may be tough for any mother to fully accept the news that her kid may be different. Mothers of disabled children bear all of the same responsibilities as other they, but due to the additional demands placed on their resources by increased caregiving tasks, mothers may experience higher levels of stress. (2012) (Oruche et al.)

### **THEORETICAL PERSPECTIVE**

The preceding literature gives insight on the numerous psychosocial, behavioural, and familial characteristics that can be utilized to describe learning impairments. The definition, diagnosis, and treatment of learning disorders have been the focus of research in the discipline. However, relatively little focus has been placed on comprehending the function of learning difficulties in personality structure (Lufi et al., 2004). The federal definition of learning impairment has also placed emphasis on its medical and cognitive features; yet, research has demonstrated that cognitive variables alone are insufficient to predict learning disorders. The following study is based on various models presented below.

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### *Family System Theory*

Bowen and Kerr's family systems theory, developed in 1988, is a technique of analysing human behaviour that focuses on interactions between family members as well as relationships between the family and the context(s) where it is placed. Family systems theory has been used in a variety of settings, including psychotherapy in general and family counselling in particular (working from a systems approach with emotional, behavioural, or relational symptoms in individuals, couples, and families); education systems; society problems (e.g., working with polarised disagreements and enabling "difficult conversations" as in the Public Discussions Project, peace studies, and nonviolence training); and organisations (consulting).

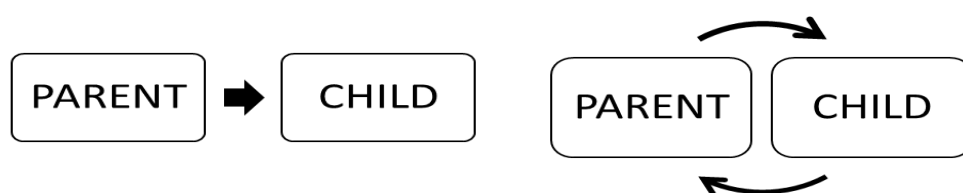
According to a family systems perspective, a person's functioning is determined not so much by internal psychological factors as by a person's place in the system(s) in which he or she tries to find himself or herself, subject to the system's pushes and pulls, such as trying to compete emotional demands, understanding of the roles and expectations, boundary and management structure issues, coalitions and collusions, loyalty conflicts, family and organisational culture and belief systems, double binds, and projections. In addition, identity and self-reinforcing feedback mechanisms in a system can aid or hinder pathology or health, breakdown or resistance. A thorough understanding of family systems theory demands a consideration of the fundamental contributions of systems theory.

Family systems theory may be traced back to the 1940s and 1950s, when it was developed in the fields of biology and cybernetics. (Wiener, 1948).

In 1950, Bertalanffy, an Austrian biologist, tried to incorporate systems thinking and biology into a general theory of living systems. Early family therapists (Speer, 1970) applied Bertalanffy's ideas to family structures, focusing on interactional patterns among members of the family and employing concepts such as equifinality (i.e., a family's ability to reach a given desired outcome in many different ways), morphostasis (i.e., forces that stabilise the family's framework), and morphogenesis (i.e., forces that support the family's ability to grow). These notions align with von Bertalanffy's concept of families as open platforms that interact with their environment.

Family systems theory, as opposed to linear causal explanations, suggests reciprocal causal explanations. According to the traditional stimulus–response behavioural method, one event "A" causes some response "B." This type of reductionist thinking does not account for individual connection in any system. While emphasising microanalytic events within the family is acceptable (for example, parents permitting their adolescent child to stay out after curfew to avoid a conflict with her), focusing only on these sequences fails to depict the actual complexity of family relations.

**Figure 3.1** *Linear vs Circular Causation*



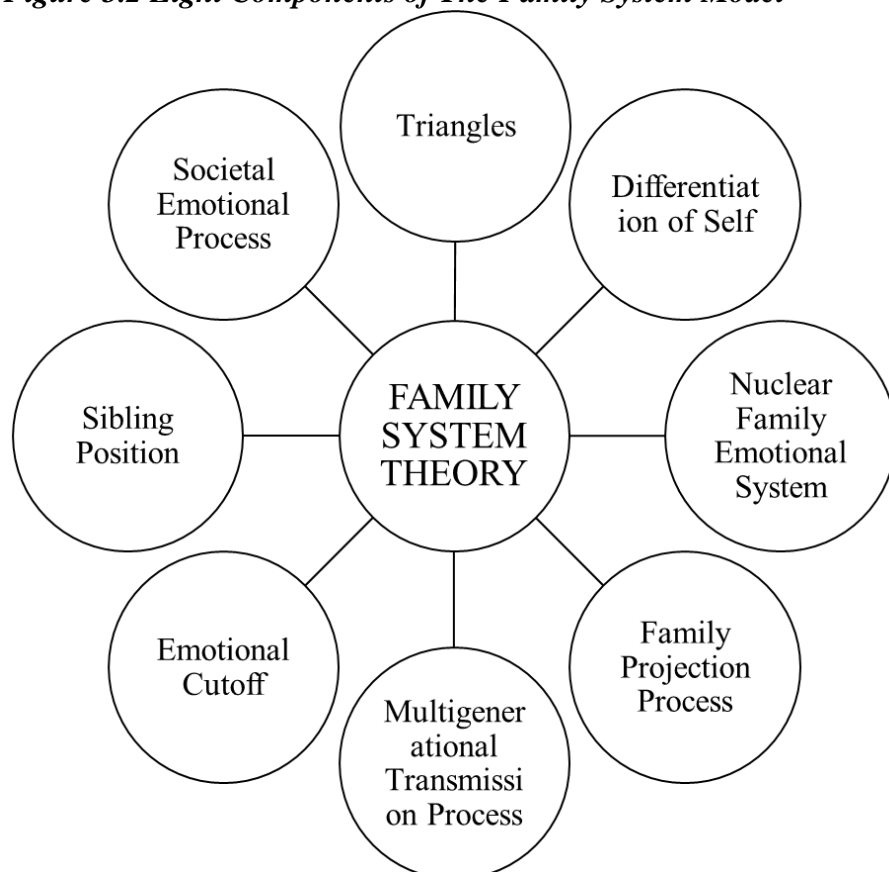
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Circular causality holds that every activity in an association is affected and impacted by other activities in the connection at the same time. To put it another way, causality is a two-way street. Thus, in the case of parents allowing their child to stay out past curfew in order to avoid a conflict, a circular view of this sequence would begin with the acknowledgement that the parent's behaviour (e.g., avoiding conflict) influenced not only the child's immediate likelihood of not being angry, but also her future likelihood of staying out past curfew. Such a parental reaction could be the result of previous interactions in which the daughter reacted furiously to the parent's confrontation.

