AN INVESTIGATION OF THE RELATIONSHIP BETWEEN FAMILY-RELATED FACTORS AND RESILIENCE IN MOTHERS OF CHILDREN WITH AUTISM

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ABSTRACT

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There is a significant body of research exploring the stressors of raising a child with an Autism Spectrum Disorder (ASD). Although some parents experience great distress because of raising a child with ASD, some parents are more adapted and can develop resilience in the face of the challenges. The aim of the current study was to investigate the relationship between resilience and family related factors, namely marital quality, family functioning, and perceived social support in mothers of children with ASD. It was hypothesized that the marital quality, family functioning, and perceived social support would predict resilience in mothers of children with ASD. Hundred mothers (M_{age} = 38 years old, SD = 5.22, Age range = 26- 55 years) whose children have been diagnosed with ASD and attending to special education institutes in Istanbul, Tekirdağ, and Kırklareli participated in the present study. They completed Demographic Information Form, Resilience in Mid-Life Scale, Turkish

Dyadic Adjustment Scale, Family Assessment Device, and Multidimensional Perceived Social Support Scale - Turkish Version. Regression analyses showed that age, social support and family functioning predicted resilience; marital quality did not predict resilience. These findings suggested that mothers with high levels of social support and family functioning, are more likely to become resilient.

Keywords: Resilience, Autism Spectrum Disorder, social support, family functioning, marital quality.

ÖZ

OTİZMLİ ÇOCUĞU OLAN ANNELERİN YILMAZLIKLARININ AİLEYLE İLGİLİ FAKTÖRLERLE OLAN İLİŞKİSİNİN İNCELENMESİ

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Otizm Spektrum Bozukluğu olan bir çocuğu büyütmenin yarattığı stresi araştıran önemli araştırmalar vardır. Bazı ebeveynler otizmi olan bir çocuğa sahip oldukları için büyük stres yaşasalar da bazı ebeveynler otizmi olan bir çocuk büyütmeye daha çok adapte olmuşlardır ve zorluklar karşısında yılmazlık geliştirirler. Bu araştırmada, çocuklarına Otizm Spektrum Bozukluğu tanısı konan annelerin yılmazlığının evlilik kalitesi, aile işlevselliği, algılanan sosyal destek gibi aileyle ilişkili olan faktörlerle olan ilişkisini belirlemek amaçlanmıştır. Aile işlevselliğinin, evlilik kalitesinin ve algılanan sosyal desteğin annelerde yılmazlığı yordayacağı beklenmektedir. Bu çalışmaya, İstanbul, Tekirdağ ve Kırklareli ilinde OSB tanısı konmuş ve özel eğitim enstitülerinde öğrenim gören çocuğa/çocuklara sahip 100 anne katılmıştır (*Ort.* = 38, *S* = 5.22, yaş aralığı = 26-55). Bütün katılımcılar Yetişkin Yılmazlık Ölçeği, Çiftler Uyum Ölçeği, Aile Değerlendirme Ölçeği ve Çok Boyutlu Algılanan Sosyal Destek

Ölçeği'ni cevaplamıştır. Regresyon analizleri, annelerin yaşının, sosyal destek ve aile işlevselliğinin annelerde yılmazlığı yordadığını, evlilik kalitesinin annelerde yılmazlığı yordamadığını ortaya koymuştur. Bu bulgular, yüksek sosyal destek düzeyi ve sağlıklı aile fonksiyonlarına sahip annelerin daha yüksek yılmazlık düzeyine sahip olduklarını göstermektedir.

Anahtar Kelimeler: Yılmazlık, Otizm Spektrum Bozukluğu, evlilik kalitesi, sosyal destek, aile işlevselliği

To my lovely mother,

father,

and sister

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CHAPTER 1

INTRODUCTION

1.1 What is Resilience?

The resilience underlines “a dynamic process encompassing positive adaptation within the context of significant adversity” (Luthar, Cicchetti, & Becker, 2000), or resistant when faced with stressful experiences (Rutter, 1999). The resilience theory claims that the ability of an individual to create a formidable balance between risk and defense factors when facing problems is fundamental to resilience (Luthar, Cicchetti, & Becker 2000).

Resilience underlines the capacity for adapting, recovery and access to a productive and meaningful life through successfully coping after stressful events (Masten & Powell, 2007). Luthar (2006) has pointed that personal resilient factors which help to build resilient behaviors include positive interactions, self-esteem, flexible and positive thinking, innovativeness, autonomy, emotional self-control, sense of humor, self-efficacy belief, altruism, assertiveness, and confidence.

