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Abstract: The research was conducted as a comparative analysis of families with children with special needs and families which have normally developed children. The aim of this study is to determine whether perceived stress, personal well-being, self-esteem, burnout, anxiety and depression levels are affected by having children with special needs. In addition, the study was conducted to determine the relationship between parents' social skill levels with and without special needs, stress, burnout, self-esteem, anxiety, depression, personal well-being and socio-demographic variables. Interviews were carried out with 240 parents who have at least one 3 years old or above child with and without special needs. Face-to-face interviews were conducted with some participants and others were contacted through teachers. A 'Personal Information Form' was filled in by the participants, 'Social Skill Scale A', 'Perceptual Stress Scale', 'Personal Well-Being Index-Adult (KIO-Y) Form', 'Rosenberg Self-Esteem Scale', 'Burnout Inventory Scale' and 'Hospital Anxiety and Depression Scale were used to determine the level of stress, personal well-being, self-esteem, burnout, depression and anxiety respectively. The findings of the statistical analyses were discussed in according to the results of the research on similar subjects. Six variables related to the parents' physical and mental health levels were considered. The regression models established to predict the differences in the lives of these parents through these variables were found to be significant for the two groups supporting the literature.

Resumen: Esta investigación se realizó para un análisis comparativo de las familias que tienen niños con necesidades especiales y las familias que tienen niños desarrollados normales. El objetivo de este estudio es determinar si los niveles de estrés percibido, bienestar personal, autoestima, agotamiento, ansiedad y depresión se ven afectados por tener hijos con necesidades especiales. Además, se llevó a cabo para determinar ninguna relación entre los niveles de habilidades sociales de los padres con y sin necesidades especiales, estrés, agotamiento, autoestima, ansiedad, depresión, bienestar personal y variables sociodemográficas. Se realizaron entrevistas con 240 padres que tienen al menos un niño de 3 años o más con y sin necesidades especiales. Se condujeron entrevistas personales con algunos participantes. Aquellos que no aceptaron entrevistas personales fueron contactados con la ayuda de los profesores. Se aplicó un "*Formulario de información personal*" a los participantes. Con el fin de determinar los niveles de habilidad social de los padres, Se utilizaron la 'Escala de Habilidad Social A' y la 'Escala de estrés perceptual' para determinar el nivel de estrés, el 'Formulario de índice de bienestar personal-adulto (KIO-Y)' para determinar el nivel de bienestar personal, la 'Escala de autoestima de Rosenberg' para determinar el nivel de autoestima, la 'Escala de inventario de agotamiento' para determinar los niveles de agotamiento y la 'Escala hospitalaria de ansiedad y depresión' para determinar los niveles de depresión y ansiedad. Los resultados de los análisis estadísticos se discutieron de acuerdo con los resultados de la investigación en temas similares. Se consideraron seis variables que se pensaba que estaban relacionadas con los niveles de salud física y mental de los padres en la investigación. Se encontró que los modelos de regresión establecidas para predecir los cambios en las vidas de los padres que tienen niños con y sin necesidades especiales a través de estas variables a ser significativa para los dos grupos con el fin de apoyar la literatura.

Keywords: Disabled children; Family; Family needs; Fatigue; Depression; Anxiety

Palabras clave: Niños discapacitados; Familia; Necesidades familiares; Fatiga; Depresión; Ansiedad

1. Introduction

Although the concept of family has different functions in different societies or different parts of the society, it is the basic unit of the society. Due to the differentiated functions, it is difficult to make a specific family definition that everyone accepts. In general, it can be defined as the smallest unit of the society in which some common developmental events occur individually or as a group (Gülerce, 2007; Kasapoglu, 1990). Although the structure and functions of the family have changed in the time, the family has survived by preserving its existence. By adapting to all social and environmental conditions, it has adapted itself to the necessary changes.

This evolutionary progress shows that in the future, different family types can emerge by continuing the change and development process of the corporation (family) (Cavkaytar, 2000). The question of how the family will progress to the future is an important issue. Since the progress of a healthy and productive existence of humanity is the common point on which all scientific studies are based, the capacity to shape the family and to raise future generations is important.
The family existence is still valuable for the future generations. This value is important for the existence of the family as well as the quality of the family.

Children are born with a number of qualities. A child finds the first answers about natural curiosity, the desire to learn, the ability to research as well as the conditions of existence in family. In other words, the first educators of children are the parents. Although they are different subgroups, such as parents or other caregivers, they are generally summarized as family surveillance. With the qualities that the child develops at home, the child can be prepared for more rich and qualified learning opportunities in formal education settings or outside the home. Since the age at which pre-school education institutions accept children, parents must support the activities of the school at home even if they think that the education is entirely undertaken by teachers. As education cannot be carried out solely by school, only by family, only by environment or by any case alone (Cook, Klein &Tessier, 2008).

At this stage, the relationship between the child and the future will proceed in a meaningful way as much as the parents are equipped to support the process for the future of their children and the society in a quality manner. It is clear that the family is accepted as the basis of the society. It is accepted that children also constitute the most important element in the existence of the family. The child is a product of the family. It is a common part of men and women. A child has the role of the continuation of the generation, a bond which connects the spouses, a vehicle that eliminates longing, the future insurance of the parents, a gift given by the mother and love (Ataman, 2005). With the participation of the child in the family, family relations change. Innovations in relationships occur. Each family tries to prepare for these changes and innovations to the extent of their knowledge, skills and competences. During pregnancy, mothers and fathers dream about the child to be born.

During pregnancy, the mother shapes her child to be born. Parents' expectations from life, profession, close environment, individuals and the society differ starting from the pregnancy (Akkök, Aşkar, Karancı; 1992).

There are no plans for children that cannot develop normally within the imagination starting with the pregnancy period. Every parent wants their children to be healthy and normal. However, this dream does not always come true. Sometimes, instead of the expected healthy child, a child may be born with disabilities who needs special attention and who will need care throughout their life. Even if the birth of a healthy child can be a disturbing event in the family system for parents, the participation of a child in the family with special development can create significant changes in the family structure and functioning of the family members. It can affect the feelings, thoughts and lives of family members in a negative way. Parents of children with special development have to undertake and fulfill some additional duties and responsibilities compared to families with normal developmental children (Tamer, 2010).

Today, many research reveal that children born with special needs need different attention, different attitudes and behaviors, different technologies, in short, different living standards. This can also be observed in practice. It is evident that parents with children with special needs have to work more in some areas in order to overcome some of the obstacles and inadequacies that parents have to cope with or have to cope with. Even for some children and their families, who are often unaware of normal development, some conditions may be encountered as difficult problems for children and families with special development. Therefore, the removal of obstacles will be possible by determining what obstacles are actually (Öznacar, 2018; Entwisle et al. ,2017).

In the comparative studies of the families of children with normal development and the families of children with special development, some differences were determined in the responses of the families.

These reactions are tried to be explained with various models. It is known as "*Stage Model*" and it is assumed that families come through various stages and come to the stage of acceptance and adaptation. Shock, denial, grief and depression (depression) in the first stage described by the stage model; mixed feelings in the second stage, anxiety, guilt, resentment, shame; in the third stage, they experience the feeling of door-to-door travel, agreement, adaptation-rearrangement, acceptance and adaptation (Ataman, 2005; MEB, 2006; Pearce, 1996; Yörükoğlu, 1998).

