THE IMPACT OF SOCIAL SUPPORTS ON FAMILIES OF YOUNG CHILDREN WITH
DISABILITIES LIVING IN LOW-INCOME COMMUNITIES

A Thesis

Presented to

The Faculty of Graduate Studies

of

University of Guelph

by

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In partial fulfillment of requirements

for the degree of

Master of Science

September, 2011

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ABSTRACT

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The present study focuses on families of children with disabilities living in low-income communities. Little research has been done previously on these families in poverty and the importance of social supports for children with disabilities. The sample consisted of 663 participants; there were 523 families of children without a disability and 140 families of children with a disability living in low-income communities. Poverty is associated with negative influences that may hinder a child’s development, moreso, the development of children with disabilities. Additionally, elevated levels of maternal depression, stress and diminished social support is related to poverty and/or at-risk situations. Importantly, social support may minimize the pressures faced by parents or children within the community. There were four parental variables used in this research along with the use of social supports (formal and informal), concerns about access to formal supports and perceived social support. Chi-squares, independent t-tests and correlation analyses were conducted to determine significant differences between both groups. The results indicated that both groups are quite similar; whereas families of children with a disability were statistically more likely to visit a health and social service professional.
Acknowledgements

My family has been the rock on which I can lean on, they remained unshaken and immovable throughout all the successes and challenges of my life. Mom and Dad, you are the only ones, who kept it real, and indeed I am a blessed daughter and friend; I am forever indebted to you for your unconditional love and support. I always want to make you both proud. Toussaint and family, thank you for your support, the ‘chill days’ which amounted to a few six-loves and an abundance of laughter. Serena, you are a very special niece & god-daughter who is always willing to help, which made and continues to make for fun and quality time with you. Finito bella...auntie loves you! Welcome to the family, Seffrah, auntie loves you! HE knew what HE was doing when I came into this world, and HE chose the right family for me.

To my friends far and wide, the phone calls, the visits, the e-mails, texts or an encouraging word it meant a lot. I’ve made it to the finish line and I kept my eye on the prize. Special thanks to my dream team, and others who I have met along my journey, you know who you are.

To Drs. Brophy and Lero, thank you for your support in the completion of my thesis. I am similarly grateful for the support of my colleagues.
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The Impact of Social Supports on Families of Young Children with Disabilities Living in Low-Income Communities

Children with disabilities and their families face major challenges. Having a child with a disability and living in poverty are risk factors that may affect parenting practices, emotional well-being, and child development (Campaign 2000, 2010). The provision of social support could enhance the wellbeing of families of children living in low-income communities, especially those families of children with disabilities (Statistics Canada, 2008). However, little is known about the impact of social supports on families of children with disabilities living in low-income communities.

Studies have shown that children with disabilities growing up in poverty are more vulnerable and more likely to experience a wide range of undesirable outcomes (Willms, 2002). Such outcomes will include more likelihood of unidentified cases of severe to very severe and mild to moderate disabilities among the children (for example: learning disabilities, emotional difficulties and chronic health conditions), life expectancy (infant mortality) and lower quality of child care services (Campaign 2000, 2010). Children of recent immigrants to Canada in racialized families, female lone-parent families, and those with a disability face an increased chance of experiencing poverty (Campaign 2000, 2010). Poverty may further affect a parent’s ability to effectively parent their child.

Research on social support suggests that families with some type of support such as instrumental and informational support will improve in their well-being and quality of life, which will further strengthen family functioning (King, Willoughby, Specht & Brown, 2006). Research on low-income families of children with disabilities indicates that low levels of informational support lead to limited access to professional services and unpredictable use of available
supports (Canary, 2008 from Baxter & Kahn, 1999; Diamond & Kontos, 2004; Duvdevany & Abboud, 2003; Ellis et al., 2002; Kuchler-O’Shea, Kritikos & Kahn, 1999; Parish, Cloud, Huh & Henning, 2005; Williams et al., 2002).

Therefore, it is important to examine families’ use of and concerns about access to support both formal and informal that are necessary to meet their children’s needs and support effective parenting. Social supports such as help from others may diminish the pressures that these families will experience and, in particular, families of children with disabilities living in low income communities.

**Literature Review**

**Definition of Children with Disabilities**

There are many terms used in referring to children with special needs including children with exceptional conditions, children who [have disorders] or [with] disabling conditions, and children who are challenged; as well as those who tend to possess significant physical, mental challenges or limitations or change in the way that they learn, respond, or behave (Crowther, 2006). According to Irwin, Lero and Brophy (2000), defining a child with special needs is very complex and definitions often refer to the child as having a physical, intellectual, emotional or behavioural impairment requiring additional support services. The Government of Ontario defines a child with special needs as “a child who has a physical or mental impairment, [where] that [impairment] is likely to continue for a prolonged period of time and who as a result, thereof, is limited in activities pertaining to normal living as verified by objective psychological or medical findings ...” (Government of Ontario, 1997:R1.1). More specifically, the Individuals with Disabilities Education Act, defines a child with a disability as a child with:

“mental retardation, hearing impairments (including deafness), speech or language impairments, visual impairments (including blindness), serious emotional disturbance,
... other health impairments, or specific learning disabilities; and who, by reason thereof, needs special education and related services” (Knoblauch & Sorenson, 1998, ED429396).

The most current statistics available on the prevalence of disability are based on Statistics Canada’s Participation and Activity Limitations Survey (PALS). In 2006, an estimated 202,350 Canadian children (3.7%) under the age of 15 were identified with one or more types of disability (Statistics Canada, 2008). Prevalence rates tend to be higher for older children, as it is often difficult to diagnose delays and disabilities in very young children and many of those with special needs such as learning disabilities are usually not assessed until they are school age.

Parents of children with disabilities are often not able to actively seek services for their children and receive the services they require (Schwartz, 2005). There are several categories in which children with special needs are recognized; however, some children need particular services due to their complex nature and conditions and it is often difficult for families to receive such funding and supports as needed. Cost and geographic factors also limit availability of supports.

Families with a child with disabilities are unusually vulnerable to many risk factors (Guralnick & Bennett, 1987). According to Schwartz (2005), some of the challenges that a child with a disability encounters can be the lack of satisfying relationships and engagement within his or her community. Canadian children with disabilities are a diverse group, having behavioural and emotional disorders, cognitive and physical impairments, as well as moderate to severe levels of disabilities (Hanvey, 2002). For children with disabilities, the need for provision of services and social support is crucial to families striving and thriving within their socially disadvantaged neighbourhoods.

For the purpose of this research, children with disabilities will be defined as children identified with health impairments, or specific learning disabilities, and those with cognitive,
emotional and physical impairments from moderate to severe levels over a significant period of time (Knoblauch & Sorenson, 1999; Smith, Polloway, Patton & Dowdy, 2008; Hanvey, 2002). Additionally, children with disabilities may have several impairments and will require the availability of special services that will help to enhance their overall development.

**Poverty and Disability**

Some describe poverty as a temporary period of economic deprivation, whereas others, such as minority populations, may experience poverty for the duration of their childhood with minimal upward mobility throughout their development (Aber, Bennett, Conley & Li, 1997). According to social researchers, poverty is usually known for its negative influences on a child’s health and development (Aber et al.). The definition of poverty or a state of being poor can mean several different things, where individuals may face concentrated neighbourhood poverty as well as family-related hardship. Among low-income families, there are differences across the age span with more than half of the young children (age six and younger) living in households under the poverty line; where “[5%] of all children experience poverty during...two thirds of their childhood years” and additionally 7% were poor up to nine years during their youth (Aber et al., p. 467).

The Campaign 2000 Report Card on Child and Family Poverty in Canada states that approximately 610,000 children (1 in 10) live in poverty (Campaign 2000, 2010). “Children living in poverty are 2.5 times more likely than those from wealthier families to have a disability, and are the least likely to access medical and community supports” (Campaign 2000, 2010; p.3). Research has shown that 21% of children with disabilities tend to live in poorer family situations than children without disabilities (Parish & Cloud, 2005). It is important to note that in 2005, approximately 19% of children with an activity limitation lived below the low-income cut-off
compared to 13% of non-disabled children (Statistics Canada, 2008). By 2010, there were six provinces and subsequently the territories as well that adopted strategies to aid in reducing poverty (Campaign 2000, 2010).

**Poverty and its Effects on Family Functioning**

Poverty, when it occurs in early life (under age five), has lifelong effects on children’s development (Aber et al., 1997). Approximately 20% of Canadian children in 2005 were living in poverty, while 7% were living in extreme poverty; and of those children, the most vulnerable children were under the age of six (Cappella, Frazier, Atkins, Schoenwald & Glisson, 2008). Research has indicated that low-income mothers, compared to those with higher incomes, are less responsive to their children, which in turn, can contribute to adverse socio-emotional development in the children (as cited in Evans, Boxhill & Pinkava, 2008 from Bradley & Corwyn, 2003; Grant et al., 2003; Magnuson & Duncan, 2002; McLoyd, 1998). Some low-income mothers face an array of psychosocial and physical stressors that may reduce their capacity to be a responsive parent. Pelchat (1989) indicated that maternal stress and social support are linked to responsive parenting. Mothers living in poverty may also be less attuned to the needs of their children and they, themselves, may lack adequate social networks (Evans et al., 2008). In addition, it is difficult for parents to maintain jobs due to reduced work hours, and at times refuse a promotion and advancement in the workforce in order to provide care and ensure the needs of their families are met (Statistics Canada, 2008).

Poverty is related to elevated levels of maternal depression, stress and diminished social support. Caring for children with a disability is physically and emotionally draining, especially for parents of children with a severe disability. As such, finding personal time is more difficult for families of a child with a disability or with an activity limitation requiring extra care.
(Statistics Canada, 2008). Living in poverty is related to a host of adverse conditions (Parish & Cloud, 2005). These adverse conditions may limit access to adequate resources depending on the level of disability and/or impairment of the children. Children with severe to very severe disabilities receive more help through government programs and agencies due to their unmet needs (Behnia & Duclos, 2003). There are factors, however, that may affect the capacity of families of children with disabilities to access and use the available supports. For example, families of these children may not have benefit plans for services such as prescription, vision and dental care (Campaign 2000, 2010).

Parents want the best for their families, and families of children with disabilities may rely on the skills of someone to care for their child; for example, the skills of other professionals who are trained in counselling or child care. This too can become a challenge when families are in need of care and support for their children and the resources and/or services are scarce or may not be available. In these cases, the relationship between mother and father, or mother and her partner may become strained; stress and depression and disagreements in these relationships tend to be the most commonly reported problems (Statistics Canada, 2008).

Poverty is an important determinant of health with many long-term effects on families with children especially families of children with disabilities. Canada provides universally accessible, publicly-funded health insurance which will assist families and their children with health related care (Campaign 2000, 2010). “More than one-third (38.4%) of parents [who are] reported[ly] working less hours in order to care for their children [with disabilities]; [and] about one in four parents had not accepted employment” (Campaign 2000, 2010, p.5). With working fewer hours, there is the possibility of less income and in turn higher expenses. Flexible work conditions are helpful for these parents “who need to care for their child and at the same time [choose] to
continue working” (Statistics Canada, 2008, p.10). Parental stress can be high and the need for social support essential.

**Importance of Social Support**

Families of children with disabilities have been identified as needing more social support in order to minimize the pressures they face within their communities; these social supports include but are not limited to, tending to other family responsibilities, chores and preparation of meals (Statistics Canada, 2008). There may be subtle to not so subtle barriers in society which may restrict the overall development of children with disabilities (Batshaw, Pellegrino & Roizen, 2007). “These barriers include cost, lack of local resources, and a lack of information [for] available services” (Statistics Canada, 2008, p.15). Additionally, children with disabilities face a number of challenges within the social and economic context of their lives. Families of children with disabilities have low incomes and yet more of their money is being spent on child care and medical expenses; and there are often minimal institutional and organizational supports for these families due to lack of resources such as employment (Canary, 2008).

Children with mild to moderate disabilities receive daily help with everyday activities and, of the children who receive help, approximately 70% of the support is received from family members living outside the home. Similarly, for parents of children with severe disabilities, approximately 50% of the support is received from family members not living at home (Statistics Canada, 2008). According to Pianta and Walsh (1996), social contact outside the home is a critical factor in the development of the child. Parents or caregivers have relationships with individuals outside the home who serve as important sources of support and help. Wong, Lai, Martinson and Wong (2006) studied Chinese parents of children with developmental disabilities and found that parenting skills used in the rehabilitation of their children and maintenance of
communication with professionals served as a means of social support. Families work with professionals [formal support] and/or personal social networks [informal support] to provide developmentally appropriate care and support for their children with disabilities (Wong et al.).

Wong, Wong, Martinson, Lai, Chen and He (2004) stated that an individual with a disability may have great potential to influence their entire family, thus changing the family structure and functioning. Sound family functioning is paramount for a supportive and developmentally appropriate environment for a child with disabilities (Guralnick & Bennett, 1987, p.368). Parents or caregivers of children with disabilities consistently identify the need to acquire more social supports (Hanvey, 2001). According to Statistics Canada (2008), families express the need for additional help to allow the parent or caregiver to have some personal time and a respite from the demands of caring for a child with a disability.

**Defining social support.**

Social support contributes to general well-being and helps to protect people from health related problems during times of stress (cited in Osterling, 2006 from Cohen & Willis, 1985). Scharer (2005) describes social support as an expression of positive affect between people, where the different types of social support included emotional, informational, material and appraisal. Emotional support involves sharing thoughts, feelings and offers of care; informational support is the transmission of knowledge; material support is providing money and assistance in the physical form; and appraisal support is providing feedback or praise (Scharer, 2005). Other studies found that social support including emotional and tangible assistance can be positively related to parenting attitudes and behaviour (Green & Rodgers, 2001).

