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THE LIFE QUALITY OF ADULTS WITH DISABILITIES: PSYCHOLOGICAL ANALYSIS OF THE SUBJECTIVE INDICATORS[1]

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Abstract

The article examines disabled-since-childhood adults' quality of life. The study reveals a conflict in empirical data: the respondents declare a high level of their life quality but they do not have explicit goals in life and focus on seeking social support in difficult situations. Two groups of the respondents who differently assess their quality of life and control over their lives, have contrasting self-perception and diverge in the existence of their life goals are compared.

Keywords: *quality of life, subjective well-being, meaningful orientations of life, coping strategies, adults with disabilities (disabled-since-childhood adults).*

Introduction

Modern transitive Russian society is distinguished by high dynamism that creates a lot of unresolved problems and difficulties laying down strict requirements on a person as a subject of their own life, his/ her ability to integrate into a rapidly changing society, be successful and reach high quality of life. These requirements are also true for people with disabilities, especially adults.

However, specialists focus on children and adolescents with developmental disorders according to Russian traditional theory and practice of special education and psychological support for people with disabilities. The psychology of adults with disabilities, in its turn, remains a gap and suffers from a profound lack of development at both theoretical and practical levels. Meanwhile, there are apparent inconsistencies in the public policy on people with disabilities aimed at their integration into the society and realities of daily life (poor availability of the cultural environment and peculiarities of public awareness). Considering disabled people's life stories, one can observe that some of them demonstrate high success and adaptiveness and fully realise their potential even if deviations in their psychological and physical development are pronounced. On the other hand, a significant proportion of different people with disabilities adopt the "social invalid" lifestyle on the principle "everybody owes

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me". It makes necessary to study different disabled adults' quality of life and subjective well-being as well as the factors (first, the inner, personal ones) behind their high level.

Theoretical Justification

Now it is difficult to detect any social knowledge area that does not address the issues of people's and individual's quality of life in one way or another. Nevertheless, the number of studies on this subject is rapidly growing while their relevance remains steady (Martyshenko, 2014). The interdisciplinarity of this phenomenon, the impossibility to describe it in terms of one science and the need for a comprehensive study are universally recognised (Goman, 2012; Lebedeva, 2012; Malikova & Pirogov, 2016).

Despite this fact, there is some specification how quality of life in understood according to knowledge area. For example, medicine, holding a leading position in the volume of publications on this subject (Martyshenko, 2014), considers quality of life to be a systematic notion that characterises how individual's physical and mental health influences their different life spheres and a product of the perception and subjective assessment of one's own place in life within a cultural context and a value system in accordance with the goals, expectations, norms and concerns. The notion "health-related quality of life" is common (Karimi & Brazier, 2016). It enables to isolate the parameters describing health condition, healthcare and the quality of medical and psychosocial assistance from the general concept of life quality (Protsenko & Abishev, 2012). Today, according to the documents of the World Health Organization, quality of life is determined by the following indicators: the physical ones (strength, energy, fatigue, pain or ache, discomfort, sleep, rest); the psychological ones (emotions, cognitive functions, self-esteem); independence level (daily activities, productivity); social life (personal relationships, including the sexual ones); environment (safety, ecology, material well-being, the availability and quality of healthcare and information, learning opportunities, daily routine). There is still a different approach (Vasserman, Trifonova, & Fedorova, 2008; Novik, Ionova, & Kaynd, 1999) which deals with life quality from the perspective of how a subject perceives one's health status and ability to lead a full-fledged life as well as the condition of physical, psychological and social well-being as its basic criterion.

In economic and socio-economic sciences, quality of life is listed among universal criteria that both more accurately reflect real socio-economic, cultural and political state of society and consider the significance of individual's or social group's subjective assessment concerning different aspects of one's life (Baranova, 2005). The authors analyse such notions as "quality of life", "Human Development Index", "Legatum Prosperity Index", "Happy Planet Index" and others. The criteria for assessing the quality of life comprise an extensive list of varieties, including the average life expectancy at birth, the level of the population's education, real gross domestic product, material benefits, the level of satisfaction of individual's needs and interests, environmental quality, social security and well-being, etc. The opportunity to unlock spiritual and moral potential, to develop one's creative abilities quite fully, conscious performance of one's spiritual, moral and professional duty is stressed within the sociological approach (Golubeva, 2016).