The idea that has been supported for years in the literature is that having a child with special needs causes the family to undergo significant tremors as a whole (Hintermair, 2006; Jackson & Turnbul, 2004; Longo & Bond, 1984; Pipp-Siegel, Sedey & Yoshinaga-Itano, 2002; Şen, 1991). The fact that one of the members in the family is in a state of inability can change the life of the family in such a way that there is no return. In this case, the psychological requirements of family members may change over time, crisis situations and long-term stress sources can affect all family members (Walsh, 2006). The role of a child with different characteristics is not a role of parents and they never prepare themselves for this role.

Having children with special needs increases the emotional, social, economic and physical difficulties in families. Parents who struggle to cope with life challenges have to face and challenge more difficulties due to the special needs of their children. In some respects, institutional structures seem to alleviate the struggle of families with difficulties, but social prejudices still continue. The inadequacy of the studies on the determination of the problems caused the families not being able to cope with the problems alone and the institutional studies on this issue are also insufficient (Güngör, 1999).

If the child who is born as a disabled person cannot play his / her role in the family fully, this may lead to adaptation problems in the family. Due to the inadequacy of the individual, age, sex, social and cultural differences due to their inability to play properly is an obstacle. This may cause harmony problems within the family (Özgüven, 1999; Özsoy, Özyürek & Eripek, 1998). The relationship between parents is negatively affected by the participation of a child with disability. The duties and responsibilities of all family members, especially the parents, increase considerably. Social, physical, material and spiritual difficulties begin. This may disrupt family relations. Some families have difficulty dealing with this situation (Sandalcı, 2002). Parents, who have children with special needs, therefore need attention and motivation (Kiani & Nami, 2017). Families with children with special needs may experience difficulties such as anxiety, stress, depression and disagreements between spouses. They may be affected by the negativity that may arise due to the degree of inadequacy of the child with special needs. It can be observed that this situation is more complicated than the families with normal development (Hastings & Brown, 2002).

2. Aim of the research

Having a child with special needs can create social, psychological and physical influences compared to non-families. Even if the parenting skills of the individuals are affected by this situation, the social relationships of the parents, mental health, social skills which have important place in life can continue in a negative way. In the studies reviewed in the literature, it is noteworthy that mental health is affected by the difficulties experienced by the family members who have children with special needs. In addition to having to live with an individual who already has difficulties and insufficiencies, they will make life more difficult for them to feel and practice some emotional and spiritual difficulties in their lives. For this reason, it is obvious that they need to get help from experts in this field for early intervention. In the studies conducted in the field, it is noteworthy that in the interviews conducted with the participants during the study, the families expressed the need for psychological help in order to cope with the problems (Özşenol et al., 2003).

All these reasons shaped this research. In this study, it is aimed to evaluate the families with and without special needs in terms of the relevant variables. Comparative analysis of families with and without children with special needs was conducted by assessing the subject in terms of depression, anxiety and burnout. Thus, it is planned to show whether there are some deficiencies due to the fact that families with children with special needs have children with special needs.

3. Methodology

3.1. Participants

The participants of the study consist of 240 parents living in the northern part of Cyprus with at least one three years old and above child. 120 of them have children with special needs and constitute 50% of the research population.

The other 50% are 120 parents with normally developed children. The parents of children with special needs are families who continue their education in a rehabilitation center. Parents, who do not have children with special needs, are the parents who attend a kindergarten or school. Having a child over 3 years of age is determined by assuming that the parent has practiced a 3-year parenting practice. It is thought that the probabilities of living in the difficulties that come with the parenthood in 3 years and their deficiencies and experienced psychological, emotional and social problems will be seen more clearly.

3.2. Scales

The personal information of the parents who participated in the study was collected by the researcher 'Personal Information Form'. In order to determine the social skill levels of the parents, ‘Social Skill Scale A’ is used to determine the level of stress, 'Perceived Stress Scale' to determine stress levels, ‘Personal Well-Being Index-Adult (KIO-Y) Form’ in order to determine their personal well-being, ‘Rosenberg Self-Esteem Scale' in order to determine self-esteem levels, 'Burnout Scale' to determine burnout levels 'Hospital Anxiety and Depression Scale was used to determine depression and anxiety levels.

Personal Information Form is an information form created and applied by the researcher for the purpose of age, marital status, income level, educational status, working status of the participants.

Social Skills Scale-80 A is a 5-point Likert-type scale consisting of 80 items. The items of the scale consisting of 24 reverse items are scored between 1 and 5 (1: Never, 5: Always). High score from the scale shows that social skill level is high (Tatar et al., 2018).

Perceived Stress Scale (PSS-Perceived Stress Scale) is a 14-item scale developed by Cohen et al. In the following part of the study, the item total correlation of the 10-item short form-generated Perceived Stress Scale was calculated by Cohen et al. It was decided to subtract the sixth and eighth item from the scale since the item total score correlation values were below 0.20. Item total correlation was recalculated after the items were removed from the scale. The Cronbach Alpha coefficient, which was 0.54 before the substances were removed, increased to 0.81 (Bilge, Öğce, Genç and Oran, 2009).

Perceived Stress Scale is a 5-point Likert-type scale (0: None, 4: Very frequent). Five items of the scale were plain (1, 2, 3, 7, and 8 items) and three items were reversed (items 4, 5, 6). The scale has two subscales: the stress subscale (items 1, 2, 3, 7, and 8) and the coping subscale (items 4, 5, 6).

The Cronbach Alpha coefficient of the stress subscale was 0.84 and the Cronbach Alpha coefficient of the coping subscale was 0.69. The total score to be taken from the scale is 0-32, the total score to be taken from the stress subscale is 0-20, and the total score to be taken from the coping subscale is between 0 and 12 points. High scores on the scale and the subscales indicate that the perceived stress is high (Bilge, Öğce, Genç ve Oran, 2009)

Personal Well-Being Index-Adult Turkish Form is a 11-point likert that aims to measure satisfaction levels of individuals in eight living areas, including standard of living, spirituality/religion, personal health, future survival, life success, social bonding, personal relationships and personal security. type (0: I'm not satisfied at all-5: I'm unsure 10: I'm completely satisfied) is a measurement tool. There is no reverse coded item of this measurement instrument.

The score that can be taken from the scale ranges between 0-80 (0: Lowest, 80: Highest). The average of the scores obtained from eight habitats is the score obtained from the scale. The increase in the score obtained from this scale shows that personal well-being increases. The score obtained from the scale is indicated by the formula [(Maximum Score from the Scale / Highest Score of the Scale) x 100] and it is evaluated between 0 and 100 points (Lau, Cummins & Mcpherson, 2005; Meral, 2014). According to the results of the item analysis, the item total correlation values ranged from 0.42 to 0.71. This shows that the scale items represent the scale adequately. The reliability of the scale was also measured by the internal consistency method. Cronbach Alpha coefficient was 0.86.

Confirmatory factor analysis as a result of the factor structure of the scale is the only original form in Turkey (Meral, 2014) as a result of Northern Cyprus is maintained in the adult sample was determined.