Green and Rodgers (2001) define social support as the quality of specific transactions or interactions between people, along with the giving of information, tangible assistance and
emotional support. Based on data collected from a population of low-income African-American new mothers, their study identified three functional areas of social support including tangible, informational and belongingness supports. It has been suggested that high-quality social support acts as a protective buffer against stress (Green & Rodgers, 2001). The size of the social support system and the satisfaction with the support received are two different dimensions of social support, each of which is independent in terms of coping with stress (Akhtar et al., 2010).

According to Oravecz et al. (2008), social networks may help in the reduction of [parental] stress, provide children with guidance and emotional support, and connect families to resources in their own communities. There are three main sources of social support which include family, friends and significant others.

Recent research suggests that perceived social support is a stronger predictor of psychological status than objectively measured social support (Akhtar, Rahman, Husain, Chaudhry, Duddu & Husain, 2010). Perceived social support is defined as the perception of available resources or support dependent on a need that may arise for an individual or a community (cited in Lowe, Chan & Rhodes, 2010 from Fleming, Baum, Gisriel, & Gatchel, 1982; Kaniasty & Norris, 1993; Kaniasty, Norris, & Murrell, 1990). Based on how an individual perceives the usage or accessibility of support, it is the perception rather than the act that conceives how social support may be measured. Distinguishing between the actual social supports received and the person’s perception of social support received can be challenging.

“Measuring constructs such as social support is probably more difficult, [where] the construct is less tangible” and similarly perceptions of the adequacy of social support vary among individuals (Sloat & Willms, 2002, p.30). In addition, research indicates that perceived support is dependent on the individual’s beliefs of how resources and services are allocated and/or made available to
them (Willms, 2002). For example, help from others may relieve some pressure that parents and families tend to experience when caring for a child with a disability. Durden, Hill and Angel (2007) indicate that social networks often consist of similar disadvantaged neighbours, friends and family members who experience diverse levels of stressors and challenges. As a result such challenges place considerable demands on relationships, especially among low-income women.

There tends to be an emphasis on social support as a resource rather than a process, and thus there is a limited sense of how individuals come to feel supported (King et al., 2006). Munn-Joseph and Gavin-Evans (2008) identify social networks as support providing capital “that helps one get by or cope; and where leverage...helps one to get ahead or change one’s opportunity” (p. 381). As such, social networks produce support and leverage. Furthermore, the family’s personal social network consists of persons and institutions that interact with the family, and acts as the primary source of support. Anchoring one’s social life in a network comprised of diverse social ties will provide returns in social capital, for example, where strong relationships either have material or emotional social support (Stalker, 2008). It is important to investigate how individuals develop, perceive, maintain and engage in different forms of social support. In particular, what supports are used by families of children with and without disabilities living in low income communities and how do their perceptions of these supports differ.

Social support refers to resources provided to individuals in response to the need for aid, an expression of positive affect between people, social reinforcement, giving and providing guidance or information (Dunst & Trivette, 1990; Scharer, 2005). Such support can also serve as a means whereby individuals feel a sense of value and care. Social support affects parent, family (community), and child functioning; it also influences parent well-being and health that, in turn, affects family functioning which also influences child behaviour and development (King et al.,
2006). Additionally, children with disabilities seem to be significantly affected by a lack of partner support especially in those children from single mother-headed homes, and the isolation of their families (Canary, 2008). There are a higher proportion of single parent families headed by women living in poverty which is of particular concern.

Social support should also be accessible, specifically, in order to minimize the stress that families of children with disabilities may face such as challenges with income, workload, or managing parents’ personal lives and their responsibilities related to the child’s condition (Statistics Canada, 2008). According to PALS Survey (2006), 45.5% of parents of children with at least one health condition report that their child’s condition is a main source of stress and has an impact in their daily lives. Subsequently, there are challenges that are faced daily which relate to the child’s condition and daily life and require a balance of responsibilities; which may also contribute to the overwhelming feelings of anxiety and stress on parents (Statistics Canada).

**Formal and informal supports.**

Support is provided through informal and formal sources. Informal sources of support are provided by family, friends and neighbours, whereas the formal support, at least 44%, tends to be from government organizations and community agencies (Behnia & Duclos, 2003). Formal support involves social networks with professionally based services such as counselling services that are organized and designed to aid families in need (Cappella, Frazier, Atkins, Schoenwald & Glisson, 2008). Informal support is typically provided by friends and family, and has been shown to reduce parental stress and depression, aid with child care responsibilities, and provide respite for parents (as cited in Baxter, Cummins & Polak, 1995; Beckman, 1991; Fisman et al., 1989; Willoughby & Glidden, 1995 from Bayley, 2003). Families of children with disabilities who have social networks with friends and other family members may have a primary source of
informal support and less formal support (King et al., 2006). Some families of children with disabilities may lack access to support and/or resources. This may be particularly so when the families are living in poverty. Looking at the differential use of services for families of children with and without disabilities would shed more understanding on the importance of social support in the lives of these families.

Walter and Petr (2006) suggest that there are numerous studies that tend to combine both types of supports (use of formal and informal supports) to present a more comprehensive perspective of social supports. However, it is necessary to differentiate between the use of formal and informal supports, particularly for families of children with disabilities and families of children without disabilities. Formal support involves influential professionals from the community who can enhance the effectiveness and sustainability of services, and will possibly bridge the gap between research and community practices (Cappella et al., 2008). Formal supports protect people from differing adverse outcomes such as destructive family functioning, low birth weight for children, depression and even premature death (Schorr, 1989).

On the other hand, informal supports are provided by family, friends and neighbours who may not receive formal training. They tend to perform similar tasks as professionals by providing support to families and their children (Walter & Petr, 2006). In families that are at greatest risk, stress can be unmanageable and their lives out of control, informal support is least likely seen as usable and available (Schorr, 1989). Families with few supports but greater needs are often vulnerable, and are more likely to use any available formal or informal supports. Informal supports such as friendships or social relationships are required by these families. These social relationships and interactions are critical to the emotional, social, and physical well being of children with disabilities (Irvine & Lupart, 2006).
Relationship between Parental Support, Emotional Well-being and Community Connectedness

There are advantages for families and their children when social supports and/or networks are established. According to Izzo et al. (2000), social support will benefit parents by helping them feel more competent and effective compared to families without any form of support. The results further suggest that there is a consistency in previous research, and that social support may likely predict more warmth and strong parenting practices (Izzo et al.). The provision of social support does not occur in isolation from others, whereby social demands can heavily contribute to role conflict and role strain. Under these conditions, individuals may struggle with competing responsibilities associated with work and family. As a result, over-commitment due to heavy social demands also impedes the actual provision of support, resulting in social conflict (Durden et al., 2007). In striking the balance between work and family, the provision of support will assist families in providing access and quality care to their children with health related problems. Support will happen through various means such as professional services and from others outside of the family’s home.

It is important to highlight and/or identify key parental variables that may relate to these types of supports such as parental depression, parental stress, parental warmth, sense of community involvement and perceived social support, especially for families of children with disabilities.

Parental depression.

There are various factors/events that place children at risk including family disruptions, environmental stressors and adverse social conditions (Hoglund & Leadbeater, 2004). These stressors tend to affect children’s development, especially for children with disabilities and their families, and those that have minimal access to social supports within their communities.
Research by King et al. (2006) found that women experience greater depression when they have less assistance from supportive networks. In most cases, it is the mother who tends to experience greater levels of depression and stress in terms of responsibility for caring for a child, and more so, a child with disabilities (King et al.). A mother whose child has a lower level of functional independence may endure a greater level of disability-related need for support, than a mother with a typically developing child who is more functionally independent (Baker, 2002). Mothers of children with disabilities who experience high levels of parenting stress, but report receiving higher levels of perceived support, exhibit fewer symptoms of depression and anxiety when compared with mothers experiencing high stress but less emotional support (Quittner et al., 1990). Consistent social support should be beneficial to those with high levels of depression.

According to Shinn, Knickman, & Weitzman (1991), social support is vital to parents or caregivers in depressive states or circumstances. The quality of one’s social ties and/or social networks improves health and well-being and will eventually lower levels of depression.

**Parental stress.**

In the present context, “stress is described as the ongoing relationship between a person and environmental factors”, which can be demanding, especially when adequate coping responses are not in place (Plant & Sanders, 2007, p.110). Generally, women tend to experience greater levels of responsibility due to nurturing young children, which further prolongs their increased levels of stress (Durden et al., 2007). The birth of a child is a transitional situation that triggers stress on the parents; adaptive strategies have to be implemented to make space for this new arrival (Pelchat, 1989). Furthermore, when the child has a health problem, the level of stress on the parents is amplified. “Almost half of parents (~46%) said that their daily stress ranged from quite a bit stressful to extremely stressful, while ~40% said that most of their days were a
bit stressful” (Statistics Canada, 2008, p.9). Of those parents, the study reported their child’s health condition as a primary source of stress (Statistics Canada, 2008). The parents will then have to grieve for the ‘expected’ child, and make provisions and adapt to the child’s health problem in order to cope with the emotional and practical aspects of living with a child with disabilities and providing appropriate care (Pelchat, Levert & Bourgeois-Guerin, 2009; Pelchat, 1989). The stress experienced by the parents of a child with a health problem or a disability is not of a different type as experienced by other families, but differs in intensity (Evans, Boxhill & Pinkava, 2008). Regardless of women’s stress level, social supports (whether formal or informal) may improve the quality of life and minimize the effects of stress that women experience. In the study by Evans et al. (2008), maternal stress and social support relate to the responsiveness of the mother to her children. Specifically, mothers tend to be more responsive when provided with appropriate social support and healthy social networks.

**Parental warmth.**

Parental warmth is an expression of increased parental confidence and how parents relate with their children in an adaptive parent–child relationship, and may also extend to emotional nurturance and affectionate care from a parental figure to the child (Operario, Tschann, Flores & Bridges, 2006). Izzo, Weiss, Shanahan and Rodriguez-Brown (2000) define parental warmth as acceptance, referring to communication or expression of affection towards children, which also enhances the children’s social and emotional milieu. Parental warmth is positively related to children’s social and emotional development. Suchman et al. (2007, p.2) define parental warmth as “the expression of interest in children’s activities” and involvement in their lives, by expressing affection and enthusiasm for children’s accomplishments. Parents who experience social support will be more effective and competent in their parenting practices and abilities,
which should favourably improve warmth and nurturance in parenting (Izzo et al., 2000). On the other hand, families living in low-income communities are more likely to have lower levels of parental confidence in their parenting skills (Izzo et al.). Children are able to cope with environmental stressors, participate in social and emotional interactions, and meet parental expectations if given the appropriate support.

**Sense of community involvement (or collective efficacy).**

Collective efficacy is defined as “strong shared values, mutual trust, and a willingness to intervene with children” that requires positive social supports from and within the community (Simons, Simons, Burt, Brody & Cutrona, 2005, p.995). It also reflects a level of social cohesion among neighbours combined with a willingness to get involved with their communities. Stajkovic, Lee and Nyberg (2009) believe that collective efficacy is based on tasks and a context that encourages initiation of action, effort, and where such tasks are driven by a group of individuals (community) in order to improve the development for community members. According to Odgers, Moffitt, Tach, Sampson, Taylor and Matthews (2009),

“the level of collective efficacy within a community is not [solely] characteristic of individual members of their respective communities. Rather, collective efficacy has been described as a combination of both informal social control and social cohesion and reflects the willingness of community members to look out for each other and intervene when trouble arises” (p.943).

In a community with shared norms, the members are connected in such a way that they work collectively to achieve a common purpose. Therefore, increased collective efficacy will build stronger neighbourhood ties and promote action within the community (Foster-Fishman, Pierce & Van Egeren, 2009). Bandura’s study on social cognitive theory refers to the implementation of collective efficacy and the capacity to take action and achieve desired outcomes (Foster-Fishman et al., 2009). Collective efficacy and community involvement play a significant role in providing
a nurturing, healthy and positive community that reflects the likelihood of viable social supports. Self-efficacy is defined as “individuals who believe that they can engage in behaviours needed to influence their personal outcomes” which continues under periods of extreme stress (Green & Rodgers, 2001, p.421). Self-efficacy reflects the need to enhance collective efficacy within our neighbourhoods, where individuals strive to create and maintain viable social supports to secure the needs of their families.

**Summary**

Social support helps parents manage various stressors and/or adversities when raising their children, which in turn supports parental nurturance and responsiveness to their children (Izzo et al., 2000). It is crucial that social supports are accessible and available to support parents in their parenting role(s) and promote the overall development of children. Although social support is an important resource for all parents (caregivers), it may be especially important for parents living in poverty; the ones who are experiencing more stress and lack of financial resources to acquire the support they need (Brown & Rodger, 2009). As well, parents of children with disabilities require additional support (both formal and informal) not only to support parenting, but to improve their child’s health and life outcomes.

**Research Questions**

There are few studies comparing families of children with disabilities and families of children without disabilities living in low-income situations with respect to their use of formal and informal support, concern about access to formal supports and perceived social supports. Another area of interest would be how families of children with and without disabilities differ in the relationship among such variables as parental stress, parental depression, parental warmth and community involvement.
The present study uses data from a multi-site primary prevention initiative in Ontario (Better Beginnings, Better Futures, 2009) that was designed to promote access to a range of child and family supports among low-income families, including families with young children with special needs. The following research questions were addressed in this study:

1. What are the sociodemographic characteristics between families of children with disabilities and families of children without disabilities living in low income communities?