Almost all researchers in psychology (Zarakovsky, 2009; Karimi & Brazier, 2016; Spilker, 1990; Perry & Felce, 2002) acknowledge the existence of two aspects in the assessment concerning psychological interpretation of life quality: the objective (social groups' and people's quality of life; their physical and emotional condition; activity; material, social, marital and employment status; social interaction; etc.) and the subjective ones. Finally, as quality is always related to some standard or ideal, social comparison can cause low personal perception of one's well-being. In this regard, emotional well-being, the sense of happiness, positive self-perception (Shiovitz-Ezra, Leitsch, Graber, & Karraker, 2009), subjective attitude towards life events (Yudina, 2017), the existence of life meaning and values (Lebedeva, 2012; Leontiev, 2014; Savchenko & Golovina, 2006), intimate relationships as opposed to loneliness (Shiovitz-Ezra, Leitsch, Graber, & Karraker, 2009) and social support quality (Khazova, 2015; Leontiev, 2014) are pointed out.

Many authors recognise the key role of subjective well-being, life satisfaction and one's personal active lifestyle in the structure of life quality. Of a particular interest, in this respect, are studies on personal development under difficult conditions (having disabilities) that prove active "individual work" to encourage "the movement to compensation defects and to quality of life", where the situation of disability is seen as a "challenge" and an incentive to self-improvement. Referring to this strategy of self-regulation as "healthy", A. A. Lebedeva (2012) contrasts it with "invalid strategy" where disablement becomes "advantageous" for a subject and personal self-regulation is based on one's physical disability (Lebedeva, 2012).

Thus, the theoretical analysis enabled to introduce the following variables in the research: subjective assessments of one's life quality and health condition, physical and mental well-being, social well-being, the perception micro-social support quality, self-perception, subjective well-being, life meaningful orientations, coping strategies as a reflection of subject's activity to overcome daily difficulties and stress.

The research object: subjective indicators of the life quality of adults with disabilities.

The aim of the research: to define and describe the features of subjective indicators emphasised by adults with disabilities.

Participants of the Research

The research was undertaken in Kostroma (Russia), a city with a population of about 270,000 people. Romanovsky Rehabilitation Centre for People with Disabilities in Kostroma region, Kostroma Public Youth Organisation of People with Disabilities "Belyi Delfin", the Club for People with Disabilities "Akvamarin", Oktyabrsky Gerontological Centre and The All Russia Association of the Blind Kostroma Regional Office were chosen as bases for the research on the ground of the serial selection method with a subsequent total survey. There were 146 adults with disabilities in these organisations at that moment.

In line with the primary objective of the research, the sample was made up of people with "a person with disabilities" status proved by the Medical-Social Expertise certificate where the cause of the disability is "disabled-since-childhood". This status implies a number of limitations on personal activity: limited abilities to work, learn, communicate, care of oneself, move freely, navigate and maintain self-control.

We adhered to the principle of voluntary participation during our research. At present, the sample does not include people with intellectual or hearing disabilities since in both cases a special adaption of methodologies is necessary to get adequate results, which is currently being brought about by the authors. The rest of the adults with disabilities served as the sample.

The empirical research involved 50 people with disabilities and officially recognised as having "disabled-since-childhood" status. The respondents' age ranges from 17 to 63 (M=37.04; SD=12.43). 18 respondents are women (36% of the sample) and 32 are men (64%). Our research represents people with sensory (eyesight, in particular, 11 individuals, 22%, residual vision less than 0.1%) and mobility disabilities: spastic cerebral palsy, ataxic cerebral palsy, hemiplegia, dyskinetic cerebral palsy, spastic diplegia (39 individuals, 78%).

The internal and external validity of the research lies in the selection of reliable and valid methodologies, a combination of quantitative and qualitative research methods, close control over the research procedure and the comparison of our results with those obtained by other authors.

Research Methods

The following techniques were used in the study:

To study life quality we used the brief questionnaire WHOQOL-BREF which includes six scales and enables to define respondent's subjective assessments of one's life quality (1 question), health (1 question), physical and mental well-being (7 questions), micro-social support (3 questions), social well-being (8 questions), respondent's self-esteem features (6 questions) (Burkovskiy et al., 1998). The answer to each question implies assessment on a scale 1–5: 1 (completely dissatisfied), 2 (dissatisfied), 3 (sometimes satisfied), 4 (satisfied), 5 (completely satisfied).

The Subjective Well-Being Scale designed by M. V. Sokolova (Sokolova, 1996) is used to assess one's subjective well-being and emotional comfort as a marker of subject's life quality. The scale includes 17 questions each of which is to be assessed using the Likert 7-point scale where 1 is "I strongly agree"; 2 is "I agree"; 3 is "I moderately agree"; 4 is "Undecided"; 5 is "I moderately disagree"; 6 is "I disagree"; 7 is " I strongly disagree". The obtained average score is converted to 1–3 as high; 4–7 as average; 8–10 as low subjective well-being.

