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Emotional and psychological variables in families with a child with a disability

Variables emocionales y psicológicas en las familias que tienen un hijo/a con discapacidad

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ABSTRACT

Keywords:
disability, families, stress, depression, resilience, parental confidence.

The birth of a child with a disability is an event that generates stress, depression a strong emotional impact on parents.
Aim: Investigate the impact of emotional and and psychological variables in families with a child with a disability.
Method: 59 families with children diagnosed with a disability in the Community of Madrid participated. We used an ad hoc questionnaire, the Perceived Stress Scale, the Beck Depression Inventory-II, the Connor and Davidson Resilience Scale (CD-RISC) and the Family Confidence Scale (Con-Fam) were used. Results: The families have manifested perceived stress, as well as mild depressive symptoms. Levels of resilience are high. Family trust was also adequate. The analysis of statistically significant differences shows the type of disability, the number of children, the search for help, the family structure and the different emotions felt at different time points showed interesting results. Conclusions: Having a child with a disability provokes stress and depression responses in the family, however, families have the will to face any type of event, since it is something that conditions the life of their own children.

RESUMEN

Palabras clave:

El nacimiento de un hijo/a con discapacidad es un acontecimiento que genera estrés, depresión y un fuerte impacto emocional en padres y

discapacidad, familias, estrés, depresión, resiliencia, confianza familiar.	madres. Objetivo: Conocer el impacto de las variables emocionales y psicológicas en familias con un hijo/a con discapacidad. Método: Han participado 59 familias con hijos/as con diagnóstico discapacidad de la Comunidad de Madrid. Se usó un cuestionario elaborado ad hoc, la Escala de Estrés Percibido, el Inventario de Depresión Beck-II, la Escala de Resiliencia de Connor y Davidson (CD-RISC) y la Escala de Confianza Familiar (Con-Fam). Resultados: Las familias han manifestado estrés percibido, así como síntomas de depresión leve. Los niveles de resiliencias son altos. En cuanto a la confianza familiar también ha sido adecuada. El análisis de las diferencias estadísticamente significativas muestra como el tipo de discapacidad, el número de hijos, la búsqueda de ayuda, la estructura familiar y las distintas emociones sentidas en distintos momentos temporales mostraron interesantes resultados. Conclusiones: Tener un hijo/a con discapacidad provoca en la familia respuestas de estrés y depresión, sin embargo, a pesar de este impacto las familias sienten capacidad de afrontamiento y confianza ante el cuidado del hijo/a.

Introduction

In more than 67,500 Spanish households there is a member with a disability and it is estimated that the number of people with disabilities between 6 and 24 years of age increased by 14% in recent years (INE, 2020). The most frequent types of disability at these ages are neurodevelopmental disorders, of which ADHD, language disorders and learning disorders make up the majority (Alcantud Marin et al., 2017; Carballal Mariño et al., 2018).

The birth of a child brings changes in the family structure, but when the expected child is diagnosed with a pathology and/or disability, the changes are even greater. Thus, a first impact of the birth of a child with a disability among families is the feeling of loss of the idealized and desired child (Chiroque-Pisconte, 2020), and later the situation is felt as unexpected, disturbing, unknown and in some cases even traumatizing (Fernández et al., 2021; Sanderson et al., 2022). Also on other occasions emotional reactions such as shock, fear, fear, depression, anger, sadness, uncertainty, stress, fatigue, restlessness appear (Bujnowska et al., 2021; González Clemente et al., 2021).

In addition, the type or degree of disability presented by the child may be a stressor for families as well (Weitlauf et al., 2020). Along these lines, parents who are caring for a child with autism or cerebral palsy or Down syndrome or behavioral problems show significantly greater symptoms of stress, depression, or anxiety (Cantero-García & Alonso-Tapia, 2017; Hartway, 2016; Scherer et al., 2019; Sharma et al., 2021; Weitlauf et al., 2020).

Some research has even shown that the emotional impact of disability differs according to family structure. So, in the single-parent family compared to the traditional ones the emotional impact and family overload is going to be higher (Tøssebro & Wendelborg, 2017).