2. What is the relationship among the use of formal supports, concerns about access to formal supports, and the differences in perceived social support for families of children with a disability and those without a disability living in low-income communities?

3. What is the relationship in parental stress, and among parental depression, parental warmth, and community involvement for families of children with a disability and those families of children without a disability living in low income communities?

4. What is the relationship among the use of formal supports, concerns about access to formal supports, and the differences in perceived social support, parental depression, parental warmth, and sense of community involvement for families of children with disabilities and without living in low income communities?
Methods

Better Beginnings, Better Futures Project & Participants

Better Beginnings, Better Futures (BBBF) was initially developed as an Ontario government primary prevention demonstration initiative that involved the Ministries of Education, Health, and Community and Social Services (Cameron, Pancer, McKenzie-Mohr & Cooper, 2006). The BBBF project focused on three key goals which were:

a) to reduce long-term emotional and behavioural problems in children;
b) to enhance social, emotional, behavioural and cognitive development in children at-risk in low-income communities; and
c) to strengthen the capacities within communities to respond effectively to the social and economic needs of children and their families (BBBF, 2009).

Projects like BBBF assist families in low-income communities to support their children by providing opportunities for parents to improve their competencies and behaviours in their roles as parents. Additionally, families are given the opportunity to engage in cooperative efforts within their community through involvement in new programs and existing community services and resources.

This study focused on parents participating in the Better Beginnings, Better Futures prevention initiative at five younger cohort sites when their children were enrolled in Grade one. These communities were Walpole Island (First Nations/Aboriginal community), Guelph, Kingston, Toronto and Ottawa. The programs in these communities focused on children from birth to age four and involved home visits, childcare enrichment and a variety of programs that focused on parent education and support. The Better Beginnings, Better Futures dataset was collected between 1993 and 2003. Data were collected from over 1500 children and their families and from teachers in BBBF younger cohort sites. Data were collected initially when the children were 3 months old. Subsequently, follow-up interviews were conducted when the children were 18 months, 33 months, 48 months old, and in Grades 1 and 3. Research
Information was collected on approximately 870 children in Grade 1, who comprised approximately 58% of the younger cohort children inclusive of all age groups. The core research team was made up of 17 members and a research director with primary responsibility for developing the research designs and measurement plans, who also oversaw the implementation of the research and maintained the database at Queen's University. This research team also had responsibility for analyzing and reporting the research findings (BBBF, 2009).

BBBF is a longitudinal research project. Children and their families experienced four years of Better Beginnings prevention programming in the younger cohort sites and were being followed over an extended period. As well, children and families are being followed in three demographically matched communities (comparison sites) that did not receive Better Beginnings funding (Cameron et al., 2006). Data from these comparison sites are not included in the BBBF dataset which comprises of the current study. The outcome measures gathered at each data collection point covered areas such as “children’s social functioning, emotional and behavioural problems, academic functioning, child and parent health promotion and health risk behaviours, parent social and emotional functioning, family functioning, community involvement, and neighbourhood quality” (Cameron et al., 2006, p. iv).

Recruitment

The recruitment of children born in 1994 was done through local BBBF programs in areas such as hospitals, playgrounds and local schools. The most widely used recruitment method involved the support of hospitals at which mothers from the BBBF communities were likely to give birth (BBBF, nd). A local interviewer (site researcher) was hired through the Research Coordination Unit (RCU) to interview the parent(s) and maintain contact with the research families. Families were paid $15 to complete an interview and were also given a BBBF magnet.
Sample Characteristics

For the present research, data from the Better Beginnings, Better Futures (BBBF) prevention initiative focused on children in grade one from the five younger cohort sites. The parent interviews were conducted by trained interviewers using a structured questionnaire developed by the RCU. The younger cohort sites (Table 1) received the majority of participants from Kingston (~31%) and Toronto (29%), with the remaining sample participants drawn from Ottawa, Guelph and Walpole Island (12-15%), respectively.

Table 1

Distribution of Participants in the BBBF Younger Cohort Sites

<table>
<thead>
<tr>
<th>BBBF Sites</th>
<th>Number of Participants</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Guelph</td>
<td>117</td>
<td>13.4</td>
</tr>
<tr>
<td>2. Kingston</td>
<td>265</td>
<td>30.5</td>
</tr>
<tr>
<td>3. Ottawa</td>
<td>130</td>
<td>14.9</td>
</tr>
<tr>
<td>4. Toronto</td>
<td>253</td>
<td>29.1</td>
</tr>
<tr>
<td>5. Walpole Island</td>
<td>105</td>
<td>12.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>870</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

The respondents were primarily parents/caregivers of children in grade one. For ease of reference and discussion, the word “parent(s)” will be used interchangeably with “respondent(s).”

The BBBF data initially consisted of 870 parent interviews; however 207 cases were excluded due to substantial missing data, resulting in a final sample of 663. Table 2 provides demographic information about the respondents and their families. A greater proportion of
female respondents (~93%) participated in the interviews. Approximately 96% of the respondents’ were biological mothers/fathers (N=636) of the target child, with biological mothers accounting for ~93% of the sample. The remaining respondents were adoptive mothers/fathers, foster mothers/fathers, guardians/other. Almost two thirds of the respondents were in marriages or partnered relationships (~64%), while almost one third of the parents managed single parent households. Most of the respondents (67%) were born in Canada (N=442) while the other respondents (33%) emigrated from 18 other countries. The most prevalent countries of origin included Vietnam, Somalia, Sri Lanka, United States of America, China and Jamaica (Table 12, Appendix A). As for the educational level of the respondents, there was considerable diversity. Almost 37% had not completed either primary school or high school; however, approximately 24% of respondents had graduated from a College/ University or professional program. The partners (spouse/non-parent) had similar levels of educational attainment: about a third had not completed high school education, 28% had graduated from high school, and another 28% graduated from a College/University or a professional program. More than half of the respondents (55%) were employed. One third had full-time employment and 21% were employed on a part-time basis; the remainder were classified as not employed (45%). Those who were not employed were either actively seeking work or more commonly were not seeking employment at all.
Table 2

*Demographic Characteristics of Respondents*

<table>
<thead>
<tr>
<th></th>
<th>Frequency (N=663)</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>49</td>
<td>7.4</td>
</tr>
<tr>
<td>Female</td>
<td>614</td>
<td>92.6</td>
</tr>
<tr>
<td><strong>Respondent’s relationship to child:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Biological mother/father</td>
<td>636</td>
<td>95.9</td>
</tr>
<tr>
<td>Guardians/other</td>
<td>27</td>
<td>4.1</td>
</tr>
<tr>
<td><strong>Duration of residence (N=660):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Two years or less</td>
<td>172</td>
<td>26.0</td>
</tr>
<tr>
<td>Three or four years</td>
<td>168</td>
<td>25.5</td>
</tr>
<tr>
<td>Five or more years</td>
<td>320</td>
<td>48.5</td>
</tr>
<tr>
<td><strong>Household:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married/partnered</td>
<td>423</td>
<td>63.8</td>
</tr>
<tr>
<td>Single parent</td>
<td>240</td>
<td>36.2</td>
</tr>
<tr>
<td><strong>Number of people in home:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Two</td>
<td>46</td>
<td>6.9</td>
</tr>
<tr>
<td>Three</td>
<td>127</td>
<td>19.2</td>
</tr>
<tr>
<td>Four or more</td>
<td>490</td>
<td>73.9</td>
</tr>
<tr>
<td><strong>Place of birth for respondent (N=660):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Canada</td>
<td>442</td>
<td>67.0</td>
</tr>
<tr>
<td>Other than Canada</td>
<td>218</td>
<td>33.0</td>
</tr>
<tr>
<td><strong>Highest educational level (respondent):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than high school graduation</td>
<td>243</td>
<td>36.7</td>
</tr>
<tr>
<td>Graduated high school</td>
<td>175</td>
<td>26.4</td>
</tr>
<tr>
<td>Some college/university</td>
<td>83</td>
<td>12.5</td>
</tr>
<tr>
<td>Graduated college/university (includes professional/graduate programs)</td>
<td>162</td>
<td>24.4</td>
</tr>
<tr>
<td><strong>Highest educational level (partner) N=408:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than high school graduation</td>
<td>140</td>
<td>34.3</td>
</tr>
<tr>
<td>Graduated high school</td>
<td>115</td>
<td>28.2</td>
</tr>
<tr>
<td>Some college/university</td>
<td>38</td>
<td>9.3</td>
</tr>
<tr>
<td>Graduated college/university (includes professional/graduate programs)</td>
<td>115</td>
<td>28.2</td>
</tr>
<tr>
<td><strong>Respondent’s employment status:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full-time</td>
<td>228</td>
<td>34.4</td>
</tr>
<tr>
<td>Part-time</td>
<td>136</td>
<td>20.5</td>
</tr>
<tr>
<td>Not employed</td>
<td>299</td>
<td>45.1</td>
</tr>
<tr>
<td><strong>Household income (monthly) N=583:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Below $1,499</td>
<td>188</td>
<td>32.2</td>
</tr>
<tr>
<td>$1,500-$2,999</td>
<td>236</td>
<td>40.5</td>
</tr>
<tr>
<td>$3,000-$4,499</td>
<td>92</td>
<td>15.8</td>
</tr>
<tr>
<td>$4,500 or more</td>
<td>67</td>
<td>11.5</td>
</tr>
</tbody>
</table>
The majority of the families (~49%) had resided in their community for five or more years when interviewed, which indicates some stability in the child’s neighbourhood; about one quarter of respondents had been living in the community for less than three years. A family of a child in the community for at least five (5) years possibly suggests some form of social tie to the community, and thus establishes where the child has resided for most of his/her life. Among children for whom data was available, 95% were born in Canada (N=481). The other 5% migrated to Canada with their families from countries such as China, Sri Lanka and Vietnam (Table 13, Appendix A).

**Children with Disabilities**

The presence of a child with a disability was determined by parents’ responses to two questions in the interview (Appendix B). The first question asked parents if a doctor had ever told them that their child had any of the following conditions, to which the parent answered yes or no. The conditions listed (D.54-D.62) were heart condition or disease, epilepsy, cerebral palsy, kidney condition or disease, mental handicap, learning disability, attention deficit disorder, emotional, psychological or nervous difficulties and any other long-term condition. Respondents were then asked if the child’s condition(s) or health problem(s) prevented or limited their child’s participation in school, at play, or in any other activity normal for his/her age, to which the parent answered yes or no. Of the 140 parents of children with a disability or health problem (identified according to the first criterion), most parents (121 or 86%) said that their child’s condition(s) limited his/her participation at home, school or in other age-appropriate activities.

Of the 663 families, there were 140 cases (~21%) in which respondents reported that their child had a disability or special need. Just over half of the parents (76 or 54%) said that their child had one condition, 41 children (29%) had two conditions, and 23 children (16%) reportedly
had three or more conditions or health problems. The most prevalent conditions identified of those listed were learning disability (LD) and attention deficit disorder (ADD); 27 parent respondents reported that their child had these conditions, respectively (see Table 3). The category identified as ‘any other long-term condition’ referred to other possible chronic conditions not included in the itemized list of conditions. Sixty-three parent respondents (45%) reported that their child had some other long-term condition. Unfortunately, the category referred to as “any other long-term condition” was left unspecified. Additionally, there was no reference made during the respondents’ interviews to the level of severity of the conditions or health problems in the children with disabilities.

Table 3

*The Frequency of Physical and Mental Conditions Among Children with a Disability in Grade one*

<table>
<thead>
<tr>
<th>Physical and Mental Conditions</th>
<th>Frequency of conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart condition</td>
<td>17</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>2</td>
</tr>
<tr>
<td>Cerebral Palsy</td>
<td>2</td>
</tr>
<tr>
<td>Kidney</td>
<td>5</td>
</tr>
<tr>
<td>Mental handicap</td>
<td>5</td>
</tr>
<tr>
<td>Learning disability</td>
<td>27</td>
</tr>
<tr>
<td>Attention deficit disorder</td>
<td>27</td>
</tr>
<tr>
<td>Emotional difficulty</td>
<td>15</td>
</tr>
<tr>
<td>Other condition or health problem</td>
<td>63</td>
</tr>
</tbody>
</table>

*Note: More than one response/condition could be given*

**Measures**

The measures used in this study were Perceived Social Support (6-items), Use of Formal Support Index (7-items), Use of Informal Support Index (6-items), Concerns about Access to Formal Support Index (2-items), Parental Warmth (6-items), Parental Depression (12-items), Parental Stress (14-items), and Sense of Community Involvement (7 items). All measures are
included in Appendix B. These measures were examined to identify the parental variables that impacted families of children with disabilities. Internal reliability was calculated for most measures for the sample of 663 participants using Cronbach’s alpha (See Table 4). Use of formal supports, use of informal supports and concerns about access to formal supports were categorized as an index based on the items in the BBBF questionnaire. These items were relevant to the current study in determining the relationship among professionally-based services, community-based programs/activities, and concerns about access to formal supports for both groups of families.

