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Children with Special Education Needs and Subjective Well-being: Social and Personal Influence

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Introduction

The promotion of Health-Related Quality of Life (HRQoL) in children and adolescents requires a developmental and an ecological approach (Bronfenbrenner, 2005). The Ravens-European group and Sieberer KIDSCREEN (2005) consider that the conceptualisation of health-related quality of life requires a subjective health and multi-dimensional comprehensive model. The authors address that the health-related quality of life can be a psychological construct that describes the physical, psychological, mental, social and functional well-being.

Children and adolescents with special educational needs (SEN) can be considered a risk group in terms of HRQoL in almost all dimensions, except in ‘school environment’ (Bullinger, Schmidt, Petersen, & The Disabkids-Group, 2002; Erhart et al., 2009; Gaspar, Matos, Ribeiro,

ABSTRACT

Children and adolescents with cognitive and developmental difficulties show difficulty in social interaction, feelings of rejection, autonomy, social rules and in behavioural and emotional self-regulation. Importantly, their subjective well-being is associated to social support and personal factors, such as self-esteem and a positive self-image. The data were collected in 16 schools, 8 in the North Region and 8 in the Lisbon Region of Portugal. The sample is composed by 1181 young people of which 51.5% were female, with ages ranging between 8 and 17 years. From the sample, 2.6% had special educational needs (SEN), and 3% did not use the Portuguese language at home. 12.2% had been retained one grade or more. Three regression models were built. Model 1 establishes the association between having SEN, grade and subjective well-being. The final model with all variables showed that social and personal characteristics present a stronger explicative value on children and adolescents’ subjective well-being. The model also showed that, when social and personal variables are included the association between being a student with SEN and well-being is not statistically significant. Research and intervention implications include the need to promote subjective well-being, social and personal skills and a positive development in children and adolescents with SEN.

KEYWORDS

Children; educational psychology; health promotion; health psychology; quality of life; special education needs; well-being

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Health related quality of life in children with special needs education

Children and adolescents with cognitive and developmental difficulties (CDD) show difficulty in social interaction, feelings of rejection, autonomy and social rules, in behavioral and emotional self-regulation. The subjective well-being is associated to social support and personal factors, such as self-esteem and a positive self-image (Hilgenkamp, Wijck, & Evenhuis, 2011; Ribeiro, 2008).

The emphasis on a comprehensive and holistic approach to human experience, enlightened by the Positive Psychology movement (Passareli & Silva, 2007; Seligman, Steen, Park, & Peterson, 2005), provided the need to assess quality of life in children with SEN. Quality of life can be used as an indicator to evaluate the efficacy of interventions and treatments (Seidl & Zannon, 2004), as well as special education programmes and services (Schalock, 1995; Wehmeyer & Schalock, 2001).

A study with children with attention deficit disorder and hyperactivity (ADHD) revealed that lower symptom severities, as well as lower comorbid psychiatric diagnosis, are associated with higher psycho-social well-being in those children (Klassen, Miller, & Fine, 2004). Also, the degree of pain felt by children with cerebral palsy has a negative impact on their quality of life (Arnaud et al., 2008).

For instance, the HRQoL in children and adolescents with Autism Spectrum Disorders (ASD), when compared to normative data, was worst for total, psychosocial, emotional and social functioning, but did not demonstrate differing scores for physical and school functioning. HRQoL is consistently related to internalising and externalising problems as well as repetitive behaviours, social responsiveness, and adaptive behaviours. Associations among HRQoL and behavioral characteristics suggest that treatments aimed at improving these behaviors may improve HRQoL (Kuhlthau et al., 2010).

Taking into consideration self-regulation and autonomy, there is a positive association between the values on these variables and quality of life in people with intellectual and developmental disability (Wehmeyer & Schalock, 2001; Wehmeyer & Schwartz, 1998). Similarly, a significant correlation was found in children with cerebral palsy regarding disease-specific measures of subjective well-being related to health and functional independence measures, in three domains – self-care, mobility and cognition (Schneider, Gurucharri, Gutierrez, & Gaebler-Spira, 2001). Unless there is social support, the lack of autonomy and independence in these functional domains will lead to limitations in activity and restrictions in participation (Ribeiro, 1999).