The Rosenberg Self-Esteem Scale was developed in 1965. From 63 items and 12 subscales (Self-Esteem, Self-Concept Continuity, Criticism to Criticism, Participation in Debates, Feeling Threatened in Interpersonal Relations, Trusting People, Depressive Affection, Imagination, Parental Interest, Father Relationship, 36 Psychic Isolation and Psychosomatic Symptoms) income. It was translated into Turkish in 1986 by Çuhadaroğlu (1986). The validity of the scale is 0.71, and the test-retest reliability is variable between 0.49 and 0.89 (Çuhadaroğlu, 1986). In this study, Self-Esteem of the Rosenberg Self-Esteem Scale was used. The Rosenberg Self-Esteem Scale consists of 10 questions and six items (The quaternary is in the form of a Likert type and each item contains options such as ‘Completely True', 'True', 'False', 'Completely False'). The first three items of the scale (Article 1), the fourth and fifth items (Article 2), the sixth (Article 3), the seventh (Article 4) and the eighth (Article 5) separately, the ninth and the tenth items (Article 6) are scored among themselves. The scores are 0-6 points and 0-2 points high, 2-4 points moderate, 5-6 points low self-esteem (Çuhadaroğlu, 1986).

The original form of Burnout Scale was developed in 1988 by Pines and Aronson. Adaptation to Turkish was done by Çapri (2006). The Cronbach Alpha coefficient was found to be 0.93 according to the results of the validity and reliability studies of the 21-item Burnout Inventory. As

a result of the factor analysis, the scale has three components but it is stated that it has only one factor.

Seven items of the scale (2, 5, 8, 12, 14, 17, 21) include emotional exhaustion; seven items (3, 6, 9, 11, 15, 18, 19) mental exhaustion; the remaining seven items (1, 4, 7, 10, 13, 16, 20) are the items of physical exhaustion components. The correlation between the three components ranges from 0.78 to 0.96("*p and lower*" scores no burnout, points between "*3-4*" is burnout sign of danger; points between "*4-5*" is burnout status, points between "*5 and above*" is high burnout level (Çapri, 2006)

3.2.1. Implementation of the scales

Face-to-face interviews were held with parents who accepted face-to-face interviews. Those who preferred to participate in the face-to-face interview were included in the research by scaling the scales to rehabilitation centers and schools. Participants with and without special needs were not asked for any identification. Answering the questions in the individually filled form lasted approximately 45-50 minutes according to the measurement of time to face.

3.2.2. Data analysis

Frequency analysis was performed to measure the distribution of sociodemographic variables. Descriptive analysis was performed in order to measure the smallest and largest values of the total scores and to examine the averages and standard deviations. Correlation analysis was performed to see the relationship between the scores of the scales. All analyses were done by using SPSS program.

4. Results

A child with special needs from the family imposes important responsibilities on the whole family. Providing special education skills for the child, managing behavioral problems, being in constant communication with the school, maintaining the relationship between spouses and other children, accepting that the child develops differently from their peers, his responsibilities such as visiting the hospital, doctor, physiotherapist, special education teacher in the order required are among the most important. Time spent with special needs and responsibilities for the care of children from their families is more than the families of children with normal development. Therefore, families who have children with special needs are more active in dealing with problems (Cavkaytar, Batu & Çetin, 2008; Ersoy & Çürük, 2009; Kiani & Nami, 2017; Özşenol, Işıkhan, Ünay, Aydın, Akın & Gökçay, 2003). The social life and social activities of the parent, who undertakes the care of the child with special needs and who are struggling more for the child, have difficulty in fulfilling their roles. It may need more social support (Cangür, Civan, Çoban, Koç, Karakoç *et al.*, 2013). Therefore, the families of children with special needs are much more affected by the difficulties. Economic problems may increase emotional exhaustion. Continuous care may cause these families to suffer from physiological disturbances, social closure, shame, guilt, anger, overload and loss of control particularly (Gallagher, Phillips, Oliver & Carroll, 2008; Sivrikaya & Tekinarslan, 2013). As a result, families of children with special needs experience more psychological problems such as stress, anxiety and depression than families with normal developmental children (Ersoy ve Çürük, 2009; Kiani & Nami, 2017; Sivrikaya & Tekinarslan, 2013). Many studies emphasize this (Şengül & Baykan, 2013). In related studies, the families with children with special needs show more depressive symptoms than other families, and they experience problems such as depression, anxiety, alcohol dependence and somatic complaints and have low social support (Smith & Grzywacz, 2014; Uğuz, Toros, İnanç & Çolakkadıoğlu, 2004). Among the mothers who have children with special needs, it is stated that mothers with mentally handicapped children experience more stress and depression than other families (Özşenol, Işıkhan, Ünay, Aydın, Akın & Gökçay, 2003; Smith & Grzywacz, 2014). Parents with mentally handicapped children, who need more care than those with mental disability levels, are reported to have more psychological and physical health problems than other parents (Cangür, Civan, Çoban, Koç, Karakoç et al., 2013;

Özşenol, Işıkhan, Ünay, Aydın, Akın & Gökçay, 2003). Likewise, the families of adults with mental disabilities who expressed less social support than their surroundings stated that they had more adverse conditions (Ben-Zur, Duvdevany & Lury, 2005). When the reasons of the physiological, psychological and social problems experienced by the family with having children with special needs are examined, it is noteworthy that families have many difficulties in meeting the needs of the care and education of children with special needs (Ersoy & Çürük, 2009). The negative reactions of the family and the surrounding environment to the situation, the disruption of the social environment, the decrease in social life activities, the changes in the roles of the parents, the mismatches between the spouses, the material problems, the family is not understood by the experts, the problems arising from the diagnosis of the child, the concern about the future of the child and the mother of the child - the high level of addiction to the father is one of the difficulties experienced (Cangür, Civan, Çoban, Koç, Karakoç et al., 2013; Özşenol, Işıkhan, Ünay, Aydın, Akın & Gökçay, 2003; Smith & Grzywacz, 2014). There are some factors affecting these difficulties. Children with special needs have disability status, behavior problems, child's gender, lack of social skills of the child, age of the child, family with other special needs, age of parents, education level of parents, occupation of parents, economic level of family and social security are shown to be the factors. (Sivrikaya & Tekinarslan, 2013; Uğuz, Toros, İnanç & Çolakkadıoğlu, 2004).

The study includes 55 people (22.9%) aged 34 or under, 67 (35.9 years) aged 35-39 years (27.9%), 50 people (20.8%) aged 40-44 years, 38 people aged 45-49 years. A total of 240 parents (15.8%) and 30 persons (50% and over) were included in the study. The marital status group consisted of single (0.8%), married 225 (93.8%), widowed 4 persons (1.7%) and divorced 9 (3.8%). 78 of the participants were primary school (32.5%), 33 secondary school (13.8%), 66 (27.5%) high school and 63 (26.3%) university education. Of the participants, 23 (9.6%) had spent most of their life in the village and 117 (90.4%) in the town / county. In the northern part of Cyprus, because of the lack of a settlement with a provincial character, the settlement was separated only as town and county. 31 (12.9%) reported physical / psychological disorders and 209 (87.1%) did not report any discomfort (Table 1).