Table 4

Reliability Analysis, Means and Standard Deviations of Parental Measures

<table>
<thead>
<tr>
<th>Parental Measures</th>
<th># of items</th>
<th>Range</th>
<th>M</th>
<th>SD</th>
<th>Cronbach’s α</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perceived Social Support Scale&lt;sub&gt;1&lt;/sub&gt;</td>
<td>6</td>
<td>11-24</td>
<td>20.40</td>
<td>2.82</td>
<td>.83</td>
</tr>
<tr>
<td>Use of Formal Support&lt;sub&gt;2&lt;/sub&gt;</td>
<td>7</td>
<td>0-7</td>
<td>2.07</td>
<td>1.40</td>
<td>-</td>
</tr>
<tr>
<td>Use of Informal Support&lt;sub&gt;3&lt;/sub&gt;</td>
<td>6</td>
<td>0-6</td>
<td>1.80</td>
<td>1.27</td>
<td>-</td>
</tr>
<tr>
<td>Concerns About Access to Formal Supports&lt;sub&gt;4&lt;/sub&gt;</td>
<td>2</td>
<td>0-2</td>
<td>.26</td>
<td>.52</td>
<td>-</td>
</tr>
<tr>
<td>Parental Warmth&lt;sub&gt;5&lt;/sub&gt;</td>
<td>6</td>
<td>13-30</td>
<td>22.99</td>
<td>3.02</td>
<td>.69</td>
</tr>
<tr>
<td>Parental Depression&lt;sub&gt;6&lt;/sub&gt;</td>
<td>12</td>
<td>12-48</td>
<td>19.93</td>
<td>6.97</td>
<td>.87</td>
</tr>
<tr>
<td>Parental Stress&lt;sub&gt;7&lt;/sub&gt;</td>
<td>14</td>
<td>0-13</td>
<td>2.55</td>
<td>1.93</td>
<td>-</td>
</tr>
<tr>
<td>Sense of Community Involvement scale&lt;sub&gt;8&lt;/sub&gt;</td>
<td>7</td>
<td>7-28</td>
<td>14.64</td>
<td>3.53</td>
<td>.82</td>
</tr>
</tbody>
</table>

1. Measured on a scale from 1 = strongly agree to 4 = strongly disagree.
2. Measured on a scale where 0 = no and 1 = yes
3. Measured on a scale where 0 = no and 1 = yes
4. Measured on a scale where 0 = no and 1 = yes
5. Measured on a scale from 0 = no and 1 = yes
6. Measured on a scale from 1 = rarely or none of the time (less than one day) to 4 = most or all of the time (5-7 days).
7. Measured on a scale where 0 = no and 1 = yes.
8. Measured on a scale from 1 = strongly agree to 4 = strongly disagree.
For the **Perceived Social Support** measure, the Support Scale originally consisted of twenty items, six of which were selected by the BBBF researchers for the BBBF questionnaire. This scale was originally modified from the Social Provisions scale developed by Cutrona & Russell for this current study (BBBF, 2006). This scale was developed to assess the degree to which respondents’ social relationships provide various dimensions of social support (Cutrona & Russell, 1987). According to Weiss (1974), these provisions reflected what respondents received from relationships with other people. The six categories of provisions included guidance (advice or information), reliable alliance (assurance that others can be counted on in times of stress), reassurance of worth (recognition of one’s competence), attachment (emotional closeness), social integration (a sense of belonging to a group of friends), and opportunity for nurturance (providing assistance to others). The scale was designed as a general measure of perceived social support.

In the present study, responses to each item consisted of a 4-point Likert scale that ranged from 1 to 4 (1=strongly agree, 2=agree, 3= disagree and 4=strongly disagree) with recoded items for questions 2, 3 and 6 (Appendix A). Higher scores indicated a lower level of perceived social support. The internal consistency of items in this scale was good. The reliability coefficient (Cronbach’s alpha) is $\alpha = .83$.

The **Use of Formal Support Index** is based on 7 items that asked “In the past year, have you seen or talked on the telephone with any (health care or social service and/or family doctor/medical specialist) about (the target child’s name) physical, emotional or mental health?” These items include a general practitioner/family physician (it was presumed most parents had access to in the previous year), another medical doctor (such as a paediatrician), emergency room personnel in a hospital, a public nurse, a psychiatrist/psychologist, a child welfare worker, and
any other person trained to provide treatment or counsel (Appendix B). The respondents would answer yes or no to the utilization of these services by health care professionals (also known as professionally-based services). The index is unique to this current study with emphasis on the professionally-based services highlighted in the BBBF questionnaire.

The **Use of Informal Support Index** consisted of 6 items that referred to whether the parent and/or child had participated in any of a variety of child-related programs or activities in the last 12 months. The respondents answered either yes (1) or no (0) to each item. These programs or activities included recreation/playground programs, sports, crafts, or organized clubs, after-school care program or drop-in centre, after-school language instruction/cultural classes, library use, and a parent resource centre (Appendix B). As such, these programs reflected the use of community services and were mostly facilitated by individuals within the community, often volunteers or paraprofessionals. The index is unique to this current study with emphasis on the community-based programs/activities highlighted in the BBBF questionnaire.

The measure of **Concerns about Access to Formal Supports Index** was based on two items that were developed by BBBF researchers. These items (p9, p10; Appendix B) assessed whether respondents wanted to see a professional for their child in the last 12 months but didn’t (proff), and whether they felt they were not receiving as good a service as other people (servicef). The respondents answered yes (1) or no (0) to each item; a score of 0 is computed when the respondents say no to both questions and a score of 1 or 2 when respondents say yes for one or both questions. Most respondents (518 or 78.1%) had a score of 0, 120 respondents (~19%) received a score of 1 and 25 respondents (~4%) that received a score of 2 on this index. The index is unique to this current study with emphasis on the dissatisfaction or concerns with the use or availability of formal supports highlighted in the BBBF questionnaire.
The measure of **Parental Warmth** consisted of items from the Positive Parent-Child Interaction and Hostile-Ineffective Parenting subscales used in the National Longitudinal Survey of Children and Youth (NLSCY). The NLSCY was developed jointly by Human Resources Development Canada and Statistics Canada, and has been used in a comprehensive study which follows the development of children in Canada (Willms, 2002). Five items were selected from the Positive Parent-Child Interaction and one item from Hostile-Ineffective Parenting subscales. The Positive Parent-Child interaction subscale (questions 13, 15, 17, 20, 21) measures levels of praise that a respondent gave to the child and the interaction between the respondent and child; while the Hostile-Ineffective Parenting subscale (question 23) measured how often the respondent interacted with the child about his/her behaviour. The response alternatives for the items on the Positive Parent-Child interaction subscale ranged from 1 to 5 (1=Never, 2=About once a week or less, 3=More than once a week but less than once a day, 4=One or two times a day, and 5=Many times each day); and for the Hostile Ineffective Parenting subscale ranged from 0 to 4 (0=Never, 1=Less than half the time, 2=About half the time, 3=More than half the time, and 4=All the time). This item was rescored to reflect the range from 1 to 5 for Positive Parent-Child Interaction. The reliability coefficient (Cronbach’s alpha) is $\alpha = .69$.

**Parental Depression** was assessed with 12 modified items from the Centre for Epidemiological Studies Depression Scale (CES-D, Radloff, 1977). The CES-D scale is designed to measure current level of symptoms that vary over time. The components of the scale include depressed mood, feelings of guilt and worthlessness, feelings of helplessness and hopelessness, loss of appetite and sleep disturbance. There were 12 items including questions 8, 12 and 16 that were recoded: These questions related to feelings of hope for the future, and being happy. Items were rated on a 4-point scale from 1 = rarely or none of the time to 4 = most or all of the time.
Total scores ranged from 12 to 48, with higher scores indicating a greater prevalence of depressive symptoms. For the current study, the reliability coefficient (Cronbach’s alpha) is $\alpha = .87$. Klein (1974) suggested that severely depressed patients are characterized by an absence of positive affect as well as the presence of negative effect.

The Parental Stress measure consisted of 14-items that assess family and parental stress. This scale was developed by BBBF researchers called Life Stress, which is based on stressful life events as formulated in the questionnaire and thus utilized for the current study. The list of stressful life events items is included in Appendix B (#7). Parents were asked whether they had experienced a variety of individual or family-related stressful events in the last year, and answered yes or no to each. Items covered a wide range of experiences including losing a job, separation from a spouse or partner, financial problems, relationship difficulties, arrival of a new baby, serious illness, and death of someone dear. Scores consisted of the total number of ‘Yes’ responses and ranged from 0 to 13, with higher scores indicating more stress. The most commonly occurring stressors reported for this sample were when a respondent lost a job and/or was unemployed (13%), stopped full-time schooling (12%), and got married (11%).

The Parents’ Sense of Community Involvement scale measured respondents’ sense of community belonging in the neighbourhood in which they reside. The scale was developed by BBBF researchers and modified from Buckner (1988). The Sense of Community Involvement scale consists of seven items (questions 1, 2, 3, 4, 5, 6, 7) designed to identify the parents’ sense of belonging to their neighbourhood and feelings of importance, willingness to work with others on something to improve the neighbourhood, and the feeling of having similar traits to other people within the neighbourhood (Appendix B). Responses were rated on a 4-point scale from 1=strongly agree to 4=strongly disagree. The reliability coefficient (Cronbach’s alpha) for the
sense of community involvement scale is $\alpha = .82$. The internal consistency of items in this scale was good.

**Data Analysis**

Prior to the analysis, the presence of missing data and the normality of the variables were examined. Although 870 participants completed the questionnaire, there were 207 participants who had missing data on at least one of the variables of interest. Consequently, most analyses were conducted on 140 families with a child with a disability or chronic health condition and 523 families of children without disabilities. Analytical procedures included Chi square comparisons and independent samples t-tests to compare the two groups. An analysis of the differences in patterns of relationships among the parental variables (except for parental stress) across the two groups used Pearson correlations.
**Results**

The results are presented in four sections. The first section describes and compares the two groups of families (high-risk families of young children in which a child had a disability or chronic health condition vs. a child without a disability) with regard to child and family sociodemographic characteristics. The second section highlights the relationship between the two groups with respect to their use of formal supports (medical, mental health and social services professionals), concerns about access to formal supports, parents’ reports of their use of informal community programs, and the differences in perceived social support. Also, it further describes the measure in the use of informal supports. The third section highlights the relationship between both groups of families in parental stress (stressful life events) items and the differences among parental depression, parental warmth in parent-child interactions, and community involvement. The fourth section considers the measures of formal supports (both use and access of support), and use of informal supports and the relationship of the parental variables in each group, and the patterns in relationship among the variables.

**Sociodemographic Characteristics**

Preliminary analyses were conducted initially to determine whether families of children with disabilities and those without disabilities differed in sociodemographic characteristics. The first question of this study addresses the differences in sociodemographic characteristics of children with disabilities and those families without disabilities. Table 5 provides information on the sociodemographic characteristics of the BBBF families of children with and without disabilities in Grade one. Chi square analyses indicated that the two groups are quite similar in most respects. Significant differences between the two groups revealed that respondent parents of children with disabilities were more likely to be born in Canada and less likely to be
employed, particularly on a full-time basis (25.9%) compared to parents of children without disabilities (36.7%). Families of children with disabilities were more likely to be employed on a part-time basis (31.1%) in comparison to those families of children without disabilities (31.4%).

With respect to child characteristics, a higher proportion of the children with disabilities were boys (61%) compared to 52% in families of children without a disability. This is a common finding in the literature (Statistics Canada, 2007). Another significant difference related to children’s place of birth. A higher proportion of the children with a disability were born in Canada than children without a disability (~99% vs. 95%, respectively).
Table 5

Sociodemographic Characteristics of Families of Children with a Disability and Families of Children Without a Disability.

<table>
<thead>
<tr>
<th>Categories</th>
<th>Families of Children With a Disability (N=140)</th>
<th>Families of Children Without a Disability (N=523)</th>
<th>Chi-square</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respondent’s Gender</td>
<td>Frequency</td>
<td>Percent (%)</td>
<td>Frequency</td>
<td>Percent (%)</td>
</tr>
<tr>
<td>Male</td>
<td>14</td>
<td>10.0</td>
<td>35</td>
<td>6.7</td>
</tr>
<tr>
<td>Female</td>
<td>126</td>
<td>90.0</td>
<td>488</td>
<td>93.3</td>
</tr>
<tr>
<td>Respondent’s relationship to child:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Biological mother/father</td>
<td>132</td>
<td>94.3</td>
<td>504</td>
<td>96.4</td>
</tr>
<tr>
<td>Guardians/other</td>
<td>8</td>
<td>5.7</td>
<td>19</td>
<td>3.6</td>
</tr>
<tr>
<td>Duration of residence:</td>
<td>N=520</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Two years or less</td>
<td>38</td>
<td>27.1</td>
<td>134</td>
<td>25.8</td>
</tr>
<tr>
<td>Three or four years</td>
<td>36</td>
<td>25.7</td>
<td>132</td>
<td>25.4</td>
</tr>
<tr>
<td>Five or more years</td>
<td>66</td>
<td>47.2</td>
<td>254</td>
<td>48.8</td>
</tr>
<tr>
<td>Household</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not a single parent</td>
<td>85</td>
<td>60.7</td>
<td>338</td>
<td>64.6</td>
</tr>
<tr>
<td>Single parent</td>
<td>55</td>
<td>39.3</td>
<td>185</td>
<td>35.4</td>
</tr>
<tr>
<td>Number of people in the home:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Two</td>
<td>13</td>
<td>9.3</td>
<td>33</td>
<td>6.3</td>
</tr>
<tr>
<td>Three</td>
<td>29</td>
<td>20.7</td>
<td>98</td>
<td>18.7</td>
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<tr>
<td>Four or more</td>
<td>98</td>
<td>70.0</td>
<td>392</td>
<td>75.0</td>
</tr>
<tr>
<td>Place of birth for respondents:</td>
<td>N=520</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Canada</td>
<td>122</td>
<td>87.1</td>
<td>320</td>
<td>61.5</td>
</tr>
<tr>
<td>Other than Canada</td>
<td>18</td>
<td>12.9</td>
<td>200</td>
<td>38.5</td>
</tr>
<tr>
<td>Educational Level (respondent):</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than high school graduation</td>
<td>52</td>
<td>37.1</td>
<td>191</td>
<td>36.5</td>
</tr>
<tr>
<td>Graduated high school</td>
<td>37</td>
<td>26.4</td>
<td>138</td>
<td>26.4</td>
</tr>
<tr>
<td>Some College/University</td>
<td>16</td>
<td>11.4</td>
<td>67</td>
<td>12.8</td>
</tr>
<tr>
<td>Graduate of College/University (includes</td>
<td>35</td>
<td>25.0</td>
<td>127</td>
<td>24.3</td>
</tr>
<tr>
<td>professional/graduate programs)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
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</table>
### Table 5 cont’d