Social support and subjective quality of life in children with special needs education

Social support and perceived social support are other important factors that contribute to quality of life. Nevertheless, the two dimensions of perceived social support – structural and functional support, are differently related to the perception of quality of life. Structural support (support related to social relationships, social network and belonging to a group)
shows a linear relation with quality of life. On the other hand, functional support (resources such as emotional support and informational support) is only related to quality of life. On the other hand, functional support – resources such as emotional support and informational support, is only related to quality of life in stress situations, serving as a buffer against adverse effects of stress (Cohen & Wills, 1985; Helgeson, 2003).

The different relations between social networks, as a form of social support, and the perception of quality of life in children with and without SEN, have been proved in different studies. Gaspar, Pais Ribeiro, Leal, and Matos (2008) revealed the importance of feeling satisfied with the social support on psychological well-being and quality of life in children and adolescents. Namely, positive interpersonal relations, in different life contexts (home, school, community), was considered a primary factor to promote quality of life.

**The impact of friends social support**

Subjective well-being, as an indicator and subjective form of evaluation of quality of life (Giacomoni, 2004), is associated to the social support in people with intellectual and developmental disabilities (IDD) (Bramston, Chipuer, & Pretty, 2005; Kroese, Hussein, Clifford, & Ahmed, 2002). The frequency of social contacts, namely with IDD friends, is of the most importance in subjective well-being (Emerson & Hatton, 2008).

**The impact of family social support**

Children with attention deficit and hyperactivity disorder (ADHD) perceive lower frequencies of overall social support. These perceptions are moderately related to the teachers and parents’ perceptions of the social support they make available. Moreover, the perception that children with ADHD have of their social support is positively correlated with student-reported social skills, behaviors and self-concept (Demaray & Elliot, 2001).

Social support is a key stone to quality of life, especially in terms of family relations that play an important in child development and subjective well-being. Family is the first context where children experience social relations and it assumes a rather important role in their development. Also, family provides a series of experiences as well as attention and specific cares, which are of utmost importance to the development of children with SEN, in particular (Silva & Dessen, 2001).

**Parental coping**

Lardieri, Blacher, and Swanson (2000) refer that the difficulties found by parents to cope with a child with disabilities is a source of anxiety, overprotection and rigidity. This reality may also account for lower levels of family coherence, a lower emphasis on personal growth of other family members and, conversely, an extreme preoccupation with control within the family (Margalit & Heiman, 1986). A child with SEN is a stress factor on the family due to the psychosocial problems derived from the lack of the child’s independence, which affects the whole family as a system (Rodríguez-Sánchez et al., 2011). It can also unsettle the family’s functioning through the disruption of parental well-being, sibling well-being and marital relationship. In addition, it can demand too much on extra-parental support. This can also have a negative effect on parenting behavior (Barnett, Clements, Kaplan-Estrin, & Fialka,
However, a revision by Neely-Barnes and Dias (2008) enlighten that child maladaptive behavior is also associated to burden and stress (Heller, Hsieh, & Rowitz, 1997; Saloviita, Italinna, & Leinonen, 2003; Simmerman, Blacher, & Baker, 2001) as well as poorer parenting efficacy (Kersh, Hedvat, Hauser-Cram, & Warfield, 2006).

Care needs also have been associated to family burden and stress (Neely-Barnes & Marcenko, 2004). Namely, the demand for time dedicated to childcare by children with SEN constitutes a risk factor to parental burnout (European Alliance for families (EAF, 2013). For instance, mothers of children with intellectual disabilities report higher social burden in comparison with mothers of physically disabled children (Tangri & Verma, 1992). Also, a study conducted by Schneider, Gurucharri, Gutierrez, and Gaebler-Spira (2001) with caregivers of children with cerebral palsy revealed no significant correlations between general and disease-specific health related quality of life (HRQL) measures, except between the dimension parent time and family cohesion of general HRQL and general score of disease-specific HRQL.