Two basic factors reemphasized in explaining resilience. The first one focuses on recovery from stressful life events (Masten, 2001; Rutter, 1987), and the ability to quickly acquire balance from stress to return to a healthy initial state, and the second factor is sustainability (Bonanno, 2004). It can be defined as the ability to sustain healthy responses in stress situations as a result of giving healthy reactions to stressful life events (Reich, Zautra, Hall, & Murray, 2010). According to Joseph (1994), resilience is an attitude, coping behavior and a personal power that can be seen and observed while struggling with troubles and successfully adapting to the changes required by the current living conditions.

Richardson (2002) suggested that resilience encompasses "the process of coping with adversity, change, or opportunity in a manner that result in the identification, fortification, and enrichment of resilient qualities or protective factors" (p. 308).

Resilient individuals have always been thought of having considerably good psychological outcomes in spite of having or undergoing dangerous experiences that would ordinarily be expected to have bad consequences (Rutter, 2006). According to Fraser, Galinsky, and Richman (1999), psychological resilience is used in the identification or categorization of individuals who attain positive outcomes when faced with distress and who have the capacity to adapt to extra-ordinary situations. This would mean that the individuals have successfully adapted to devastating life stresses and events.

Resilience is also defined as a dynamic process that includes risk and protective factors (Gu & Day, 2007). In the early studies (Rutter, 1985; Werner, 1984), certain individual characteristics such as sociability and locus of control were thought to be a protective factor associated with positive outcomes when facing

adversity. Campbell-Sills, Cohan, and Stein (2006) investigated the relationship of resilience to personality traits and found that resilience was positively associated with extraversion and conscientiousness. Liu, Wang, Zhou, and Li (2014) examined the mediator effects of affect and self-esteem on resilience and psychological adjustment and found a positive relationship between self-esteem and resilience. However, later on, the field of research has extended with including external protective factors that might increase resilience, such as healthy family systems (Luthar, Cicchetti, & Becker, 2000). Werner (1989) suggested three types of protective factors enhancing resilience in high-risk children. These are dispositional attributes of the individual, affectional ties within the family, and external support systems.

Numerous literary and scholarly works have examined the concept resilience among children and adolescents, with recent research concentrating on resilience among caregivers and adults experiencing challenging situations. For example, Zauszniewski Bekhet, and Suresky (2010) explored the concept of resilience with a particular focus on female family caregivers of adults with serious mental illness. In the present study, parents' resilience in another challenging situation, which is having a child with a developmental disorder, specifically Autism Spectrum Disorder was examined.

1.2. Characteristics of Autism Spectrum Disorder (ASD)

Autism Spectrum Disorder (ASD) is a life-long neurodevelopmental disorder, the symptoms of which generally occur in early childhood. ASD involves variable impairments which affect a diagnosed child's communication, social interactions, and behavior patterns (APA, 2013).

The DSM-V criteria for Autism Spectrum Disorder is listed as following (APA, 2013):

"A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following:

1. Deficits in social-emotional reciprocity
2. Deficits in nonverbal communicative behaviors used for social interaction,
3. Deficits in developing, maintaining, and understanding relationships,

B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following:

1. Stereotyped or repetitive motor movements, use of objects, or speech
2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior
3. Highly restricted, fixated interests that are abnormal in intensity or focus
4. Hyper- or hyporeactivity to sensory input or unusual interest in sensory aspects of the environment

C. Symptoms must be present in the early developmental period

D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.

E. These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay."

The term “Autism” was first introduced by psychiatrist Leo Kanner at John Hopkins University (Kanner, 1943; Rakap et al., 2017). He defined autism with the core symptoms such as restricted patterns of behavior, abnormalities in social functions, limited and stereotyped interest in verbal and nonverbal communication.

Further studies following the first studies by Kanner (1943) aimed to identify the causes of ASD and the characteristics of individuals with ASD. Although there is not a single known cause of ASD, there are research findings suggesting that genetic and environmental factors and abnormalities in brain structure or function during brain development cause ASD. For example, studies have shown that children with ASD and neurologically normal development show differences in their brain structure and shape (Volkmar, Lord, Bailey, Schultz, & Klin, 2004). In addition, studies with children and their families with ASD conclude that ASD may have a genetic link because ASD and related disorders are seen in different people within the same family (Volkmar, Rogers, Paul, & Pelphrey, 2014).

1.3. Impacts of ASD on Families

Children with ASD often pose numerous challenges and stressors for all family members. This is predicated on the fact that this pervasive disorder has a negative impact on almost every other element of the family’s functioning (Kapp & Brown, 2011). It is noteworthy that ASD diagnosis in children is typically traumatizing for families and the child (Wolfensberger & Menolascino, 1970; Blacher et al., 2002). Indeed, such diagnosis was followed by negative perception and stigmatization of the child by the parents themselves who often face heightened stress due to concerns pertaining to the child’s future and upbringing (Kanner, 1943). Children with ASD often require additional assistance and care coupled with enhanced monitoring to safeguard their safety and wellness in the short- and long-

term (Peer & Hillman, 2014). This is worsened by the fact that ASD usually involves problems with social adjustment, communications, as well as having stereotypical and repetitive tendencies. The tension and psychological pressure would be increased by the wide range of problematic tendencies. Studies have suggested that mothers and parents of children with ASD have twice or thrice the potential for demonstrating clinically significant depression levels, stress and anxiety compared to mothers of healthy children (Bailey, Golden, Roberts, & Ford, 2007; Emerson, Hatton, Llewellyn, Blacker, & Graham, 2006).