The Ways of Coping Questionnaire (WCQ; Folkman and Lazarus, 1988) adapted by Kriukova in collaboration (Kriukova & Kuftiak, 2007) is used to define disabled people's eight coping strategies, i.e. the means they use in everyday life to overcome difficulties of different mental activities. The Questionnaire consists of 8 scales: Confronting Coping, Distancing, Self-Control, Seeking Social Support, Accepting Responsibility, Escape-Avoidance, Planned Problem-Solving, Positive Reappraisal. It comprises 48 questions where each answer is assessed on a scale from 0 (never) to 3 (always). The total score on each scale is converted to percentiles.

The Life Meaningful Orientations Test (Leontiev, 2006), which is the Russian adaptation of Purpose-in-Life Test (PIL, Crumbaugh & Maholick, 1964) by D. A. Leontiev (2006), allows to assess existence of goals in one's life and its meaningfulness, satisfaction with self-realisation and subject's control over one's life. The Test includes 20 pairs of conflicting claims for the respondent to choose one that, in their opinion, reflects the reality and to assess it from 1 to 3 (or 0 if both claims are equally true).

The Phenomenological Interview was designed by the authors to obtain detailed data on different aspects and event contents of subject's life (Tikhonova & Adeeva, 2017).

Statistical Analysis

The research data was calculated by using 10.0 Statistica software. The data was also described in terms of descriptive statistics (mean, std. deviation, frequencies). The correlations were calculated by means of the Spearman's Rank Correlation Method. Non-parametric criteria were used for statistical analysis as distribution of the measured phenomenon's indicators did not satisfy normal distribution requirements. The differences between the groups were defined employing the Multifunctional Fisher Criterion, the angular conversion Fischer (φ*). To divide the sample into groups, we used Cluster Analysis (K-mean Clustering Method) in which such characteristics as coping strategies, life quality criteria, life meaningful orientations and subjective well-being level were included.

Results and Discussion

The results of the first stage of the research: general trends. The results of the research on subjective well-being and life quality (Table 1) suggest quite high satisfaction with different aspects of one's life among most adult disabled people.

Table 1. Analysis of well-being and quality of life

Parameter	M	σ
Quality of life	3.49	0.92
Health condition	3.53	1.06
Physical and mental well-being	25.49	4.21
Self-perception	20.80	3.36
Micro-social support	10.61	2.17
Social well-being	26.51	5.16
Subjective well-being	3.92*	2.00

*1–3 as high SWB; 4–7 as average; 8–10 as low

61.9% of the respondents demonstrate high subjective well-being (M=3.43, SD=2.17), 84.8% report satisfactory quality of their lives (M=3.69, SD=0.98) and good health condition (M=3.75, SD=0.93). About 80% of the respondents are characterised with social (M=28.18, SD=5.46), physical and mental well-being (M=26.6, SD=3.69), positive self-perception (M=21.9, SD=3.09) and are satisfied with their micro-social support (M=11.22, SD=2.10). They mention the availability of healthcare, transport services, sport and other recreation facilities; do not confront any big financial problems; have good sleep and high work capability; are satisfied with their cognitive capacities; care about their appearance. Still, there was noted an opposite data situation: 19% of the respondents experience stress, anxiety, absent-mindedness, prone to depression; 18% feel alone and are pessimistic; 23% feel bored and face difficulties with self-organisation and behaviour control.

On the other hand, the results of the research on life meaningful orientations (Table 2) demonstrate lower values for all criteria compared to the test norms (Leontiev, 2006).

Table 2. Analysis of life meaningful orientations

Life meaningful orientations	M	σ	Test norms	
			M	σ
Goals in life	29.07	10.01	38.91	3.2
Living process	26.00	9.73	35.95	4.06
Life result	24.21	7.93	29.83	3.0
Locus of control – I	18.98	6.33	24.65	2.39
Locus of control – life	25.86	9.96	34.59	4.44
Life meaningfulness	92.01	27.97	120.36	10.21

