

Stress and Relief: Parents Attending a Respite Program

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Abstract

Objective: The objectives of this study were to examine changes in stress among parents of children with special needs in a respite service and consider parental experience of the service. **Methods:** Families who were enrolled in a ten-month centre-based respite program were invited to participate in the evaluation. Change in parent stress, indexed by the Parent Stress Index-Short Form (PSI-SF), was determined. These results were compared with findings from exploratory qualitative interviews with a subset of parents and a small comparison group who also completed the PSI-SF. **Results:** At baseline, 69% of parents (n=45) had high total stress scores on the PSI-SF. No significant improvements were detected on parent stress over time or differences from improvements in the comparison group. In contrast, the subgroup of parents (n=10) who participated in the qualitative interviews described substantial benefits from the respite program including a sense of relief and having time for other activities. **Conclusions:** It is proposed that the respite program may have provided a temporary break to parents thereby bestowing a sense of relief, but was not adequate to impact on more chronic stress patterns, suggesting that these are related but separate constructs and experiences.

Key words: *respite care, stress, parent, mixed methods*

Résumé

Objectif: Les objectifs de cette étude étaient d'examiner les changements de stress chez les parents d'enfants ayant des besoins spéciaux dans un service de relève, et d'examiner l'expérience parentale du service. **Méthodes:** Les familles qui étaient inscrites à un programme de relève en centre de 10 mois ont été invitées à participer à l'évaluation. Le changement de stress parental, mesuré par la version abrégée du Parent Stress Index-Short Form (PSI-SF), a été déterminé. Ces résultats ont été comparés avec ceux d'entrevues qualitatives exploratoires menées auprès d'un sous-ensemble de parents et d'un petit groupe de comparaison qui ont aussi rempli le PSI-SF. **Résultats:** Au départ, 69 % des parents (n=45) avaient des scores totaux élevés de stress au PSI-SF. Aucune amélioration significative n'a été détectée dans le stress des parents avec le temps, ni de différences par rapport aux améliorations du groupe de comparaison. Par contre, le sous-groupe de parents (n=10) qui ont participé aux entrevues qualitatives ont décrit des avantages substantiels tirés du programme de relève, notamment un sentiment de soulagement et d'avoir du temps pour d'autres activités. **Conclusions:** Il est proposé que le programme de relève puisse avoir fourni aux parents une détente temporaire leur procurant ainsi un sentiment de soulagement, mais qu'il ne suffisait pas à influencer sur des modèles de stress plus chroniques, ce qui suggère que ces derniers sont des constructions et expériences reliées mais distinctes.

Mots clés: *soins de relève, stress, parent, méthodes mixtes*

Introduction

While stress is a common parental experience, high parental stress has been related to a number of concerns including increased use of undesirable parenting strategies

(Rodgers, 1993), internalizing (Bakoula, Kolaitis, Veltsista, Gika, & Chrousos, 2009) and externalizing problems (Bagnier et al., 2009), as well as lower social competence in children (Anthony et al., 2005). Periods of high stress may be more common for those parents caring for children with

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mental and/or developmental problems or at risk for such (Evans, Sibley, & Serpell, 2009; Paley, O'Connor, Frankel, & Marquardt, 2006; Norizan & Shamsuddin, 2010; Secco, Askin, & Yu, 2006; Tervo, 2010; Wulfaet, Scholte, & Van Berckelaer-Onnes, 2010).

Strategies aimed at reducing parent stress may be beneficial to children and their parents. Respite care, a temporary break provided to caregivers, is one class of interventions which may help reduce parent stress. Prioritizing families with children with mental and/or developmental problems for respite care may be appropriate given their typical higher stress levels and greater needs. However, the evidence-base for the effectiveness of different types of respite care is thin, impeding efforts aimed at evidence-informed service improvements.

