

Psychological Wellbeing and Life Satisfaction Among Parents of Children with Special Needs: A Cross-Sectional Study from Ghaziabad, India

Vaani Sethi¹, Debapriya², Priyanka Jha³

¹M. Sc Clinical Psychology (Final Year), Dept. Of Clinical Psychology, Santosh (deemed to be) University, Ghaziabad, Uttar Pradesh

²Assistant Professor, Dept. Of Clinical Psychology, Santosh (deemed to be) University, Ghaziabad, Uttar Pradesh

³Assistant Professor, Dept. Of Clinical Psychology, Santosh (deemed to be) University, Ghaziabad, Uttar Pradesh

ABSTRACT

Background: Parents of children with special needs face sustained caregiving demands, yet Indian research has rarely measured psychological wellbeing and life satisfaction together, using validated instruments, across a gender-balanced, diagnostically diverse sample. **Objective:** This study examined psychological wellbeing and life satisfaction among parents of children with special needs in Ghaziabad, India, and tested whether these outcomes differed by parent gender and child disability type. **Methods:** A cross-sectional, correlational design was used with 180 parents (90 fathers, 90 mothers) stratified across nine disability categories ($n = 20$ each). Ryff's Psychological Well-Being Scales and Diener's Satisfaction with Life Scale were administered. Data were analyzed using Pearson correlation, independent samples t tests, and one-way ANOVA. **Results:** Psychological wellbeing and life satisfaction were strongly correlated, $r(178) = .694$, $p < .001$. Fathers reported significantly higher wellbeing ($d = 0.57$) and life satisfaction ($d = 0.74$) than mothers. Disability type produced very large effects on both wellbeing ($\eta^2 = .733$) and life satisfaction ($\eta^2 = .571$), with parents of children with Specific Learning Disabilities and ADHD reporting the most favorable outcomes and parents of children with Multiple Disabilities, Autism Spectrum Disorder, Cerebral Palsy, and Muscular Dystrophy reporting the least favorable. **Conclusion:** Findings support disability-specific, gender-sensitive family support strategies over generic caregiver interventions in the Indian context.

Keywords: psychological wellbeing, life satisfaction, parents, special needs, disability type, India

How to cite this article: Vaani Sethi¹ Debapriya² Priyanka Jha³. Psychological Wellbeing and Life Satisfaction Among Parents of Children with Special Needs: A Cross-Sectional Study from Ghaziabad, India. *Int J Drug Deliv Technol.* 2026;16(83s):990-995. DOI: 10.25258/ijddt.16.83s.111

Source of support: Nil

Conflict of interest: None

INTRODUCTION

What formal systems don't get across to parents of children with special needs is therapy schedules, educational advocacy, stigma, and a future that is not what they envisioned. Around 1.3 billion people, or 16% of the world's population, have a significant disability,¹ and a large proportion of these are children who rely on family carers for daily care. In lower and middle income countries, where formal support systems are more fragile, this care responsibility is taken up almost entirely, and largely unnoticed, by families. The literature on this population has been dominated by the study of stress, burden, and pathology, with a large and consistent body of evidence on the costs to parents of caregiving, and relatively little research on the question of whether these parents are coping or thriving.

Ryff conceptualized psychological wellbeing (PWB) as active engagement with life's existential challenges across six interrelated dimensions: Autonomy, Environmental Mastery, Personal Growth, Positive Relations with Others, Purpose in Life, and Self-Acceptance.² This eudaimonic framework, drawing on earlier humanistic and developmental theory,^{3,4,5} treats wellbeing as more than the

absence of distress, asking instead whether a person is growing, connected, purposeful, and authentic. Diener offered a complementary, evaluative account, defining life satisfaction (LS) as a global cognitive judgment of one's life measured against self-chosen criteria rather than externally imposed standards.⁶ Though theoretically distinct, PWB and LS have been shown to be empirically related yet separable constructs,⁷ and measuring both together, rather than treating either as a proxy for the other, offers a fuller picture of caregiver mental health than either construct alone.