**Parental styles**

Another important dimension in family relations is parenting style. Baumrind (1991) considered the existence of three types of parenting style related to the degree of control exerted: authoritarian (high control, restriction and discipline and low emotional support); authoritative (high levels of emotional support, independency and mutuality); and permissive (lack of control but good responsiveness to child needs). Authoritative parenting style has a positive effect on educational advancement, self-sufficiency and relationships with peers. It is also associated to less misbehavior (Laali-Faz & Askari, 2008). High psychosocial well-being in children with cerebral palsy is associated with autonomous/allowing parenting styles (Aran, Shalev, Biran, & Gross-Tsur, 2007). Authoritative parenting style is associated with antisocial behavior, somatic complains and somatisation disorders (Bloomquist, 2004).

A study conducted by Bolghan-Abadi, Kimiaee, and Amir (2011) revealed that authoritative child rearing style is positively associated with mental health; permissive style is positively associated with child quality of life, conversely to authoritarian style which is negatively associated with quality of life. In this way, responsiveness and sensitivity are keystones to promote secure attachments in children with SEN (EAF, 2013) as well as adaptive behavior and quality of life. Taking into account the factors mentioned above, the main purpose of this study is to verify the quality of life, perceived social support and family relations within a group of children with SEN. Parents (Benjak, 2011), teachers (Roll-Pettersson & Ala’l-Rosales, 2009) and students with SEN reported a need for more social support (formal and informal support), specific strategies on how to deal with daily activities and psychological support (Brown et al., 2011).

**The impact of social and personal skills promotion**

The educational curriculum should include life skills in which teachers can promote psycho-social competence among students (Pavri, 2004; Smith, Robb, West, & Tyler, 2010), such as problem-solving skills, self-regulation (Matos, Gaspar, Ferreira, & Social Adventure Group, 2011), critical thinking, communication and interpersonal skills, empathy and emotional management. These skills enable children and adolescents to develop a positive mental health and greater well-being (Black, McConkey, Roberts, & Ferguson, 2010). In some cases,
teachers do not have specific education skills to manage students with SEN (Stephenson, Carter, & Arthur-Kelly, 2011). Programmes that aim at promoting cognitive and emotional skills (Simões, Matos, & Social Adventures Group, 2012) should include knowledge and specific strategies to help teachers and parents promote HRQoL in students with SEN, especially in the promotion of communication skills (Goodwin, 2003). Most of these programmes aim at reducing social and environmental barriers to enable the promotion of inclusion in school, family and community activities, and to promote better social integration, social/self-knowledge and social/self-acceptance. This study focuses on students with SEN, their teachers and parents and aims to identify their specific needs and challenges in order to promote a better HRQoL. This knowledge will create a baseline and allow researchers to renew and deepen their research in the interactional perspective that focuses on child developmental stages and special needs (Capps, Kehres, & Sigman, 1998).

Research shows that children with special education needs present a less positive perception of their quality of life (Gaspar et al., 2009, 2012). Our present research question is related to the positive influence of social and personal factors in the subjective quality of life in children with special education need. This work’s main objective is to study the impact of SEN in the subjective well-being of children and adolescents and the role of social (social support satisfaction related to parents and friends) and personal factors (optimism, resilience and self-esteem) in this relation.

**Method**

**Participants**

Data were collected in 16 schools, 8 in the North Region (NR) and 8 in the Lisbon Region (LR) of Portugal. One thousand, one hundred and eighty-one young people responded to the questionnaires (33.4% in the NR and 66.6% in the LR), 51.5% were female and ages ranged between 8 and 17 years with an average of 9.8 years (SD = 1.32). The boy’s age average is 10.0 (SD = 1.53). The sample was mainly by convenience balanced through the geographic location. Of the participants 2.6% had SEN, and 3% did not use the Portuguese language at home. 12.2% had been retained one grade or more. (National data revealed that around 5% of children present SEN and Portugal have a mean of 10% of retention (Education Ministry data, DGIDC, 2013)). The Special Educational Needs Status was reported by the teachers and is according Portuguese legislation. Those children could present cognitive disability, sensorial disability, neurodevelopmental disorders but with mild or moderate symptomatology because they are integrated in regular public schools.

**Measures**

**Subjective well-being**

The KIDSCREEN-10 Index has items derived from a longer version. The good internal consistency reliability (Cronbach’s alpha = 0.82) and the good test-retest reliability/stability (r = 0.73; ICC = 0.72) enable a precise and stable HRQoL measurement.