Table 1.
Age, marital status, education, the place of a major part of life, number and percentage distribution of physical / psychological disorders

Variables		Whole Group		Children with special needs		No children with special needs	
		N	%	n	%	n	%
Age	34 & under	55	22,9	44		11	
	35-39	67	27,9	35	36,7	32	9,2
	40-44	50	18,3	22	29,2	28	26,7
	45-49	38	12,5	15	18,3	23	23,3 19,2
	50 & over	30	0,8	4	12,5 3,3	26	21,7
Marital Status	Single	2			0,8		
	Married	225		1	93,3	1	
	Widow	4	0,8 93,8	112	1,7	113	0,8 94,2
	Divorced	9	1,7 3,8	2 5	4,2	2 4	1,7 3,3
Education	Primary	78	32,5	48	40	30	
	Middleschool	33	13,8	18	15	15	25
	Highschool	66	27,5	31	25,8	35	12,5
	University	63	26,3	23	19,2	40	29,2 33,3
The Place of Major Part of Life	County	23		12	10	11	9,2
	Town	117	9,6 90,4	118	90	109	90,8
Physical / Psychological Disorders	Yes	31	12,9	22	18,3	9	7,5
	No	209	87,1	98	81,7	111	92,5
TOTAL		240	100	120	100	120	100

The study included 39 people (16.3%) who were married for 9 years and less, 102 people (42.5%) who were married between 10 and 19 years, 86 persons (35.8%) who were married for

20 years or more, and left blank. 13 people (5.4%), physical / psychological discomfort in his wife 29 (12.1%), his wife / partner physical / psychological discomfort without physical / psychological disturbance (82.5%) 13 people (5.4%) to be blank A total of 240 mothers attended (Table 2).

Table 2.
Number of marriage period and physical / psychological disorder variables in the parent

Variables		Whole Group		Children with Special Needs		No Children with Special Needs	
		n	%	N	%	n	%
Marriage Period	9 years & under	39	16,3	25	20,8	14	11,7
	10-19 years	102	42,5	61	50,8	41	34,2
	20 years & above	86	35,8	28	23,3	58	48,3
Unanswered		13	5,4	6	5	7	5,8
Physical / Psychological Disorder in the Family	Yes	29	12,1	20	16,7	9	7,5
	No	198	82,5	93	77,5	105	87,5
Unanswered		13	5,4	7	5,8	6	5
TOTAL		240	100	120	100	120	100

The number of people living at home is 69 persons (28.8%), 101 persons (42.1%) with 4, 42 people (17.5%) with 5 A total of 240 people (28%) were enrolled in the study. 54 people (22.5%) with one child, 115 people (47.9%) with 2 children, 51 children (21.3%) with 3 children and 20 people (8.3%) with 4 and more children. There are 52 people (21.7%) and 188 people (78.3%) who do not receive assistance for the care of the child. While 74 people (30.8%) spent enough time for themselves, 166 people (69.2%) did not have enough time (Table 3).

Table 3.
Number of people living at home, number of children, getting help for child care, number and percentage distribution of self-sufficient time allocation variables

Variables		Whole Group		Children with Special Needs		No Children with Special Needs	
		n	%	N	%	n	%
Number of people living at home	3 or more people	69	28,2	30	25	39	32,5
	4 people	101	42,1	52	43,3	49	40,8
	5 people	42	17,5	24	20	18	15
	6 or more people	28	11,7	14	11,7	14	11,7
Number of Children	1 child	54	22,5	30	25	24	20
	2 children	115	47,9	58	48,3	57	47,5
	3 children	51	21,3	23	19,2	28	23,3
	4 children or more	20	8,3	9	7,5	11	9,2
Getting help for children care	Getting help	52	21,7	29	24,2	23	19,2
	Unhelpful	188	78,3	91	75,8	97	80,8
Self-Sufficient Time Allocation	Time spare	74	30,8	17	14,2	57	47,5
	No time spare	166	69,2	103	85,8	63	52,5
TOTAL		240	100	120	100	120	100

When the descriptive results of the total scores and sub-dimensions scores of the scales used for mothers with children with special needs were examined, the total score of A Social Skill

Scale-80 was between 189-387 points (x = 315,07 ± 40,05 points), and the total Stress Scale score was 4. -30 points (x = 17,73 ± 5,47 points), Perceived Stress Scale perceived stress sub-dimension total score 0-20 points (x = 11,78 ± 4,58 points) and Perceived Stress Scale perceived coping The total sub-dimension score was found to be between 1-11 points (x = 5.94 ± 2.11 points). Personal Well-Being Index (PPI-Y) Adult Form total score is between 16-78 points (x = 49,83 ± 14,60 points), Personal Well-Being Index (KIO-Y) Adult Form Standard (over 100) -98 points (x = 62,28 ± 18,25 points), Rosenberg Self-Esteem Scale total score 0-3,66 points (x = 1,15 ± 0,74 points), Burnout Scale total score 1-6 between points (x = 3,64 ± 1,35 points), HAD Scale Anxiety total score between 1-21 points (x = 9,60 ± 4,37 points) and HAD Scale Depression total score between 0-16 points (x = 7.88 ± 3.96 points) (Table 4).

Table 4.
General total scores of scales used for families with special needs children - descriptive statistical table of sub-size scores

Total Scores	n	Smallest Value	Largest Value	X	Standard Deviation
A Social Skill Scale-80	120	189	387	315,07	40,05
Perceived Stress Scale	120	4	30	17,73	5,47
Perceived Stress Scale Perceived Stress Sub Size	120	0	20	11,78	4,58
Perceived Stress Scale Perceived Coping Lower Size	120	1	11	5,94	2,11
Personal Well-Being Index (KIO-Y) Adult Form	120	16	78	49,83	14,6
HAD Scale Anxiety	120	1	21	9,6	4,37
HAD Scale Deppression	120	0	16	7,88	3,96
Personal Well-Being Index (KIO-Y) Adult Form Standard (over 100)	120	20	98	62,28	18,25
Rosenberg Self-Esteem Scale	120	0	3,66	1,15	0,74
Burnout Scale	120	1	6	3,64	1,35

When the descriptive results of the total scores and sub-dimensions scores of the scales used for the mothers without special needs were examined, the total score of A Social Skill Scale-80 was found between 243-389 points (x = 331,75 ± 28,92 points), and the Perceived Stress Scale total score. 0-31 points (x = 15,17 ± 6,12 points), Perceived Stress Scale perceived stress sub-dimension total score 0-20 points (x = 9,88 ± 4,65 points) and Perceived Stress Scale detected head the total sub-dimension total score was found between 0-12 points (x = 5.29 ± 2.33 points). Total score of Personal Well-Being Index (PPI-Y) Adult Form between 18-79 points (x = 57,08 ± 13,11 points), Personal Well-Being Index (KIO-Y) Adult Form Standard (over 100) total score 23 -99 points (x = 71.34 ± 16.38 points) and Rosenberg Self-Esteem Scale total score is between 0-3 points (x = 0.86 ± 0.57 points), Burnout Scale total score is between 1-7 points (x = 2,86 ± 1,13 points), HAD Scale Anxiety total score between 1 and 13 points (x = 8,41 ± 3,69 points) and HAD Scale Depression total score between 0-19 points (x = 5). , 65 ± 3,31 points) (Table 5).