Constructivist theorists (Von Foerster, 1981; Maturana and Varela, 1980) claimed that nothing is directly observed, but is processed through the observer's imagination. What members of the family witness in reciprocal encounters has a significant impact on their connections? As a result, while working with families, language became extremely important. Social constructivism theorists (Gergen, 1985) went a step further, saying that the social framework in which families live impacts their experiences and the meaning they acquire from interacting within that environment.

Triangles, Differentiation of Self, Nuclear Family Emotional Process, Family Projection Process, Multigenerational Transmission Process, Emotional Cut-Off, and Sibling Positions are the eight interconnecting principles in Bowen's family systems theory. (Gergen, 1985). This model explains the influence of various family members on each other via day to day communication and influence of the environment used to explore various childhood developmental disorders like SLD.

**Figure 3.2 Eight Components of The Family System Model**



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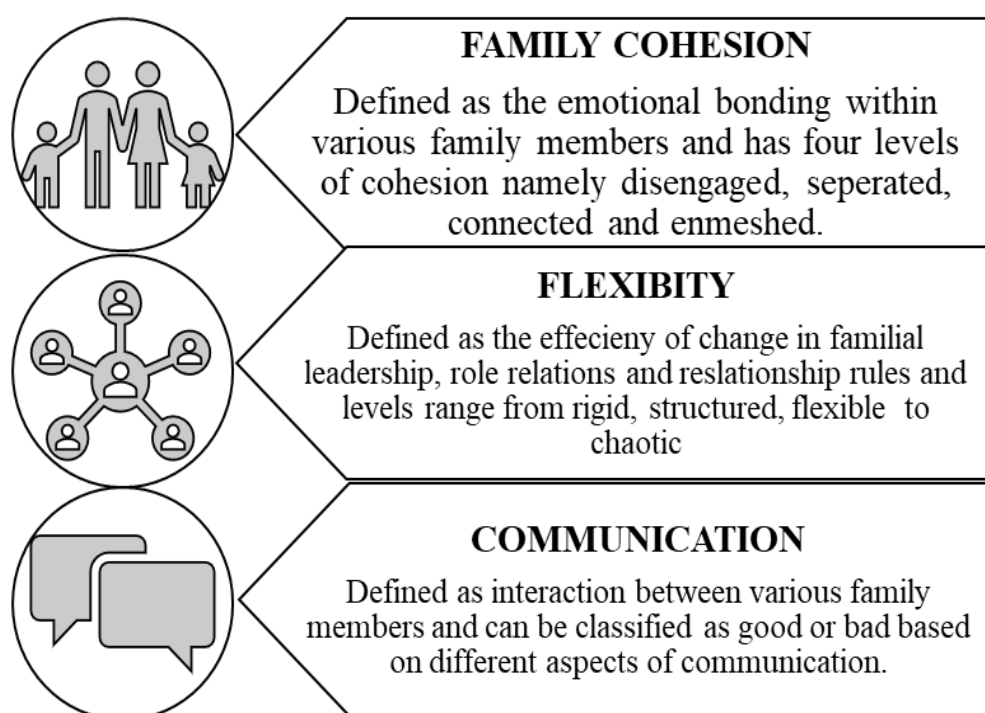
### *Circumplex Model of Family Systems*

Dr. David Olson developed the Circumplex Model of Marital and Family Systems in an effort to bridge the gap that frequently exists between research, theory, and practise (Olson et al., 1989). The Circumplex Model is particularly effective for relationship diagnoses because it is system-focused and incorporates three qualities that have repeatedly been rated highly relevant in a diversity of family theory models and family therapy techniques. ' The paradigm, as well as the evaluation tools based on it, are designed expressly for clinical examination, treatment, and research on the efficacy of marital and family therapy outcomes.

The Circumplex Model is divided into three parts: family cohesion, flexibility, and communication. These three features arose from the development of more than fifty ideas used to analyse marriage and relationships. Although some of these ideas have been around for a long time, many were created by family therapists who examined problematic families from a systems viewpoint. A number of other family theories have separately focused on variables related to cohesion, flexibility, and communication.