Even with this theoretical sophistication, both constructs are yet to be measured together in Indian caregiving studies. Previous research in India has focused on maternal stress and a single diagnostic category, primarily autism spectrum disorder, with fathers and families with other disability categories being under-represented. The overall prevalence of disability in India is just below 1%, with the most common disabilities being locomotor, mental and speech disabilities, and children aged 0-14 years having the highest proportion of speech disability in the country.⁸ This means that millions of Indian families are living with developmental, behavioural and educational complexity

without sufficient institutional support. This study directly tackled the resulting gap by measuring psychological wellbeing and life satisfaction simultaneously, with validated instruments, in a gender-balanced sample of Indian parents across nine different disability categories, and by testing whether there were systematic differences between parent gender and between the type of disability a parent's child had.

Literature Review

A substantial international caregiving literature documents prominent parenting stress relative to parents of typically developing children, confirmed meta-analytically for autism spectrum disorder specifically.⁹ This stress operates through multiple, partially independent pathways rather than a single mechanism: marital quality significantly predicts maternal depressed mood and subjective wellbeing both cross-sectionally and longitudinally,¹⁰ daily maternal mood and family inflexibility predict relationship quality on a day-to-day basis,¹¹ and child behavior problems predict poorer parent mental health partly through their effect on parental coping style.¹² Resilience, hope, and social support consistently buffer these effects, though the literature is divided on the precise mechanism, with some studies framing psychological resources such as resilience as a mediator between life satisfaction and wellbeing and others finding that social support functions as both a mediator and a direct moderator of the relationship between parenting stress and life satisfaction.^{13,14} Hope has been shown to predict subjective wellbeing independent of employment status or disability severity,¹⁵ and access to social and institutional support remains among the strongest predictors of parental wellbeing across caregiving populations generally.¹⁶

Within India specifically, qualitative work has documented those caregiving dynamics in granular detail. Parents of children with autism in Goa move through distinct temporal phases before arriving at diagnostic acceptance, beginning with a period of relative normalcy and ending in a prolonged reorganization of family life,¹⁷ alongside substantial unmet service needs that shape which coping strategies families are able to draw on.¹⁸ Affiliate stigma, internalized stigma experienced by association with a child's diagnosis rather than direct stigma toward the parent, has been documented as a specifically South Asian dimension of caregiving distress among Indian parents of children with autism.¹⁹ Evidence from Northern India further suggests that parental adjustment and life satisfaction are closely tied to a child's acquisition of functional skills, with parents of children who develop basic self-help and communication skills through intervention reporting reduced emotional exhaustion regardless of underlying diagnosis.²⁰

A smaller but important comparative literature has examined whether the psychological cost of caregiving is uniform across disability diagnoses or diagnosis-specific.

Comparative studies directly contrasting parents of children with autism and Down syndrome have found that mothers of children with autism report significantly higher parenting stress than fathers, while no comparable gender difference emerges among parents of children with Down syndrome, indicating the psychological cost of a diagnosis is not simply a function of intellectual disability severity.²¹ Similarly, mothers of youths with autism report significantly more pessimism about their child's future and lower wellbeing than mothers of youths with Down syndrome or fragile X syndrome despite broadly comparable objective caregiving demands, suggesting behavioral and communicative profile, not diagnosis alone, drives much of the disparity.²² Despite this accumulating evidence base, no identified Indian study has measured psychological wellbeing and life satisfaction together, using validated instruments, across a mixed-diagnosis, gender-balanced sample recruited in a single urban Indian setting, precisely the gap the present study addresses.

METHODOLOGY

Aim and Objectives

Aim: To assess psychological wellbeing and life satisfaction among parents of children with special needs.

Objectives:

1. To measure psychological wellbeing and life satisfaction among parents of children with special needs.
2. To analyze the correlation between psychological wellbeing and life satisfaction.
3. To compare psychological wellbeing and life satisfaction between fathers and mothers of children with special needs.
4. To analyze the difference across various disability categories in relation to life satisfaction and psychological wellbeing.

