The Child Behavior Checklist was used to examine the relationship between child behavior problems and various positive and negative stress and support outcomes in 100 Canadian parents of children with intellectual disability (ID). The highest scores were observed on the Thought, Attention, and Social Problems subscales, suggesting the Internalizing and Externalizing broad-band scales may underestimate behavior problems in children with ID. The parents of the 43% of children with clinically significant scores on the Total Problems scale reported more stress and lower levels of well-being, social support, and family-centered school services than the parents of the children without clinically significant scores on the Total Problems scale; however, their levels of empowerment were similar. Parents who reported both Internalizing and Externalizing problems in their children reported the most negative experiences.

Keywords: behavior problems, Child Behavior Checklist (CBCL), children, developmental disability, developmental disorder, empowerment, family-centered services, intellectual disability, mental retardation, parent stress, psychiatric disorder

An intellectual disability (ID) is defined as a significant limitation in both intellectual functioning and conceptual, social and practical adaptive skills, originating before the age of 18. This disability manifests as a lowered ability to cope with common life demands and the failure to meet the standards of personal independence expected for the individual in at least two of the following domains: communication, self-care, domestic skills, social skills, self-direction, community, academic skills, work, leisure, and health and safety.

Individuals with ID are at higher risk than individuals without disabilities for developing a psychiatric disorder. Research has reported the prevalence of mental health problems to occur in approximately 10 to 40% of individuals with ID. Studies have also shown a high incidence of clinically significant behavior problems in children with ID. Behavior problems may begin to develop in children with ID as young as two-years-old and remain stable across time, possibly developing into a dual diagnosis in adulthood. Behavior problems in children are most often referred to as being either internalizing or externalizing in nature, and can include behaviors that are a danger to oneself or to others, such as self-injury, self-isolating or biting and hitting. In this study, the prevalence of behavior problems in a Canadian sample of children with ID will be reported.

Parents of children with ID have been shown to experience more stress than parents of children without disabilities, as well as higher incidence of socio-economic disadvantage, physical illness, and mental health effects including worry, tiredness, and depression. Previous studies have focused on the characteristics of the child, such as age, type of disability, and level of disability to determine the relationship of these characteristics to parental adaptation. An important focus of research is the mitigation of maladaptation through the use of positive, proactive coping mechanisms. As well, many researchers have examined the use of formal and informal support as a buffer for family maladaptation. Child behavior problems have been shown to impact family outcomes in families of children with ID. Research has shown that the severity of a child’s behavior problems is an important contributor to a variety of outcomes, including parental stress and coping. A strong negative relationship between child behavior problems and parent stress has been shown to account for differences in parent stress regardless of ID diagnostic status or specific etiological diagnosis.

Furthermore, mothers who are more stressed are more likely to be users of formal...
support services, including mental health, physical health, and community services, straining our social service systems. The purpose of the current study is to examine the relationship between child behavior problems and various positive and negative stress- and support-related outcomes in Canadian parents of children with ID.

Despite findings that parents of individuals with behavior problems actively seek help from medical, psychological, and behavioral services, the research regarding the relationship between child behavior and formal resources has been variable. Using the Double ABCX model Orr, et al. found that behavior problems did not significantly predict family resources although they did predict an outcome of parental stress as well as the parents’ ability to reframe their perception of the stressor. Herman and Marcenko also found that the amount of care required by children with a disability did not predict the use or quality of informal or formal support services. However, Floyd and Gallagher found that increased utilization of formal services was related to the presence of child behavior problems, regardless of ID status. Floyd and Gallagher argue that correlations between care demands and service use may be attenuated by the helping nature of the services themselves; thus, parents who have more demands receive more services, thereby reducing their demands. It may also be argued that the more important service use variable concerns the degree to which the parent finds the service useful or helpful.