The Circumplex Model's most important concept is that balanced families perform better than unbalanced variants based on three components. Couples and families that are well-balanced in terms of cohesion allow their members to feel both independent and connected to their family. In terms of flexibility, balance means maintaining some measure of stability in a system while remaining open to some change when necessary. Extreme behaviours on these 2 components may be appropriate during certain stages of life or when a family is stressed, but they can be destructive when families remain stuck at the extremes. (D.H. Olson, 1986)

*Figure 3.3 Components of the Circumplex Model*



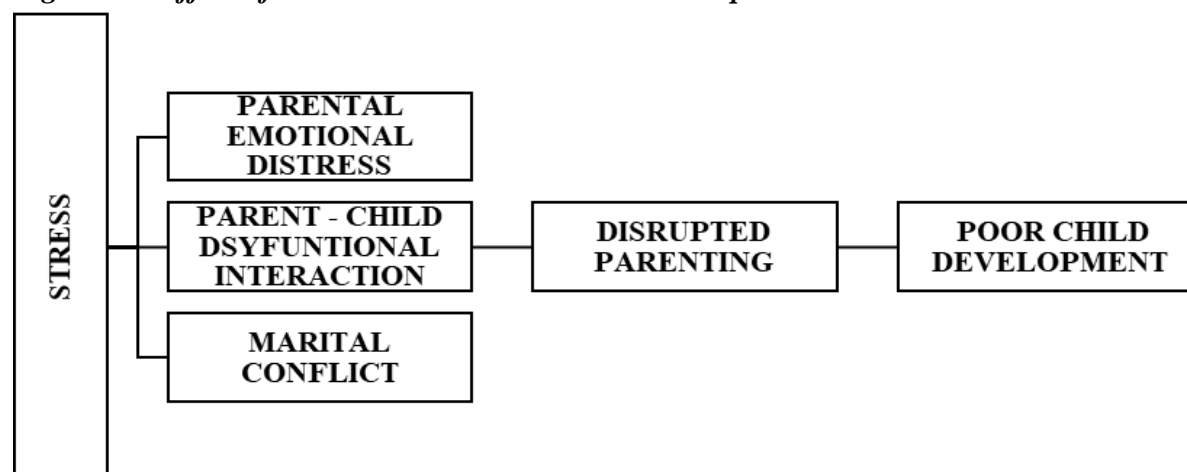
## An Exploration into Dysfunction and Stress in Indian Families with Children having Specific Learning Disabilities

### *Parenting Stress Model*

According to Abidin's (1992) parenting stress model, high levels of parental distress, perceived child difficulties, and dysfunctional parent-child relationships, as measured by the Parenting Stress Index (PSI; Abidin, 1990), lead to an increase in negative parenting (Abidin, 1990; Vondra & Belsky, 1993). Detrimental parenting (for example, physical discipline) has a direct and negative impact on children's conduct. Abidin's model has been used to explain the negative effects of parenting stress on kids in clinical and nonclinical populations, as well as in minority and limited populations (Abidin, 1993). Parents that are stressed in their parenting roles have more negative and harsh parenting, less supportive and caring interactions with their children, and report greater child behaviour problems than stressed parents. (Abidin, 1993)

For example, mothers who report higher levels of parent-child dysfunction are more punitive, less intellectually stimulating, and less emotionally receptive to their two-year-olds. Abidin (1993). Although Abidin's theory is not gender-specific, it has been mostly tested with women, probably reflecting the notion that mothers are more prone to experience parental stress because they are responsible for the majority of caring and parenting. However, in recent years, both scholarship and initiatives have focused on the role that dads play in families, particularly the involvement of low-income minority males with their children (Cabrera, Tamis-LeMonda, Bradley, Hofferth, & Lamb, 2000).