From a narrative review of studies of respite care for families with a child with developmental disabilities completed a decade ago, it was concluded that there was some evidence for a reduction of parental stress with respite services but various methodological limitations were noted in the few studies identified (Chan & Sigafos, 2001). There also needs to be substantial caution in making blanket statements about the effectiveness of a service that can take such varied forms (e.g., home-based versus centre-based), intensities, and durations. A more recent review identified 15 studies and identified a pattern of parent stress reduction with respite services; however, the author noted the continued limited research database and methodological limitations to the studies identified with only two of the studies employing even a quasi-experimental design (Strunk, 2010). One of the quasi-experimental designs contrasted a respite care service consisting of an inpatient admission for a mean of 8.8 (S.D. 3.1) days without explicit evaluation and treatment components ($n=14$) and contrasted this with an inpatient hospitalization of a mean of 63.9 (S.D. 43.6) days with evaluation and treatment components ($n=18$) (Aniol, Mullins, Page, Boyd, & Chaney, 2004). While direct analysis of the change of the parent stress measure was not reported, analysis of the data available in a table in this paper found no evidence of significant reduction in either group. In contrast, the other quasi-experimental study did find a significant decrease in parent stress (Mullins, Aniol, Boyd, Page, & Chaney, 2002). This similar study by the same study group compared an inpatient respite stay of a mean of 9.3 (S.D. 8.1) days ($n=39$) to an inpatient hospital stay of a mean of 48.4 (S.D. 27.2) days ($n=41$) (Mullins et al., 2002). Parent stress was found to significantly drop from pre- to post-intervention for both groups but returned to pre-intervention levels at the six month follow-up (Mullins et al., 2002). Given this limited database, further evaluation of respite services for families with children with special needs is required.

Objectives

The objective of this study was to examine stress of parents who attended a centre-based respite program for children with special needs using a mixed methods approach. The research questions were:

1. What are the changes in stress levels over time for parents who are participating in a new centre-based respite program?
2. How do these changes differ from a comparison group not exposed to this new centre-based respite program?
3. How do parents describe their experience of this new centre-based respite program and how do these compare with quantitative measures of stress?

Methods

General: This study included a pre-post quantitative assessment of parent stress in a naturalistic follow-up of participants in a new respite program, and a comparison group not in this respite program, as well as a qualitative exploratory component with participants in the new respite program. Throughout this paper, the participating child's guardian is referred to as "parent," however, as detailed in Table 1, this includes guardians other than biological mothers and fathers. In all cases, the "parent" was providing a central parenting role for the child at the time of the study.

Sample: Sample 1 ("Intervention Group") is composed of parents of young children (aged three to eight) participating in a new centre-based respite program. All parents enrolling within a two-year period were eligible to participate in the associated evaluation. In total, 85 children started the respite program over the two years. Parents of 62 children (72.9% of total) agreed to participate in the evaluation study. Twelve families had more than one child in the program (eight families with two children each, and four families with three children each). To avoid more than one rating per family, one child was randomly selected for each family with more than one child participating. This reduced the sample size to 46 at baseline. The participating parent completed the core parent stress measure (described below) at baseline ($n=45$), interim-follow-up (three to four months after program start) ($n=35$), end-point of the program (approximately ten months) ($n=29$) and at follow-up (approximately six months later) ($n=21$). Sample size at each subsequent point decreases due to lack of completion of ratings at later points. For analysis contrasting the intervention and comparison group, sample was restricted to those with both baseline and interim data points ($n=35$).

Children/families entered the program upon referral from various community agencies based on agencies' perceptions of a need for respite or belief that the child or family would benefit from such. Funders of the respite service wanted preferential access to children who had fetal alcohol

spectrum disorder (FASD) or at-risk for such given reported prenatal alcohol exposure. Therefore agencies serving this population were notified and had first access to the service. However, space was also available for children with no reported previous alcohol exposure. These latter children were principally referred from a call centre receiving respite service requests. In addition to the age requirement, these children also had to have demonstrated some mental health difficulties, which were indexed by scoring in the abnormally high range on the parent-report Strengths and Difficulties Questionnaire (Goodman, 2001; YouthMind, 2009). Given incomplete access to medical records, it was not possible to determine those children who had an FASD diagnosis, however a screening question was asked of the current parent as to alcohol exposure in utero and 56.3% indicated definite prenatal alcohol exposure (although no further information was gathered).

A subgroup of Sample 1 (“Qualitative Inquiry Group”), participated in qualitative exploratory interviews. Research staff approached several parents in the respite program who had participated in the quantitative component of the study to participate in a qualitative interview. They were approached towards the end of their participation in the respite program. There was an explicit aim to obtain different types of parents. In total ten parents were recruited: six foster mothers; two biological mothers; and, two grandmothers. Four of the parents had two children attending the program; all others had one. Eight of the ten had parent stress data at baseline and the interim time point.