Faced with this situation of the birth of a child with a disability, resilience understood as the ability to recover from adverse situations (Luthar, 2006) and coping as the thoughts and behaviors used to manage the internal and external demands of high stress situations (Folkman and Moskowitz, 2004) leads to families with more resilience and/or coping capacity being able to more effectively manage child rearing and family functioning (Cantero-García and Alonso-Tapia, 2017; 2018; Vela and Suarez, 2020).

As a consequence, in many occasions in order to have an optimal, healthy, resilient level of family functioning and a good family climate, families need specialized support where to address difficulties, fear, anxiety, stress, etc., which contributes to improve the well-being of families both in family functioning and child rearing, as well as in family adaptation and reduction of stress and depression symptoms (Cantero-García & Alonso-Tapia, 2017; Bradshaw et al., 2019; Ting et al., 2018).

Therefore, the aim of this study is to analyze the level of stress and depression, family functioning and coping skills experienced by families whose children have a diagnosis of disability. Likewise, the emotional impact experienced by them at different times will be studied. So we expect to find levels of stress, depression and good coping skills. Likewise, we expect to find differences according to family structure and family role.

Method

Participants

This study involved the participation of families with children with disabilities from the ADEMPA early intervention center located in the town of Parla (Madrid). This center is attended by about 214 families, and 59 families volunteered to participate in this study (see Table 1). These families have children with a diagnosis of disability, of whom 69.5% (N=41) are boys compared to 30.5% (N=18) girls. The age range of the children was 3 to 7 years (M=4.88; T.D.=0.81), with a majority of children aged 5 years (54.2%, N=32), 4 years (22%, N=13), 6 years (10%, N=16.9%), 3 years (5.1%, N=3) and 7 years (1.7%, N=1). All the subjects in the sample receive some type of professional support within the center such as speech therapy, physiotherapy, occupational therapy and/or psychotherapy. Likewise, all the children presented a definitive diagnosis of disability, with a prevalence of Autism Spectrum Disorder (ASD) with 64.4% (N=38), followed by Maturity Delay with 27.1% (N=16), Restricted Intrauterine Growth Restriction (RIG) with 3.4% (N=2), Rare Diseases with 3.4% (N=2) and finally there is one case of Autism Spectrum Disorder (ASD) with comorbidity of Attention Deficit Hyperactivity Disorder (ADHD) with 1.7% (N=1).

Table 1

Sociodemographic data of the families

Sociodemographic variables of the families	N (%)
Family type	
Single parent	23 (39%)
Traditional	36 (61%)
Genre	
Male	17 (28.8%)
Female	42 (71.2%)
Age	
Mean (Standard deviation)	40.03 (3.86)
Minimum	29
Maximum	50
Level of education	
Basic education	19 (32.2%)
Baccalaureate	24 (40.7%)
University	16 (27.1%)
Profession	
Senior officials and special bodies of the public administration	5 (8.5%)
Householder	1 (4.3%)
Unemployed	4 (17.4%)
No record	8 (13.7%)
Professional and highly technical staff	1 (1.7%)
Professionals and technicians	11 (18.6%)
Other service workers	27 (45.8%)
Self-employed workers	1 (4.3%)
Other administrative and commercial personnel	1 (4.3%)
Number of children	
1	26 (44.1%)
2	26 (44.1%)
3	5 (8.5%)
4	1 (1.7%)
5	1 (1.7%)
Usual caregiver	
Mother	13 (22%)
Both	46 (78%)

Instruments

All participants who collaborated in the study completed a research battery, which included an ad hoc questionnaire and various standardized scales and inventories.

Ad hoc" questionnaire consisting of three sections. The first collects sociodemographic data on the families, such as: sex, age, educational level, profession, place of residence, number of children, family structure and main caregiver, as well as on the children, such as: sex, age and type of disability. The second asks three closed questions with one option to be marked to find out what emotions they felt at three points in time throughout the process of diagnosing the child's disability (the first at the time the child's disability was diagnosed, the second to find out how they experienced the diagnosis process, and the third refers to the emotion they are currently experiencing). The classification of basic emotions described by Aguado (2014) has been considered, which are surprise, fear, anger, disgust, guilt, sadness, curiosity, admiration, security and joy. In turn, each question includes whether they sought professional help to cope with the situation at each of the 3 points in time. The third section contains 12 Likert-type questions with 5 response alternatives (1=Never, 2=Rarely, 3=Sometimes, 4=Quite often and 5=Very often) on the psychoemotional experiences and emotional impact of families with children with disabilities as proposed by other studies (Fernández et al., 2021; Sanderson et al., 2022).