**Figure 3.4 Effect of Stress on Parent-Child relationships**



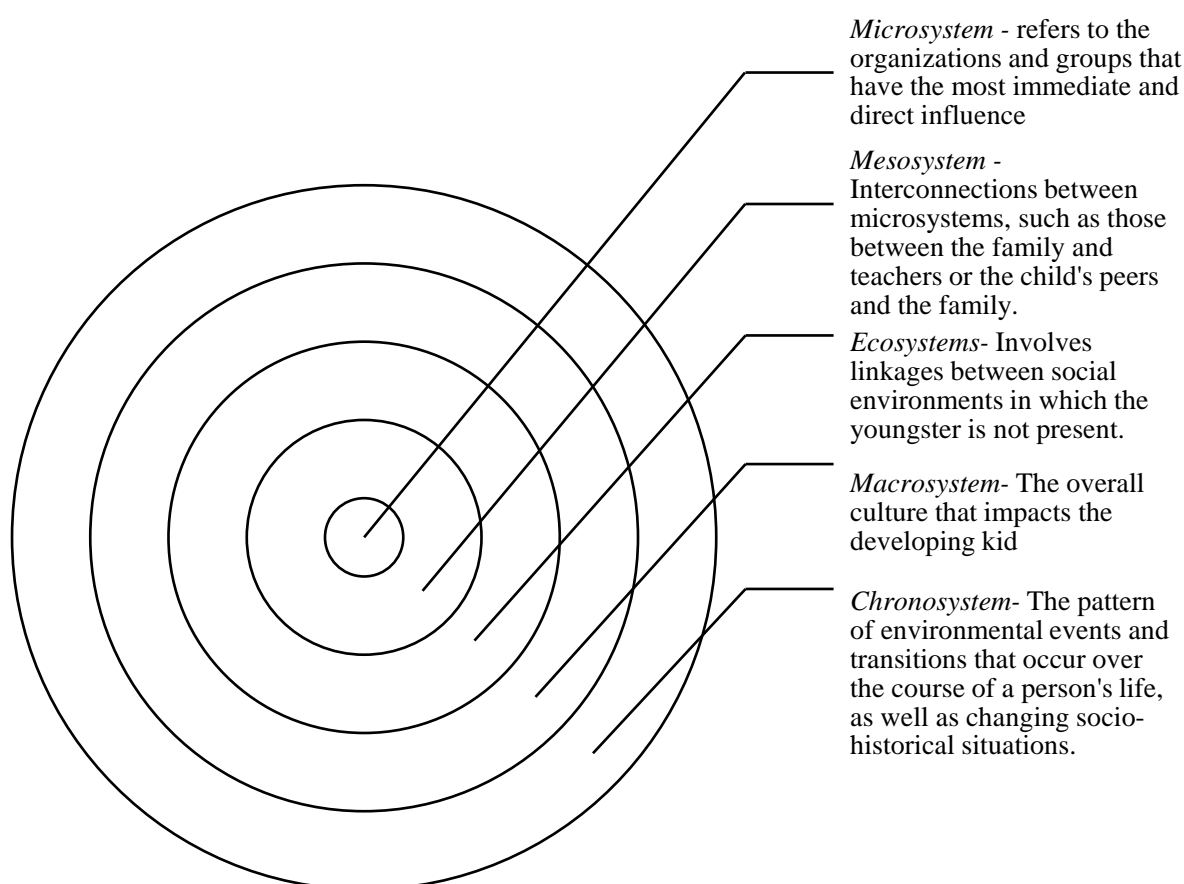
### **Ecological System Model**

Bronfenbrenner (1979) developed his Ecological systems theory to describe how everything in a child's environment influences how the youngster grows and develops. Bronfenbrenner's original thesis proposed that in order to comprehend human development, the entire ecological system in which growth happens must be considered. This system is made up of five socially organized subsystems that aid and direct human development. Each system is dependent on the environment of a person's life and provides an ever-expanding range of possibilities and sources of growth. Furthermore, there are bi-directional influences inside and between each system. These bi-directional affects mean that relationships have an impact in both directions, away from and towards the individual. Researchers who investigated the function of a family in the lives of special-needs children used an ecological approach, which evaluates the environment within the family in terms of its effect on one another (Bristor and Gallagher, 1986).



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**Figure 3.5 Ecological Model**



### **Parent-Child Interactive Stress Model**

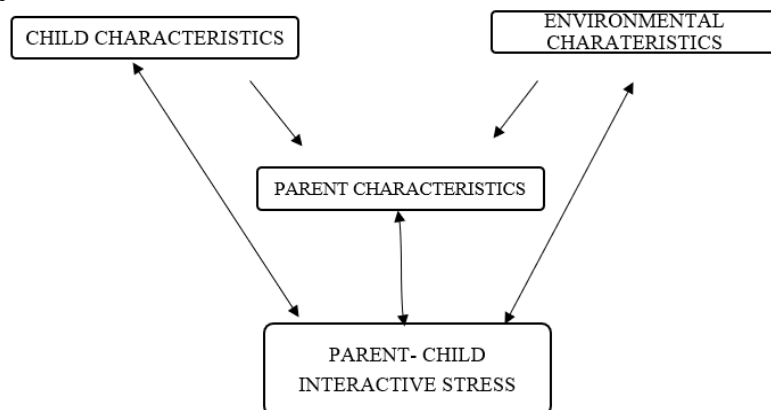
The rationale for integrating parental stress in the family environment to assist in profiling a learning challenged kid was based on a model proposed by Mash and Johnston (1990). This model incorporates three types of variables: child characteristics, parent characteristics, and environmental features. According to the notion, child characteristics contribute mostly to parent-child stress, although environmental elements have a direct link to stress. According to this idea, parent-child stress effects child, parent, and environmental condition. (Mash and Johnston, 1990)

In this concept, parental qualities mediate the effects of child and environmental factors, which include parental cognitions (especially attributions for child behaviours), affective states, temperament, behavioural repertoires, and wellness (Mash & Johnston, 1990). According to this theory, cognitions have affect-generating and motivational properties. Parenting conceptual frameworks that influence parent-child stress include the severity of child behaviour and parenting efficacy (one's belief in one's ability to influence the aspects of parenting).

Furthermore, research on family members who are more likely to have a poor developmental outcome has discovered that when parents are stressed, they have less effective parenting abilities (Secco et al., 2006 & Ostberg et al, 1998), which may aggravate the psychological, emotional, and attitudinal deregulations in the learning-disabled child.

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**Figure 3.6 The Parent - Child Interactive stress model**



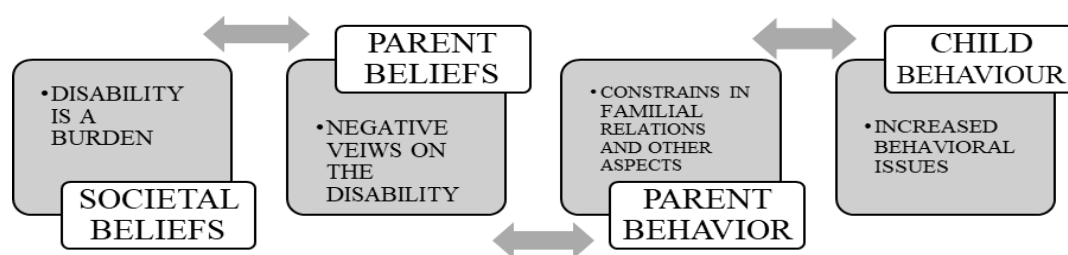
### **Psycho-Social Model of Disability**

It is argued that non-disabled parents of impaired children, as members of society, are more inclined to adopt unfavourable conventional views of disability. When families change their perspective on disability to one that promotes a positive identity for their kid, similar to the perspectives articulated in the affirmation model of disability, their parenting is just as likely to be effective as it is with non-disabled children. That is to say, non-disabled children exhibit behavior difficulties such as tantrums, anger, and non-compliance with parental requests, and disability issues are not the only probable source of problems within a family. Effective parents see teaching their children the rules of appropriate behavior within their culture as part of their role as parents.