Even more noteworthy is the fact that social stigma from people brings immense stress for parents of children with ASD. Most of the stigma is predicated on the pervasive cultural beliefs particularly in developing countries where children with ASD were seen as having resulted from the previous wrongful acts of their parents. This is often the precursor for social exclusion, which would cause heightened levels of stress for such families and parents of children with ASD (Marsack & Perry, 2017).

Having or raising children with ASD comes with immense stress not only for the individual but also for other members of the family. As much research has examined the impacts on family members or relatives of individuals with ASD, Hasting's et al. (2005) suggested that all family members would not be affected in the same way. Hastings (2003), for instance, noted that mothers experienced more negative outcomes and anxiety compared to fathers in the same family.

1.4. Resilience in Mothers of Children with ASD

Researchers have emphasized the significant difficulty and the negative effects pertaining to bringing up children with ASD. According to Ruiz-Robledillo et

al., (2013), informal caregivers of people suffering from ASD have been found to experience more somatic symptoms, anxiety, depression, social dysfunction compared to the general population. Nevertheless, some caregivers have demonstrated the capacity for effective coping mechanism with stress pertaining to care situations, namely resilience. Bayat (2007) indicated that caregivers of children with ASD showed personal improvement indicating that they become more resilient by raising a child with ASD. In the core context, resilience is shaped by particular skills that foster successful adaptation to care situations without affecting the health of the individual. This underlines the fact that resilience is not an entirely static capacity rather it is dynamic in the sense that not only caregivers can be assisted to increase but also shape it to suit particular situations.

Rea-Amaya et al. (2017) emphasized the importance of resilience in eliminating stress and safeguarding the raising of the child in a healthy environment. It is noteworthy that resilience offers a society, family, individual or institution the competencies and resources for facing adversity and favorably withstanding vulnerability conditions. Varying environments in which individuals live would offer the elements for establishment of resilience.

According to Khan et al., (2017), the effects of any form of disability would be felt not only by the disabled person but also by the entire family. Indeed, raising a child with ASD is a life-long situation, and it might be difficult for parents to be resilient. However, Özbay and Aydoğan (2013) noted protective factors to build resilience of parents whose children have physical and mental disabilities. These factors are noted as relationships within family members and social support from spouses and relatives.

Parents of children with ASD would have to spend considerably more time in childcare activities compared to parents of healthy children. This means that there would be a considerable decrease in the time they have available for other activities including personal care, work, leisure and others, which implies that they would be more likely to be mentally and physically exhausted since they would spend the bulk of their time meeting these heightened care needs without spending as much time in personal care activities such as sleeping (Brandon, 2007).

Even more fundamental is the fact that there is a deficiency of information pertaining to ASD in the society, an element that could cause parents of children with ASD to be subjected to considerably higher levels of stigma and to be affected by the cultural beliefs and undergo self-blame for the diagnosis of their children. The deficiency of support and sufficient knowledge at the societal level could increase the difficulty against which the families struggle to make sense of the behavior of their children, which could consequently increase the stress levels experienced. Behavioral and emotional problems of the child had a significant contribution to the mothers' stress, paternal mental health issues, perceived dysfunction of the family compared to the gender of the child, development delay or diagnosis itself (Brei, Schwarz & Tasman, 2015).

Researchers have also concentrated on the gender differences in the impact of ASD on families. McStay et al., (2014) noted that mothers being the primary caregivers are more likely to experience difficulties associated with parenting compared to fathers and other family members. Mothers experience higher stress levels compared to fathers. Gau et al. (2012) noted that the negative impact of raising a child with ASD appears to be greater for mothers than fathers, as noted in research of 151 families of children with ASD. Further, Gau et al. (2012) indicated that mothers

of children with ASD found to take more personal responsibility on caregiving than fathers. Rea-Amaya, Acle-Tomasini, and Ordaz-Villegas (2017) indicated that mothers are more required to care daily for their children (Gargiulo, 2015), and that mothers are more capable of seeking support than fathers.