Sample 2 (“Comparison Group”) is composed of parents of children with similar characteristics to those in Sample 1, but who sought respite care through a different service provider in the same city (the “comparison group”). This turned out to be a particularly difficult population to recruit and retain in the study, although not surprising given most would have more pressing priorities than participation in a research project. Only 11 families with 11 children were available for this analysis (we used the same restriction of including only one child per family as in Sample 1). While not able to enter the new centre-based respite program because it was full, the call centre for respite services offered their regularly available services which typically included short-term crisis respite services.

Intervention: The centre-based respite program was a new service located in a major urban centre in Canada. Children were eligible to attend six hours/week of respite care for ten months (Tuesday/Thursday evenings or Saturdays). The children engaged in a variety of activities each session including activities centres, physical activity, and snack time. All front-line staff were experienced working with children and families. Of note, this was not a research intervention, but a community developed respite program with an associated research evaluation.

Measures: The Parent Stress Index-Short Form (PSI-SF) was the core quantitative measure employed to measure parental stress. This is a 36-item standardized, norm-referenced assessment tool measuring facets of the parent-child system, including child characteristics, parent characteristics, family context, and life stresses (Abidin, 1995). It generates scores on four subscales (total stress; parental distress; parent-child dysfunctional interaction; and, difficult child). It has good psychometric properties including high internal consistency and moderate to high test-retest reliability (Abidin, 1995; Reitman, Currier, & Stickle, 2002). Cutpoints at the 85th percentile of normative data are proposed to indicate severe parenting stress and are labelled “high” in our analysis (Abidin, 1995). Those in Sample 1 completed the PSI-SF at four time points (baseline; midway through program; at the end of the program; and, six months after the program). Those in Sample 2 completed the instrument at baseline and three months later which was approximately the same timing as “midway through the program” for Sample 1.

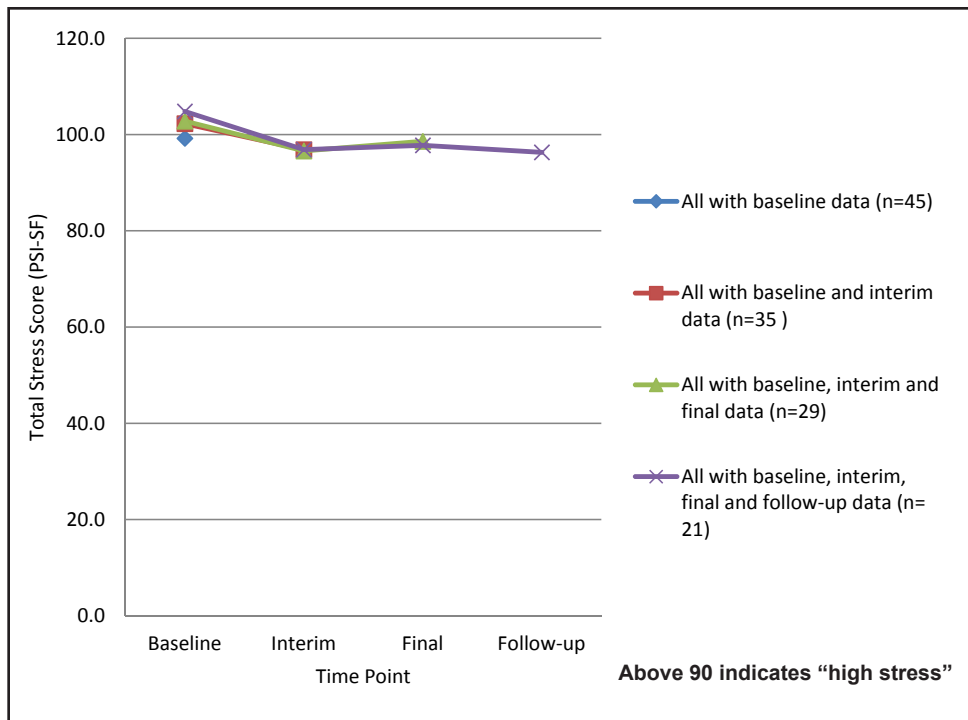
An interview guide was used to structure the qualitative interviews. It was employed flexibly depending on the knowledge-base of the informant and to explore concepts raised by the informant. A significant focus of the interview was to explore the perceived impacts of the respite program from the informant’s point of view.

