



Behavior problems in children with mild intellectual disabilities: An initial step towards prevention

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ABSTRACT

To develop prevention activities, an analysis is conducted of child and parent characteristics that occur significantly more often among children with a mild intellectual disability and behavior problems than among children with a mild intellectual disability and no behavior problems and their families. The sample consisted of 45 children attending schools for special education. Data were collected from the children, their parents, and their teachers. The instruments used are the Dutch version of the Parenting Stress Index, the Nijmegen Child-Rearing Situation Questionnaire and the Strengths and Difficulties Questionnaire for parents, teachers and children. On the basis of the results of parents on the Strengths and Difficulties Questionnaire, the research sample was divided into one group of children with behavior problems and one group without behavior problems. Parents of the children with behavior problems were found to feel less competent, more socially isolated, less satisfied about their relationship with their partner, and indicate more negative life occurrences than the parents of the children without behavior problems. Characteristics in the area of adaptability, mood, distractibility/hyperactivity, demandingness, reinforcement of parents, and acceptability were found to contribute to the total stress in the child–parent relationship for those children with behavior problems and their parents. On the basis of these results prevention activities will be developed and tested on their effectiveness.

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Children with mild intellectual disabilities (MID) have a greater risk for developing psychopathology and behavior problems compared to children without MID (Dekker & Koot, 2003). According to this Dutch study of Dekker and Koot, executed by 474 children, 38.6% of the participants had a DSM-IV diagnose, compared to 21.5% of the normal population. Beside the higher levels of psychopathology, behavior problems are also more prevalent in children with MID. A study of Einfeld and Tonge (1996) showed that well over 40% of the children with MID have serious emotional and behavioral problems. Moreover, the majority of children and adolescents with MID referred for mental health care, suffer from disruptive behavior problems and/or aggressiveness, oppositionality, defiance and conduct disorders (Wallander, Dekker & Koot, 2003). The prognosis for these children and adolescents is unfavorable: behavior problems co-occur with internalizing and social problems, minimize opportunities in society and predict a host of unfavorable adult outcomes. The burden of the

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behavior problems on families and friends is such that they have been reported to consider these problems the most important issue for treatment.

When children with MID and/or their parents need help, the Dutch government strives to see that support, guidance and treatment is provided within the immediate environment and family system of the child whenever is possible. One of the first steps in this process is offering prevention programs for the children with ID and/or their parents. Nevertheless, within the care for people with ID prevention programs are still in its infancy, as well as incorporating family processes in these programs, although several studies highlight the impact of behavior problems on families (e.g., [Femmie, Bakermans-Kranenburg & Ijzendoorn, 2005](#)). Meta-analyses within mental health care conclusively show that prevention programs resulted in a reduction of 25% in symptoms of depression, fear, stress and behavioral problems. This effect is comparable to the decrease achieved by psychological, educational and behavioral treatment ([Jané-Llopis, 2002](#); [Jané-Llopis, Hosman, Jenkins & Anderson, 2003](#)). In addition, it appeared that effects were stable until at least 1-year follow-up and that interventions were twice as effective if performed by specialized professionals compared to exclusively offered by non-professionals ([Jané-Llopis, 2002](#)).

Prevention programs can be used autonomously or be a part of a extensive outpatient or residential treatment. Because outpatient treatment is increasingly undertaken to prevent the need for residential treatment, [Embregts \(2009\)](#) explored differences in child and family characteristics of children with a MID who were placed in residential treatment following outpatient treatment and children with a MID who only followed the outpatient treatment. The results showed that there were significantly more children placed in residential treatment having educationally incapable parents, parents with alcohol/drug problems and/or psychiatric problems than in the group of children without residential treatment following outpatient treatment. There is also a strong evidence base for positive associations between the frequency and/or severity of behavior problems in children with ID and parental psychological difficulties (e.g., [Beck, Hastings, Daley, & Stevenson, 2004](#); [Hastings, 2003](#)). Parents of children with ID report more parenting stress and mental health problems such as depression than parents of children without disabilities (e.g., [Emerson, 2003](#)). High levels of stress influence whether families remain in treatment and, for those who do remain, the extent to which children improve and maintain treatment gains over time (e.g., [Kazdin, 1995](#)).

The aim of the present study therefore was to identify variables (i.e., child characteristics, parent characteristics, and situations that are directly related to the role of being a parent) related to children with MID and behavior problems. The Dutch version of the Parenting Stress Index and the Nijmegen Child-Rearing Situation Questionnaire were administered to the parents of 45 children with MID for this purpose. The results were judged to be of use for the design of an effective preventive program aimed at the occurrence of behavior problems of children with MID.

1. Method

1.1. Participants

A total of 45 children with MID met the following criteria: (1) MID or borderline functioning; (2) age between 12 and 16 years and (3) visiting a school for special education for at least three months. They participated in this study based on informed consent: their parents were willing to fulfill the questionnaires. The average age of the children was 13.5 years (range 12–16); 27 of the children were males and 18 were females. The intellectual disabilities were described as borderline in 2 cases, mild in 42 cases and unknown in 1 case. In 71.1% ($n = 32$) of the cases the family situation consisted of 2 parents. A total of 19 children (42.2%) had additional psychiatric disorders according to the SDQ fulfilled by their parents, in 40.0% ($n = 18$) of the cases according to the teachers version, and only in 31.1% ($n = 14$) according to the children themselves.

1.2. Instruments

1.2.1. The Strengths and Difficulties Questionnaire (SDQ)

The SDQ ([Goodman, 1997](#)) is a 25-item questionnaire for assessing the psychosocial adjustment of children and adolescents with three response categories (not true, somewhat true, certainly true), and 5 scales: (1) emotional symptoms, (2) conduct problems, (3) hyperactivity, (4) peer problems, and (5) prosocial behavior. A high score on the scale prosocial behavior is a reflection of strengths, while high scores on the other scales show difficulties. A total problem score is obtained by adding up scales 1, 2, 3 and 4. The sum of these scores may vary from 0 to 40. A score equal to or higher than 17 indicates psychopathology; a score between 14 and 16 implies borderline.

The SDQ can be filled in by parents, teachers and children themselves. Several studies (including the Dutch version) have evaluated the internal consistency of the SDQ total difficulties scales and subscales in community populations ([Goodman, 2001](#); [Goodman & Scott, 1999](#); [Muris, Meesters, Van den Berg, 2003](#); [Widenfelt, Goedhart, Treffers, & Goodmann, 2003](#)). For the total difficulties scale, all studies reported Cronbach $\alpha \geq .70$ for all types of participating informants. For the subscales emotional symptoms, conduct problems, hyperactivity-inattention, peer problems and prosocial behavior, the internal consistencies ranged from α is .63 to .78, .45 to .77, .66 to .89, .39 to .74 and .57 to .84, respectively.

1.2.2. Parenting Stress Index (PSI)

The parent–child relationship was assessed using a Dutch version (Nijmegen Parental Stress Index; [de Brock, Vermulst, Gerris & Abidin, 1992](#)) of the Parenting Stress Index ([Abidin, 1983](#)). The PSI was designed to assess the degree of stress related to parenting. The Dutch translation of the PSI consists of 123 items divided in two domains, the parent and child domain

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