However, various cultural expectations of disabled persons may influence how some parents of impaired children regard their position as parents. The psychological model of behaviour difficulties associated with handicap illustrates how societal attitudes about disability might be translated at the level of parent beliefs, and predicts that they will be troublesome for good parenting. It hypothesises possible links between societal ideas and child behaviour problems, through parent beliefs about their role in parenting and discipline their impaired child, and subsequent parental behaviour.

The model also reveals what the beliefs of those families who have successfully re-evaluated their views on parenting a disabled child might be, as well as appropriate solutions for those families who require assistance in doing so. Because there appears to be a scarcity of direct research in these areas, support for the parental beliefs and behaviors indicated in the model and their relationship to child behaviour in impaired children is offered mostly by studies that refer indirectly to similar components.

**Figure 3.7 Psycho-Social influences on children with disability and their parents**



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The following theoretical framework provides basis to the context of the study. It highlights the importance of family correlates in the development of a child.

### EMPIRICAL STUDY

#### *Objectives*

- To study dysfunction in families with and without children having specific learning disabilities.
- To study in parenting stress in families with and without children having specific learning disabilities.
- To study demographics of age and gender in family dysfunction and parenting stress level in families with and without children having specific learning disabilities.
- To study domains of family dysfunction associated with families with children having specific learning disabilities.
- To study the family dysfunction domain, cohesion associated with families with children having specific learning disabilities.
- To study the family dysfunction domain, support associated with families with children having specific learning disabilities.
- To study the family dysfunction domain, beliefs about family associated with families with children having specific learning disabilities.
- To study the family dysfunction domain, deviant beliefs associated with families with children having specific learning disabilities.
- To study the family dysfunction domain, organization associated with families with children having specific learning disabilities.
- To study the family dysfunction domain, communication associated with families with children having specific learning disabilities.

#### *Hypothesis*

1. **Hypothesis 1:** There is a significant difference in dysfunction in families with and without children having specific learning disabilities.
2. **Hypothesis 2:** There is a significant difference in parenting stress in families with and without children having specific learning disabilities.
3. **Hypothesis 3:** There is a significant difference in demographics of age and gender in family dysfunction and parenting stress level in families with and without children having specific learning disabilities.
4. **Hypothesis 4:** Domains of family dysfunction will be significantly associated with families with children having specific learning disabilities.
  - **Hypothesis 4.1:** The family dysfunction domain, cohesion will be significantly associated with families with children having specific learning disabilities.
  - **Hypothesis 4.2:** The family dysfunction domain, support will be significantly associated with families with children having specific learning disabilities.
  - **Hypothesis 4.3:** The family dysfunction domain, beliefs about family will be significantly associated with families with children having specific learning disabilities.
  - **Hypothesis 4.4:** The family dysfunction domain, deviant beliefs will be significantly associated with families with children having specific learning disabilities.
  - **Hypothesis 4.5:** The family dysfunction domain, organization will be significantly associated with families with children having specific learning disabilities.

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- *Hypothesis 4.6:* The family dysfunction domain, communication will be significantly associated with families with children having specific learning disabilities.

### ***Sample and Sampling Techniques***

For the present study, a sample of families without children having specific learning disabilities (n=50) and families with children having specific learning disabilities (n=50) (with at least one child pre-diagnosed with SLD) were sampled for participation.

### ***Convenient Sampling Techniques***

Since the Covid-19 pandemic and enforced social isolation, non-probability sampling techniques was the only feasible option in those convenient sampling techniques was used. This technique is also known as incidental sampling. Convenience sampling, as defined by Dörnyei (2007), is a type of non-probability or non-random sampling in which members of the target population are chosen for the purpose of the study if they meet certain practical criteria, such as geographical proximity, availability at a specific time, easy accessibility, or willingness to volunteer. According to Dörnyei, "captive audiences such as students at the researcher's own university are good examples of convenience sampling."

Sampling is a technique that provides knowledge about a population based on data from a subset of the population rather than investigating every person. This decrease in the number of people in a study lowers the cost and workload, and may make it easier to acquire high-quality data, but it must be balanced against having a big enough sample size with enough power to discover a true relationship. There are various sampling techniques available, which can be split into two categories: probability sampling and non-probability sampling.

### ***Research Design***

#### **Exploratory Research Design**

The process of investigating a phenomenon is referred to as "exploratory research design." The exploratory design is concerned with gathering primary data in an unstructured manner and evaluating it using informal processes. Exploratory research is carried out when there is poor information about a behaviour or an issue that has not been precisely characterised (Saunders et al., 2007). Its objective is not to provide conclusive solutions to research issues, but rather to investigate the study topic in various depths. As a result, its theme is to address new challenges that have received little or no prior investigation (Brown, 2006). Even in the most extreme circumstances, exploratory research serves as a basis for more conclusive study and aids in the development of the first research plan. (Singh,2007)

The techniques for collecting, analysing, interpreting, and reporting data in research projects are characterised as a study design (Creswell & Plano Clark 2007, p.58). It is the overarching strategy for linking conceptual research challenges to appropriate empirical research. In other words, the study design specifies the technique for collecting the necessary data, the methods for collecting and analysing the data, and how all of this will be used to answer the research questions (Grey, 2014). Robson (2002) distinguishes three sorts of study designs: exploratory, descriptive, and explanatory. His categorization is based on the objective of the research area, because each design continues to operate a particular ultimate goal.

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The survey consisted of 84 questions, including demographic details, family relationship scale and parenting stress scale to understand parenting stress and family dysfunction in parents with children having specific learning disability. The present study uses exploratory research design.