**Sociodemographic Characteristics of Families of Children with a Disability and Families of Children Without a Disability.**

<table>
<thead>
<tr>
<th>Categories</th>
<th>Families of Children With a Disability (N=140)</th>
<th>Families of Children Without a Disability (N=523)</th>
<th>Chi-square</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educational Level (partner):</td>
<td></td>
<td></td>
<td>1.475</td>
<td>3</td>
</tr>
<tr>
<td>Less than high school</td>
<td>26</td>
<td>31.3</td>
<td>114</td>
<td>35.1</td>
</tr>
<tr>
<td>Graduated high school</td>
<td>27</td>
<td>32.5</td>
<td>88</td>
<td>27.1</td>
</tr>
<tr>
<td>Some College/University</td>
<td>6</td>
<td>7.2</td>
<td>32</td>
<td>9.8</td>
</tr>
<tr>
<td>Graduate of College/University (includes professional/graduate programs)</td>
<td>24</td>
<td>29.0</td>
<td>91</td>
<td>28.0</td>
</tr>
<tr>
<td>Employment:</td>
<td>N=521</td>
<td></td>
<td>5.886*</td>
<td>2</td>
</tr>
<tr>
<td>Full-time</td>
<td>36</td>
<td>25.7</td>
<td>191</td>
<td>36.7</td>
</tr>
<tr>
<td>Part-time</td>
<td>32</td>
<td>22.9</td>
<td>104</td>
<td>20.0</td>
</tr>
<tr>
<td>Not employed / Not in the labour force</td>
<td>72</td>
<td>51.4</td>
<td>226</td>
<td>43.3</td>
</tr>
<tr>
<td>Household Income (monthly):</td>
<td></td>
<td></td>
<td>6.240</td>
<td>3</td>
</tr>
<tr>
<td>0-1499</td>
<td>47</td>
<td>36.7</td>
<td>141</td>
<td>31.0</td>
</tr>
<tr>
<td>1500-2999</td>
<td>51</td>
<td>39.8</td>
<td>185</td>
<td>40.7</td>
</tr>
<tr>
<td>3000-4499</td>
<td>12</td>
<td>9.4</td>
<td>80</td>
<td>17.6</td>
</tr>
<tr>
<td>4500-13500</td>
<td>18</td>
<td>14.1</td>
<td>49</td>
<td>10.8</td>
</tr>
<tr>
<td>Child’s Gender</td>
<td></td>
<td></td>
<td>3.946*</td>
<td>1</td>
</tr>
<tr>
<td>Boy</td>
<td>86</td>
<td>61.4</td>
<td>272</td>
<td>52.0</td>
</tr>
<tr>
<td>Girl</td>
<td>54</td>
<td>38.6</td>
<td>251</td>
<td>48.0</td>
</tr>
<tr>
<td>Place of birth for children:</td>
<td></td>
<td></td>
<td>4.039*</td>
<td>1</td>
</tr>
<tr>
<td>Canada</td>
<td>105</td>
<td>99.1</td>
<td>376</td>
<td>94.5</td>
</tr>
<tr>
<td>Other than Canada</td>
<td>1</td>
<td>0.9</td>
<td>22</td>
<td>5.5</td>
</tr>
</tbody>
</table>

*indicates significance, p<.05
**indicates significance, p<.01
Use of Formal Supports, Concerns about Access to Formal Supports, and the use of Informal Supports

The second question of this study addresses the relationship among the use of formal supports, concerns about access to formal supports, and the differences in perceived social support among families of children with a disability and those without a disability living in low-income communities. The relationship in the use of informal supports for both groups of families is highlighted in Table 8.

Use of formal supports.

It is likely that the families of children with disabilities will have more contact with health and social service professionals due to their child’s chronic condition(s). The research literature suggests that many families who need the most support or those seeking and receiving formal supports are parents with high stress levels, and are also parents without partners to assist in the care of the children (Canary, 2008). Table 6 shows the number and nature of formal supports (health and social services) used by families of children with a disability and those without a disability in the 12 months preceding the interview.

Formal supports were grouped into three categories: medical professionals, mental health and social services, and other professionals. Medical professionals include a family doctor/general physician (GP), another medical doctor (e.g., a paediatrician or eye specialist), emergency room staff at a hospital, and a public health nurse/practitioner. Mental health and social services consisted of a psychiatrist or a psychologist, and a child welfare worker or children’s aid worker. “Other professionals” includes any other trained individual who provided treatment for a child or other family member in the last 12 months. Parents indicated with a yes or no response whether they had seen or visited professionals in these subgroups at sometime in the past 12 months. The affirmative responses represent how the parents responded in use of the
formal supports, as referenced in Table 6. Some families may have seen these or other professionals or specialists more often throughout the 12 month period.

Table 6

The Number and Nature of Formal Supports used by Families of Children with and Without a Disability in the Previous 12 Months

<table>
<thead>
<tr>
<th></th>
<th>Families of Children with a Disability (N=140)</th>
<th>Families of Children without a Disability (N=521)</th>
<th>Chi-square</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td><strong>Medical Professionals</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General practitioner/family physician</td>
<td>113</td>
<td>80.7%</td>
<td>388</td>
</tr>
<tr>
<td>Another medical doctor</td>
<td>93</td>
<td>66.4%</td>
<td>175</td>
</tr>
<tr>
<td>Emergency room at the hospital</td>
<td>58</td>
<td>41.7%</td>
<td>140</td>
</tr>
<tr>
<td>Public health nurse</td>
<td>38</td>
<td>27.1%</td>
<td>78</td>
</tr>
<tr>
<td><strong>Mental Health and Social Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatrist/psychologist</td>
<td>33</td>
<td>23.6%</td>
<td>25</td>
</tr>
<tr>
<td>Child welfare worker/children’s aid worker</td>
<td>25</td>
<td>17.9%</td>
<td>52</td>
</tr>
<tr>
<td><strong>Other Professionals</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other persons trained to provide treatment or counsel</td>
<td>71</td>
<td>50.7%</td>
<td>78</td>
</tr>
</tbody>
</table>

* indicates significance, p<.05
** indicates significance, p<.01
***indicates significance, p<.001

Overall, families in both groups were most likely to have seen a GP or family doctor in the last year. Approximately 81% of families of children with a disability visited a general practitioner (GP) or a family physician, as did 75% of families of children without a disability (see Table 6). Beyond a GP or family doctor, only a small proportion of families of children without a disability visited each of the other types of professionals or services indicated. By contrast, two thirds of the families of children with a disability saw another medical doctor (66.4%); half (50.7%) saw another (unspecified) professional for their child; and 41.7% visited a hospital emergency room at least once. In fact, families of children with a disability were
statistically (significantly) more likely to visit each type of professional listed in Table 6, other than a GP or family doctor.

Further examination revealed that there is a significant relationship between families of children with a disability and their counterparts in the use of medical professionals other than GP, use of mental health and social services, use of other professionals, and the two items of concerns about access to formal supports (see Table 7). The yes responses highlight the possible needs as it relates to the use of formal supports, and the likely dissatisfaction and concerns about access to formal supports between both groups of families. Approximately 70% of families of children without a disability had contact with at least one medical professional other than a GP, compared to 30% of families of children with a disability. Similarly, the proportion of families who had contact with the use of mental health and social services was approximately 45% among families of children with a disability compared to approximately 55% in families of children without a disability (p< .001). For the use of other professionals, approximately 48% of families of children with a disability in comparison to approximately 52% of families of children without a disability responded in the affirmative. In fact, a higher proportion of parents in families of children with a disability had contact with other professionals within the last year; the same was true of parents in families of a child without a disability who had contact with medical professionals other than GP.
Table 7


<table>
<thead>
<tr>
<th>Variables</th>
<th>Disability Status (0 or 1)</th>
<th>N</th>
<th>%</th>
<th>Chi-square</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of Medical Professionals other than GP</td>
<td>1</td>
<td>112</td>
<td>29.6</td>
<td>36.8**</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>267</td>
<td>70.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of Mental Health and Social Services Professionals</td>
<td>1</td>
<td>51</td>
<td>44.7</td>
<td>45.3**</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>63</td>
<td>55.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of Other Professionals</td>
<td>1</td>
<td>71</td>
<td>47.7</td>
<td>80.7**</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>78</td>
<td>52.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concerns about Access to Formal Supports (prof)</td>
<td>1</td>
<td>32</td>
<td>35.2</td>
<td>12.43**</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>59</td>
<td>64.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concerns about Access to Formal Supports (servicef)</td>
<td>1</td>
<td>24</td>
<td>28.9</td>
<td>3.36</td>
<td>.067</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>59</td>
<td>71.1</td>
<td></td>
<td></td>
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</tbody>
</table>

*indicates significance, p<.05
**indicates significance, p<.001

Disability Status of Child: 1=with disability, N=140; 0=without disability, N=522

<table>
<thead>
<tr>
<th>Variable</th>
<th>Disability Status (0 or 1)</th>
<th>M</th>
<th>SD</th>
<th>t-test</th>
<th>df</th>
<th>p value</th>
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</thead>
<tbody>
<tr>
<td>Perceived Social</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support</td>
<td>1</td>
<td>20.71</td>
<td>2.96</td>
<td>-.71</td>
<td>472</td>
<td>.475</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>20.49</td>
<td>2.78</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*indicates significance, p<.05
**indicates significance, p<.01
+ indicates t-statistic based on unequal variances

Disability Status of Child: 1=with disability, N=140; 0=without disability, N=516

Concerns about access to formal supports.

Two questions were asked of respondent parents to determine how satisfied they were or whether they had concerns about the access to formal supports for themselves or their child. The two questions were: 1) (prof) Was there ever a time during the past 12 months when you wanted to see a professional for your child but didn’t? and 2) (servicef) Did you ever feel you were not getting as good service as other people? In reference to question one, of the families of children with a disability, approximately 35% wanted to see a professional for their child but didn’t; in answer to question two, approximately 29% of the parents of a child with a disability
felt that they were not getting as good service as others. By contrast, approximately 65% of parents in families of children without a disability wanted to see a professional but didn’t, and 71% felt that they were not getting as good service as others. Question 2 (servicef) did not have a significant relationship between both groups of families. As such, there was no difference in how the respondent parents answered to feelings of not getting as good service as other people. Chi-square analysis based on these two questions revealed that a relationship between the parents in families of children with disabilities expressed some concern or dissatisfaction with the availability or quality of service available to them or their children; although, significantly less concern when it related to wanting to see a professional in the last 12 months for their child but didn’t.

**Use of informal supports: community-based programs.**

The use of informal supports was based a measure of parents’ use of various community-based programs and services for children and parents in the previous year. Informal community-based programs included a recreation/playground program; sports, crafts, or organized clubs; an after-school care program or drop-in centre; after-school language instruction/cultural classes; a library; and a parent resource centre/parent group. There was no significant relationship among the number of community-based programs used between the two groups of families. As shown in Table 8, there was general similarity in the use of community programs by families of children with and without a disability. Chi-square analysis revealed no significant relationships between families of children with a disability and families of children without a disability in the proportions that used particular types of community programs. The one exception was the use of after-school language instruction/cultural classes, which had a significant relationship between both groups, a larger proportion of families of children without a disability (90.7% vs. 9.3%) in
comparison to the families of children with a disability. This difference most likely reflects the fact that a larger proportion of parents and children without a disability were immigrants.

Table 8

*Relationship in the Use of Informal Supports (Community-based Programs) in the last 12 Months by Families of Children with a Disability and Families of Children Without a Disability*

<table>
<thead>
<tr>
<th>Use of Informal Support (Community-based programs)</th>
<th>Families of Children with a Disability (N=140)</th>
<th>Families of Children Without a Disability (N=522)</th>
<th>Chi-square</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Recreation/playground program</td>
<td>49</td>
<td>24.1</td>
<td>154</td>
</tr>
<tr>
<td>Sports, crafts, or clubs</td>
<td>73</td>
<td>23.1</td>
<td>243</td>
</tr>
<tr>
<td>After-school care program/drop-in centre</td>
<td>24</td>
<td>19.7</td>
<td>98</td>
</tr>
<tr>
<td>After-school language instruction/cultural classes</td>
<td>7</td>
<td>9.3</td>
<td>68</td>
</tr>
<tr>
<td>A library</td>
<td>72</td>
<td>20.2</td>
<td>284</td>
</tr>
<tr>
<td>Parent resource centre, parent group, etc.</td>
<td>24</td>
<td>19.8</td>
<td>97</td>
</tr>
</tbody>
</table>

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

Perceived social support.