Life meaningfulness criteria suffer the most dramatic decline (M=99.0, SD=27.11). Besides, the results point to: 1) less comprehensive awareness of one's goals in life, life prospects and living at the moment (*Goals in life* scale, M=31.38, SD=9.44); 2) more frequent perception of life as uninteresting and emotionally poor (*Living* scale, M=28.64, SD=9.09); 3) a low level of satisfaction with one's past and life in general (*Life productivity or satisfaction with self-realisation* scale, M=26.48, SD=7.34); 4) the life lacking free choice and opportunity to live in accordance with one's goals and understanding of life meaning (*Locus of control – I* scale, M=20.32, SD=6.53); 5) individual's limited opportunity for conscious control over one's own life (*Locus of control – life* scale, M=27.70, SD=10.86). In general, approximately 60% of disabled adults do not have explicit goals in their lives, 40% are dissatisfied with their current achievements, 60% are unconfident about their opportunities to control their lives by choice. Our data diverges from that acquired by other authors and showing no differences in the structure and expression of disabled and partially disabled adults' values and goals (Leontiev, 2014). This fact is even more interesting since most respondents in our research either attend The All Russia Association of the Blind Regional Office or participate in different sports contests for people with disabilities. The clue to this contradiction is probably disabled people's strong reliance on the quality of social support and little opportunity for them to make independent plans, which influences creation of prospective lives, long-term goals and self-esteem.

The analysis of coping behaviour based on descriptive statistics (Table 3) identified the following strategies as the favourite ones: *Seeking Social Support* strategy (M=55.19, SD=30.31), *Positive Reappraisal* (M=53.68, SD=29.71) and *Planned Problem-Solving* strategy (M=65.93; σ=21.75), *Escapes/Avoidance* (M=44.93; σ=18.91) and *Distancing* (M=47.30; σ=18.01) strategies are among the most frequently used. On the one hand, it is important to note the prevalence of active coping strategies to cope with daily-life difficulties; on the other hand, we can speak about reliance on other people's assistance and support as in other cases.

Table 3. Analysis of coping strategies

Coping strategy	**M**	**σ**	**Test norms**	
			M	**σ**
Confronting Coping	46.57	23.36	53.00	15.61
Distancing	38.89	22.15	52.96	15.55
Self-Control	49.99	25.08	60.38	14.60
Seeking Social Support	54.90	25.55	56.03	19.34
Accepting Responsibility	50.47	29.50	58.40	19.04
Escape-Avoidance	33.81	23.13	46.51	16.30
Planned Problem-Solving	51.73	29.20	63.31	17.16
Positive Reappraisal	49.83	30.69	57.14	15.48

A small number of the correlations of life meaningful orientations with life quality indicators and coping strategies was registered. *Control Locus-I* correlates with general assessment of *Life Quality* (r=0.332, p≤0.05), so does *Control Locus-Life* with *Self-Perception* (r=0.342, p≤0.05). It turns out that positive self-perception, general assessment of life quality in some sense depend upon the assessment of both oneself as a master of one's own life and one's life as the meaningful, controllable and manageable. As for the coping strategies, all three relationships are the ones among *Accepting Responsibility* strategy, the existence of *Goals in Life* (r=0.439, p≤0.05), satisfaction with *Living Process* (r=0.368, p≤0.05, and assessment of oneself as a master of one's own life.

This leads to a contradiction: adults with disabilities are quite successfully adapted, satisfied with their lives and actively cope with but not avoid difficulties according to both formal criteria of life quality established by the WHO and the indicators of subjective well-being. In this regard, Diener (2000) discusses the "paradoxes" of disability, stating that a certain part of people with chronic diseases or developmental disorders are able to maintain and restore quality of life. However, a large part of our respondents do not have any explicit goals and ability to articulate them independently as well as they do not perceive themselves as masters of their own lives and rely on other people's assistance and social support in critical situations.

These results suggest the non-homogeneous nature of this social group, the need to obtain more accurate data description what was done in the second stage of the research.

The results of the second stage of the research: comparative analysis. At the second stage we carried out a cluster analysis as a result of which the sample split into two clusters. The first cluster includes 32 people: 11 women and 21 men, the average age is 41.0 years (min=17, max=63, SD=8.2). The second one consists of 18 people: 10 men and 8 women, the test subjects' average age is 38.4 (min=17, max=65, SD=14.7). Both clusters include people with visual and mobility disabilities as well.

All variable data (21) was in the comparative analysis. However, dramatic differences were noticed only in 14 of them and none were spotted in 7. The comparative analysis on the averages of life quality and subjective well-being unexpectedly gave no significant differences suggesting the idea that all respondents are satisfied with their lives, physical environment and social relationships with their inner circle as well as social support. The data coincides with the general trends described above (Table 1). The received results can be attributed to the similarity of the respondents' life experiences and the level of their claims: living in a situation of poor social contacts related to activity limitations, reduced mobility and activity options, a subject adapts to the actual condition of life and starts to think it completely caters for one's basic needs.