Perceived Stress Scale (Cohen et al., 1983), in its Spanish version by Remor and Carrobles (2001). It consists of 14 items that measure the degree to which, during the last month, people have felt annoyed or worried or, on the contrary, have felt confident to control their personal problems. The scale is scored between 0-56, with higher scores indicating greater perceived stress. It uses a five-alternative Likert-type response format with 0=Never, 1=Almost never, 2=Once in a while, 3=Often and 4=Very often. Cronbach's Alpha coefficient was 0.84.

Beck Depression Inventory (BDI-II) (Beck et al., 1996), in its Spanish version by Sanz et al. (2003). This instrument provides the presence and severity of depression in adults and adolescents over 13 years of age. It includes 21 items that indicate symptoms such as sadness, crying, loss of pleasure, feelings of failure and guilt, thoughts or desires of suicide, pessimism, among others. The scale scores between 0 and 63, where a score of 18 points would indicate that the person suffers from depression. Cronbach's Alpha = 0.89.

Connor and Davidson Resilience Scale (Connor & Davidson, 2003), based on the Spanish adaptation of Crespo et al. (2014). This instrument is composed of five factors, persistence-tenacity-self-efficacy, control under pressure, adaptability and support networks, control and purpose, and spirituality. The scale consists of 25 items that refer to the person's resilient behaviors in the last month. Responses are Likert-type with 0=Not at all, 1=Rarely, 2=Sometimes, 3=Often and 4=Always. The higher the score in each dimension, the more indicators of resilience the individual shows. Cronbach's Alpha is 0.86.

Family Confidence Scale to help with Child Functioning in routines and family functioning (McWilliam & Garcia-Grau, 2018). Composed of two scales. The first (Con-Fam CAN), refers to the family's confidence in helping the child participate at different times of the day (meals, unstructured play, outings, bath time and bedtime). In each of these moments it should be indicated whether the child "participates", "is autonomous", "communicates" and "behaves appropriately". The second scale (Con-Fam CAF) with 18 Likert-type items from 1= "I am not very sure how I can help with this" to 4= "I am totally confident in how to help my family with this", measures family confidence in aspects related to family functioning in areas such as informational, emotional, material support and family needs. Both Con-Fam CAN and Con-Fam CAF scores are calculated by averaging the scores of each scale. Finally, the total Con-Fam Total scale is the sum of Con-Fam CAN and Con-Fam CAF. Cronbach's Alpha was 0.96.

Procedure

This research consists of an epidemiological, descriptive or observational cross-sectional study.

First, a meeting was held with the management of the ADEMPA Early Intervention Center to find out which families with children with a definitive diagnosis of disability could participate in the research. At this meeting, it was estimated that there were about 80 families who were invited to participate in this research on a voluntary and anonymous basis.

Therefore, these 80 families were given a sealed envelope containing the information sheet about the objective of the study, the measurement instruments and the informed consent form on the day they attended the speech therapy session with their child. In this way, families could carefully read the objective of the research through the information sheet and, subsequently, determine whether or not to participate. The delivery of the envelopes began on March 8, 2022 and ended on April 8, 2022, during which time the families returned the sealed envelopes to the speech therapist in charge of the child's intervention.

Finally, 59 families participated in this study because they submitted the duly signed informed consent form and completed research questionnaires in due time and form.

The Organic Law 3/2018 of December 5, 2018, on Personal Data Protection and Guarantee of Digital Rights has been taken into account at all times, in addition, this research has been approved by the Social Research Ethics Committee of the University Castilla-La Mancha with reference number CEIS-642759-C2B7.

Statistical analysis

Statistical analysis was performed using IBM SPSS Statistic 28.0 software.

The K-S test determined that the sample does not follow a normal data distribution, but that all the variables evaluated follow a probability less than or equal to 0.05. Therefore, for data analysis, the nonparametric Mann-Whitney test was performed, which is the nonparametric test parallel to the t-test for independent samples. A confidence level of .05 has been taken into account for all statistical analyses. In addition, frequency and descriptive distributions (mainly means and standard deviations) and Chi-square tests of independence were used.