### ***Procedure***

For the present study, due to Covid-19 pandemic, online mode of data collection was used. A Google form was created and open access link of the questionnaire was used. Participants were asked to click on the link to access the survey. Information about the study and consent for voluntary participation was provided on the first page of Google research questionnaire form and appropriate instructions were also given. All the data was collected anonymously. No intervention was conducted and no material or monetary incentive was provided. There was no feedback provided to the participant. Further all data was collected and analysed.

### ***Measures***

**Social demographic status:** Socio-demographic data sheet has been used to get some primary information such as parent's age, gender and the child's age and gender.

**Family Relationship Measure:** The Family Relationship Measure (Tolan, Gorman-Smith, Huesmann, & Zelli, 1997) is a 61-item multiple-informant rating scale that assesses aspects of family functioning and beliefs. The Family Relationship Scale (FRS) has been used for both research and clinical purposes to measure six aspects of family relationships (Beliefs About Family, Cohesion, Shared Deviant Beliefs, Support, Organization, & Communication) and the three underlying basic dimensions (Cohesion, Family Beliefs, & Structure). It was developed by both Dr. Patrick H. Tolan and Dr. Deborah Gorman-Smith. The measure was designed for use with low-income urban families; however, as a predictor of psychopathology, relations vary little by age, ethnicity, parent marital status, or family income.

The Family Relationship Measure employs 5-point Likert scales to assess how true a respondent believes an item is for his or her family. For administration, a computerised questionnaire or a self-report paper-and-pencil format can be used. Examples of items of the relevant statement are "Family members ask each other for help", "My family expects too much of me" and "My family knows what I mean when I say something". Total scores from each subscale were summed up and average was taken from the calculation respectively. The Family Relationship Scale was validated on two independent samples - one sample consisted of adolescent male inner-city youth and their parent(s) and the other sample consisted of parents of inner city and urban poor elementary school children.

**Parent Stress Scale:** Berry and Jones (1995) established the parent stress scale as an alternative to the 101-item Parenting Stress Index and gives a measure that examines both positive and negative, 'stressful' elements of parenting. The measure is an 18-item self-report scale with items representing positive (e.g., emotional rewards, personal growth) and negative (resource needs, constraints) motherhood themes. In terms of their typical connection with their child or children, respondents agree or disagree. The score is calculated using a five-point Likert scale: strongly disagree, disagree, uncertain, agree, highly agree. The scale is designed to assess changes in parental stress levels among parents/caregivers who have received targeted treatment such as support from family, parenting classes, and one-on-one parenting support. The outcomes of programmes or areas

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of work aimed at increasing the parenting ability of parents/caregivers. The scale is conducted either self-completion or as an interview. The scale is quick and simple to administer; it may be completed in less than 10 to 15 minutes. (Berry, JD, and W.H. Jones, 1995)

### *Inclusion Criteria*

- Parents' informed consent was achieved for administrating the tests and parents who agreed to participate in the study were chosen.
- Parents of Indian Nationality were included in the study
- Parents between the age of 18-60 were included in the study
- Only those parents having children below the age of 18 were included in the study.
- Only those parents having children who had a diagnosis of learning disabilities were included in the study.

### *Exclusion Criteria*

- Parents of children not yet clinically diagnosed with specific learning disabilities were excluded in the study
- Parents of children who were slow learners, comorbid with autism or other neurological deficits were excluded in the study.

### *Data Analysis Strategy*

After collection of the data using the google form, analysis of the data was conducted. For analysis, descriptive statistics like measures of central tendency (mean) and measures of variance (standard deviation) were used. Further inferential statistics were used in form of independent t-test, One way ANOVA and linear regression model. All the data analysis was done using the software of SPSS statistics Version 26. The independent t-test was used for analysis of family dysfunctionality and stress levels in families with children having typical development and families with children having specific learning disability, further the parent's gender was also studied. Furthermore, the six domains of family dysfunctionality namely: beliefs about family, support, communication, organization, deviant beliefs and cohesion were analysed through the linear model of regression. No violations were made in assumptions of independent t – test, one way ANOVA and linear regression model. Some of the assumptions include, assumption of independent sample, homogeneity of variance and normality of distribution.

## RESULTS

**Table 4.1 Mean, Standard Deviation and t-values of Family Dysfunction and Parenting Stress and Family type (N=100)**

Variables	PND (n=50)		PSLD (n=50)		t value (98)
	Mean	SD	Mean	SD	
Dysfunction	2.9360	0.28372	2.6622	0.32046	<b>4.532***</b>
Parenting Stress	42.7400	12.61488	55.2800	15.60879	<b>4.418***</b>

Note: PND = parents with children having normal development, PSLD= parents with children having specific learning disability, SD= standard deviation

\*\*\*p<0.001

There was significant difference in family dysfunction in parents with children with normal development (M=2.936, SD=0.283) and in parents with children having specific learning

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disabilities ( $M=2.66$ ,  $SD=0.320$ ): [ $t(98) = 4.532$ ,  $p<0.001$ ]. based on the following results, H1 which states, “There is a significant difference in dysfunction in families with and without specific learning disabilities” is accepted. There was significant difference in stress levels of parents with children with normal development ( $M=42.74$ ,  $SD=12.614$ ) and in parents with children having specific learning disabilities ( $M=55.28$ ,  $SD=15.608$ ): [ $t(98) = 4.418$ ,  $p<0.001$ ]. Based on the following results, H2 which states, “There is a significant difference in parenting stress in families with and without specific learning disabilities” is accepted.