Particularly relevant to the experiences of parents of young children with ID is the nature of service delivery in the school system. Current Canadian law has confirmed that school boards must accommodate the needs of children with developmental disabilities in order to provide an appropriate educational environment. As such, both segregated and integrated classrooms continue to exist in Canada and, in each setting, the school must develop an individualized program. Parents are expected to participate in this process. They are encouraged to speak out for their child’s needs, which can be an empowering experience. The degree to which the schools are family-centered in their interactions with families is especially important. The relevant goals of family-centered practices include the provision of emotional and educational supports to families, opportunities to participate in services and make decisions and the enhancement of family strengths and capabilities. These goals are achieved through an interaction style that is family-oriented, positive, sensitive, responsive, and friendly. The family-centered approach respects the knowledge and competencies of parents and is designed to involve parents in decision-making. The authors posit that family-centeredness is critical in the school system, where parents are expected to participate in educational decisions for their children. Parents viewed the more family-centered practice descriptions as being more ideal than descriptions of practices that were less family-centered. The current study explored whether the presence of clinically significant behavior problems is related to parents’ perceptions of family-centered school services.

The value of social support is described frequently in studies of parental stress and coping. Research has shown that being connected to informal sources of support can “buffer” the effects of a stressor. Intagliata and Doyle submit that parent groups may be popular because of the social support provided by “a very special group of others all of whom share the same types of stress and burden as they do.” A recent review of the literature on social support and outcomes in mothers of children with autism highlighted the benefit of social support, as compared to more formal sources of support, as a buffer for parental stress. Shin and Crittenden found that maladaptive behavior predicted decreased social support in American parents of children with ID, but did not predict social support at all in a Korean sample. The current study will explored the differences in social support in parents of children with ID with and without behavior problems.

Recently, researchers have argued for an increase in studies examining positive outcomes in families of children with disabilities. Glidden argued that “positive outcomes can coexist and even be orthogonal to negative outcomes but may never get measured if investigators are not hypothesizing that they are present.” An example of a positive outcome is family empowerment. Family empowerment has been defined as: “...an intentional, ongoing process... through which people lacking an equal share of valued resources gain greater access to and control over those resources.” Empowerment outcomes include intrapersonal...
(beliefs about control, self-efficacy, and perceived competence), interactional (the individual's relationship to their social environment), and behavioral (the person's actions taken to exert some control over the environment) components. A correlational analysis indicated that higher levels of empowerment were found to be significantly related to lower parental stress, more flexible and adaptable family functioning, lower stress due to the child, parental employment, and higher parental education. Self-efficacy, which can be viewed as a component of empowerment, has been found to be strongly related to child behavior problems in mothers of children with autism. In addition to examining differences in negative family outcomes such as stress, this paper will contribute to the literature by examining the positive outcome of empowerment for parents of children with ID with and without behavior problems.

**Method**

**Participants**

The presence of an ID was assessed using four questions. The first asked the parents to list any diagnoses that the child had received. The parents were then asked if the child was in a special school or class, whether or not the child had been identified as an exceptional student, and whether or not the child had an Individualized Education Plan (IEP). Children with a diagnosis of an ID and/or who had been identified by their school as having an ID were included in the study. Children whose diagnostic or IEP status was unclear or clearly indicated that the child did not have an ID were excluded from the study. Children were not directly assessed by the research team; therefore, the intellectual level and specific adaptive behavior skills of the sample are unknown. Participants included 100 parents of children with ID from across Canada. The majority of parents were from Ontario (82%), 15% were from the West Coast of Canada (British Columbia, Alberta, and Manitoba), and 3% were from New Brunswick. The two most common diagnoses were autism (38%) and Down syndrome (32%). An additional 5% had a diagnosis of cerebral palsy or spina bifida, while 13% had another diagnosis, such as fragile X syndrome or fetal alcohol syndrome. The remaining 12% had a disability due to an unknown cause. The children had a mean age of 8.61 (SD = 2.63) 70% of which were boys. Twenty-seven percent of the children were in a special class or school and of those, 70% were in a segregated developmental program, whereas 22% were in a developmental program with integration.

Each participant family chose either the mother or the father to complete the questionnaires and mothers formed the majority of the respondents (97%), with a mean age of 40.32 years (SD = 5.45). The majority of parents were married, remarried or in a common-law relationship (85%). The parents were highly educated, with 69% having at least a college or university education. Only 16% had a high school education or less. Socioeconomic status (SES) was calculated using Hollingshead's Four-Factor Index of Social Status, revealing a mean SES of 48.19 (SD = 12.33; maximum SES = 66), indicating a high-SES sample.