Results

Results of the emotional impact and psychoemotional experiences arising from the diagnosis of disability

Table 2 shows the descriptive results on the emotional impact of their child's diagnosis of disability at three points in time (at the time they received the diagnosis, throughout the evaluation and diagnosis process, and at the present time), as well as the support received.

Table 2

Emotions felt at different times when faced with the diagnosis of disability

Variable	N (%)
TIME OF DIAGNOSIS	
What did you feel at the time of diagnosis	
Surprise	5 (8.5%)
Fear	13 (22%)
Rabia	3 (5.1%)
Blame	3 (5.1%)
Sadness	31 (52.2%)
Curiosity	3 (5.1)
Admiration	1 (1.7)
He sought professional help at that time	
Yes	23 (39%)
No	36 (61%)
To which professional did you turn	
Psychologist	21 (35.6%)
Psychiatrist	3 (5.1%)
None	35 (59.3%)
DURING DIAGNOSIS	

What did you feel during the diagnostic process?	
Surprise	1 (1.7%)
Fear	20 (33.9%)
Rabia	3 (5.1%)
Blame	6 (10.2%)
Sadness	18 (30.5%)
Curiosity	6 (10.2%)
Admiration	3 (5.1%)
Security	2 (3.4%)
Sought professional help during the process	
Yes	27 (45.8%)
No	32 (54.2%)
To which professional did you turn	
Psychologist	22 (37.3%)
Psychiatrist	5 (8.5%)
None	32 (54.2%)
AT THE PRESENT TIME	
How do you feel now	
Fear	12 (20.3%)
Rabia	2 (3.4%)
Blame	1 (1.7%)
Sadness	12 (20.3%)
Curiosity	9 (15.3%)
Admiration	10 (16.9%)
Security	11 (18.6%)
Joy	2 (3.4%)
Go now to a professional	
Yes	31 (52.5%)
No	28 (47.5%)
Which professional do you use?	
Psychologist	27 (45.8%)
Psychiatrist	4 (6.8%)
None	28 (47.5%)

In addition, the mean scores for the Likert-type questions related to the psychoemotional experiences arising from the diagnosis of disability can also be seen (see Table 3).

Table 3

Psychoemotional experiences arising from the diagnosis of disability

Variables	Media	SD	Minimum	Maximum
E.P. Did you feel guilty at some point	3.05	1.38	1	5
E.P. Relied on a family member	3.20	1.49	1	5
E.P. You felt rejection because of the birth of your child	1.15	0.61	1	5
E.P. He hid his feelings	2.93	1.51	1	5
E.P. You felt embarrassed to be with your child	1.20	0.51	1	3
E.P. He blamed his partner	1.22	0.81	1	5
E.P. Concealed the situation	1.93	1.4	1	5
E.P. He has felt capable of resolving the situation	3.57	1	1	5
E.P. He was informed of the situation at all times	3.88	1.27	1	5

E.P. He imagined living in such a situation	1.15	0.36	1	2
E.P. He feels that he has had the necessary support	3.50	1.04	1	5
E.P. Believes it has acted appropriately	3.89	0.99	1	5

Results of standardized scales

Table 4 shows the descriptive results for the measurement instruments used in this study.

Table 4
Descriptive results

Standardized Scales	Media	DT	Minimum	Maximum
Total Perceived Stress Scale	32.98	6.02	17	44
Beck Depression Inventory II	19.01	9.57	1	40
Total Resilience Scale	63.18	12.38	40	86
Persistence-Tenacity-Self-Efficacy	19.27	4.88	9	29
Control under pressure	17.91	4.88	5	28
Adaptability-Support Networks	13.44	3.45	8	20
Control and purpose	8.37	2.47	4	19
Spirituality	4.5	2	1	8
Con-Fam Total	2.65	0.62	1.21	3.70
Con-Fam CAN	2.68	0.77	1	4
Con-Fam CAF	2.64	0.63	1.15	3.94

Table 5 shows that there are statistically significant differences between some of the variables in this study.