Analysis: Initially, paired t-tests were performed to determine whether there were any significant differences in the PSI-SF scales between baseline and midpoint within groups (i.e., intervention group; comparison group; and, qualitative inquiry subgroup). Next, independent t-tests were used to compare baseline to midpoint change scores on the PSI-SF subscales between: (i) intervention versus comparison group; and, (ii) intervention qualitative subgroup versus intervention non-qualitative subgroup. In addition, the total PSI-SF scores from the four data collection points was plotted for the intervention group.

The qualitative interviews were conducted individually via telephone at the end of the respite program year and were audiotaped. Questions were asked in an open-ended manner following interview guides that were adapted as interviewing progressed, based on issues surfacing in initial conversations. Among the questions discussed, parents were asked to describe their experience with the respite program, including their perceived likes/benefits of the program and dislikes/concerns. Interviews were transcribed verbatim and were analyzed by one of the authors using a content analysis approach aimed at identifying themes arising from within the text.

Table 1. Characteristics of participants in different subgroups			
Variables	Intervention group (n=35) % (n)	Comparison group (n=11) % (n)	Qualitative inquiry group (n=8) ^a % (n)
Parent type ^b			
Biological mother	37.1 (13)	90.9 (10)	25.0 (2)
Adoptive mother/other female	25.7 (9)	-	12.5 (1)
Foster mother	22.9 (8)	-	62.5 (5)
Biological/adoptive father	11.4 (4)	-	-
Parent marital status			
Married/common-law	62.9 (22)	45.5 (5)	50.0 (4)
Single/divorced/separated	37.1 (13)	54.5 (6)	50.0 (4)
Parent education ^b			
University/college/trades	62.9 (22)	36.3 (4)	75.0 (6)
High School	22.9 (8)	-	25.0 (2)
Less than high school	11.4 (4)	54.5 (6)	-
	Mean (SD)	Mean (SD)	Mean (SD)
Index child age (years)	5.5 (1.6)	5.4 (1.7)	6.0 (1.1)
^a While there were ten participants in the qualitative study, socio-demographic data on only eight are included here for comparison purposes as only eight had PSI-SF data at baseline and midpoint.			
^b Respondent type is missing for one family in the intervention and comparison group.			

Table 2. Parent stress scores and change scores for different subgroups			
Subscale scores	Intervention group (n=35) ^a Mean (SD) [% high] ^d	Comparison group (n=11) ^b Mean (SD) [% high] ^d	Qualitative inquiry group (n=8) ^c Mean (SD) [% high] ^d
Total stress score			
Baseline	102.3 (20.7) [71.4]	109.5 (20.2) [81.8]	100.0 (21.6) [62.5]
Midpoint	96.9 (20.8) [57.1]	101.0 (17.7) [72.7]	97.9 (22.5) [50.0]
Change	-5.4 (15.8)	-8.5 (15.4)	-2.1 (17.8)
Parental distress			
Baseline	32.2 (10.2) [37.1]	37.4 (8.1) [63.6]	31.8 (10.8) [50.0]
Midpoint	28.5 (9.5) [20.0]	35.3 (7.7) [54.5]	28.5 (11.0) [12.5]
Change	-3.7 (8.7)	-2.2 (5.8)	-3.3 (10.4)
Parent-child dysfunctional interaction			
Baseline	29.5 (7.5) [54.3]	33.1 (9.1) [81.8]	28.6 (9.2) [37.5]
Midpoint	29.0 (7.3) [62.9]	28.6 (5.9) [45.5]	28.6 (6.8) [37.5]
Change	-0.5 (5.3)	-4.5 (8.2)	0.0 (4.4)
Difficult child			
Baseline	40.6 (8.0) [77.1]	39.1 (8.3) [54.5]	39.6 (5.5) [87.5]
Midpoint	39.3 (9.1) [57.1]	37.2 (7.1) [63.6]	40.8 (8.7) [62.5]
Change	-1.2 (7.0)	-1.9 (6.8)	1.1 (7.5)
^a No statistically significant pre-post changes (baseline to midpoint) within groups using paired t-tests.			
^b No statistically significant change scores between intervention and comparison groups using independent t-tests.			
^c No statistically significant change scores between intervention group which participated in qualitative interviews and the group which did not using independent t-tests.			
^d % high corresponds to cutpoints at the 85 th percentile of normative data and suggests severe parenting stress.			

Figure 1. Patterns of parent Total Stress Scores over time

Results

Socio-demographic characteristics of the intervention group, comparison group, and qualitative inquiry group (a subset of the intervention group) are summarized in Table 1.