Research Question

What are the levels of psychological wellbeing and life satisfaction among Indian parents of children with special needs, and how do these outcomes relate to one another and vary by parent gender and child disability type?

Hypotheses

H₁: There is a significant association between psychological wellbeing and life satisfaction among parents of children with special needs.

H₂: There is a significant difference in psychological wellbeing and life satisfaction between fathers and mothers of children with special needs.

H₃: There is a significant difference in psychological wellbeing and life satisfaction across disability categories among parents of children with special needs.

Inclusion and Exclusion Criteria

Inclusion Criteria:

1. Biological or legal parent of a child aged 3–18 years with a diagnosed special need.

2. Parent has been the child's primary caregiver for at least one year.

3. Parent is able to read, understand, and respond to the study instruments in English or Hindi.

4. Parent voluntarily provides written informed consent to participate in the study.

Exclusion Criteria:

1. Parents of children with a disability diagnosis outside the nine study categories (Intellectual Disability, Multiple Disabilities including Deafblindness, Attention-Deficit/Hyperactivity Disorder, Specific Learning Disabilities, Blindness, Deafness, Muscular Dystrophy, Cerebral Palsy, and Autism Spectrum Disorder).

2. Parents currently receiving treatment for a diagnosed major psychiatric disorder.

3. Parents who are unable or unwilling to provide informed consent.

4. Both parents from the same family were excluded; only one parent per family was included.

Design, Sample, Instruments, and Procedure

Design: A cross-sectional, correlational design was used. Participants: 180 parents (90 fathers, 90 mothers; age range 24–50, $M = 36.49$) were recruited via purposive sampling through special schools and rehabilitation centers in Ghaziabad, India, with exactly 20 parents (10 father & 10 mother) recruited per disability category: ADHD, ASD, Blindness, Cerebral Palsy, Deafness, Intellectual Disability, Multiple Disabilities including Deafblindness, Muscular Dystrophy, and SLD. Only one parent per family participated. **Instruments:** Psychological wellbeing was measured using Ryff's Psychological Well-Being Scales (42 items, six subscales, range 7–42 per subscale; original $\alpha = .86-.93$).² Life satisfaction was measured using Diener et al.'s five-item Satisfaction with Life Scale (range 5–35; original $\alpha = .87$).²³ Both scales have established structural validity and cross-population reliability.^{24,25} **Procedure and Ethics:** Written informed consent was obtained; the study followed standard ethical guidelines for human participants research, with confidentiality maintained throughout. **Analysis:** Data were analyzed in SPSS using Pearson correlation, independent samples t tests (with

Cohen's d), and one-way ANOVA with Tukey HSD or Games-Howell post hoc tests as appropriate, at $\alpha = .05$.

RESULTS

Across the full sample ($N = 180$), PWB Total averaged 161.50 ($SD = 34.06$, possible range 42–252, observed range 95–252) and life satisfaction averaged 16.11 ($SD = 5.96$, possible range 5–30). Most parents (75.0%, $n = 135$) fell in the moderate PWB category, with 14.4% ($n = 26$) classified as high and 10.6% ($n = 19$) as low. Life satisfaction responses were more evenly spread across the seven-point classification, ranging from extremely dissatisfied (7.8%) to extremely satisfied (7.2%), with the largest single group (22.2%) falling in the slightly dissatisfied band.

Relationship between PWB and LS. PWB Total and life satisfaction were strongly and positively correlated, $r(178) = .694$, $p < .001$, sharing roughly 48% of variance in common. Among the six PWB dimensions, Environmental Mastery ($r = .467$) and Personal Growth ($r = .466$) showed the strongest associations with life satisfaction; Autonomy showed the weakest, though still significant, association ($r = .293$). All six dimensions correlated significantly and positively with both PWB Total and life satisfaction (all $p < .001$), with no negative associations observed anywhere in the correlation matrix.