However, the frequency analysis (Table 4) of the data suggests significant differences in the assessment of one's life quality ($\varphi^*=2.688$, $p\leq0.000$) and self-perception ($\varphi^*=2.688$, $p\leq0.000$). Clearly, 15.6% subjectively assess their life quality as high and 6% speak of it as of low in the first cluster. There are virtually no high assessments of one's life quality in the second one, except for one, almost all the respondents (88.9%) assess it the fair one.

Table 4. The frequency analysis of life quality indicators and self-perception by level

Level	Cluster 1 (N=32)		Cluster 2 (N=18)		φ*	p
	N	%	N	%		
Quality of life						
High	5	15.6	0	0	2.688	0.000
Average	25	78.1	16	88.9		
Low	2	6.3	1	11.1		
Self-perception						
High	5	15.6	0	0	2.688	0.000
Average	24	75	12	66.7		
Low	3	9.4	6	33.3		

As for one's self-perception, it is necessary to mention the lack of high assessment and the large percentage (33.3%) of the low ones regarding oneself in general, one's capacities, including the cognitive ones, and the acceptance of one's appearance in the second cluster. It suggests a less positive self-attitude and self-perception among the respondents from this group.

The analysis of the results of coping behaviour diagnosis (Table 5) suggests statistically significant differences in the coping strategy choice, except for the *Accepting Responsibility* strategy (p≤0.08).

Table 5. Analysis of coping strategies by cluster

Parameter	Cluster 1 (N=32)		Cluster 2 (N=18)		F	p
	M	σ	M	σ		
Confronting Coping	56.89	17.14	28.22	21.90	26.34	0.00
Distancing	47.30	18.01	23.92	21.26	17.05	0.00
Self-Control	59.37	17.59	33.32	28.09	16.31	0.00
Seeking Social Support	61.15	19.28	43.81	31.61	5.83	0.02
Accepting Responsibility	55.91	25.94	40.79	33.55	3.16	0.08
Escape-Avoidance	44.93	18.91	14.06	15.62	34.58	0.00
Planned Problem-Solving	65.93	21.75	26.47	23.24	36.11	0.00
Positive Reappraisal	68.54	18.04	16.55	17.04	99.52	0.00

The other seven strategies of coping are more pronounced among the respondents from the first cluster. The *Positive Reappraisal* (rating 1; M=68.54; σ=18.04), *Planned Problem-Solving* (rating 2; M=65.93; σ=21.75) and *Seeking Social Support* (rating 3; M=61.15; σ=19.28) strategies are common for them. Problem *Escape-Avoidance* (rating 8; M=44.93; σ=18.91) and *Distancing* (rating 7; M=47.30; σ=18.01) strategies are the least pronounced. It is worth noting the prevalence of active strategies in a difficult life situation. In general, the results from this duplicate age-appropriate trends.

Such coping strategies as the *Seeking Social Support* (rating 1; M=43.81; σ=31.61), *Accepting Responsibility* (rating 2; M= 40.79; σ=33.55) and *Self-Control* (rating 3; M=33.32; σ=28.09) are the most pronounced among the second cluster's respondents, while the *Positive Reappraisal* (rating 7; M=16.55; σ=17.04) and *Escape-Avoidance* (rating 8; M=14.06; σ=18.91) are the least pronounced. This group of adults is the least active in terms of coping. All respondents' turning to the *Seeking Social Support* strategy under stress results from the need for assistance and often a lack of opportunities to cope with difficulties due to the disabilities. Of particular importance for us is the high prevalence of the ability to reassess a situation and find a positive meaning in terms of self-development among the respondents from the first group who see the world in a more optimistic way and feel chances to change their lives through their own efforts, which helps them to find positive moments even in hard and stressful life situations.

We also found out that such life meaningful orientations as the existence of goals in one's life, the perception of life completeness and event saturation, life meaningfulness in general, self-realisation and life productivity satisfaction as well as the assessments of one's own opportunities to build life in accordance with one's goals were differently pronounced in the groups: the first cluster had them more pronounced (Table 6). Adults with disabilities from the second cluster are less likely to accept the value of living process and more deeply feel their dependence on others and circumstances. Nevertheless, the respondents from both groups perceive life as hardly controllable by an individual, which is probably related to disabilities as it was mentioned above.