The KIDSCREEN-10 is able to differentiate groups: low scores can be read as feeling unhappy, unfit and dissatisfied regarding family life, peers and school life and high scores
indicate the opposite – feeling happy, fit and satisfied with family, school and peer group (The KIDSCREEN Group Europe, 2006).

The instrument has 10 items and results in one global score, where a one-dimensional measure represents a global score for the longer KIDSCREEN versions (KIDSCREEN-52 and KIDSCREEN-27). It is adequate for large (epidemiological) surveys (The KIDSCREEN Group Europe, 2006). According to international guidelines, the translation of the KIDSCREEN draft questionnaire included a forward-backward-forward translation procedure with harmonisation processes. The Portuguese version shows good psychometric properties (Cronbach's alpha = .78) and the factorial confirmatory analysis show a good fit model (Matos, Gaspar, & Simões, 2012).

**Resilience**
The resilience scale was elaborated within the International Resilience Research Project (Grotberg, 2001) and measure resilience skills in children and adolescents. The back translation method was used, in order to translate and adapt the scale. The scale was translated into Portuguese by two Portuguese researchers, and the two versions were compared and integrated. The resultant version was translated back to English, and then revised by a bilingual researcher and compared with the original version. The resultant Portuguese version was tested with some children and adolescents in order to adapt the language. After this process, the final Portuguese version was obtained. The Grotberg's scale integrates three correlated dimensions of resilience, organized around their sources: provided external support, developed inner strengths, acquired interpersonal and problem solving skills. These are respectively labeled 'I Have,' 'I Am,' and 'I Can' (Grotberg, 2001), which are used to deal with adversity. Like the original, five items were used (manifest variables) for each of the considered dimensions. The instrument presents a total of fifteen items. In the result analysis, higher values reflect less resilience.

The Portuguese version demonstrated reliability, convergent and discriminant validity. Reliability was good for all latent variables: .79 for 'I Have,' .85 for 'I Am,' and .80 for 'I Can.' The scale was cross-validated and the results show parameter invariance (Coelho, Gaspar, & Albergaria, 2014).

**Optimism**
The Life orientation - Revised Test (LoT-R; Scheier, Carver, & Bridges, 1994) is a self-response instrument composed by ten items, four of which are distractors and six of which evaluate dispositional optimism. The possible responses are presented in an ordinal scale of five points which vary between ‘I totally agree’ to ‘I totally disagree.’ The respondents should therefore register the degree of agreement to the presented statements. The LOT-R (Scheier et al.) was translated and adapted for children and adolescents by Gaspar, Ribeiro, Matos, Leal, & Ferreira (2010) with an internal consistency of $\alpha = .59$.

**Self-esteem**
Self-esteem was measured with the Portuguese translation and adaptation of the short version of Kelley’s scale Hare Self-Esteem Scale (Kelley, Denny, & Young, 1997) using the back translation process (the same used and describe above for the resilience measure). Kelley’s short form reduces the Hare scale to 18 items, six items in each of the three subscales, while maintaining the integrity of the original scale, has three dimensions: home self-esteem,
self-esteem related to friends, and school self-esteem. Reliabilities (coefficient alpha) for the sample were Home = .60, Peer = .77, School = .73. Sample items are: (Peer) ‘I have at least as many friends as other people my age’; ‘People my age often pick on me’. (Home) ‘My parents are proud of the kind of person I am’; ‘My parents believe that I will be a success in the future’. (School) ‘I am usually proud of my report card’; ‘My teachers are usually happy with the kind of work I do’. Items are scored on a four point scale from ‘strongly disagree’ to ‘strongly agree’. Some items on each subscale are worded in a manner that requires ‘reverse scoring’. For this study, each item scores were summed to provide a total score of Self-Esteem. The metric properties of the Portuguese version of the instrument are being prepared (Gaspar, Tomé, Albergaria, Freire, in preparation).