Table 5.
Descriptive statistical table of the general total scores-sub-size scores of the scales used for families without special needs children

Total Scores	n	Smallest Value	Largest Value	X	Standard Deviation
A Social Skill Scale-80	120	243	389	331,75	28,92
Perceived Stress Scale	120	0	31	15,17	6,12
Perceived Stress Scale Perceived Stress Sub Size	120	0	20	9,88	4,65
Perceived Stress Scale Perceived Coping Lower Size	120	1	12	5,29	2,33
Personal Well-Being Index (KIO-Y) Adult Form	120	18	79	57,08	13,11

HAD Scale Anxiety	120	1	20	8,41	3,69
HAD Scale Deppression	120	0	19	5,65	3,31
Personal Well-Being Index (KIO-Y) Adult Form Standard (over 100)	120	23	99	71,34	16,38
Rosenberg Self-Esteem Scale	120	0	3	0,86	0,57
Burnout Scale	120	1	7	2,86	1,13

The results of item analysis and reliability analysis for the whole group of 240 participants: Social Skill Scale of 80 items with a value of 0.93, Percepted Stress Scale of 8 items with 0,81 value, Perceived Stress Scale with 5 items was found to be 0.86, Perceived Stress Scale with 3 items is 0.53 in the perceived coping sub-dimension, The Personal Well-Being Index (KIO-Y) with 8 items was calculated as 0.85 in Adult Form, Burnout Scale of 21 items with a value of 0.94, HAD Scale made with 7 items According to the anxiety rate of 0,80, HAD Scale with 7 items An alpha value of 0.75 was found in depression dimension. s a result of the reliability analysis, the Cronbach Alpha coefficients showed only the low reliability coefficient for the perceived coping subscale of the Perceived Stress Scale (α=0,53) (Table 6).

Table 6.
Internal consistency reliability analysis results for research scale and sub-dimensions

TOTAL		Whole Group	Special Need Children	No Special need children
	No of items	80	80	80
	Alpha	0,93	0,94	0,9
A Social Skill Scale-80	N	240	120	120
	No of items	8	8	8
	Alpha	0,81	0,76	0,84
Perceived Stress Scale	N	240	120	120
	No of items	5	5	5
	Alpha	0,86	0,85	0,85
Perceived Stress Scale Perceived Stress Sub Size	N	240	120	120
	No of items	3	3	3
	Alpha	0,53	0,42	0,62
Perceived Stress Scale Perceived Coping Lower Size	N	240	120	120
	No of items	8	8	8
	Alpha	0,85	0,84	0,85
Personal Well-Being Index (KIO-Y) Adult Form	N	240	120	120
	No of items	7	7	7
	Alpha	0,8	0,83	0,74
HAD Scale Anxiety	N	240	120	120
	No of items	7	7	7
	Alpha	0,75	0,75	0,7
HAD Scale Depression	N	240	120	120
	No of items	21	21	21
	Alpha	0,94	0,94	0,94
Burnout Scale	N	240	120	120

4.1. Comparison of the problems of families with and without special needs

4.1.1. Stress

It refers to a state of physical or mental discomfort that occurs in the person with the change in the internal or external environment. Stress due to an illness and a trauma, as physical stress or stress caused by actual, expected and perceived threats is called psychological stress (Özer, 2002). Stress is discussed in two ways as useful and harmful stress. While beneficial stress facilitates the adaptation of the person to changes and improves his performance, harmful stress leads to decrease in efficiency, deterioration of health and depression (Ünal, 1999).

Stressful events can be determined based on the relationship between vital events and their negative consequences for the person. In some cases, even if the death of a parent is not a great source of stress for some people, small life events such as living together with a helpful but annoying relative can be a great source of stress (Baxter, Cummins & Yiolitis, 2000). The cognitive-behavioral model of stress provides a theoretical perspective to stressful life events. According to this model, stress is the result of a stressful event, the cognitive evaluation of the stressful event, the personal resources needed to cope, and the interaction of coping reactions (Miller, Gordon, Daniele & Diller, 1992). The reactions of the person in the face of stressful events consists of three stages. It is called 'General Harmony Syndrome'. These stages are the alarm response, resistance and extinction stages (Güçlü, 2001).

1) Alarm Response: When a person encounters a stressful event, the body gives 'fight or go'. This is called alarm response. As a result of the stress, the person's sympathetic nervous system becomes effective, accelerating the heart rate, accelerating breathing, and increasing the release of adrenalin. This is exactly what leads to the reaction of fight or go.

2) Resistance Stage: It is the stage where the person strives to resist stress. If a person adapts to the state of stress, everything begins to return to normal. Lost energy is gained. It normalizes bodily symptoms such as heart rate, respiratory acceleration.

3) Extinction Stage: As long as the stressful situation does not diminish and continues to increase, the resistance of the person is broken, deviations and frustrations occur in his behavior. If the person cannot cope with the stressful situation, he / she cannot use his / her physical resources and the person goes into the depletion stage.

Having a child with special needs causes many negative changes within the family and causes negative feelings. The care of the child with special needs, the difficulties experienced in the education process, the negative attitude of the peers against the special need of the child and the society, the restriction of the social life due to the responsibilities of the home and the child, the lack of self-sufficient time, the difficulties experienced when going out with the child causes the parent to experience stress. In addition, the child's need for special needs is occasionally perceived and blamed as a failure of the parent. Various physical and psychological disorders occur as a result of the stress experienced in this process (Ayyıldız, Şener, Kulakçı & Veren, 2012; Duygun & Sezgin, 2003).

Studies on the relationship between having a child with special needs and stress revealed that having a child with special needs for the family is more stressful than having a normal developing child (Baxter, Cummins & Yiolitis, 2000; Cummings, Bayley & Rie, 1966; Esdaile & Greenwood, 2003; Macias, Saylor, Rowe & Bell, 2003). In a study, it was stated that families perceived their children with special needs as a more significant source of stress than other children (Baxter, Cummins & Yiolitis, 2000). There are significant studies demonstrating that mothers with children with special needs have two or three times more prevalence of stress than mothers with normal-developing children (Miller, Gordon, Daniele & Diller, 1992).