Table 6. Analysis of life meaningful orientations by cluster

Parameter	Cluster 1 (N=32)		Cluster 2 (N=18)		F	p
	M	σ	M	σ		
Goals in life	31.78	8.12	24.11	11.60	7.52	0.01
Living process	28.97	7.82	21.33	10.95	8.19	0.01
Life result	26.50	5.39	20.78	10.10	6.87	0.01
Locus of control – I	20.41	5.47	16.56	7.27	4.49	0.04
Locus of control – life	27.09	8.46	23.72	12.39	1.30	0.26
Life meaningfulness	99.72	19.82	79.50	35.80	6.65	0.01

The data was also confirmed by analysis of the interview that allowed to construct broad psychological profiles of each cluster. The respondents from the first cluster (n=32) have the following socio-demographic characteristics: 91% of the respondents are alone and only three of them (9%) have their own families; three respondents stay at a residential care institution, while others live either in families with their parents or separately but receiving their support; two respondents have gained higher education (6%), the four interviewed (12%) have obtained lower secondary education (9 years of school education), fifteen people with disabilities (47%) attended special residential schools. 30% of the respondents are employed, two of them are students and sport is the main activity for the other two.

Most respondents have positive memories of their childhood. This phase of life is perceived as full of events and emotions. The respondents described themselves as being active, energetic, able to stand up for themselves, and having qualities of a leader; no "special nature" or sense of being constrained was mentioned: "*I had a lot of adventures. I felt like a leader among ordinary children", "I was bull-headed".* The group members stress their independence and others' respect and are anxious to become self-reliant and proud of it: "*I was on my own and did not follow anyone around, everybody respected me", "I went to school myself"*. Some of them mention such traits as mischievousness and fiery temper. A small percentage of the respondents (15%) describe their childhood as a period of loneliness and acknowledge adjustment difficulties: "*I did not study or communicate and had no relationships*", *"I took great pains to start feeling okay at a new school".*

Family situations developed in different ways. About 30% of the respondents refer to both parents' and more frequently their fathers' explicitly negative attitude towards them and try not to discuss the relationships with their fathers, still feeling bitter and hurt. Two people (6%) openly speak about the abandonment by their parents: "*They kicked me out as if I were a foundling. My mother resented having given birth to such a child*". One man is still endeavouring to find his mother. Many respondents mentioned their grandmother's support. As adults, these people mostly speak about loneliness and difficulties in building up relationships: *"negative attitude towards people, I can be selfish", "I am single".* Nearly half of the respondents describe friendly and good relationships in their families, especially with their mothers: "*my mother is good and kind", "she supported me"* (21.9%); "*we mutually helped and loved each other in the family*" (9.4%). Not only the relationships with one's parents but also those with teachers and other children and the existence of friends are considered as resourceful: "*very close and good relationships with teachers" (21.9%); "Moscow bikers came and we had a walk together".*

Being adults, the respondents mention emerging isolation *("a private person")* which can be the result of insufficient skills to communicate and the lack of adults' support during their childhood (9.4%). On the other hand, the being private can be regarded as a part of growing up. Speaking about themselves as *"cheeky and prone to quarrel about trifles"* children, the respondents speak about changes in their characters related to greater control, adequate assessment of events and independence: "*I became more level-headed and tried to do what my parents said",* independent (9.4%), *"I became more careful*". The respondents mention self-control and rationality as significant traits: *"I do not go mad about anything*".

The behaviour is characterised by some degree of insistence and activity but, at the same time, there are no established patterns of one's behaviour in a difficult life situation. On the one hand, the avoidance of an open conflict: *"I keep silent and so does she (my mother) – that is the kind of personality it is", "I do not want to speak about (sad) events*" (12.5%); on the other hand, quite hostile reactions can be detected: "*I am a good guy if everyone treats me well*".

It is worth noting that a lot of the respondents experience positive reappraisal of life events related to disabilities: "*I see life in a different light (after my injury)", "I had felt worse, the surgery was performed, and now everything is alright", "my resentment is fading away while my life is going on".* Some answers emphasise the importance of a membership in a public organisation where the admission played an important role in the assessment of one's life situation: *"sport has had a beneficial influence. Now I have a lot of friends", "I am as good as the healthy members", "I came to "Belyi Delfin" (the name of a club) – now all is okay".*

A sufficient level of self-control, self-criticism and ability to correct one's mistakes are observed in the group: "*It is my fault that everything happened that way, that such a mistake was made*", "*I went to evening classes myself and got rid of a "fool" name-tag*", "*I started going in for sports, though had no interest, but I managed it", "I sought to study and acquire a profession".*