Parent gender. Fathers reported significantly higher PWB ($M = 170.91$, $SD = 35.01$) than mothers ($M = 152.09$, $SD = 30.47$), $t(174.68) = 3.85$, $p < .001$, 95% CI [9.17, 28.48], Cohen's $d = 0.57$ (moderate to large effect). Fathers also reported significantly higher life satisfaction ($M = 18.17$, $SD = 5.63$) than mothers ($M = 14.04$, $SD = 5.58$), $t(178) = 4.93$, $p < .001$, 95% CI [2.47, 5.77], $d = 0.74$ (moderate to large effect).

Disability type. One-way ANOVAs revealed statistically significant differences across all nine disability groups on every dependent variable examined (all $p < .001$), with effect sizes that were, without exception, large by conventional standards, and especially striking for the two composite outcomes: PWB Total, $F(8,171) = 58.66$, $\eta^2 = .733$, and life satisfaction, $F(8,171) = 28.48$, $\eta^2 = .571$. Table 1 summarizes group means, ranked in descending order of PWB Total.

Table 1. Mean PWB Total and Life Satisfaction by Child Disability Type, Ranked by PWB Total

Disability Type	PWB Total M (SD)	Life Satisfaction M (SD)
Specific Learning Disabilities	209.25 (19.10)	25.05 (3.80)

ADHD	206.85 (12.75)	19.35 (4.58)
Deafness	174.15 (25.84)	20.20 (3.49)
Blindness	172.55 (17.22)	17.80 (5.32)

Intellectual Disability	151.45 (19.01)	13.45 (4.40)
Muscular Dystrophy	140.10 (15.41)	13.25 (3.43)
Cerebral Palsy	133.90 (16.23)	11.65 (3.92)

Autism Spectrum Disorder	133.55 (15.57)	13.55 (3.32)
Multiple Disabilities incl. Deafblindness	131.70 (17.96)	10.65 (3.17)

Post hoc comparisons (Tukey HSD, or Games-Howell where Levene's test indicated unequal variances) confirmed that the highest-scoring cluster (Specific Learning Disabilities, ADHD) and lowest-scoring cluster (Multiple Disabilities, Autism Spectrum Disorder, Cerebral Palsy, Muscular Dystrophy) differed significantly from one another, the majority at $p < .001$, while groups within each cluster did not differ significantly from one another. Deafness and Blindness formed a distinct intermediate tier, scoring significantly higher than the lowest cluster but not significantly different from each other.

DISCUSSION

The strong PWB–LS correlation observed here replicates prior work showing the eudaimonic and evaluative traditions of wellbeing research to be related but empirically distinguishable,^{7,26} while extending that pattern specifically into a high-burden Indian caregiving population. The outsized role of Environmental Mastery and Personal Growth, relative to Autonomy, suggests that for parents raising children with special needs, a felt sense of competence in managing daily caregiving demands and a continued sense of growth despite them matter more to overall life satisfaction than independence from external pressure, a pattern consistent with role engulfment accounts in which the caregiver identity comes to occupy much of the self.²⁷ This finding carries a practical implication distinct from a generic wellbeing intervention: programs that build parents' felt competence in navigating educational, medical, and rehabilitative systems may do more for life satisfaction than programs oriented primarily around independence or self-care framed in isolation from the caregiving role itself.

The gender gap favoring fathers replicates a pattern documented across Indian and international caregiving research,^{13,28,29} and is plausibly explained by this sample's own demographic profile, in which mothers served as the primary caregiver in 54.4% of families compared with 13.3% for fathers, combined with marital quality's well-documented impact on maternal psychological outcomes specifically.¹⁰ Family support services organized around a single, generic parent profile risk under-serving mothers in particular, and interventions aimed at more evenly redistributing caregiving labor, or more directly engaging

fathers in hands-on caregiving roles, may yield measurable wellbeing benefits for the family unit as a whole.