**Social support satisfaction**
The Satisfaction with Social Support Scale (SSSS; Ribeiro, 1999) measures satisfaction with social support and was constructed for young adults and adult populations in situations of illness, as well as chronic and psychological disease. On constructing this scale, a group of health-related and well-being dimensions were considered along with other directly related dimensions. The original SSSS is composed of 15 affirmative sentences that are displayed for self-response. Subjects should mark the degree to which they agree with the statement (if it applies to the individual) on a Likert scale with five positions from ‘I totally agree’ to ‘I totally disagree’. These 15 items are distributed through four dimensions or factors, which are empirically generated, to measure the following aspects related with Social Support Satisfaction: ‘Satisfaction with Friendship’, ‘Intimacy’, ‘Family Satisfaction’, and ‘Social Activity’. The Satisfaction with Social Support Scale (SSSS; Ribeiro, 1999) was translated and adapted for children and adolescents by Gaspar et al. (2009) and the total scale obtained an internal consistency of $\alpha = .77$.

**Data collection and analysis**
This study was part of a broader survey aimed to examine other variables related to well-being in Portuguese children and adolescents. All the instruments included in the questionnaires were filled in Portuguese, as self-reporting instruments. The application was in a classroom setting and students and their parents agreed to participate in the study. Confidentiality and anonymity was preserved. First School Director was contacted in order to evaluate the availability to participate in the study. Based on this information, was sent out 1500 questionnaires, 500 questionnaires was send to Schools in the North of Portugal and 1000 questionnaires were applied in Schools in Lisbon. Questionnaires were applied by a member of our research team. Were applied 1300 questionnaires and 119 were excluded because they are not valid (miss gender or age information or were not filled). Our final response rate was 78, 73%.

For the data analysis, the statistical software SPSS 20 was used to perform descriptive statistics, ANOVA and linear regression models.

**Results**
Statistical differences were found between students with and without special education needs. Students with special education needs present less healthy indicators than the students that do not have special education needs. Students with special education needs
present low values in subjective well-being, optimism, resilience, self-esteem and social support satisfaction (Table 1).

Three regression models were developed, in order to better understand the impact of having special education needs in subjective quality of life in children and the meditative effect of personal and social factors in this the perception of quality of life in children with special education needs. Those models (see Table 2) use subjective quality of life as a moderating variable and Model 1 use only special education needs condition as a mediating variable, Model 2 use special education needs and personal variables as mediating variables and model 3 use special education needs, personal variables and social variables as mediating variables. Model 1 studied the impact of being a student with special education needs in subjective well-being; Model 2 adds the impact of personal characteristics (optimism, self-esteem and resilience) in subjective well-being; Model 3 adds to the previous the impact of social characteristics (Social Support Satisfaction – friends and parents).

Table 1. ANOVA – Analyses of personal and social characteristics – students with and without special education needs.

<table>
<thead>
<tr>
<th>Student's status regarding special education needs</th>
<th>Students with special education needs</th>
<th>Students without special education needs</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dimensions</td>
<td>M</td>
<td>SD</td>
<td>M</td>
</tr>
<tr>
<td>Subjective well-being (KIDSCREEN-10)</td>
<td>39.47</td>
<td>6.75</td>
<td>42.58</td>
</tr>
<tr>
<td>Optimism</td>
<td>20.86</td>
<td>3.51</td>
<td>22.56</td>
</tr>
<tr>
<td>Resilience</td>
<td>60.42</td>
<td>12.34</td>
<td>64.68</td>
</tr>
<tr>
<td>Self-esteem</td>
<td>54.49</td>
<td>7.79</td>
<td>57.74</td>
</tr>
<tr>
<td>Social support satisfaction</td>
<td>42.36</td>
<td>7.93</td>
<td>45.71</td>
</tr>
</tbody>
</table>

*p < .05; **p < .01; ***p < .001.

Table 2. Impact of personal and social characteristics in subjective well-being in children according with SEN status (SEN/without SEN) – Regression models – dependent variable subjective well-being.