A lot of the respondents describe their lives as rich and define the range of their interests that often include nature and communication: "*a lot of friends"* (9.4%), "*I like travelling, forests and animals"* (6.2%), "*I focused on helping everyone in the special residential school*". The group members with higher education or sporting achievements to a greater degree seek to ignore disabilities: "*I studied and worked, I do not want to settle down for this", "I pursued everything I succeeded in", "I have no limitations for my life*". It is interesting that these people mention their achievements of objective significance and can assess their contribution to them: "*academic success is notable*", "*I can dig up gardens"*, "*I am a member of Russian national arm-wrestling team*", "*I am as good as healthy people, graduated from a university, now I work*", "*My character is stronger, more forceful. I wanted to be a nurse, so I did*". The relative diversity of life goals and positive reappraisal of one's life situation can be identified: "*I want to make my dream come true: a family, children, love*" (9.4%), "*I am a Paralympic sportsman, I want to become a coach and attend competitions"; "I want to join Russian nation powerlifting team", "I want to enter a university", "I want to find a job", "I want to be* *a father*". Nonetheless, 12% found it difficult to articulate their expectations and goals: "*I cannot imagine my future*".

This group has a code named "hypersthenic", the one with a high level of vital forces and psychological manifestations, the one that is extremely active and productive.

The second cluster (n=18) comprises hyposthenic respondents. Here only one person had higher education, three people (16.7%) completed only elementary education (the respondents reported "four years of school" themselves), six of them (33.3%) had lower secondary education (9 years of school education). Most respondents have mobility disabilities (four of them do not move independently but with other people's assistance and assisting equipment), eight people stay in residential institutions (44.4%), two respondents live independently, the rest (44.4%) live in families with their parents. The majority of the interviewed have no families of their own, only two respondents (11%) have relationships and one person is a widower.

The greater part of the respondents evoke relatively numerous childhood memories and past life (only there respondents, 16.6%, did not manage to describe their childhood). Their contents have pronounced negative undertone, helplessness, developmental difficulties, passivity, adjustment problems in childhood being stressed: "*I could not speak", "I was utterly stupid", "it took me long to sit or keep my head up, I started walking late", "I always stayed at home, in my bed*". Only minor part of the respondents mention their vitality and activity: "*I was a leader*", *"I was active and liked dynamic games*". Current self-perception contrasts with the self-image from the past: gained self-reliance and independence from one's relatives are stressed: "*I believe in myself and became independent*", *"self-reliant, I do everything myself and work hard*", "*I am engaged in public work and help others*".

Reactions of distraction, passive adjustment and emotional processing prevail in the behaviour: *"I was expelled from my school – I did not make a fuss", "I was on my own", "sewing and embroidering do not let me to get bored", "I like watching streets through my window", "I cry for a long time".* Just 11% refer to active forms of their behaviour in difficult life situations, but it represents hardly a meaningful and impulsive activity: "*I could do something rash, recklessly", "I ran away*".

The relationships with one's inner circle is currently limited to social networks, irregular contacts with one's relatives and friends; there is social distance: "*I look for communication in social nets", "I am hardly in touch with my relatives, sometimes I write them", "I communicate only with my relatives", "I get on well in a team, but I have no friends, only acquaintances".* Notwithstanding, the relatives' attitudes in the past are marked with compassion for the respondents and strong attachment to the close ones: *"My father felt terribly sorry for me, he cried because of me", "Everybody wanted to look after me*"; a sense of gratitude and guilt for the impossibility to thank and improve old relationships is observed: *"I always wanted to say "Thank you" to my mom for her care", "My mother died – nobody needs me since then", "the quarrel with my father and no contact with him for several years".*

A considerable number of the respondents experienced hope and healing (of variable duration), frustration (felt by their relatives, too), which implies reactions of disorder denial in the families: "*I was taken to healers until 10, they thought I would get better*"; "*I was taken to doctors – they hoped these doctors would cure me*", "*I had a lot of surgery operations, everybody hoped for the best but I knew it would not help".* The respondents seldom use positive reinterpretation but draw attention to the opportunity of personal growth than achievements through one's pain and loss: "*I lost all my relatives but I became independent*", *"I underwent a lot of surgeries but I started walking myself".*

Life goals of many respondents are not clear but practical and are meant to maintain one's position in life, i.e. the focus on stability is pronounced: *"Everything will be this way in my life, no changes, there is nothing to expect"; "one cannot discover their fate"; "I will live the way I will be able to"*. However, there is also a clear socially approved focus among life goals – family, home, work. The living process is scarcely reflected in the mindsets of the interviewed from this group, they mainly focus on their past, and, as it was already stated, the respondents have no clear picture of their future. They evaluate their own activity and opportunity to shape their destiny as a low one, passive life's philosophy and as light degree of subjectivity can be observed: the respondents see themselves as objects influenced by other people: *"I was taught how to wash and make the bed"; "They taught me to read, write, sew, embroider and draw"; "I did not decide anything"*.