**Procedure**

Participants were recruited through several organizations serving individuals with disabilities, local school boards, list-serves and websites, and through posters and advertisements about the study. Parents who were interested in participating contacted the researcher by phone or by email. The questionnaire package took approximately one to two hours to complete. Questionnaire packages were mailed or delivered personally to families who then returned their packages once completed.

**Measures**

**Demographics**

A demographic questionnaire included questions relating to the child, the parent completing the questionnaire, and the rest of the family.

- *The Child Behavior Checklist*

The Child Behavior Checklist (CBCL) is a 113-item checklist that measures children's competencies and problems as reported by their primary caregiver. Nine subscales reflect syndromes, or groupings of symptoms which have been shown to empirically co-occur. Internalizing subscales include Withdrawn, Somatic Complaints, and Anxious/Depressed. Externalizing subscales include Delinquent Behavior and Aggressive Behavior. The CBCL employs T-scores, in reference to age and gender norms, so that scores can be compared across age groups. Norms for this version of the CBCL were only available for children without disabilities.
Social Problems, Thought Problems, Attention Problems and Other Problems are also measured. As well, a Total problem score is measured.

A review by Embregts states that the CBCL has frequently been used with children with intellectual disabilities; however, the instrument was not normed on a population of children with ID. A factor analysis conducted on the CBCL by Borthwick-Duffy, et al. found that the broad-band factor structure was confirmed for children with developmental disabilities. A recent re-examination of the reliability of the subscales of the CBCL for children with ID, using parents as respondents, found adequate internal consistency for all narrow-band and broad-band scales. Although Achenbach recommends using raw scores for statistical research with the syndrome scales, the Internalizing, Externalizing, and Total Problems scales can be compared using T-scores, to prevent the age and sex variables from being confounded with other variables.

- **The Parenting Stress Index**

  The Parenting Stress Index (PSI) is a 120-item self-report instrument developed to measure stress in parent and child domains, and has been used with families of children with developmental disabilities. The Child Domain consists of six subscales: Adaptability, Acceptability, Demandingness, Mood, Distractibility/Hyperactivity, and Reinforces Parents. The Parent Domain consists of seven subscales: Depression, Attachment, Restriction of Role, Sense of Competence, Social Isolation, Relationship with Spouse, and Parental Health. The internal consistency of the PSI subscales ranged from .70 to .83 for the subscales of the Child Domain and from .70 to .84 in the Parent Domain. Factor analytic studies have supported the structure of the PSI and it has been validated in studies with parents of children both with and without intellectual disabilities.

- **The Family-Centered Elementary School Practices Scale**

  The Family-Centered Elementary School Practices Scale (FCESPS) is a 20-item scale designed to measure family-centered practices in elementary schools. Fourteen items address general family-centered school practices, and six items address family-centered special education practices. Each item on the scale consists of five statements reflecting different levels of family-centered practice. Parents are asked to select the statement that best reflects the typical practice, and a statement that reflects the practices that they would consider to be ideal.

  The internal consistency of the scale was found to be adequate (α = .90). The construct validity of the measure was assessed by comparing it to the Helpgiving Practices Scale. Moderately large correlations were found. The authors conclude that the FCESPS is a reasonable measure of perceptions of family-centered practices in elementary schools for both parents of children with and without developmental disabilities.

- **The Social Support Index**

  The Social Support Index (SSI) is a 17-item instrument that uses a 5-point Likert scale ranging from Strongly Disagree to Strongly Agree. The SSI was not specifically designed for families of children with intellectual disabilities; however, it measures the degree to which families view their community as a source of support. The internal reliability of the SSI has been found to be adequate (α = .82), with test-retest reliability of r = .83.

- **The Family Member Well-Being Index**

  The Family Member Well-Being Index (FMWB) is an 8-item measure of the family members’ well-being in the areas of health, tension, energy, cheerfulness, fear, anger, sadness, and general concern. This 8-item scale, which was not developed specifically for use with families of children with intellectual disabilities, has been found to have adequate reliability (α = .86) and validity.