**Table 4.2 Mean, Standard Deviation and t-values of Family Dysfunction and Parenting Stress and Parent Gender (N=100)**

Variables	Male (n=41)		Female (n=59)		t value (98)
	Mean	SD	Mean	SD	
<b>Family Dysfunction</b>	2.77	0.375	2.81	0.297	1.66
<b>Parenting Stress</b>	52.07	17.98	46.88	13.18	0.73

Note -SD = standard deviation

There is no significant difference in level of dysfunction for males ( $M=2.77$ ,  $SD=0.375$ ) and females ( $M=2.81$ ,  $SD=0.297$ ). Further, there is no significant difference in level of stress for males ( $M=52.07$ ,  $SD=17.98$ ) and females ( $M=46.88$ ,  $SD=13.18$ ). Based on the results, H3 which states “There is a significant difference in demographics of age and gender in family dysfunction and parenting stress level in families with and without children having specific learning disabilities” is not supported

**Table 4.3 Mean, Standard Deviation and F-values of Family Dysfunction and Parenting Stress with Parent Age (n=100)**

Variables	18-25 (n=25)		26-45(n=45)		46-60(n=30)		F- value (98)
	Mean	SD	Mean	SD	Mean	SD	
<b>Family Dysfunction</b>	2.71	0.356	2.85	0.297	2.79	0.350	1.523
<b>Parenting Stress</b>	48.20	14.91	50.68	15.24	47.16	16.45	0.508

Note: SD= standard deviation

There is no significant difference in level of dysfunction for the age group of 18-25 years ( $M=2.71$ ,  $SD=0.356$ ), for the age group of 26-45 years ( $M=2.85$ ,  $SD=0.297$ ) and the for the age group of 46-60 years ( $M=2.79$ ,  $SD= 0.350$ ). Further, there is no significant difference in level of stress for 18-25 years ( $M=48.20$ ,  $SD=14.71$ ), for 26-45 years ( $M=50.68$ ,  $SD=15.24$ ) and 46-60 years ( $M=47.16$ ,  $SD = 16.45$ ). Based on the results, H3 which states “There is a significant difference in demographics of age and gender in family dysfunction and parenting stress level in families with and without children having specific learning disabilities” is not supported

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**Table 4.4 Results from the Linear Regression Analysis where Cohesion, Organization, Support, Beliefs about Family, Deviant Beliefs, Communication was regressed upon Parents with children having specific learning disability on dysfunctionality score (n=50)**

Predictor Variable	Family Dysfunction in Families with children with SLD				
	R square	R square change	t – value	Beta (β)	F (48)
<b>Cohesion</b>	0.841	0.071	<b>4.600***</b>	0.479	<b>46.676***</b>
<b>Support</b>	0.650	0.267	<b>3.167*</b>	0.276	<b>43.585***</b>
<b>Beliefs about family</b>	0.771	0.066	<b>5.471***</b>	0.359	<b>37.827***</b>
<b>Deviant Beliefs</b>	0.705	0.055	<b>4.035***</b>	0.275	<b>36.601***</b>
<b>Organization</b>	0.838	0.003	<b>1.526</b>	0.143	<b>58.316***</b>
<b>Communication</b>	0.382	0.382	<b>1.064</b>	0.118	<b>29.706***</b>

Note: \*p<0.05, \*\*\*p<0.001

There are six sub- domains of family dysfunction measured by the Family Relationship Measure namely: cohesion, support, organization, communication, beliefs about the family and deviant beliefs. For cohesion, the regression model was significant [F (48) =46.676, p<0.001] and cohesion appeared to be a significant and positive predictor of family dysfunctions (β = 0.479, p<0.001). Based on these results, H4.1 which states “The family dysfunction domain, cohesion will be significantly associated with families with children having specific learning disabilities.” is retained. This domain explains 7.1 % of total variance in dysfunction in families with children having SLD.

For support, the regression model was significant [F (48) = 43.585, p<0.001] and support appeared to be a significant and positive predictor of family dysfunctions (β = 0.276, p<0.001). Based on these results, H4.2 which states “The family dysfunction domain, support will be significantly associated with families with children having specific learning disabilities.” is retained. This domain explains 26.7 % of total variance in dysfunction in families with children having SLD.

For beliefs about family, the regression model was significant [F (98) = 37.827, p<0.001] and belief about family appeared to be a significant and positive predictor of family dysfunctions (β = 0.359, p<0.001). Based on these results, H4.3 which states “The family dysfunction domain, beliefs about family will be significantly associated with families with children having specific learning disabilities.” is retained. This domain explains 6.6 % of total variance in dysfunction in families with children having SLD.

For deviant belief, the regression model was significant [F (48) = 36.601, p<0.001] and deviant belief appeared to be a significant and positive predictor of family dysfunctions (β = 0.275, p<0.001). Based on these results, H4.4 which states “The family dysfunction domain, deviant beliefs will be significantly associated with families with children having specific learning disabilities.” is retained. This domain explains 5.5 % of total variance in dysfunction in families with children having SLD.

For organization, the regression model was significant [F (48) = 58.316, p<0.001] and organization appeared to be a significant and positive predictor of family dysfunctions (β = 0.143, p<0.001). Based on these results, H4.5 which states “The family dysfunction domain,



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organization will be significantly associated with families with children having specific learning disabilities.” is retained. This domain explains 0.3 % of total variance in dysfunction in families with children having SLD.

For communication, the regression model was significant [ $F(48) = 29.706, p < 0.001$ ] and cohesion appeared to be a significant and positive predictor of family dysfunctions ( $\beta = 0.118, p < 0.001$ ). Based on these results, H4.6 which states “The family dysfunction domain, communication will be significantly associated with families with children having specific learning disabilities.” is retained. This domain explains 38.2 % of total variance in dysfunction in families with children having SLD.

Based on the above results, H4 which states that “Domains of family dysfunction will be significantly associated with families with children having specific learning disabilities.” is accepted. Overall, family dysfunction explained 84.4% of total variance in dysfunction in families with children having SLD.