PSI-SF scores for the different groups at baseline and mid-point and extent of change between these two points are summarized in Table 2. No significant differences were found between baseline and midpoint on any of the PSI-SF scales within any of the groups. No significant differences were found in change scores contrasting intervention and comparison group, or between the subgroups in the intervention group (i.e., those who participated in the qualitative inquiry and those who did not).

The total PSI-SF scores for the intervention group at each of the four time points are summarized in Figure 1 demonstrating only small reductions over time.

In contrast to the very modest shifts in values of the PSI-SF, responses within the qualitative inquiry were substantially positive. Participants spoke of the respite program as “immensely beneficial” and “a win, win [situation] for everybody.” Parents had many positive things to say about the impact it had had on themselves, their children, and the rest of their family members.

Four themes related to stress and relief were identified within the qualitative analysis of text derived from the parent interviews: (i) strain reduction; (ii) a gift of time; (iii) increased capacity to handle day to day life; and, (iv) positive emotional impact. Additional analysis of the text explored

and identified factors that may have negated, lessened and/or worked contrary to the experience of reduction in parental stress. Supporting text for each of these themes is presented in Table 3.

Discussion

At the group level, there was little to no evidence that the respite program resulted in reduction in stress levels as measured on the PSI-SF. This lack of measurable change for parent stress was similar to the lack of change found on a measure of child mental health status from analysis of the same dataset (Hutcheon, McLennan, & Urchuk, 2011). This lack of demonstrable improvement in child mental health status and the relatively high child mental health difficulty levels perceived by the parents may be a contributing factor to the lack of measurable change in parent stress. The need to link children in respite programs to evidence-based child mental health interventions was flagged in the previous paper and may be an important mechanism for reducing parent stress as well.

While not reporting on stress per se, a meta-analysis of 78 studies for family caregivers of older adults found statistical improvements in related measures of caregiver burden, depression, and subjective well-being (Sörensen, Pinquart, & Duberstein, 2002). While we were not able to identify a meta-analytic examination of respite care for children, individual studies have found significant quantitative changes in parent stress (Chan & Sigafos, 2001; Strunk, 2010). However, this cannot be extended to presume that all or

Table 3. Themes and supporting quotes from qualitative analysis of parent interviews

Theme title	Theme summary
Strain reduction	Decreased stress levels were reported as a benefit for some parents. Others reported no change, but were still happy with the program and believed it to be beneficial for themselves and their loved ones. Improved mood, outlook, and attitude, increased energy level, and piece-of-mind or "sanity" were also reported. Additionally, some participants felt that respite diminished financial strain.
The gift of time	Respite was described as "spare time", "free time," and "a treat." It provided opportunities to "have a life" and to spend time with others; time for planning activities for the target child or for doing activities that the target child couldn't participate in. It allowed time to work, to get "caught up", "get things done", and for activities of daily living. It was also used for personal care, to rest, and to be alone.
Increased capacity to handle day to day life	Respite was described as "a lifeline" and "an infusion to keep going"; a consistent break from the "negative repetition" of everyday life. Interviewees felt that parents had increased ability to handle crises and that they learned strategies to deal with their child(ren).
Positive emotional impact	Participants felt that respite imparted a feeling of being appreciated (e.g., when the children made their parents gifts at the program). It also gave parents a chance to see their child in a more positive light (e.g. when they received positive feedback about their child from the respite providers).
Undermining the effect	For the majority of the parents there were many other demands that had to be dealt with on a day-to-day basis, resulting in respite not being a true "break" or not having a lasting impact. Some of these demands included: work, raising other children, dealing with the target child's many other needs, meetings and appointments, activities of daily living, and personal health issues. Other factors, including worry about the child's behaviour upon return home from the program, dealing with organizational issues such as negotiating transportation to and from the program, and worry regarding the future availability of respite services may have undermined potential positive impacts of the program. Factors both intrinsic and extrinsic to the program were identified within the interviews as possible reasons why the respite provided might not have resulted in stress reduction.

even most respite services are achieving this goal. There may even be a potential for some programs to increase stress. One pilot study of caregivers of adults with mental illness reported that those who received a respite intervention reported an increase in stress compared to those not receiving the service (Jardim & Pakenham, 2009).

Despite the lack of quantifiable improvements in parent stress, a subgroup of parents' articulated substantial benefits, several that presumably are related to stress. Another study found a similar split between the qualitative and quantitative findings from a family intervention. Kalek (2009) reported very positive feedback as captured in narratives

from parents about an early intervention program, however, minimal changes in parent stress were found.