4.1.2. Anxiety

One of the reasons for many psychopathologies is a feeling that is demonstrated with fear and anxiety that can accompany many psychopathologies. Low satisfaction and high levels of arousal in anxiety (Şahin, Batıgün & Uzun, 2011). The concept of anxiety is different from fear. In the case of anxiety, the fact that the source of the threat and the absence of a dangerous situation are important points of the difference between anxiety and fear (Karamustafalıoğlu & Yumrukçal, 2011). Fear would last longer than anxiety. The severity is higher. The effects of fear are felt longer (Cüceloğlu, 2003). Anxiety is a feeling condition with many clinical signs and causes. One of the two most important components of anxiety is the recognition of fear and anxiety. The person is concerned at this stage that something bad will happen at any moment, the person would be uneasy but cannot show a dangerous situation or source of threat that will cause this. The other component of anxiety is physiological symptoms such as tremors, sweating and restlessness (Çelik & Acar, 2007). The autonomic nervous system is stimulated with the increase of the person's anxiety, and arousal causes problems such as diarrhea, dizziness, palpitations, physiological symptoms such as frequent urination, problems related to memory, decreased attention, and learning difficulties (Kocabaşoğlu, 2008). The evaluation of anxiety, the way of life of the patient, the presence of a medical condition, the substance or drug use, the situations in which anxiety occurs, the characteristics of the problem, how the problem arises, the factors that cause the problem to arise, increase and decrease, the person's coping mechanisms The person's perspective and the results of the problem should be evaluated from a general point of view (Karamustafalıoğlu & Yumrukçal, 2011). Having examined the related studies, it was seen that parents who have children with special needs experience anxiety problems. The parent, who has to deal with the care of the child with special needs, lays down their other roles, sacrifices their personal development and freedom, and participates less in social life. The uncertainty of the child's present and future situation and the inability to see who will care for the child in the future increase the concerns of the parent. In this process, stressful life of the mother cannot cope with stress and anxiety problems are reported to live (Ayyıldız, Şener, Kulakçı & Veren, 2012; Cummings, Bayley ve Rie, 1966; Kazak & Marvin, 1984; Tura, 2017). Having analysed the studies about the anxiety levels of the parents with and without special needs, it was seen that the anxiety levels of the mothers who have children with special needs are higher (Toros, 2002; Tura, 2017; Uğuz, Toros, İnanç & Çolakkadıoğlu, 2004).

4.1.3. Depression

It is a very common disorder that one out of every five people live in a period of life (Mete, 2008). It is an important condition that affects not only the person but also the family and the society (Glidden & Schoolcraft, 2003). The prevalence of depression was found between 6.7% and 87% in European and American studies. In terms of Turkey, 'the prevalence of depressive episodes by the Ministry of Health 'Mental Health Profile of Turkey' performed in the study was found to 4% (5.4% for women and 2.3% for men) (Bag, 2014). Symptoms of depression include (Mete, 2008):
1. Grief, unhappiness, crying, sadness, 2. Unwillingness, apathy and lack of pleasure, 3. Despair, failure and feelings of guilt, feelings of worthlessness, 4. Suicidal thoughts, 5. Energy loss, fatigue, 6. Appetite problems (over or under eating),7. Attention clutter, indecision, 8. Sleep problems (More or less sleep, sleep asleep), 9. Agitation or psychomotor deceleration.

Depression loss, energy shortage and depression are the most important symptoms. These symptoms, along with other symptoms, lead to significant deterioration in the social and occupational functionality of the individual. Each period of depression may take place with different severity. The severity of depression, what the symptom is, the intensity of 24, and the number of symptoms present in the individual have an effect (Karamustafalıoğlu & Yumrukçal, 2011).

Having compared the families with special needs, families with children with special needs seem to have high risk of physical and psychological disorders such as clinical depression (Oelofsen & Richardson, 2006). In studies conducted on the levels of depression of parents with and without special needs, mothers with children with special needs were reported to have

higher levels of depression (Miller, Gordon, Daniele & Diller, 1992; Toros, 2002). In particular, the mother's accusation of the child's condition inappropriately blames herself may be an important risk factor for depression (Esdaile & Greenwood, 2003).

4.1.4. Burnout

Depression of internal resources seen in people who are faced with unacceptably intense demands, depletion and energy reduction accompanied by symptoms of helplessness, failure, hopelessness of the person's business life, life and people around it is a syndrome that reflects the reflection of negative attitudes (Ardıç & Polatcı, 2008; Maslach & Jackson, 1981). The concept of burnout is addressed through three components: emotional exhaustion, lack of personal success, and depersonalization. Emotional exhaustion is the result of exhaustion of emotional resources. Desensitization is that the person is insensitive to them by developing negative attitudes and feelings towards the people around them. Lack of personal success is a person's negative self-assessment of human relations and work, insufficient to feel insufficient to work and do not feel (Ardıç & Polatcı, 2008; Maslach & Jackson, 1981). Burnout is a slowly occurring condition and can be rendered ineffective as a result of ignoring symptoms. The symptoms of burnout are examined under three categories as psychological, physical and behavioral (Ardıç ve Polatcı, 2008; Erçen, 2009):

1) Physical symptoms: Sleep problems, fatigue, weakness in the immune system, skin diseases, respiratory disorders, weight loss, heart related problems, high blood pressure, drowsiness, forgetfulness and headache.

2) Psychological symptoms: Restlessness, lack of self-confidence, lack of disability, lack of energy, alienation, depression, aggression, disappointment, increase in problems related to family and social environment, uncertainty in thoughts, loss of interest and hopelessness.

3) Behavioral symptoms: Anger can be listed as the lack of control, family conflicts, desire to stay alone, delay to work, permanent leave or not to work, low job performance, loss of concentration, susceptibility, personal inadequacy and feeling of failure. It causes many physical, psychological and behavioral problems such as burnout, morale, fatigue, non-attendance, stress, depression, anxiety, physical fatigue, insomnia, respiratory diseases, heart diseases, increased drug and substance use, and family members feel lonely. It makes individuals feel ignored. It leads to marriage and family problems. Family members accuse the individual of thinking that they do not want to be with them. This situation increases the feeling of guilt that the person feels as a result of burnout, and this leads to problems such as increased family conflicts, divorce, and the separation of children and parents (Ardıç ve Polatcı, 2008; Güleryüz & Aydın, 2006; Maslach & Jackson, 1981). Factors affecting burnout include individual factors, motivation, age, personality, marital status, personal expectations, number of children, education level, and occupation. Organizational factors are expressed as values, work load, justice, control, awards and belonging. Having examined the gender studies, it was seen that women generally have more burnout than men (Erçen, 2009). The inclusion of a new individual in the family leads to many innovations within the family and increases the duties and responsibilities of family members. Families who learn that the child has special needs give a strong reaction. This creates an additional source of stress that significantly affects the family life. Families with children with special needs assume different duties and responsibilities in addition to the responsibilities undertaken by other families. It consumes a lot of energy for the care of their children. The responsibilities of the child cause stress. As a result of their accumulation, they experience a state of burnout dominated by physical and psychological fatigue. Relevant studies show that parents, who have a stressful process in providing care for children with special needs, show burnout symptoms. As a result of an interview with families with children with chronic diseases, it was found out that these families live with a load for a long time, but also show signs of stagnation and fatigue and showed signs of burnout (Duygun & Sezgin, 2003;

Lindström, Aman & Norberg, 2010). When the studies comparing the levels of burnout of parents with and without special needs are examined, it can be seen that those who have children with special needs have a higher level of burnout compared to those who do not have children with special needs. (Duygun & Sezgin, 2003; Lindström, Aman & Norberg, 2010; Weiss, 2002).