This scale was designed as a general measure of perceived social support, which captures the extent to which participating parents felt they had instrumental and emotional support from family members, friends and others. There was no significant difference in the average perceived social support, or the availability of support from family members, friends, or neighbours between the two groups. Mean scores were recorded as $M=20.71$, $SD=2.96$ for parents in families of children with a disability and $M=20.49$, $SD=2.78$ for parents in families of children without a disability. As shown in Table 7, independent sample t-tests revealed no significant difference between the two groups on the perceived social support measure ($t=-.71$, df=472, $p>.05$).
Parent Stress, Depression, Parental Warmth and Community Involvement

These are key variables that reflect family dynamics and parental well-being. The parental variables of family dynamics are parental warmth and community involvement; and parent well-being are parental stress and parental depression. The third question of this study addresses the characteristics in parental stress (stressful life events items; see Appendix B #7), parental depression, parental warmth, and community involvement among families of children with a disability and those families of children without a disability living in low income communities. Examination revealed that parents in families of a child with a disability had statistically higher scores on parental depression, and parental stress items such as serious illness of someone dear, death of someone dear and cared for someone with a serious chronic illness, just to name a few, in comparison to respondent parents in families without a child with a disability (see Table 9).
Table 9

*Characteristics of Parental Stress, Parental Depression, Parental Warmth and Community Involvement using Chi-square and T-test Analyses for Families of Children with a Disability and Families of Children Without a Disability*

<table>
<thead>
<tr>
<th>Parental Stress (Stressful Event Items)</th>
<th>Disability Status (0 or 1)</th>
<th>N</th>
<th>%</th>
<th>Chi-square</th>
</tr>
</thead>
<tbody>
<tr>
<td>School</td>
<td>1</td>
<td>15</td>
<td>28.3</td>
<td>1.68</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>38</td>
<td>71.7</td>
<td></td>
</tr>
<tr>
<td>Lost job</td>
<td>1</td>
<td>43</td>
<td>24.2</td>
<td>1.32</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>135</td>
<td>75.8</td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>1</td>
<td>2</td>
<td>20.0</td>
<td>.01</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>8</td>
<td>80.0</td>
<td></td>
</tr>
<tr>
<td>Moved in</td>
<td>1</td>
<td>31</td>
<td>29.0</td>
<td>4.73*</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>76</td>
<td>71.0</td>
<td></td>
</tr>
<tr>
<td>Finances</td>
<td>1</td>
<td>72</td>
<td>26.3</td>
<td>7.47**</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>202</td>
<td>73.7</td>
<td></td>
</tr>
<tr>
<td>Separation</td>
<td>1</td>
<td>19</td>
<td>28.8</td>
<td>2.66</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>47</td>
<td>71.2</td>
<td></td>
</tr>
<tr>
<td>New baby</td>
<td>1</td>
<td>15</td>
<td>24.6</td>
<td>.49</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>46</td>
<td>75.4</td>
<td></td>
</tr>
<tr>
<td>Moved out</td>
<td>1</td>
<td>39</td>
<td>32.5</td>
<td>11.40***</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>81</td>
<td>67.5</td>
<td></td>
</tr>
<tr>
<td>Serious illness</td>
<td>1</td>
<td>17</td>
<td>27.0</td>
<td>1.42</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>46</td>
<td>73.0</td>
<td></td>
</tr>
<tr>
<td>Serious illness of someone dear</td>
<td>1</td>
<td>72</td>
<td>34.3</td>
<td>32.00***</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>138</td>
<td>65.7</td>
<td></td>
</tr>
<tr>
<td>Quit</td>
<td>1</td>
<td>6</td>
<td>18.8</td>
<td>.11</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>26</td>
<td>81.3</td>
<td></td>
</tr>
</tbody>
</table>
Table 9 cont’d

Characteristics of Parental Stress, Parental Depression, Parental Warmth and Community Involvement using Chi-square and T-test Analyses for Families of Children with a Disability and Families of Children Without a Disability

<table>
<thead>
<tr>
<th>Parental Stress (Stressful Event Items)</th>
<th>Disability Status (0 or 1)</th>
<th>N</th>
<th>%</th>
<th>Chi-square</th>
</tr>
</thead>
<tbody>
<tr>
<td>New job</td>
<td>1</td>
<td>49</td>
<td>24.5</td>
<td>1.97</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>151</td>
<td>75.5</td>
<td></td>
</tr>
<tr>
<td>Death</td>
<td>1</td>
<td>60</td>
<td>26.4</td>
<td>5.78*</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>167</td>
<td>73.6</td>
<td></td>
</tr>
<tr>
<td>Cared for someone with a serious chronic illness</td>
<td>1</td>
<td>31</td>
<td>35.2</td>
<td>12.13***</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>57</td>
<td>64.8</td>
<td></td>
</tr>
</tbody>
</table>

*indicates significance p<.05  
**indicates significance p<.01  
***indicates significance p<.001  
Disability Status of Child: 1=with disability, N=140; 0=without disability, N=517

<table>
<thead>
<tr>
<th>Variables</th>
<th>Disability Status (0 or 1)</th>
<th>M</th>
<th>SD</th>
<th>t-test</th>
<th>df</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parental Depression</td>
<td>1</td>
<td>21.94</td>
<td>7.75</td>
<td>-3.55**</td>
<td>472</td>
<td>.011</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>19.39</td>
<td>6.64</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parental Warmth</td>
<td>1</td>
<td>23.38</td>
<td>3.00</td>
<td>-.20</td>
<td>472</td>
<td>.231</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>23.00</td>
<td>2.95</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Involvement</td>
<td>1</td>
<td>14.78</td>
<td>2.98</td>
<td>-.36</td>
<td>472</td>
<td>.717</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>14.64</td>
<td>3.62</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*indicates significance p<.05  
**indicates significance p<.01  
+ indicates t-statistic based on unequal variances  
Disability Status of Child: 1=with disability, N=138; 0=without disability, N=509

**Parental stress**

Respondent parents in families of children with a disability had significant relationships among some of the stressful life events (parental stress measure) which included someone moving in, financial problems, someone moved out of the home, serious illness of someone dear, death of someone dear and cared for someone with a serious chronic illness compared to parents in families of children without a disability. The respondents were asked to indicate what they have experienced or what has happened in the last 12 months. For the families of children with a disability, nearly half of the sample responded positively about experiencing financial problems and a serious illness of someone dear in the past 12 months; it is also a significant
relationship between both groups. It is also important to note that there was no significant relationship in serious illness, yet a significant relationship for serious illness of someone dear. It appears that once the serious illness is related to someone dear, for example: a child with a disability, then it affects the stressful life experience of the respondent. In terms of someone moving in or moving out, there is a significant difference between families of children with a disability and families of children without a disability. One interpretation about someone moving in is that there is a possibility of higher levels of stress in taking care of an additional person in the household, such as providing meals and provision of necessities. Similarly, it appears that when someone moves out, it can be related to losing a form of informal support, or losing an additional income which once provided for the family.

**Parental depression**

The t-test comparisons revealed that parents of children with a disability had significantly higher mean scores on the measure of parental depression ($t=-3.55$, $p<.01$). This results in similar findings in other studies (Gupta & Singhal, 2004). Parents of children with disabilities probably are at significantly greater risk of experiencing stress and depression, especially if their child’s condition is severe and/or if parents lack adequate support systems. There was no significant relationship in parental warmth and community involvement.

**Parental warmth.**

The variable, parental warmth refers to the reported frequency of positive parent-child interactions that convey emotional nurturance and positive affect exhibited by a parent to his/her child. As shown in Table 9, parents of children with a disability and parents in families without a child with a disability had similar scores on this measure of parental warmth. There was no significant difference in mean scores as reported by respondent parents. It appears that
the scores for parental warmth in both groups are similar in the intensity levels and/or how parent-child interactions are established among families.

**Community involvement.**

Community involvement was based on a 7 item scale that reflects parents’ sense of community involvement and belonging. It is likely that parents’ sense of community involvement stems from their own, and their child’s level of involvement in community activities as well as the degree to which they engage in reciprocal interactions with friends, family and neighbours. As shown in Table 9, parents in the two groups had similar average scores ($M=14.78$, $SD=2.98$) for parents in families of children with a disability compared to an average of $M=14.64$, $SD=3.62$ for parents in families of children without a disability. There was no significant difference between the groups.

**Relationships Among the use of Formal Supports, use of Informal Supports, Concerns about Access to Formal Supports, and the Differences in Perceived Social Support, Parental Depression, Parental Warmth and Community Involvement**

Parental stress, parental warmth, parental depression and parental sense of community involvement are important variables that reflect parents’ functioning and well-being. It is important to examine how these parental variables relate to each other in families at risk and especially in families of children with disabilities. Earlier in the current study, there have been references (key research questions) which highlighted the use of formal supports, use of informal supports, concerns about access to formal supports, perceived social support and the parental variables in relation to both groups of families. The fourth question addresses the relationship pattern for perceived social support, parental warmth, parental depression and community involvement for all the families of young children (for families of children without disabilities and families of children with disabilities, respectively). Correlation matrices were
used to compare the interrelationships among these parental variables (with the exception of parental stress). As shown in Table 9, parental stress in relation to both groups is clearly highlighted to provide further description and characteristics of each item which will help with further discussion and ideas for future trends/research. Table 10 presents the intercorrelations for parents in families of young children without a disability living in low-income communities.

Table 10

*Correlation Matrix of Perceived Social Support, Parental Warmth, Parental Depression and Community Involvement in Families of Children Without Disabilities*

<table>
<thead>
<tr>
<th>Measures</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Perceived Social Support</td>
<td>-</td>
<td>.246**</td>
<td>-.332**</td>
<td>-.196**</td>
</tr>
<tr>
<td>2. Parental Warmth</td>
<td>.246**</td>
<td>-</td>
<td>-.084+</td>
<td>-.080</td>
</tr>
<tr>
<td>3. Parental Depression</td>
<td>-.332**</td>
<td>-.084+</td>
<td>-</td>
<td>.203**</td>
</tr>
<tr>
<td>4. Community Involvement</td>
<td>-.196**</td>
<td>-.080</td>
<td>.203**</td>
<td>-</td>
</tr>
</tbody>
</table>

**+ indicates significance, p<.01**
+N= 495

Measures of Social support include the use of specific formal supports, concerns about access to formal supports, use of informal supports and perceived social support. In Table 10 above, the following relationships will be addressed for families of children without disabilities: relationship among perceived social support, parental warmth, parental depression and community involvement.
There is a significant correlation \( (r = .246) \) between perceived social support and parental warmth. As well, parental depression and community involvement has a significant correlation \( (r = .203) \). As parental depression increases so will community involvement, which makes it seem as if a parent who is undergoing depressive symptoms will possibly realize that they may need to engage with their communities by participating in activities and professionally-based services.

As part of the BBBF initiative, participants may also be provided with appropriate resources and services in order to engage parents and foster interaction within communities. Additionally, there is a significant correlation \( (r = -.332) \) inverse relationship between perceived social support and parental depression; and similarly with perceived social support and community involvement \( (r = -.196) \). There is a trend in correlation \( (r = -.084) \) between parental warmth and parental depression.

There are several inverse relationships that will be highlighted. The first is the relationship between parental depression and perceived social support where the perceived social support decreases as parental depression increases. It appears that a respondent’s perceived social support whether accessed or made available will lessen as parental depression increases. Therefore, parents with more depression may most likely perceive that they have less social support. Another inverse relationship involves perceived social support and community involvement where perceived social support decreases as community involvement increases. One interpretation could be that the families’ perception of social support decreases as they become more involved with their communities. The BBBF prevention initiative supported all communities to develop community based programs to serve all children living in the participating communities. As a result the families in this study may be actively involved for many reasons with the BBBF project, regardless of their perceptions of social support. There is
also an inverse relationship or trend in correlation between parental warmth and parental
depression (as parental warmth decreases, parental depression increases or vice versa).
Therefore, parental depression increases as it relates to lower parental confidence or minimal
parent-child interactions such as nurturance and emotional support for a child.

Table 11

*Correlation Matrix of Perceived Social Support, Parental Warmth,
Parental Depression and Community Involvement in Families of
Children With Disabilities*

<table>
<thead>
<tr>
<th>Measures</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Perceived Social Support</td>
<td>-</td>
<td>.358**</td>
<td>-.379**</td>
<td>-.333**</td>
</tr>
<tr>
<td>2. Parental Warmth</td>
<td>.358**</td>
<td>-</td>
<td>-.269**</td>
<td>-.101</td>
</tr>
<tr>
<td>3. Parental Depression</td>
<td>-.379**</td>
<td>-.269**</td>
<td>-</td>
<td>.315**</td>
</tr>
<tr>
<td>4. Community Involvement</td>
<td>-.333**</td>
<td>-.101</td>
<td>.315**</td>
<td>-</td>
</tr>
</tbody>
</table>

**indicates significance, p<.01
+ indicates trends
N= 113

In Table 11 above, the following relationships will be addressed for the families of children
with disabilities: relationship among perceived social support, parental warmth, parental
depression and community involvement.

There is a significant correlation \( r = .358 \) between perceived social support and parental
warmth. There is a significant relationship \( r = .315 \) between parental depression and community
involvement; and a significant negative correlation \( r = -.379 \) between perceived social support
and parental depression. The negative correlation indicates an inverse relationship, where
perceived social support tends to increase as parental depression may decrease. Additionally, there is significant correlation ($r=-.333$) inverse relationship between perceived social support and community involvement; and significant correlation ($r=-.269$) between parental warmth and parental depression. As parental depression decreases, then parental warmth increases; perhaps when parents feel less depressed they are more likely able to have nurturing and positive parent-child interactions. As for the relationship between parental depression and community involvement, it suggests that parents who tend to be depressed and more involved in the community. Possibly the BBBF project and the various research sites would have developed various supports and services so that families can feel safe. Therefore, these families, despite their depressive state, may want to get involved with their community or the programs initiated by BBBF both for themselves and their children.

**Comparing both Groups: Families of Children Without Disabilities and Families of Children with Disabilities**

In both groups, families of children without disabilities and families of children with disabilities, there is no significant relationship pattern between parental variables: parental warmth and community involvement. In terms of the families of children without disabilities, there is only a trend in correlation between parental warmth and parental depression, where families of children with disabilities have an inversely significant relationship. There is a stronger pattern in correlation or higher correlation patterns for families of children with disabilities.