It is proposed that the respite program under study may have provided a temporary break giving a sense of relief but did not impact on more chronic stress patterns and that these are related but separate constructs and experiences. Though the respite time was substantial (over 200 hours in 10 months), it represents only a fraction of care-giving time of the parents. Additional or different interventions are likely needed if the intent is to lower chronic stress levels of parents with special needs children.

Supporting quotes for theme

"The Respite Program has just alleviated so much stress because this is not a child that can just be babysat by anybody and by no means would anybody choose to babysit her. With the Respite Program I don't worry...she's in a very safe environment, it just offers such a relief ..."

"...I can't really plan to do anything, 'cause I have to be here right when the bus drops her off. But it is a nice break not having to go get her at daycare every day...That simple little thing sometimes means my sanity."

"How has it helped me? It gives me time to rest, I actually sleep. I take naps; I catch up on housework;...I do absolutely nothing. I do what I please when I please because I can, otherwise I would be so exhausted I would not be able to move...It has benefitted me beyond my wildest dreams..."

"...I think it's fantastic. It's incredible. At first when I first started going it was like "Oh geeze the kids aren't home what am I gonna do?" right? And now I look forward to it, I get so much done on a Saturday when they're gone it's just, it's given me free time, it's given me extra time to get caught up and stuff. If I want to go shopping, get my hair cut, I don't have to worry about having three kids tagging along. I just love it. They come home, they're happy, they're – they enjoy it."

"...[I]f I can rest all day, I can function for the three hours that night that [my child is home], like for supper or after supper time and bed time scheduling. I can function, I can do it. I can do it without being stressed which means I'm not irritable, I'm not yelling, I'm not impatient. My character and demeanor are far more sociable and fun (laughs). It turns out I'm a fun and spontaneous person now. I have the energy to be more flexible and spontaneous."

"[Our biological kids] feel like they have us back [when the other two are at respite], because when you have a special needs child, and we have more than one, there are so many appointments that I have to go to during the week, right?...Your whole life could be absorbed by one, two children. These guys get us back for like what normal kids get, well, for half a weekend, you know? That's good and the reality for us, in terms of [the two foster kids], we don't know how long we can do this, right? Especially with the raging [and their other problems]. This helps us to do it longer..."

"...I'm happier, I'm more relaxed, I've got more patience..."

"[T]hey made this beautiful mother's day card for me and I just thought that was so special...[T]hey took the time out to take a picture and [in] the picture, [my daughter's] having a cup of tea and there's flowers on the table and it says "It's Mother's Day, Time to Celebrate!" and [my daughter] made the rest of the card. I thought that was fantastic."

"[I spend respite time with my other kids, or] just sometimes putting everything back in order after a week. Gee, is there any other time? No, because we have six other kids, right? So if I didn't have six other kids I might have a nap. I can tell you all the things I would dream of doing. I'd go on a date with my husband, all those things. Sure, yeah, I could use that time. But because the other kids need it, that's what we've committed it to."

"Because I work, so she goes from school and then I have about an hour and a half in between my work and her pick up time for respite. That's my three hours a week that I utilize for just some self-care."

"Oh yeah, I work all year round, vacation doesn't exist in my vocabulary, not being a single mom, nope, nope. It doesn't work."

"They seemed to have a lot of problems with the bussing. Yeah, because we are in the [one] end of the city, apparently that's quite a problem, not many other children are in this area. So they weren't even sure if they were going to be able to bus her and I'm like, "Well if I have to take her there then I'm not going to have her in the program". Because I can't leave work to go and take her down there and then be back there before 6:30, it's just not, that's not a break for me if I've got to run her all over the place, right? 'Cause that seemed to be a really big issue in the beginning...It's good [now], she is bussed, but like I said, it was very chaotic there for the first couple of months."

"I'm hoping they will [offer the program] again, and if they do, I really need for [my daughter] to be in that program. She will be in kindergarten this year, she will have more free time which means the demand on me physically is going to be higher. She's going to be really challenging. She will become more active and more independent and she is going to need a lot of activity to hold her attention. I would be ever so grateful if they were to continue this."