Table 5
Significant relationships between variables

DIAGNOSIS							
ITEMS	χ2	*p*	**TEA** (n= 38)	**Maturational Delay** (n= 16)	**RIC** (n= 2)	**E. Rare** (n= 2)	**ASD-ADHD** (n= 1)
E.P. Properly acted	16.513	.002	25.37	41.41	50	15.50	12.50
NUMBER OF CHILDREN							
	Z	*p*	**One** (n= 26)	**More than one** (n= 33)			
E.P. Blame partner	-2.608	.009	33.17	27.50			
E.P. Concealed the situation	-2.036	.042	34.44	26.50			

SEEK HELP AT THE TIME OF DIAGNOSIS

	Z	*p*	**YES** (n= 23)	**NO** (n= 36)
E. P. Feeling guilty	-2.677	.007	37.30	25.35

SEEK HELP DURING THE DIAGNOSTIC PROCESS

	Z	*p*	**YES** (n= 27)	**NO** (n= 32)
E.P. Imagine living	-2.036	.038	33.15	27.34

SEEKING HELP TODAY

	Z	*p*	**YES** (n=31)	**NO** (n= 28)
E.P. Feeling guilty	-2.358	.018	34.89	24.59
E.P. Imagine living	-2.352	.019	33.11	26.55

FAMILY TYPE

	Z	*p*	**Single parent** (n= 23)	**Traditional** (n= 36)
E.P. Blame partner	-2.896	.004	33.91	27.50

In addition, statistically significant differences were found between the emotions felt by families during the diagnostic process and at present with some of the variables in this study. Thus, the emotions felt during the diagnostic process are related to the psycho-emotional experience "feeling that I have had the necessary support" (χ2: 16.509; p: 0.021), where the emotions surprise and security have an average score of 53, followed by fear (37.73), guilt (27), sadness (24.67), curiosity (21), and anxiety (21. 25) and anger and admiration (20.50, respectively).

Currently feeling emotions obtained statistically significant differences with the total Con-Fam scores (χ2: 16.035; p: 0.025), where fear prevails with an average score of 42.58, followed by guilt (41), admiration (35.05), security (30.86), sadness and curiosity both emotions with an average of 22.83, joy (20.50) and, finally, with an average score of 6.50, anger.

Similarly, the emotions that families are currently feeling showed statistically significant differences with the Con Fam factors. First, statistically significant differences in the Con Fam CAN (χ2: 14.471; p: 0.043), show guilt with an average of 48, followed by fear (42.13), admiration (42.13), fear (42.13), admiration (32.25), security (29.05), sadness (25.92), happiness (23.75), curiosity (23.28) and anger (3.25). Secondly, the Con Fam CAF (χ2: 15.673; p: 0.028), where again guilt has an average score of 42, followed by fear (41.75), admiration (35.10), followed by security (33.64), anger (21.00), sadness (20.58), curiosity (20.44) and joy (16.50).

Discussion and conclusions

First, all the children participating in this study are diagnosed with Autism Spectrum Disorder (ASD) being the most prevalent. This is one of the most frequent early onset neurodevelopmental disorders today (Alcantud Marin et al., 2017; Carballal Mariño et al., 2018). Also, very prevalent has been the diagnosis of Maturational Delay, which occurs in children who show significant delays in one or more areas of development, compared to peers of the same age, who receive this diagnosis while waiting to achieve the evolutionary milestones of development so that, generally, early care is provided by a multidisciplinary team consisting of speech therapy, occupational therapy, pediatrics, neurology, psychiatry and / or psychology for early addressing these maturational delays (Taboada et al., 2020).

Secondly, many families go through multiple professionals to obtain a diagnosis of what is happening to their child, with pediatricians, neuropediatricians, neonatologists, neurologists and psychologists being the first professionals to establish a diagnosis in most cases (Buffle and Naranjo, 2021; García Toro and Sánchez Gómez, 2019; Onandia-Hinchado, 2022). This evaluative process to provide a definitive diagnosis generates great emotional variability in families (Bujnowska et al., 2021; González Clemente et al., 2021; Hartway, 2016). Thus, our results highlight how at the moment when families received the diagnosis of disability the emotion that most experienced was sadness and fear which seems to be usual as proposed by some studies (Girli, 2018). Likewise, surprise is also an emotion present at the time of diagnosis due to the emotional impact of this news as the diagnosis is perceived as something unexpected that breaks expectations about the desired child (Chiroque-Pisconte, 2020).