There is a significant relationship in the use of informal supports with higher proportions of community-based programs used by families of children without disabilities. Furthermore, lower proportions in the use of formal supports (as described per item, each professional-based service) for families of children without a disability have a significant relationship with families
of children with disabilities. In relationship with concerns about access to formal supports (respondents answered that they wanted to see a professional but didn’t), the families of children without disabilities are significantly related to the use of formal supports. There is a significant difference between both groups of families for parental depression; as for parental stress, there are some significant relationships among the stressful life events listed in Table 9. It appears that these significant relationships may also contribute to an individual’s well-being. For example, from the stressful life events when someone loses a job, this possibly affected the significant relationship between both groups in terms of financial problems, which is found moreso, in families of children with disabilities than the families of children without disabilities.
Discussion

The primary purpose of this research was to examine the impact of social supports on families of young children with disabilities in grade one living in low-income communities. Social supports were further examined as use of formal support and informal supports (community-based programs), and concerns about access to formal supports and the relationship among all social supports and the parental variables: parental stress, parental depression, parental warmth and community involvement.

Families of children with disabilities are already at a higher risk due to their lower socioeconomic status. Similarly, families of children with chronic conditions and disabilities tend to use and may need more access to formal supports such as health and social service professionals; as well as informal supports. Children with disabilities are children first, and also have needs typical of all children; professionals need to be mindful of each child within their care and in society as a whole (Warner, 2006). It is also crucial that all children, especially those with disabilities, should gain access to available supports within their communities. There are programs or interventions like the BBBF that provide support in assisting families of children in low-income communities. As such, this study highlighted those families of children with disabilities within their low-income settings with little to no research in this area of interest.

Question 1

Chi square analyses indicated that the two groups are quite similar in their sociodemographic characteristics. There were significant differences between families of children with disabilities who were more likely to be born in Canada, and less likely employed on a full-time basis, than families of children without disabilities. Higher proportion of the boys had disabilities; this is also a common finding in the literature. According to Statistics Canada (2007), males between the ages of 0-14 having a disability are proportionately higher than
females. Having a disability and living in poverty is a major challenge that these families may face. Willms (2002) suggests that children with disabilities are more vulnerable in low-income settings and may likely experience a variety of outcomes.

**Question 2**

Families of children with a disability were statistically more likely to visit health and social service professionals. All the formal supports had a significant difference except for the general practitioner/family physician, which may indicate that all families had access to a family physician either before or during the BBBF intervention. As cited in Canary (2008), research on families of children with disabilities indicates that low levels of informational support possibly limits access and unpredictable use of services. The relationship between use of formal supports and the concerns about access to formal supports highlight that families of children without disabilities have a higher proportion than families of children with disabilities. In comparison, more families of children without disabilities were less satisfied or had concerns about access to formal support than the families of children with disabilities. Chi-square analysis was utilized for use of formal supports, concerns about access to formal support, use of informal supports, and t-test comparison for the measure of perceived social support.

In terms of informal supports (community-based programs), there was no significant difference in the how community-based programs were used between the two groups of families. Overall, there was no significant difference in perceived social support for both groups. The BBBF initiative had as its core a process of community-based services for all families involved in the various communities. Informal support or community-based programs seems to be a constant resource in the lives of both groups. Both formal and informal supports are necessary to meet the needs of children. In the Statistics Canada (2008) study, families of children with
disabilities are identified as needing more social support. Sloper and Turner (1992) found that parents of children with disabilities on average have contact with at least 10 different professionals in a 12-month period; and children with disabilities have a range of care needs which is not usually met by one professional group (as cited in Teare, 2008 from Sloper & Turner, 1992).

The after-school language instruction/cultural classes is a significant difference between both groups. Due to the recent immigration of those families of children and/or families and children to Canada, there seems to be an increase in the need of after-school language instruction/cultural classes to assist these families in settling into their new country. The families’ immigrant status may create barriers to supports, and may provide additional stress to the parent(s) and family.

Question 3

When the relationship among the parental variables was examined, chi-square was executed for parental stress, where t-test comparison for the remaining parental variables indicated that the families of children with a disability had statistically higher mean scores on parental depression, with significant relationship for parental stress items in comparison to the families of children without a disability. These results are similar in other studies, which suggest that families of children with disabilities are at greater risk in experiencing stress and depression especially among mothers (Statistics Canada, 2008). Similarly, King et al. (2006) found that women who experienced greater levels of depression had less supports. As well, stress is birth from ongoing relationship and environmental factors (Plant & Sanders, 2007). As indicated in the stressful life events, a variety in the items may be as a result of possible triggers for the intensity of the stress levels. There were no significant differences between both groups for
parental warmth and community involvement. Parental warmth and community involvement are positive affects in relationship with families and children. Izzo et al. (2000) suggest that parental warmth supports the parent being involved in the lives of the children; and community involvement is the willingness to get involved in the community.

**Question 4**

The analysis confirms the belief that when families are supported by their community, or feel a sense of involvement within their community, usage of supports will be promoted by all families. The research literature highlights that the levels of parental stress and depression are lower when informal support is used and available within the community (as cited in Baxter, Cummins & Polak, 1995 from Beckman, 1991; Fisman et al., 1989; Willoughby & Glidden, 1995 from Bayley, 2003). Parents with lower income may lack resources in order to access appropriate care for their children (Porterfield & McBride, 2007). The relationship pattern between perceived social support and parental warmth; perceived social support and parental depression; perceived social support and community involvement; parental warmth and parental depression and parental depression and community involvement are similar.

According to the literature, Durden et al. (2007) and Plant & Sanders (2007) suggest that the increased risk of depression and stress among low-income women or caregivers stem from a lack of resources or availability of adequate resources. A potential explanation in the current study is that the majority of respondents were females, mothers or female role models in the lives of the children. As supported by Quittner et al. (1990), low-income mothers experience high levels of stress as it relates to particular stressful life events, and thus will need higher levels of perceived support to minimize such factors as parenting stress, parental depression and thus improving parental warmth and parental sense of community involvement. This supports the
notion that stress is not related in the same way for families of children without disabilities as it is in families of children with disabilities.

**Strengths and Contributions**

The family is a dynamic and complex system with each member having his/her own characteristics and particular needs (Warner, 2006). Quality care is the working partnership among children, their families, and those who support them (Warner). In the literature, there is little to no information on the usage of support (whether formal or informal) for the families of children with disabilities. It is paramount to focus on the benefits of social supports, use of and concerns about access to formal supports, informal supports, perceived social support and the relationship among the parental variables especially for families of children with disabilities. This study was able to inform researchers about these two groups and the importance of providing resources, services and interventions for families of children living in low-income communities. The BBBF initiative provided supports such as home visitors and programs to assist families manage or cater to the well-being of children in their care. These supports may have been accessed by all families in the various communities in this study.

**Health care system and access to health and social services.**

“Children living in poverty are at risk for poor physical and mental health outcomes” (Guttmann, 2001, p.509). In Canada, the health care system is universal for all families notwithstanding families’ socioeconomic status. According to Guttmann (2001), children in low-income settings may not receive care and/or access care from a medical professional such as a paediatrician over time. In this study, there was a significant difference between families (those with and without disabilities) in the use of supports such as another medical doctor other than a GP, visits to the emergency room at the hospital, and consultations with a public health nurse.
Additionally, the quality of care such as the continuity of provider care (medical professional) and the number of visits for services such as immunization tends to be minimal for children from low-income families. In reference to the literature, provision of care and access to appropriate health care from medical professionals improves health outcomes and thus reduces possible chronic diseases among children (Guttmann, 2001). In the families of children with a disability, it is likely that access and availability of social support fosters better health improvement in the lives of these children.

**Limitations**

The Better Beginnings, Better Futures dataset used for this study focused on a unique sample of families with young children with and without disabilities in Grade one living in low-income communities. The questionnaire responses from the parents provided information about the use of formal and informal supports including perceived social support, as well as measures of parental stress, parental depression, parental warmth, and parental sense of community involvement. The researcher was bound by the questions and measures used in this version of the questionnaire. Overall, the questionnaire from the BBBF dataset was pre-designed based on the initial research project which includes the data from interviews of all participants. In addition, the research was bound by the measures selected for the overall BBBF study.

The identification of children with disabilities was also limited by the questions asked within the BBBF questionnaire. In the general population there are many children whose diagnosis of disability does not happen until grade 3. With this in mind, there could have been children who were unidentified at the time of data collection and were recorded in families of children without disabilities. In addition, the children with disabilities may also still have had
unidentified health problems or additional disabilities which may have affected the types of
social supports necessary for appropriate development.

The data used from the questionnaire may have been influenced by the respondents’ biased
responses and self-reporting. The parent may interpret the child’s current state differently than
the professional in some cases, where the limitation in activities, social support, concerns about
access of services and support may or may not be identified. Also, another concern relates to
who is best qualified to decipher the type or level of disability, and whether there is a need for
differentiating between formal support and informal support.

Perhaps there are differences in the nature of support for families of children with
disabilities and those families of children without disabilities. The current study did not
necessarily have clear examples of informal supports to suggest how these services were
implemented within the communities. The informal supports were mainly focused on community
programs such as recreational activities and parent resource centre and a library; these supports
were more organized services and programs that the community offered. It is assumed that
parents or families of these children would participate if they are currently involved in their
community programs.

**Directions for Future Research**

The needs of children with disabilities should be served adequately due to minimal services
and supports for these children and their families (Statistics Canada, 2008). BBBF is a
longitudinal study dataset, where there is a possibility of using the other school age samples such
as Grades 3 & 6 from the BBBF project to understand how the needs of families of children with
and without disabilities are served as the children progress through school. In addition, focusing
solely on the children with disabilities, a longitudinal study following the BBBF families from
preschool through to school ages would provide insight into the needs, strengths and supports
used by families of children with disabilities living in low-income communities. Also, the use of
the comparison sites would shed some clarity on the strength of the intervention initiative of
BBBF in the lives of families and their children with and without disabilities.

Future work is recommended to explore specific items/questions relevant to the
communities especially for the Use of Formal Support and Use of Informal Support scales;
which will clearly identify the types of supports that families of children with or without
disability may use and have access to within their communities. Research has emphasized that
there is a social stigma on people with disabilities which creates “physical and social barriers to
their full participation in society” thus creating a disadvantage for people with disabilities
(Seligman & Darling, 2007, p.5). Although the social model of disability has been gaining
momentum; as such, many families of children with disabilities focus on interventions (ways to
support) that will improve the children’s ability to function adequately or appropriately within
their communities.

A crucial issue is the lack of identification of learning disabilities, emotional/behavioural
problems. In some cases, you may have a family of children with disabilities and the child’s
condition is still unidentified. In contrast, it may be the case that a family classified as having
children without disabilities may actually have disabilities which creates for more challenges and
stressors in the family. According to Willms (2002), all children in Canada live with some form
of being at-risk. As such, risk research can be examined in providing prevention and early
intervention strategies (Pianta & Walsh, 1996). A possible means of attaining specific
information of the usage of supports can be found in time diaries or journals of the participants in
future research to obtain a more accurate depiction (that is, types of supports within the specific
periods referred to in the BBBF questionnaire). The time commitment involved in completing such a research tool would likely be overwhelming, but also descriptive for the researcher in implementing effective intervention strategies and plans for usage and access of supports.
Conclusion

Parenting a child with a disability can be both a challenge as well as a rewarding experience (Brown & Rodger, 2009). According to this study, social supports, whether formal or informal, provide resources and services to help both families of children with disabilities or without disabilities. The concerns about access to formal supports and perceived social support require more research in terms of usage and satisfaction with social supports; and whether or not when utilized, services can substantially provide the support required especially by families of children with disabilities. For families of children with disabilities, a significant problem stems from lack of employment where families may want to work but may not have the time to dedicate to the workforce and simultaneously caring for their child with a disability. Due to the stressful life events or economic pressures, families may face unmet needs and support which may result in higher levels of stress and further health issues (Teare, 2008). The impact of poverty does affect support levels, child care and other means of supporting or meeting the needs of children with a disability.

Both formal and informal supports play an important role in whether or not these resources and services are being accessed for families of children with disabilities; which in turn is influenced by parents’ mental health and emotional capability in providing for their child.
References


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Adolescence, 29, 299-305.