The disability type findings were the study's most striking result, and in several respects ran counter to expectations set by the wider literature. That parents of children with Specific Learning Disabilities and ADHD outranked even parents of children with sensory disabilities, historically supported by well-established special education infrastructure, was unexpected, as was the finding that Multiple Disabilities including Deafblindness, rather than Autism Spectrum Disorder specifically, produced the single lowest-scoring group, despite ASD's frequent framing in the international literature as the most psychologically burdensome childhood diagnosis for parents.⁹ This pattern likely reflects differences in caregiving chronicity, unpredictability, and the visibility of functional progress rather than diagnostic category alone: conditions permitting a clearer developmental trajectory and measurable skill acquisition over time were associated with more favorable parental outcomes,²⁰ while conditions involving substantial and often lifelong physical care demands, communication barriers, or documented affiliate stigma clustered at the bottom of the distribution.^{19,30} Comparative evidence that autism-specific parental stress is not simply a function of intellectual disability severity, since mothers of children with Down syndrome do not show comparable stress elevations to mothers of children with autism despite broadly similar cognitive profiles, further supports a diagnosis-specific rather than severity-general interpretation of these results.^{21,22} Practically, this argues strongly against a one-size-fits-all model of family support and toward disability-specific investment, more intensive psychological and respite support for families managing Multiple Disabilities, Autism Spectrum Disorder, Cerebral Palsy, and Muscular Dystrophy, alongside continued investment in the specialized educational infrastructure associated with comparatively better outcomes among families managing Deafness and Blindness.

CONCLUSION

This study demonstrates that psychological wellbeing and life satisfaction are strongly linked among Indian parents of children with special needs, that fathers report meaningfully better psychological outcomes than mothers,

and that child disability type is the single strongest correlate of parental psychological outcomes identified in this sample, accounting for a substantially larger share of variance than parent gender. Together, these findings confirm all three alternate hypotheses and reject all three null hypotheses stated at the outset of this study.

Practical and Future Implications

These findings argue against generic, one-size-fits-all caregiver support models and toward disability-specific, gender-sensitive psychosocial interventions delivered through the special schools and rehabilitation centers that already serve as these families' primary point of contact with formal support systems. In practice, this means allocating more intensive psychological and respite support toward families managing Multiple Disabilities, Autism Spectrum Disorder, Cerebral Palsy, and Muscular Dystrophy specifically, rather than distributing family support resources evenly across diagnostic categories. It also means designing caregiver interventions with explicit attention to gender, given that mothers, who served as the primary caregiver in the substantial majority of families in this sample, reported significantly poorer outcomes than fathers on both measures. Future research should build directly on these findings by measuring resilience, hope, social support, and child functional skill level as mediating or moderating variables rather than treating them as background context, by adopting longitudinal designs capable of tracking how these outcomes shift as a child ages and caregiving demands change, and by extending this line of inquiry to rural and non-metropolitan Indian populations to test whether the present pattern replicates outside a single urban setting.

Limitations

Several limitations qualify these findings. The cross-sectional design precludes causal inference regarding the direction of the relationships reported here. Reliance on parental self-report introduces the possibility of social desirability bias, a concern particularly relevant to the gender comparison if fathers and mothers differ systematically in their willingness to disclose personal distress. The sample, while balanced by design across nine disability categories and by parent gender, was drawn entirely from Ghaziabad, which may limit generalizability to rural populations or to regions with different service infrastructure. Finally, resilience, hope, social support, and child functional skill level were drawn on throughout the Discussion to interpret these findings but were not directly measured, which limits how precisely the underlying mechanisms can be specified.

Delimitations

Certain boundaries were deliberately set to keep the scope of this study well defined. Only parents of children falling within nine specified disability categories were included, and parents of children with other or dual diagnoses were excluded, in order to keep the disability-type comparison

statistically well powered and conceptually clear. Only one parent per family participated, which preserved the independence of observations required for the statistical analyses but means this study does not capture within-family, cross-spousal comparisons. The study was further delimited to two core constructs, psychological wellbeing and life satisfaction, with plausible correlates such as resilience, coping style, and social support deliberately left unmeasured so as to keep the investigation conceptually focused rather than attempting to model every contributing variable simultaneously. Finally, the study was delimited to parents recruited through special schools and rehabilitation centers in a single urban Indian city, Ghaziabad, rather than a broader national or rural sample, in order to keep the study logistically feasible within its intended scope.

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