During the diagnostic process, the predominant emotions are fear and sadness. Once a disability diagnosis is established, families are plunged into one of the most difficult stages of coping with and coming to terms with the disability diagnosis (Sanderson et al., 2022).

Regarding the emotions they currently feel, fear and sadness continue to appear, but other emotions such as security, admiration and curiosity emerge. So we can think that once time has passed and families have been accepting, adjusting and integrating this situation they feel safe and relieved to continue with the process, where security, admiration and curiosity provide a response of attachment and protection, as well as, generate emotional tranquility in the family environment (Aguado, 2014; Rabba et al., 2019).

These emotional responses in many situations require professional assistance because of the impact on the mental health of families. Thus, our results are clear in this regard since at all times of diagnosis (before the diagnosis, during the process and currently) we found how families have sought professional help, with the psychologist being the one who mostly assists and accompanies families at all three times, as is the case in other studies (Cantero-García & Alonso-Tapia, 2017; Bradshaw et al., 2019; Rabba et al., 2019; Ting et al., 2018). In addition, it is interesting to note that the percentage of families seeking help is gradually increasing, with the highest percentage at the present time. Therefore, it is very important to nurture and provide interventions aimed at mental health, well-being, social support and information for parents with children with disabilities (Cantero-García & Alonso-Tapia, 2017; Bradshaw et al., 2019; Buffle & Naranjo, 2021; Fernández Suárez & Espinoza Soto, 2019).

Thirdly, the psychoemotional experiences experienced by the families in the study after the diagnosis of disability show, on the one hand, high scores in the psychoemotional experiences related to "having acted appropriately", "feeling informed at all times", "feeling able to cope with the situation", "feeling that they had the necessary support" and "support from a relative", and on the other hand, psychoemotional experiences where there was no rejection of the birth of the child or shame for the child or where the partner was blamed or the situation was hidden. Therefore, we can think that families have felt informed, supported and accompanied by the diagnosis of their child's disability and that there are few cases of families showing rejection of their child.

However, the psychoemotional experience "feeling guilty at some point" presents a high score. Thus, in some cases guilt emerges after learning of a child's disability diagnosis, where families begin to question the reasons that may have caused the disability of their children trying to find answers to all their questions (Bradshaw et al., 2019; García Lara and Buere Figueroa, 2017). On the contrary, the psychoemotional experience "imagining living such a situation" has very low scores, so that our results show how families do not expect to live such an event since what is expected is the birth of a child with health and normotypical development (García Toro and Sánchez Gómez, 2019; Girli, 2018).

Fourth, the measurement instruments used for the study reveal the existence of stress. Other studies also find stress in families who have a child with a disability (Cantero-Garcia and Alonso-Tapia, 2018; Scherer et al., 2019; Weitlauf et al., 2020).

Regarding depression, the scores obtained are average; however, other works do find elevated depressive symptoms in families with a child with a disability (Scherer et al., 2019).

Regarding resilience, we observed that it can be considered high, as well as the rest of the factors, so that the families in our study feel able to cope with raising their child with a disability (Vela and Suarez, 2020). However, Chiroque-Pisconte (2020) find low levels of resilience in parents of children with disabilities.

Regarding family confidence, both in total and in the two factors of the scale, average scores were found in the knowledge of how they can help in the child's functioning, as well as in personal skills, confidence and competencies. Other studies have found higher scores (Subiñas-Medina et al., 2022).

Fifth, the statistically significant differences found in some of the variables of the study show how these differences only occurred in the psychoemotional experiences that arise when faced with the diagnosis of disability and in the emotions felt by the families during the diagnostic process and at the present time. Thus, the type of diagnosis was significantly related to the psychoemotional experience "acting correctly", with the highest scores being found in the diagnoses of RIC and Maturity Delay. Therefore, since these are delays, of a temporary and reversible nature, during gestation or in the acquisition of the first developmental milestones, families are focused on the resources, therapies and alternatives necessary to address these delays in their child, hence they feel that they have acted correctly (García Toro & Sánchez Gómez, 2019; Onandia-Hinchado, 2022).