Statistics Canada. (2007). In Focus Fact Sheet, Diversity: Disability issues in home and community care. *Canadian research network for care in the community, Toronto: Canada*


### Table 12

*Immigrant Status of Respondents* *place of birth*

<table>
<thead>
<tr>
<th>Places</th>
<th>Frequency</th>
<th>%</th>
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<td>.2</td>
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<tr>
<td>Hong Kong</td>
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<td>.5</td>
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<td>.2</td>
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<tr>
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<tr>
<td>Jamaica</td>
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<tr>
<td>Pakistan</td>
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<td>.6</td>
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<tr>
<td>Trinidad</td>
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<td>.3</td>
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<td>Total</td>
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Table 13

*Immigrant Status of Children *place of birth*

<table>
<thead>
<tr>
<th>Places</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
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<tr>
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<tr>
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<td>1.6</td>
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<td>.5</td>
</tr>
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<td>.2</td>
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<td>.1</td>
</tr>
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<td><strong>Total</strong></td>
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Table 14

Respondent’s Educational level

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<th>Level of Education</th>
<th>Frequency</th>
<th>Percent</th>
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<td>No schooling</td>
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<tr>
<td>Some primary school</td>
<td>24</td>
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<tr>
<td>Primary school</td>
<td>28</td>
<td>4.2</td>
</tr>
<tr>
<td>Some high school</td>
<td>190</td>
<td>28.7</td>
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<tr>
<td>High school</td>
<td>175</td>
<td>26.4</td>
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<td>Some college</td>
<td>61</td>
<td>9.2</td>
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<td>College</td>
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<td>University (professional)</td>
<td>9</td>
<td>1.4</td>
</tr>
<tr>
<td>University (graduate)</td>
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<td>.8</td>
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<td><strong>Total</strong></td>
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<td><strong>100.0</strong></td>
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Table 15

*Partners’ Educational level*

<table>
<thead>
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<th>Level of Education</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
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<td>No schooling</td>
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<td>.2</td>
</tr>
<tr>
<td>Some primary school</td>
<td>13</td>
<td>3.2</td>
</tr>
<tr>
<td>Primary school</td>
<td>18</td>
<td>4.4</td>
</tr>
<tr>
<td>Some high school</td>
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<td>26.5</td>
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<td>High school</td>
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<tr>
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<td>College</td>
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<td>Some university</td>
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<tr>
<td>University</td>
<td>35</td>
<td>8.6</td>
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<tr>
<td>University (professional)</td>
<td>5</td>
<td>1.2</td>
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<td>3.2</td>
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<tr>
<td>Total</td>
<td>408</td>
<td>100.0</td>
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</table>
Appendix B: Questions and Measures

1. Demographics

A.2 (Ingrscyf) How long has (name of child) lived in this neighbourhood? (Record years and months. e.g., years 02 months 06.)

A.3 (relachlf) What is your relationship to (USE NAME OF CHILD)? Are you (read until you get an answer.) Leave answer blank if this question is skipped.

1. The biological mother/father,
2. The adoptive mother/father
3. The stepmother/father
4. The foster mother/father
5. The guardian
6. In some other relationship to the child (please specify on long form)

A.6 (sexrf) What is the sex of the respondent?
Male.............................1
Female..........................2

A.7 (sexchldf) What is the sex of the child?
Male.............................1
Female..........................2

A.8 (pplehomf) How many people currently live in your home?
PROBE if necessary with “Could you tell me their relationship to you and (name of child)?

The response to this question is the total number of people living in the home, including the child. Questions A.9-A.15 require a breakdown of the total recorded in A.8. Establish how many are...(see following)

A.9 (childhomf) The focal child
A.10 (parnhomf) The child’s parent(s)
A.11 (spshomf) Spouse or partner who is not the child’s parent
A.12 (sibshomf) The child’s brothers or sisters
A.13 (granhomf) The child’s grandparents
A.14 (aunthomf) The child’s aunts and uncles
A.15 (othrhomf) Friends or family/boarders/others

A.25 (bprf) Where were you born?
In Canada:
1. Ontario 2. Outside Ontario
Outside Canada:
3. China
4. Germany
5. Hong Kong
6. India
7. Iran
8. Italy
9. Jamaica
10. Pakistan
11. Poland
12. Portugal
13. Somalia
14. Sri Lanka
15. Trinidad
16. United Kingdom
17. U.S.A.
18. Vietnam
19. Lebanon
20. Haiti
21. Other (please specify on long form)

A.29 *(bpcf)* Where was (NAME OF CHILD) born? (Use codes from A. 25, above)

A.36 *(edlevlrf)* What is the highest level of schooling that you have completed? (Include any programs to prepare a person for work)
1. No formal schooling (Go to A.38)
2. Some primary school *ask A.37
3. Primary school
4. Some secondary or high school
5. Completed secondary or high school
6. Some community college, technical college, CEGEP, or RN program without university degree (Go to A.38)
7. Completed community college, technical college, CEGEP, or RN program without university degree (Go to A.38)
8. Some university (not completed) (Go to A.38)
9. University degree (completed); B.A./B.Sc. (Go to A.38)
10. University degree (completed); Professional (e.g., law, medicine, dentistry, engineering, nursing, commerce) degree (Go to A.38)
11. University degree (completed): M.A./Ph.D. (Go to A.38)

A.37 *(edysrsrf)* How many years of elementary and high school have you successfully completed?

*A.38 *(edlevlpf)* What is the highest level of schooling that your (husband/wife/partner) has completed?

No formal schooling (Go to A.40)........ 01
Some primary school .................... 02
Primary school ......................... 03
Some secondary or high school .......... 04
Completed secondary or high school .... 05
Some community college, technical college, CEGEP, or RN program without a
university degree (Go to A.40)....... 06
Completed community college, technical college, CEGEP, or RN program without a
university degree (Go to A.40).... 07
Some university (not completed) (Go to A.40).............................. 08
University degree (completed): B.A./B.Sc (Go to A.40).................. 09
University degree (completed): Professional (e.g., law, nursing, dentistry, medicine,
commerce, engineering) degree (Go to A.40)...... 10
University degree (completed): M.A./Ph.D. (Go to A.40)............. 11

A.39 (edyrsf) How many years of elementary and high school has s/he successfully
completed?

A.40 (ftimerf) Do you have a paid full-time job?
0. No 1. Yes (GO to A.45)

A.41 (ptimerf) Do you have a paid part-time job?
0. No 1. Yes (GO to A.45)

A.49 (ftimepf) Does your (husband/wife/partner) have a paid full-time job?
No.........................................................0
Yes (Go to A.52).....................................1

A.50 (ptimepf) Does he/she have a paid part-time job?
No........................................................0
Yes (Go to A.52).....................................1

A.54 (mincomf/mincom1f/mincom2f) What is the current total monthly household
income from all sources before taxes or other deductions? (Record full amount, e.g.,
“eighty-five” as 00850. Use 3 month average if R says it changes. Probe. If R is unable to
answer then say: “Could you give me a range?”)

Now I would like to ask some questions about your housing and the neighbourhood you live in.
(Note: If you already know answer to O.1 just record it)

O.1 (publicf) Is this dwelling in a public housing complex?
No....................................................1
Yes....................................................2

O.3 (ncmoveyf) How many times has (name of child) moved in the last year, since (name
of child) 2000?
2. **Children with disabilities is defined by two identifiers:**

   ➔ The number of chronic conditions for each child related to physical and mental conditions

   I’m going to read through a list of physical and mental health conditions. Has a doctor ever told you that (name of child) has any of the following conditions and these have lasted or are expected to last 6 months or more:

   No ................................................. 0
   Yes ........................................... 1

   D.54 *(helth06f)* Heart condition or disease.
   D.55 *(helth09f)* Epilepsy.
   D.56 *(helth08f)* Cerebral palsy.
   D.57 *(helth15f)* Kidney condition or disease.
   D.58 *(hltq45df)* Mental handicap.
   D.59 *(hltq45ef)* Learning disability.
   D.60 *(hltq45ff)* Attention deficit disorder.
   D.61 *(hltq45gf)* Emotional, psychological or nervous difficulties.
   D.62 *(helth16f)* Any other long-term condition.

   ➔ D.64 *(limscf)* Does(do) this(these) condition(s) or health problem(s) prevent or limit your child’s participation in school, at play, or any other activity normal for a child his/her age?

   No ................................................. 0
   Yes ........................................... 1

3. **Social Support scale (Perceived Social Support)**

   Here are some statements about your relationships with others. For each, could you please tell me whether you strongly disagree, disagree, agree or strongly agree.
1=strongly agree; 2=agree; 3=disagree; 4=strongly disagree

J.1 (socsup1f) If something went wrong, no one would help me.
J.2 (socsup2f) I have family and friends who help me feel safe, secure and happy.
J.3 (socsup3f) There is someone I trust whom I could turn to for advice if I were having problems.
J.4 (socsup4f) There is no one I feel comfortable talking about problems with.
J.5 (socsup5f) I lack a feeling of intimacy with another person.
J.6 (socsup6f) There are people I can count on in an emergency.

a) Formal supports

In the past year, have you seen or talked on the telephone with any of the following about (NAME OF CHILD)’S physical, emotional or mental health?

P.1 (rescy01f) A general practitioner, family physician?
No ........................................ 0
Yes ....................................... 1

P.2 (rescy13f) Another medical doctor (such as a pediatrician, orthopedist, or eye specialist)?
No ........................................ 0
Yes ....................................... 1

P.3 (rescy12f) Emergency Room at Hospital
No (Go to P.8)........................................ 0
Yes ........................................................ 1

P.4 (rescy03f) A public health nurse or nurse practitioner
No ........................................ 0
Yes ....................................... 1

P.6 (rescy07f) A psychiatrist or psychologist?
No ........................................ 0
Yes ....................................... 1

P.7 (rescy14f) Child welfare worker or children’s aid worker?
No ........................................ 0
Yes ....................................... 1

P.8 (rescy15f) Any other person trained to provide treatment or counsel, for example a speech therapist, a social worker?
No ........................................ 0
Yes ....................................... 1

Note: *If there is a feeling of social support then this support increases in parental warmth and parents’ sense of community involvement*
b) Informal supports

Have you or your child participated in any of the following programs or activities in the last 12 months?

No.........................................................0
Yes........................................................1

P.11 (playgrnf) A recreation/playground program
P.13 (sportsf) Sports, crafts, or clubs (this question refers to organized activities e.g. hockey team, beavers, brownies)
No (Go to P.15).................................0
P.15 (dropinf) An after-school care program or drop-in centre
No (Go to P.17).................................0
P.17 (aftlngf) After-school language instruction/cultural or heritage classes
No (Go to P.19).................................0
P.19 (librarf) A library
No (Go to P.19).................................0
P.21 (rescentf) A parent resource centre, parent group, etc.
No (Go to the next section).............0

c) Concerns about Access to Formal Supports

P.9 (proff) Was there ever a time during the past 12 months when you wanted to see a professional for your child but didn’t?
No.........................................................0
Yes........................................................1

P.10 (servicef) Did you ever feel you were not getting as good service as other people?
No.........................................................0
Yes........................................................1

4. Parental Warmth

The following questions have to do with things that your child does and ways that you yourself as a parent react to him/her.

1=never; 2=about once a week or less; 3=more than once a week but less than once a day; 4=one or two times a day; 5=many times each day

Positive Parent-child Interaction-NLSCY

E.19 (parnt13f) How often do you praise your child, by saying something like “Good for you!” or “what a nice thing you did!” “Thank you!” or “That’s good going!”
E.20 (parnt15f) How often do you and your child talk or play with each other, focusing attention on each other for five minutes or more, just for fun?
E.21 (parnt17f) How often do you and your child laugh together?
E.23 (parnt20f) How often do you do something special with your child that he or she enjoys?
E.24 (parnt21f) How often do you play sports, hobbies, or games with your child?

We know that when parents spend time with their children, some of the time things go well and some of the time they don’t go well. I would like you to use the answers on page 5 to tell me what fraction, or proportion, of the time things turn out in different ways.

- Never ........................................... 0
- Less than half the time ..................... 1
- About half the time .......................... 2
- More than half the time .................... 3
- All the time ................................... 4

Hostile-ineffective parenting-NLSCY
E.26 (parnt23f) Of all the times that you talk to your child about his or her behaviour, what proportion is praise?

5. Parental depression scale

Now I would like you to think of how you have felt in the past week. During the past week:

1=rarely or none of the time(less than one day); 2=some or little of the time (1-2 days);
3=occasionally or a moderate amount of time (3-4 days); 4=most or all of the time (5-7 days)

K.1 (cesd02f) I did not feel like eating; my appetite was poor.
K.2 (cesd03f) I felt that I could not shake off the blues even with help from my family or friends.
K.3 (cesd05f) I had trouble keeping my mind on what I was doing.
K.4 (cesd06f) I felt depressed.
K.5 (cesd07f) I felt that everything I did was an effort.
K.6 (cesd08f) I felt hopeful about the future.
K.7 (cesd11f) My sleep was restless.
K.8 (cesd12f) I was happy.
K.9 (cesd14f) I felt lonely.
K.10 (cesd16f) I enjoyed life.
K.11 (cesd17f) I had crying spells.
K.12 (cesd19f) I felt that people disliked me.

6. Parental sense of community involvement

_Sense of Community Involvement Scale_

Could you tell me how much you agree or disagree with these statements, using the answers in the booklet?

Strongly agree.................................................................1
Agree................................................................................2
Disagree........................................................................3
Strongly disagree............................................................4

O.13 (nghiv11f) I feel like I belong to this neighbourhood.
O.14 (nghiv12f) If some change was going to be made in my neighbourhood that I did not like, I would try to stop it.
O.15 (nghiv13f) I feel I am important to this neighbourhood.
O.16 (nghiv14f) I would be willing to work with others on something to improve my neighbourhood.
O.17 (nghiv15f) I like to think of myself as similar to the people who live in this neighbourhood.
O.18 (nghiv16f) I feel that people of different cultures and races are accepted in this neighbourhood.
O.19 (nghiv17f) I feel proud to be a member of this neighbourhood.

7. Parental stress

Please indicate which of the following has happened to you [or your spouse/partner] during the past 12 months:

0. No  1. Yes
M.1 (stres01f) Stopped full-time schooling
M.2 (stres02f) Lost job or was unemployed
  0. No
  1. Yes (GO to M.3)
M.4 (stres03f) Got married?
M.5 (stres04f) Someone moved into your home
M.6 (stres05f) Had financial problems
M.7 (stres06f) Got separated
M.8 (stres07f) Arrival of baby at home
M.9 (stres08f) Someone moved out of our home
M.10 (stres09f) Serious illness
M.11 (stres10f) Serious illness of someone dear
M.12 (stres11f) Quit or retired from full-time work
M.13 (stres12f) Started working or changed jobs
M.14 (stres13f) Death of someone dear
M.15 (strscarf) Cared for someone with a serious chronic illness