4.1.5. Self-esteem

Self is a dynamic and complex system of thoughts, positive and negative attitudes and beliefs (Avşaroğlu & Üre, 2007). Self-esteem is a general evaluation of self and is measured by the expressions used in evaluating the self. (Baumeister & Tice, 1985). In other words, self-esteem is a person's self-acceptance, acceptance, and self-esteem (Avşaroğlu & Üre, 2007). The high or low self-esteem affects the person's power, the perspective of the world, the ability to love and be loved, the person's perspective, social participation, academic life, thought, behavior, emotions, choices and discourses (Aydın & Güloğlu, 2001). Individuals who want to feel valuable try to protect their self-esteem and to have high self-esteem. Individuals with high self-esteem accept themselves as they are, find themselves valuable and have high self-esteem. High self-esteem, which is one of the important symptoms of psychological health, is one of the important indicators of general well-being. Individuals with low self-esteem have a structure dependent on others, see themselves as inadequate, do not have confidence in their behaviors and beliefs (Avşaroğlu & Üre, 2007; Karaırmak & Çetinkaya 2011; Nir & Neumann, 1995).

Symbols such as social life, talents, material possibilities determine the value in the society. One of the symbols that causes a decrease in the value of a person in the society is to have a child if he or she does not have or is lost. The physical, intellectual and psychological characteristics of the child affect the perception of the family towards its own value. Particularly, the negative attitudes of the society towards families with children with special needs causes them to think that they are worthless. (Cummings, Bayley & Rie, 1966; Girli, Yurdakul, Sarısoy & Özekes, 2000). In addition, the family, who has a child with special needs, experiences a stressful process, financial difficulties, family relations are damaged, and the burden of children with special needs leads to the restriction of employment opportunities of families. Although there is a child with special needs, families are experiencing isolation, not being satisfied and a decrease in self-esteem as a result of increasing family burden and limiting employment opportunities (Gallagher, Phillips, Oliver & Carroll, 2008; Özşenol, Işıkhan, Ünay, Aydın, Akın & Gökçay, 2003).

4.1.6. Personal well-being

In recent years, the concept of quality of life has become an important indicator in understanding people's lives and needs. The subjective quality of life, also known as subjective well-being, expresses how the individual feels about his or her life and provides a broad knowledge of the individual's quality of life. Although it is stated that there are some differences between the concept of subjective well-being and the concept of personal well-being, the concept of personal well-being is a more general framework. These two concepts are sometimes used interchangeably. At the same time, it can be seen that the Personal Well-Being Scale is accepted as a measure of subjective well-being (Lau, Cummins & Mcpherson, 2005; Meral, 2014). Therefore, it is preferred that the concept of subjective well-being and personal well-being are used interchangeably in the research. Studies show that life satisfaction is related to other criteria of personal well-being (Yiengprugsawan, Seubsman, Khamman, Lim, Sleigh & Thai Cohort Study Team, 2010). Personal well-being refers to a comprehensive and long-term evaluation of life satisfaction, not the feelings that a person feels about life in a given period. The concept of personal well-being, which points to life satisfaction, good level of mental health and overall happiness, includes an individual assessment of the person's emotional responses, life satisfaction, cognitive satisfaction and quality of life (Meral, 2014).

In general, it can be seen that personal well-being is composed of three characteristics (Diener, 1984): 1. Personal well-being is subjective and includes personal experiences of the individual. 2. Personal well-being includes positive measures with the absence of negative factors. 3.

Personal well-being includes a general assessment of every aspect of a person's life. Emotion or satisfaction in a particular area is assessed, but an emphasis is placed on the whole of the individual's life.

While assessing the personal well-being of the individual, it can be done by testing eight areas that include personal assessments. These are the standard of living, health, success in life, relationships, security, social relations and commitment, future security and religion/spirituality (International Wellbeing Group, 2006). According to the cross-sectional studies, families with special needs show flexibility over their well-being. In order to adapt to the care and needs of children with special needs, mothers participate in less business life, fathers work longer hours and family responsibilities are arranged accordingly (Seltzer, Greenberg, Floyd, Pettee & Hong, 2001). Experimental studies investigating the effect of special necessity on the well-being of the family indicate that the special need has a negative effect on well-being and that this negative effect is on the most material well-being (Fafchamps & Kebede, 2008). The study by Emerson, Hatton, Llewellyn, Blacker and Graham (2006), it was stated that mothers with children with special needs have a lower level of well-being than mothers who do not have children with special needs.

5. Discussion

Individuals need to establish social relations in order to interact with their environment. At the same time, social relations, which have a significant impact on the psychological health of the person, support health protection and prevent physical and psychological problems against stressful life events. The fact that these social relations are established in a healthy way is related to the acquisition of social skills. Social skills are important in the field of mental health in order to be able to strike out emotions, to reject the inappropriate requests, to protect their rights and to ask for help when necessary (Sorias, 1986; Yalçın, 2012). When the variables that affect social skill are examined, sociodemographic variables such as age, gender, social status, marital status, socio-economic level, birth order, educational status, gender, working status, cultural structure, family width, as well as depression anxiety, anxiety, burnout etc., it is seen that the problems are related to the social skill level of vital problems such as illness and divorce. (Booth, Mitchell, Barnard & Spieker, 1989; Elliott, Sheridan & Gresham, 1989; Karahan, Dicle & Eplikoç, 2007; Seven, 2008; Trower, 1987; Yüksel, 1999).

Having a child with special needs is an important vital problem. When a child with special needs is present in the family, parents, especially mothers, may experience physical and psychological disorders as a result of many difficulties (Ayyıldız, Şener, Kulakçı & Veren, 2012). In families with children with special needs, who struggle with more difficulties than families without children with special needs, it is observed that the person interested in the care of the child with special needs is mostly mother. Physical and psychological disorders interact with social skills. As a result of physical and psychological disturbances, people may experience social skills deficiency, and the lack of social skills may aggravate the consequences of physical and psychological disorders (Rustin & Kuhr, 1999).

22 out of 31 240 participants who stated that they had a physical/psychological problem had parents with special needs and only nine of the parents had normal problems. This rate is approximately 2.5 times higher. Those who define physical/psychological problems in their spouses are close to the same rates and corresponds to 20 people. Having taken the marriages of couples living in the country into consideration, it is also noteworthy that the couples with children with special needs have stayed longer together. This may lead to the conclusion that supporting each other and the needs and difficulties are linked to each other for a long time. In case of further investigation, the real result can be revealed (Rustin & Kuhr, 1999) (Table1).

According to the number of children the parents have, it can be seen that parents with children with special needs are less likely to have children than those who do not, and do not exceed 2 children. It is also possible to investigate in which order the child has special needs and to evaluate the family from various perspectives (Table2).

There was no significant difference between the families in terms of getting help in the answers to the questions about getting child care. With little difference, families with children with special needs were found to receive more help (Table 2).

While 85.8% of the parents with children with special needs did not have enough time, only 14.2% of them took the time, while the parents who had no children with special needs had plenty of time for them (Table 3).