In families with only one child versus those with more than one child, statistically significant differences appeared in the psychoemotional experience of "blaming the partner" and "hiding the situation". This result could indicate how sometimes between the couple fall the causes and blame that has caused the disability, generating conflicts between them, and likewise, sometimes families face the repercussion that the diagnosis of disability may have in their social environment coming to hide the situation (Marsh et al., 2018).

Regarding the search for specialized help, we found that the families who needed it both at the time of diagnosis, during the whole process and at present, are the ones who have more psychoemotional experiences of "feeling guilty" and "imagining living something like this". This result is interesting because, despite having professional help, families feel guilty about the child with a disability and feel that they would never experience something like this (Chiroque-Pisconte, 2020; García Lara and Buere Figueroa, 2017). It is important that the mental health specialist provides families with the strategies, intrapersonal resources and support networks necessary to manage the child's disability and reduce the guilt that this circumstance provokes. For all these reasons, it is recommended to address the mental health of parents with children with disabilities by contributing to improving the well-being of families both in family functioning and parenting and in reducing symptoms of stress and depression (Cantero-García and Alonso-Tapia, 2017; Bradshaw et al., 2019; Ting et al., 2018; Vela and Suarez, 2020).

The family type variable showed a statistically significant difference with the psychoemotional experience "blaming the partner", which could be due to the absence of a parent, lack of affection, lack of socioeconomic resources, or family overload (Tøssebro & Wendelborg, 2017). However, no statistically significant differences in family role between father and mother were found with any of the variables in this study. In previous studies, discrepancies have been observed in the role of the father and the mother, with the majority of the responsibility for the care of the child with a disability falling on the mother (Nunes et al., 2021; Sharma et al., 2021). Therefore, the absence of statistically significant differences would indicate that the child receives the same care from the father and the mother, with co-responsibility in domestic and educational tasks (Chiroque-Pisconte, 2020; Dantas et al., 2019).

With regard to emotions, our results show that during the diagnostic process, the emotions of security and surprise are higher in families that experienced the psychoemotional experience of "having the necessary support". Therefore, apart from perceiving during the disability process the surprise, because of the uncertain future and because of that situation unexpected situation (Rabba et al., 2019), security also appears as an enabling emotion when it comes to feeling safe to face this circumstance and having the necessary support (Aguado, 2014; Rabba et al., 2019).

Likewise, our results show how at the present time the emotions of guilt and fear appear to be related to the questionnaire Con Fam total, Con Fam CAN and Con Fam CAF. The total Con Fam questionnaire refers to family confidence in helping the child participate at different times of the day (meals, unstructured play, outings, bath time, and bedtime), as well as family confidence in aspects related to family functioning in areas such as informational, emotional, material support, and family needs (McWilliam and Garcia-Grau, 2018). Therefore, we can think that families currently feel fear and guilt in order to be confident in their ability to care for their child with a disability (Marsh et al., 2018; Rabba et al., 2019;). However, our results also show how the emotions of admiration and security related to the questionnaire Con Fam total, Con Fam CAN and Con Fam CAF appear at present. Perhaps, the progress their children make, the acceptance of the disability by families, etc., may provide admiration and security to continue acting with family confidence (Rabba et al., 2019; Subiñas-Medina et al., 2022).

With respect to the limitations affecting this study, it is worth highlighting the small sample size, as it only included families attending an early intervention center in the Community of Madrid, restricting a more complete vision and obtaining less significant values. At the same time, the data may not be representative of the families, since we have counted those who come to the center and therefore their degree of involvement and motivation is high. Another important limitation has to do with the small number of fathers with respect to mothers who participated in this research. This fact may be due to the fact that mothers spend the most time with their children. Perhaps the families (fathers and mothers) could have responded differently, but this is something that could not be controlled for and future research would be very interesting to investigate further. Finally, we consider that this study has not assessed the quality of life of families, a dimension that is affected by the presence of a child with a disability and that could be studied in future studies.

In conclusion, this study has shown that the birth of a child with a disability provokes diverse psychoemotional experiences and an emotional impact on the family as stress and depression responses appear; however, despite this impact, families have good resources, coping capacity and confidence in the care of the child. Variables such as type of disability, number of children, help-seeking, family structure and different emotions felt at different times have shown statistically significant relationships.

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