<table>
<thead>
<tr>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
<th>B</th>
<th>Std. Error</th>
<th>Beta</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Constant)</td>
<td>35.645</td>
<td>2.140</td>
<td></td>
<td></td>
<td>16.656***</td>
</tr>
<tr>
<td>With SEN</td>
<td>3.547</td>
<td>1.101</td>
<td>.171</td>
<td>3.221***</td>
<td></td>
</tr>
<tr>
<td>Model 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Constant)</td>
<td>10.111</td>
<td>2.516</td>
<td></td>
<td></td>
<td>4.018***</td>
</tr>
<tr>
<td>With SEN</td>
<td>1.628</td>
<td>.899</td>
<td>.078</td>
<td>(n.s.)</td>
<td></td>
</tr>
<tr>
<td>Optimism</td>
<td>.349</td>
<td>.069</td>
<td>.240</td>
<td>5.030***</td>
<td></td>
</tr>
<tr>
<td>Resilience</td>
<td>.081</td>
<td>.031</td>
<td>.124</td>
<td>2.623**</td>
<td></td>
</tr>
<tr>
<td>Self-esteem</td>
<td>.277</td>
<td>.033</td>
<td>.403</td>
<td>8.454***</td>
<td></td>
</tr>
<tr>
<td>Model 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Constant)</td>
<td>8.158</td>
<td>2.475</td>
<td></td>
<td></td>
<td>3.296***</td>
</tr>
<tr>
<td>With SEN</td>
<td>1.466</td>
<td>.873</td>
<td>.071</td>
<td>(n.s.)</td>
<td></td>
</tr>
<tr>
<td>Optimism</td>
<td>.238</td>
<td>.071</td>
<td>.164</td>
<td>3.333***</td>
<td></td>
</tr>
<tr>
<td>Resilience</td>
<td>.063</td>
<td>.030</td>
<td>.096</td>
<td>2.070*</td>
<td></td>
</tr>
<tr>
<td>Self-esteem</td>
<td>.234</td>
<td>.033</td>
<td>.341</td>
<td>7.081***</td>
<td></td>
</tr>
<tr>
<td>Social Support Satisfaction</td>
<td>.185</td>
<td>.039</td>
<td>.235</td>
<td>4.742</td>
<td></td>
</tr>
</tbody>
</table>

Note: Dependent variable subjective quality of life.
*p < .05; **p < .01; ***p < .001.
Considering the subjective well-being as a dependent variable and as dependent variable SEN, we found that personal variables (self-esteem, resilience and optimism) and social variables (social support from friends and family) are mediating variables, because when they are introduced in the regression equation, decrease the magnitude of the relationship between the independent variable (SEN) and the dependent variable (Quality of Life perception). Regarding the Regression Model 1, an adequate model was achieved $[F(1, 346) = 10.37; p < .001]$ and the explained variance was 2.9%. The variable ‘Students with SEN’ was associated to subjective well-being. Regarding the Regression Model 2, an adequate model was achieved $[F(4, 343) = 55.78; p < .001]$ and the explained variance was 39.4%. All variables part of ‘personal characteristics’ (optimism, self-esteem, and resilience) were associated to subjective well-being. In Model 2 the variable ‘student with SEN’ does not have a statistically significant impact on ‘subjective well-being’. Regarding the Regression Model 3, an adequate model was achieved $[F(5, 342) = 51.92; p < .001]$ and the explained variance was 43.1%. The variable ‘social support satisfaction’ and all ‘personal characteristics’ variables (optimism, self-esteem, and resilience) were associated to subjective well-being. In Model 3 the variable ‘student with SEN’ does not have a statistically significant impact on subjective well-being.

A strong association was observed between ‘subjective well-being’ and ‘student with SEN’ in Model 1. When personal characteristics (optimism, self-esteem, and resilience) are included, the association between ‘subjective well-being’ and ‘student with special education needs’ is no longer statistically significant. A strong association was observed between ‘subjective well-being’ and all ‘personal characteristics’ (optimism, self-esteem, and resilience) in Model 2.

Model 3, which included ‘social support satisfaction’, presented a strong association with ‘subjective well-being’ and with ‘personal characteristics’ (optimism and self-esteem). Resilience with the inclusion of ‘social support satisfaction’ presents a less strong association with subjective well-being. The status of being a pupil with SEN is still not significantly associated with subjective well-being.

**Discussion**

Our main objective is to better understand and characterise the association between subjective well-being and children and adolescents with SEN, alongside the impact of social and personal characteristic in this relation.