- **The Family Empowerment Scale**

  The Family Empowerment Scale (FES) is a 34-item instrument developed to assess empowerment in families whose children have “emotional disabilities.” The framework of the questionnaire consists of two dimensions. The first dimension reflects three levels of empowerment: (a) Family, (b) Service System, and (c) Community/Political. Only the family level was used in this analysis, reflecting the ability to manage day-to-day situations. The second dimension reflects the expression of empowerment: (a) Attitudes, (b) Knowledge, and (c) Behaviors. Responses fall on a 5-point Likert scale ranging from Not True at All to Very True.
The psychometric properties of the questionnaire were examined in a study of 440 parents of children with emotional and behavioral disorders. The scale was found to have adequate internal consistency for each of the three subscales (Family: α = .88; Service System: α = .87; and Community/Political: α = .88). The test-retest reliability (N = 107) was also found to be adequate for each of the three subscales (Family: r = .83; Service System: r = .77; and Community/Political: r = .85) over a 3- to 4-week interval. Validity of the scale was assessed through a factor analysis, which supported the correspondence of the Level dimension of the conceptual framework. As well, the questionnaire was found to significantly discriminate parents who were involved in a variety of advocacy-related activities from those who were not. The FES has been also been successfully used in studies involving families of children with ID.

RESULTS

The percentage of children reported by their parent to have problems within the clinically significant range on each of the narrow-band scales on the CBCL is presented in Figure 1. On the broad-band scales of the CBCL, 14% of parents reported that their child had only Internalizing Problems in the clinical range, 11% reported only Externalizing Problems in the clinical range, and 7% reported the presence of both clinically significant Internalizing and Externalizing Problems. Forty-three percent of the children were reported by their parents to have a Total Problems scale score in the clinically significant range.

Due to the large number of identified children with Down syndrome (n = 32) and autism (n = 38), it was possible to compare the two groups on the narrow-band scales of the CBCL to determine the differences in behavior problems by diagnosis. The mean age of the children in the autism group was 8.13 (SD = 2.81), which did not differ (t(67) = 0.74, ns) from the mean age of the children in the Down syndrome group (M = 8.63, SD = 2.65). The results of T-scores presented in Figure 2 demonstrate that parents of children with autism report significantly more behavior problems on all scales except for the Delinquent Behavior subscale.

Participants were separated into two groups, depending on whether their Total Problems Scale score was in the clinical range (Behavior Problem (BP) group; n = 43) or not (No Behavior Problem (No BP) group; n = 57). The children in the two groups did not differ in age (t(98) = -.75, ns). The no BP group (M = 50.52, SD = 11.39) had a higher SES (t = 2.09, p < .05) than the BP group (M = 45.31, SD = 12.97); however, both groups were found to be in the middle class range. A Chi-square analysis revealed that there was no significant difference in the distribution of boys and girls between the two groups (χ² (1) = 0.36, ns).

T-tests were run to determine differences in the outcome variables based on Total Problems status. Not surprisingly, parents of children with BP (M = 151.11, SD = 21.02) reported more stress on the Child Domain of the PSI, t(98) = -7.62, p < .001, than parents of children without BP (M = 119.07, SD = 20.66). Furthermore, parents of children with BP (M = 141.86, SD = 24.89) reported more stress on the Parent Domain of the PSI, t (98) = -3.63, p < .001, than parents of children without BP (M = 125.23, SD = 20.83). Parents of children with BP (M = 40.53, SD = 15.56) also reported significantly less overall well-being on the Family Member Well-Being scale, t(98) = 2.21, p < .05, than parents of children without BP (M = 46.86, SD = 13.07).

In regard to informal sources of support, the difference between the groups on the SSI was not significant, t(98) = 0.72. Parents of children with BP (M = 51.05, SD = 12.28) reported that their typical school services were significantly less family-centered, t(98) = 3.00, p < .01, than parents of children without BP (M = 43.60, SD = 12.27). However, the difference between the groups with regard to their ideal school services was not significant, t(98) = 0.30. These findings suggest that parents of children with BP perceived more disparity than parents of children without BP between the services that they were currently receiving and their ideal level of services.

Despite reporting more stress, less well-being, and less social support than parents of children without BP, parents of children with BP reported similar levels of empowerment on each of the Family (t(98) = 0.81, ns), Service System (t(98) = 1.22, ns), and Community/Political (t(98) = 0.22) subscales of the Family Empowerment Scale.