Either recognised, documented achievements, i.e. certificates, medals, awards, medal positions, or more "minor" ones that reflect an increase in the level of one's life competence, such as *"I learned to cook and knit"*, *"I can play the guitar and I write poems"*, *"I became familiar with computer"*, "*I learned to paint and plaster walls",* are mentioned as statuses acquired at this point of life. Two respondents fully describe their social statuses, posts and demonstrate their social significance.

We characterise this group as hyposthenic with a low level of psychological manifestations, activity, productivity and vitality.

Conclusions

The results from the first stage of the study revealed the contradiction between a quite high level of subjective well-being and life quality declared by people with disabilities residing in Russian provincial towns and a lack of clear goals, opportunities to control their lives and cope with difficulties and dissatisfaction with one's achievements.

This allowed to spot two groups of people with disabilities. The respondents from the second group, the so-called hyposthenic one with a low level of psychological manifestations and productivity, have dominant average level of life quality assessment and low assessment of themselves and their capacities; they are more focused to receive social support. The first group, the very productive and hypersthenic one with greater vital forces, highly assess quality of life and opportunities to control their lives, have positive self-perception and goals in life, use active strategies of coping, perceive life as a rich process and are more completely satisfied with self-realisation. The most important thing is that positive reappraisal of a traumatic experience related to disabilities prevails in this group.

It is worth noting that the research was conducted in the regional centre with an average population rate; therefore, the received results will be relevant to this type of Russian cities. The results obtained in polyfunctional cities with a larger population will, probably, be attributed with different features.

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THE LIFE QUALITY OF ADULTS WITH DISABILITIES: PSYCHOLOGICAL ANALYSIS OF THE SUBJECTIVE INDICATORS

Summary

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The article examines disabled-since-childhood adults' quality of life and subjective well-being (n=50). The work briefly analyses main approaches to the current study of the issue in terms of human sciences. As a result of the analysis, central aspects of the study on life quality were detected: subjective assessment of one's life quality and health condition, physical and mental well-being, social well-being, the perception micro-social support quality, self-perception, subjective well-being, life meaningful orientations, coping strategies as a reflection of subject's activity to overcome daily difficulties and stress.

The following techniques were used in the study: the brief questionnaire WHOQOL-BREF includes six scales and enables to define respondent's subjective assessment of one's life quality, health condition, physical and mental well-being, micro-social support, social well-being, respondent's self-esteem features (Burkovskiy et al., 1998). The Subjective Well-Being Scale designed by M. V. Sokolova (Sokolova, 1996) is used to assess one's subjective well-being and emotional comfort as a marker of subject's life quality. The Ways of Coping Questionnaire (WCQ; Folkman and Lazarus, 1988) adapted by Kriukova in collaboration (Kriukova & Kuftiak, 2007) is used to define disabled people's eight coping strategies, i.e. the means they use in everyday life to overcome difficulties of different mental activities. The Life Meaningful Orientations Test (Тест смысложизненных ориентаций (СЖО) (Leontiev, 2006), which is the Russian adaptation of Purpose-in-Life Test (PIL, Crumbaugh & Maholick, 1964) by Leontiev D. A. (2006), allows to assess existence of goals in one's life and its meaningfulness, self-realisation satisfaction and subject's control over one's life. The Phenomenological Interview was designed by the authors to obtain the detailed data on different aspects and event contents of subject's life (Tikhonova & Adeeva, 2017).

The empirical study was undertaken in two steps.

We collected conflicting data at the first stage. On the one hand, the respondents declare quite a high level of their life quality, which suggests good adjustment and life satisfaction. On the other hand, they do not have explicit goals in life, are dissatisfied with their current achievements, report lack of capacities to control their lives and focus on seeking social support in difficult situations.

The respondents were divided into two clusters at the second stage of the study. The statistically reliable differences between them are analysed.

The members from the first cluster (n=32) more often assess their life quality as high, they have more positive self-perception. This group has a code named "hypersthenic", i.e. the one with a high level of vital forces and psychological manifestations, the one that is extremely active and productive.

The respondents from the second cluster (n=18) have a dominant average level of life quality assessment and low assessment of themselves and their capacities. This group has a code named "hyposthenic".

The coping strategy *Seeking Social Support* is significant for both clusters. Nevertheless, active strategies of one's behaviour in difficult situations and positive reappraisal of a traumatic experience related to disabilities are prevailing in the first cluster. The respondents from this group have goals in life, perceive their lives as a rich process, are more satisfied with self-realisation and rate the opportunities to control their lives higher.

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