### **DISCUSSION**

The present study aims to explore dysfunction and stress in Indian families with children having specific learning disabilities. Past literature suggests that the adverse effects of having a learning disability does not only affect the kid, but also has a significant impact on the psychological, emotional, and financial resources of the parents and family as a whole. Dyson, L. L. (1996) The majority of research in the subject of learning difficulties has focused on definition, diagnosis, and treatment. However, there has been little research into the effects of learning difficulties on family environment (Lufi et al., 2004).

The results in Table 4.1 suggest that there was significant difference in family dysfunction in parents with children with normal development and in parents with children having specific learning disabilities. This could be due to increase in perceived burden, constraints of financial resources and further the responsibilities of taking care of a child with learning disabilities. Further due to constrained communication and societal stigma, family dysfunction could be further explained. The findings are similar to studies done previously. (Clark RE et al, 1994 & Oostburg et al, 2002)

The results in table 4.2 suggest that there was significant difference in stress levels of parents with children with normal development and in parents with children having specific learning disabilities. This could be due to increased challenges, responsibilities and extra care required in child rearing. Further management of the child’s problematic behaviour could add to day to day stress. According to Rogers (2007), parents of learning challenged children experience significant levels of stress as a result of their internalised norms and society expectations to raise perfect infants who meet all of their demands. Receiving an LD diagnosis for their child may heighten levels of stress in the face of such high expectations. (Gupta et al, 2007 & Hoffman et al, 2004 & Mahoney et al, 2009).

The results in table 4.3 suggest that even though the difference in means was statistically insignificant, level of dysfunction for males was lower than females. This could be due higher maternal involvement with the child, lack of family support. Further, difference in level of stress for males was higher than females. this could be due to work-life management, work responsibilities with future concerns and constant need for financial

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resources. These findings are substantiated by Baker and Heller 1996; Lecavalier, Leone, and Wiltz 2006.

Further for the demographic of age as depicted in table 4.4, the age group of 26-45 showed highest levels of both dysfunction and stress as compared to other age groups of 18-25 years and 46-60 years respectively. This could be due to peak career opportunities and increased responsibility of child rearing. According to studies, older parents had higher levels of positive well-being and lower levels of negative affect (Carstensen and Charles 1998). (Mroczek and Kolarz 1998). Furthermore, Ha, J. H., Hong, J., Seltzer, M. M., & Greenberg, J. S. 2008, suggests that older persons rate several areas of psychological well-being higher than younger adults (Ryff and Keyes 1995). Lawton, Kleban, and Dean (1993) discovered that older adults have lower levels of depression and anxiety than younger adults, despite the fact that other studies have found a curvilinear relationship between age and depression, with levels of depressive symptoms being lowest in midlife and highest in younger and older adults (Drentea 2005; Mirowsky and Ross 1992).

The results in table 4.5 suggest that there is significant association with explaining 84.4 % of total variance of family dysfunctionality in parents with children having specific learning disability. The reason for family dysfunction was poor adaptability, poor partnership, lack of growth, lack of affection, and poor resolve. Such findings have been recorded in the past in similar family contexts (Arulmani et al, 1991). (Herrings et al, 2006 & McDaniel et al, 2012 & Peshawaria R et al, 1995).

### ***Implication of the Study***

#### **Theoretical Implications**

This study has theoretical framework as the basis of its relevance in context in today's time. A child's functioning, according to a family systems perspective, is determined not so much by intrapsychic factors as by a person's place in the family system(s) in which he or she finds himself or herself, subject to the system's pushes and pulls, including competing emotional demands, role definitions and expectations, boundary and hierarchy issues, and institutional culture and belief systems which leads to conflicts and dysfunction. Further, the concept of circular causality is supported by two – way impact in form of behavioural problems in the child and stress in the parents. The following study measured two out of three dimensions of the circumplex model of family systems. Both cohesion and communication were significantly associated with dysfunctionality in parents having children with specific learning disabilities.

#### **Clinical Implications**

This study has practical relevance since the findings may help professionals who work with children with specific learning disabilities and their families deal with their problems more effectively. It highlights the various psychological, social, and emotional difficulties that the learning-disabled child and their parents faces, so that special educators can pay attention to helping the parents manage their parenting stress and family dysfunction and other such emotional and psychological problems that accompany a learning disability in addition to academic intervention. The research also revealed insights into how stress should be handled, changes that need to be made in the family setting. The current study thus implies to educational providers and families of learning challenged children to apply wholesome intervention approaches that benefit not only the child but also his family.

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### *Limitations*

The following study was done in order to explore the variables of dysfunctionality and stress on families with children having specific learning disability. The data was subject various limitations. Parents of only Indian nationality were included in the study leading to low generalizability of the study. Further parents with children below 18 years were included, which lead to less understanding regarding manifestation of specific learning disabilities in adulthood and parenting stress related to the same. A cross-sectional study was done leading to scope of a longitudinal approach for in-depth analyses of the variable.

### **CONCLUSION**

The present study aims to explore dysfunction and stress in Indian families with children having specific learning disabilities. After collection and analysis of data, it is concluded that there is significant difference in family dysfunction and parenting stress in families with children having specific learning disabilities and with children having typical development.

### *Suggestions for Future Research*

For future direction, it is suggested dysfunctionality be studied in depth as family psychopathology has been documented among special families now in India and other cultures as well. These families with significant dysfunction should be identified for other developmental disorders like Autism and Attention Deficit Hyperactivity Disorder, and family therapy should be developed as future treatments. Family therapy models have to be designed based on the psychopathologies that have been documented in families with children with special needs.

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### **Conflict of Interest**

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