Having a child with special needs brings many problems and responsibilities. Children with special needs require intensive care and support. Generally, the need for care and support is met by mothers (Doğru & Arslan, 2008; Tura, 2017). The need for continuous care creates a burden on the family. This condition, called caregiver burden, is also referred as mother burden. This is due to the fact that the care of the child with special needs is usually provided by mothers. This type of mother burden may sometimes cause negative feelings in mothers and these negative emotions may cause stress (Sivrikaya & Tekinarslan, 2013). In a study by Esdaile and Greenwood (2003), parents with children with special needs have higher levels of parenting stress associated with children than families with no children with special needs. In the study by Uğuz, Toros, İnanç & Çolakkadıoğlu (2004), the stress levels of the mothers, who had children with special needs, were higher than those of the other mothers. The mothers expressed that their children were more dependent on their family life. It was declared that more responsibility increased their stress levels. As a result of studies investigating the stress levels of parents with and without special needs, the perceived stress and coping subscale total scores of the parents with children with special needs were higher than those of mothers who do not have children with special needs. The stress levels of parents with children with special needs are significantly affected by the difficulties of having children with special needs. In addition to problems such as the child's social skills being weak, having difficulty in communication, increasing the burden of the parent for most of his time and increasing the external responsibilities of the child may lead to an increase of the stress life (Sivrikaya & Tekinarslan, 2013). In a study by Kazak and Marvin (1984), similar to the findings of the study, it was stated that families with children with special needs experience more stress than families without children with special needs. The child's need for constant care and living dependent on the parent leads to stress and anxiety in the parent. Anxiety problems are experienced, especially in cases where the mother takes care of the child and the child is seen as the parent's failure to have special needs (Doğru & Arslan, 2008; Tura, 2017). As a result of the study, the mean total anxiety scores of the parents, who have children with special needs, are higher than the anxiety scores of the parents who do not have children with special needs. There are many studies demonstrating that parents, who have children with special needs, have higher levels of anxiety than those without children with special needs (Toros, 2002; Tura, 2017; Uğuz, Toros, İnanç & Çolakkadıoğlu, 2004) This study reveals that the levels of depression of parents with children with special needs are higher than those without special needs. Parents, who have children with special needs, also have higher levels of depression (Şengül & Baykan, 2013; Uğuz, Toros, İnanç & Çolakkadıoğlu, 2004). In a study by Miller, Gordon, Daniele and Diller (1992), it was reported that mothers with children with special needs had more depressive symptoms than mothers who do not have children with special needs. Similarly, in studies conducted by Toros (2002) and Tura (2017), the fact that parents with special needs had higher levels of depression compared to mothers without children with special needs reveals that having children with special needs is an important risk factor for depression. In addition, there is a statistically significant correlation between social skill and depression at r = -0,50, indicating that social skills levels may decrease as mothers with special needs increase their depression levels. Parents with children with special needs are thought to have suffered from burnout due to the child's being held responsible for his situation and feeling helpless, having difficulty accepting his diagnosis, and overloading a large part of the responsibilities for home and child (Duygun & Sezgin, 2003). At the same time, individuals who have been under stress for a long time are reported to have burnout when they have difficulty in performing their roles (Lindström, Aman & Norberg, 2010). Parents who have children with special needs who have many stress factors in their lives are considered to be a risk factor for burnout. In the study conducted by Duygun and Sezgin (2003), it can be seen that parents who have children with special needs

have higher emotional exhaustion scores than those who do not have children with special needs. Another study showed that families with children with special needs show more burnout symptoms than families who do not have children with special needs. It is stated that this difference is seen especially among mothers with and without special needs (Lindström, Aman ve Norberg, 2010). In line with the results of the study, similarly supported in the literature, it is seen that the burnout levels of the parents with children with special needs are higher than the mothers who do not have children with special needs.

According to the results of the study, the mean score of the Rosenberg Self-Esteem scale of the parents having children with special needs was found to be higher than the ones without the children with special needs. However, the high score from this scale indicates low self-esteem (Çuhadaroğlu, 1986). In other words, parents who have children with special needs have lower self-esteem than those who do not have children with special needs. In a study by Emerson, Hatton, Llewellyn, Blacker and Graham (2006), it was reported that parents with children with special needs had lower self-esteem than parents without children with special needs. In a study on families with children with special needs, it was stated that mothers who have children with special needs have more feelings of guilt than their fathers, and that self-esteem increases as a result of group counseling to these families. In this study, self-esteem problems due to feelings of guilt, inadequacy and loneliness may be improved as a result of group counseling (Yurdakul, Sarısoy & Özekes, 2000). It is thought that the parents who have children with special needs, who feel guilt and inadequacy, think that they have lost their value in the society when they have such a child and therefore their self-esteem decreases.

It is stated that families with children with special needs have a negative effect on the well-being, especially when the child's behavioral problems increase. Problems such as stress, low self-esteem, anxiety, and depression in parents who have a difficult process with the difficulties of having children with special needs are more common than those who do not have children with special needs. The change in mood with these problems negatively affects the quality of life and life satisfaction (Canarslan & Ahmetoğlu, 2015). In a study by Werner & Shulman, 2013), families with children with autism were found to have personal well-being below normal. In this discriminatory study, it is stated that the feelings of shame, stigmatization, quality of life, concern about the future of the child and the restriction of leisure activities are effective on low personal well-being. Similar to the results of the study conducted by Palancı (2018), it can be seen that the personal well-being of the families with children with special needs is lower than the families with normal development. The analysis of many qualitative and quantitative data together with these studies shows that families with children with special needs are at risk for low quality of life (Cummins, 2001).

6. Conclusion

The study conducted with the aim of examining the social skill levels of mothers with and without special needs in terms of relevant variables have various results. Within the scope of the research, a statistically significant difference was found between the social skill levels of parents with special needs and age, the place where a large part of life is spent, physical/psychological discomfort, and the duration of marriage and socio-demographic variables. There was no significant difference in terms of physical/psychological disturbance, educational status, working status, working condition before child, income level, social security, getting social assistance, number of people living, self-sufficient time allocation, number of children and getting child care. Parents who have children with special needs were generally found to have lower social skill scores as the age increases, social skills scores of mothers living in districts are higher than the mothers growing up in the villages, and parents who do not have physical/psychological discomfort have higher social skill scores than their parents who have physical/psychological discomfort. There was a statistically significant difference between social skills, perceived stress, personal well-being, self-esteem, burnout, anxiety and depression levels of parents who have children with and without special needs.

The social skills and personal well-being total scores of the parents who do not have children with special needs were found to be higher than the mean scores of the social skills and personal well-being of the parents with special needs.

The mean scores of perceived stress, self-esteem, burnout, anxiety and depression of the parents with children with special needs were found to be higher than the total points of perceived stress, self-esteem, burnout, anxiety and depression of those without special needs.

The multiple regression model for predicting the Social Skills Scale A total score was found to be statistically significant in mothers with special needs. A Social Skill Scale, 39% of the independent variables taken from the model, Rosenberg Self-Esteem and HAD Scale Depression subscale were statistically significant. A multiple regression model was used to predict the total score of A Social Skills Scale for mothers without special needs.

The HADS Scale Anxiety subscale was statistically significant. Within the scope of the research, the limitations of the study are the lack of special needs of children with special needs.

Although there is a significant relationship between the social skill levels of parents and their parenting skills and mental health, it was observed that there are very few studies conducted in the literature on this subject. Therefore, there is a need to conduct more research on the social skill levels of families.

7. References

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