Our data revealed statistically significant differences between children and adolescent who have or do not have SEN. Students who have SEN present less positive social and personal health indicators, such as less optimism, less resilience, present low self-esteem and less social support satisfaction related to parents and friends. In fact, children and adolescents with SEN can be considered a risk group in terms of subjective well-being (Bullinger, Schmidt, Petersen, & The Disabkids-Group, 2002). Those results are confirmed in a Portuguese representative sample of children and adolescents (Gaspar et al., 2009, 2012). Children and adolescents with SEN have more difficulty in social relationships, feelings of rejection. They also present less autonomy and are more like to have behavioral and emotional/self-regulation difficulties. Subjective well-being is associated to social support and personal factors, such as self-esteem, self-image (Hilgenkamp et al., 2011; Ribeiro, 2008), resilience, optimism, coping strategies (Dawson & Pooley, 2013; Gaspar et al., 2012; Harding, 2001; Utsey, Hook, Belvet, & Fisher, 2008).
Children with more risk factors and less protective factors present a more negative subjective well-being. Our results revealed a strong association between subjective well-being and students with SEN. Those students present less subjective well-being than the students that do not have SEN, and school success and achievement are positively related to subjective well-being (Gaspar et al., 2009).

In order to understand the impact that social and personal characteristics can have on the relation between students with SEN and well-being, we introduced the variable personal characteristics (optimism, resilience, and self-esteem) and, later, the social characteristic here measured with social support satisfaction with parents and friends. The final model with all variables showed that social and personal characteristics present a stronger explicative value on children and adolescents’ subjective well-being. The model also showed that, when social and personal variables are included the association between being a student with SEN and well-being is not statistically significant. Therefore, we conclude that personal and social factors can be considered protective factors related to students with SEN. The prevention and intervention in SEN should include the promotion of social and personal skills in students, teachers, friends, family and the community.

Parents (Benjak, 2011) who have children with SEN and their teachers (Roll-Pettersson & Ala’l-Rosales, 2009; Stephenson et al., 2011) sometimes do not have specific knowledge, specific professional and/or personal skills to help promote a positive development in these children and adolescents (Brown et al., 2011).

The educational curriculum should include life skills in which teachers can promote psychosocial competence among students (Pavri, 2004; Smith et al., 2010), such as problem-solving skills, self-regulation (Matos, Gaspar, Ferreira, & Social Adventure Group, 2011) critical thinking, communication and interpersonal skills, empathy and managing emotions. Those skills enable children and adolescents to develop a positive mental health and a greater well-being (Black et al., 2010; Morgan, 2007).

Monitoring quality of life related to subjective well-being in children and adolescents with SEN is particularly important, despite the variety of medical, educational and psychosocial interventions they may have had. A psychologist, other educational or health professionals who measure the HRQoL can promote a better multidimensional welfare in these children and adolescents in terms of friends, family, school and other areas that reflect risk or protective factors in relation to their development.

The assessment of subjective well-being may be useful in screening and identifying individuals who are at risk of developing behaviour problems, which is crucial for academic programmes, health promotion and prevention programmes.

The relationship between subjective well-being and students with SEN, and the protective impact that personal and social factors can have in those students’ health and subjective well-being, are important indicators and provide a strong argument for scientific research in children and adolescents by psychologists, other educators, teachers, school and community contexts who have to confront the challenge of providing services that are sensitive to cultural and individual differences (Gaspar et al., 2010; Huebner, Suldo, Smith, & McKnight, 2004).

**Practical implications**

Our results suggest strongly that, the existence of special education needs can impair pupils’ academic performance and perception of subjective wellbeing, or at least increase their
vulnerability, but the most important feature is that this situation is really impacted by the strength of personal and social factors that can have a buffering effect. The pedagogical consequences of this impact are huge and call for a change in the organisation of support services for children with special needs, that must include a positive focus: the promotion of personal and social competences and the promotion of a social support net, including family, peers and teachers.

Having special needs education can be considered a risk factor related to subjective well-being in children and adolescents. The impact of this risk or the developmental and psychological consequences can be reduced if children and adolescents develop social and personal skills to face the risk and improve positive developmental opportunities.

**Disclosure statement**

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