To further examine the role of behavior problems, the children were separated into four groups depending on whether they had clinically significant Internalizing problems only (n = 14), Externalizing problems only (n = 11), both Internalizing and Externalizing problems (n = 7), or no behavior problems (n = 57); children with Total problem scores in the clinical range were...
**Figure 1. Percentage of Children With Clinically Significant Scores on the Subscales of the CBCL**

![](image1)

**Figure 2. T-Scores on the Subscales of the CBCL for Children With Down Syndrome (n=32) and Autism (n=38)**

![](image2)

*p < .05, **p < .01, ***p < .001.
excluded from this group, even though they did not have Internalizing or Externalizing scores in the clinically significant range). Table 1 contains the findings for the analyses. Post-hoc analyses of significant results revealed that parents who reported both externalizing and internalizing problems experienced more stress on the Parent and Child Domains of the PSI, lower levels of social support, and lower family empowerment than the other three groups. Parents of children with neither internalizing nor externalizing behaviors reported the least stress. Parents of children with internalizing and externalizing behavior problems reported equivalent levels of stress, social support, and empowerment. One interesting finding was that parents of children with internalizing behavior problems reported lower levels of family-centered school services than parents of children with externalizing behavior problems or neither type of behavior problems. Similarly, parents of children with both types of behavior problems also reported lower levels of family-centered school services.

**DISCUSSION**

Consistent with estimates from previous studies both in the US and Canada investigating behavior problems in children with ID, 6,7,24 43% of the parents in this Canadian sample reported clinically significant behavior problems in their children with ID. Interestingly, the prevalence estimates of behavior problems in this sample of children also appear to correspond with prevalence estimates of dual diagnoses in the adult population. 55 6,7 This parallel lends support to the hypothesis that these problems are stable over the life span. 55 Further longitudinal research should be conducted to investigate whether childhood behavior problems develop into psychopathology in adulthood. These findings highlight the need to study the developmental trajectories of psychopathology in individuals with ID in order to promote early identification and intervention in this population.

More parents reported internalizing versus externalizing problems in their children with ID; however, an examination of Figure 1 suggests that the traditional structure of the broad-band clusters of the CBCL may not capture the range of behaviors displayed by children with ID. More specifically, children in this sample were most likely to display clinically significant behavior problems on the Social Problems, Thought Problems, and Attention Problems subscales, corroborating results of a study by Dekker, Koot, van der Ende and Verhulst 18 who suggested that “these areas of problem behavior should be a major point of focus in the care of these children.” (p.1093) Furthermore, the Social, Thought and Attention Problems subscales do not contribute to either the Internalizing or Externalizing factors on the CBCL; thus, research employing only the broad-band scales may underestimate behavior problems in children with ID. Given these differences, when comparing children with and without ID, it is of importance for researchers to include the analyses of all the narrow-band subscales of the CBCL.

Parents of children with autism reported significantly more problem behaviors on all scales of the CBCL than parents of children with Down syndrome, except for the Delinquent Behavior subscale on which the difference was non-significant. Dykens and Hodapp 20 describe a “Down Syndrome advantage,” (p.57) which they attribute to the relative visibility of the diagnosis as well as two characteristics of children with Down syndrome, namely sociability and a lack of psychopathology. According to their review, children with Down syndrome are less likely than children with other disorders to evidence psychopathology and when they do, the symptoms tend to be less severe. It may also be that the specific tool used was more sensitive to the problems associated with disorders of the autism spectrum, including items such as “stares blankly,” “withdrawn,” “repeats strange acts,” and “strange behaviors.” 5,18

Considering the results of previous research highlighting the saliency of behavior problems as predictors of family outcomes, 6,7 it is not surprising that parents of children with behavior problems reported more stress, less well-being, and perceptions of less family-centered school services than parents of children without behavior problems. Interestingly, both groups reported equivalent levels of social support and the positive outcome of empowerment. These findings support the notion that positive outcomes must be examined in addition to negative family outcomes, as the two may exist simultaneously. 29,31