There are a number of limitations to this study. The sample size for the quantitative analysis was relatively small which reduced the power to detect smaller differences. In addition, the nature of the sample may also have implications. This includes a relatively high percentage of the participants having more than high school education suggesting that the participants may not represent the typical distribution of families accessing respite care. In addition, there was a diversity of parent types and combining these different types may have limitations given potential differences in parent characteristics, experiences, and contexts (e.g., Dolan, Casanueva, Smith, & Bradley, 2009; Daniel, 2011). Given

the small sample size it was not possible to analyze the data separately by parent type.

There may also be concerns about the comparison sample given the non-randomized nature of group assignment. However, were the positions not filled in the intervention program, these families could have been participants, i.e., they would have met the inclusion criteria for the intervention program. As well, the attempt to include some comparison sample in program evaluation is important to look at the potential "natural course" for families not getting the intervention in question, in this study a specific intensive respite program. In particular, if the "natural course" is one

of deterioration, then a finding that the intervention group, while not improving, did not deteriorate may actually be a positive finding. This did not appear to be the case in this study based on the small comparison sample. While it could be argued that the respite services received by the comparison group was also effective in preventing deterioration, this then raises the question as to whether a less intensive and expensive intervention may be similarly effective as the centre-based program, however, a rigorous cost-effectiveness study would be required to determine this.

There may also be limitations to the qualitative component of the study. The sample was selected purposively to capture a diversity of perspectives and was not aimed at obtaining a representative sample. In addition, there may be a bias towards parents reporting positive experiences with the receipt of social and health services, particularly with more direct approaches with personal contact (Garratt, Bjertnaes, Holmboe, & Hanssen-Bauer, 2011). This may have been exacerbated in this study given some evidence of a social desirability bias reporting with telephone interviews versus survey (Bjertnaes, Iversen, & Bukhom, 2010). In attempt to mitigate this bias, the researcher staff members were quite distinct from the provider staff and emphasis was placed on the anonymity of responses and the request to describe any positive or negative experiences with the service. An additional limitation is that only one author coded the qualitative text and therefore inter-rater agreement on coding was not conducted.

Finally, this study only considered the evaluation of one respite program and generalizability to other respite programs is unknown.

Despite these limitations, the study flags the need for further evaluation of respite services. There are still many unanswered questions as to what types of respite services work best for whom, for what problems, and to what effect. Building in rigorous evaluation within real-world services is essential if there is an interest and aim to optimize the impact of health and social services. Thoughtful use of mixed-method designs incorporating quantitative and qualitative components should be considered given the potential for complementary information derived from these different approaches. An aim should be that interventions that demonstrate meaningful gains as captured by both quantitative and qualitative means receive priority funding.

Acknowledgments / Conflicts of Interest

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2013 CONFERENCE WATCH

ANNUAL CANADIAN PSYCHOLOGICAL ASSOCIATION CONVENTION

June 13 - 15, 2013
Quebec City, Quebec
Website: www.cpa.ca

CANADIAN PAEDIATRIC SOCIETY ANNUAL MEETING

June 19 - 22, 2013
Edmonton, Alberta
Website: www.cps.ca

INTERNATIONAL ASSOCIATION FOR CHILD AND ADOLESCENT PSYCHIATRY AND ALLIED PROFESSIONS (IACAPAP) WORLD CONGRESS

August 11 - 15, 2013
Durban, South Africa
Website: <http://iacapap.org/world-congresses>
Website: www.resotel.eu

ANNUAL CANADIAN PSYCHIATRIC ASSOCIATION CONFERENCE

September 26 - 28, 2013
Ottawa, Ontario
Website: www.cpa-apc.org

CANADIAN ATTENTION DEFICIT HYPERACTIVITY DISORDER RESOURCE ALLIANCE ANNUAL MEETING

October 4 - 6, 2013
Montreal, Quebec
Website: www.caddra.ca

CANADIAN ASSOCIATION OF PAEDIATRIC HEALTH CENTRES ANNUAL MEETING

October 20 - 23, 2013
Toronto, Ontario
Website: www.caphc.org

AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY ANNUAL MEETING

October 22 - 27, 2013
Orlando, Florida
Website: www.aacap.org

CANADIAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY ANNUAL MEETING

November 15 - 17, 2013
Vancouver, British Columbia
Website: www.cacap-acpea.org

Editorial staff invite CACAP members and Journal readers to forward listings for upcoming conferences and meetings to be promoted in the Journal of the Canadian Academy of Child and Adolescent Psychiatry "Conference Watch". Please submit listings to: MS VICKI SIMMONS, Editorial Assistant vsimmons@shaw.ca