Not surprisingly, parents of children with both Internalizing and Externalizing problems reported the most negative and the least positive outcomes whereas parents of children without any behavior problems reported the least negative and the most positive outcomes. Generally, parents of children with only Externalizing and only Internalizing
<table>
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<th>Scale</th>
<th>df</th>
<th>$F$</th>
<th>$p$</th>
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<th>Externalizing $(M, SD)$</th>
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<tr>
<td>PSI Child Domain</td>
<td>3.85</td>
<td>22.50</td>
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<td>145.41, 20.50</td>
<td>145.90, 18.86</td>
<td>175.00, 9.43</td>
<td>119.18, 20.83</td>
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<tr>
<td>PSI Parent Domain</td>
<td>3.85</td>
<td>8.71</td>
<td>&lt;.001</td>
<td>140.93, 22.54</td>
<td>131.42, 24.49</td>
<td>164.60, 14.14</td>
<td>124.81, 20.47</td>
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<td>3.85</td>
<td>4.24</td>
<td>&lt;.01</td>
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<td>49.82, 5.17</td>
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<td>FCESPS: Typical Services</td>
<td>3.85</td>
<td>5.88</td>
<td>&lt;.01</td>
<td>39.79, 10.59</td>
<td>49.91, 10.05</td>
<td>37.14, 9.81</td>
<td>51.21, 12.32</td>
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<tr>
<td>FCESPS: Ideal Services</td>
<td>3.85</td>
<td>0.22</td>
<td>ns</td>
<td>71.57, 3.91</td>
<td>71.64, 3.29</td>
<td>70.71, 4.11</td>
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<tr>
<td>FES: Family Empowerment</td>
<td>3.85</td>
<td>3.01</td>
<td>&lt;.05</td>
<td>51.07, 5.51</td>
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<td>44.14, 9.25</td>
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<td>B &lt; I = E = N</td>
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<tr>
<td>FES: Service System Empowerment</td>
<td>3.84</td>
<td>1.31</td>
<td>ns</td>
<td>51.07, 5.51</td>
<td>52.00, 6.99</td>
<td>44.14, 9.25</td>
<td>49.75, 5.04</td>
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<tr>
<td>FES: Community/Political Empowerment</td>
<td>3.85</td>
<td>1.96</td>
<td>ns</td>
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<td>ns</td>
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<td>48.09, 14.55</td>
<td>35.43, 10.55</td>
<td>46.09, 13.80</td>
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</table>

**NOTE:** PSI Parenting Stress Index, FCECPS Family-Centered Elementary School Practices Scale, FES Family Empowerment Scale
behaviors were equivalent. However, one of the most surprising findings was that parents of children with Internalizing problems reported equivalent levels of perceived family-centered services as parents of children with both Externalizing and Internalizing problems. Parents of children with Externalizing problems, however, were similar to parents of children without any clinically significant behavior problems. This finding suggests that families of children who are withdrawn or depressed may be falling through the cracks when it comes to family centered services in the school, lending support to the adage “the squeaky wheel gets the oil.” Another plausible hypothesis is that parents whose children display Internalizing behaviors may also tend to be more withdrawn, thus interacting less with educational professionals.

This study was not structured as a randomized study. The sample was self-selected, comprised mainly of married, highly educated, upper-middle class mothers, and therefore the results are limited in their generalizability. Hence, the results may not be applicable to fathers or to parents with less education, lower SES, or single parents. Furthermore, those parents who completed and mailed in the lengthy questionnaire package may be more organized than those who were unable to complete the package. Although it was not possible due to ethical constraints to estimate response rates through the organizations, such information would be valuable in the future in order to explore the differences between parents who do and do not respond to these recruitment techniques. As well, fathers were underrepresented in this sample, and their perspectives on empowerment as well as their participation in such research are needed. Future researchers should take special care to include fathers in their recruitment of participants.

It was not possible to assess the intellectual level or adaptive behavior skills of the sample for the purposes of this study. Future researchers should examine the link between ID, problem behaviors, and the family variables discussed in this study. This study was cross-sectional in nature, and thus causality can only be theoretically inferred. It may be that parents who feel more stress may perceive and report higher levels of behavior problems in their children. The methodology of the study was also limited, in that only parents’ perceptions of their current experiences were gathered. Future research is needed to explore the perceptions of other relevant individuals, particularly teachers.

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REFERENCES


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