1.4.1 Resilience and Social Support in Mothers of Children with ASD

Social support underlines the extent to which an individual benefits or gains from the social resources via the relations or associations on which he/she can rely. This was predicated on the Lewin's field theory of human behavior, which suggested that behavior underlines the total of the modifications in the psychological environment. There is the possibility for the elimination of negative tendencies of individuals and assist them to gain new tendencies through assisting them to modify their psychological environment (Yıldırım, 1997).

Studies have shown that both formal and informal social support are related to resilience for parents of children with intellectual deficiencies (Peer & Hillman, 2014). Indeed, informal support is provided by family and friends has been deemed particularly efficient in lowering stress among mothers whose children have ASD. Underlining the efficacy of social support in enhancing resilience is the fact that most of the parents of children with ASD reported that they felt the need to rely on their spouses more for emotional, psychological and mental support, an element that caused them to be considerably closer to each other (Ilias, Cornish, Park, Toran, & Golden, 2019).

Mothers of children with ASD who receive high levels of social support from their relatives and spouses were shown to have decreased amounts of depression-associated somatic symptoms, as well as less marital problems (Dunn et al., 2001).

Moreover, Tobing and Glenwick (2006) conducted a study with mother of children with ASD, and the results indicated that maternal stress and satisfaction with social support are negatively correlated Ekas et al., (2010) obtained similar results and underlined the fact that family support brought a significant reduction in maternal stress and depression in a study involving 119 mothers who have children with ASD. Hall and Graff (2011) examined a sample of parents of children aged below 21 years had ASD. Their study demonstrated that participants reported that their spouse or partner was their most helpful support source. It is noteworthy that support from spouses was shown to lower parenting stress in mothers and increase their capacity to bear the burden of stress associated with their children with ASD (Hall, Graff, 2011). In addition, Carter and colleagues investigated depressive symptoms in mothers of children with ASD and found that social support was associated with depression severity. Plumb (2011) acknowledged that mothers who obtained high levels of formal and informal social support had decreased amounts of anger, anxiety and depression. In addition, the decreased amounts of social support were perceived as the most powerful predictor of anxiety and depression in parents who have children with ASD.

Despite the parents of children with ASD need more support from their spouses; it was indicated that parents of children with ASD experience marital difficulties, lower satisfaction with their marriage and demonstrate considerably lower dyadic adjustment when compared to parents of children who do not have any disability (Lee et al., 2009). The marital difficulties of parents of children with ASD may affect their resilience.

1.4.2 Resilience and Marital Quality in Mothers of Children with ASD

Marriage quality primarily encompasses the spouses' perception of the health of their marriage (Glenn, 1990). The key aspects that define marital quality include marriage satisfaction, marriage unity, marital adjustment, and marital happiness (Faulkner, 2002; Nabarro, 2004). There are variations in researchers' understanding of these concepts with some perceiving them as synonymous (Heyman, Sayers, & Bellack, 1994; Lenthall, 1977). Nevertheless, it is noteworthy that high marriage quality is directly associated with satisfaction and happiness in marriage (Erberk, Baştepe, Akar, Eradamlar & Alpkan, 2005). This means that marriage quality encompasses marriage adjustment and marriage satisfaction (Erberk et al., 2005). In addition to challenges associated directly raising the child with ASD, parents also report adversities in family and marital relationship. Families of children with disabilities have lower marital satisfaction than do families whose children do not have disabilities (Brobst et al. 2009; Gau et al. 2012; Higgins et al. 2005).

Bristol, Gallagher, and Schopler (1988) investigated adaptation and family roles with 56 parents of disabled and nondisabled children and found that parents of disabled children were found to have more martial adjustment problems than parents of nondisabled children. Kersh and colleagues (2006) conducted a study with 67 families of children with developmental disorders to examine the contribution of the marital relationship to psychological well-being of both mothers and fathers. Results suggested that for mothers, marital quality contributed significantly to the indicators of well-being. Mothers who reported higher levels of marital quality also reported lower levels of depressive symptomology, lower levels of stress related to the parenting role, and greater parenting efficacy.

In a study by Brobst et al. (2009), parents whose children had ASD and parents who had typically developing children were compared. This study indicated that the former group had considerably lower marital relationship satisfaction, as well as more parenting stress compared to the latter group. Similar results were obtained by Hartley, Barker, Seltzer, Greenberg, and Floyd (2011) who examined a sample of 91 parents of adolescents and adults with ASD. They suggested that parents who experienced reduced marital satisfaction significantly had more burdens of the problems pertaining to additional responsibilities for children with ASD compared to those that had more marital satisfaction. Bailey, Higgins, and Pearce (2005) conducted a study to investigate the relationship between ASD characteristics, family functioning, and coping strategies in a sample of 52 parents with children with ASD. Results suggested that parents of children with ASD had demonstrated lower marital satisfaction, as well as lower family functioning (in terms of their adaptability and cohesiveness) than the parents who have normally developing children.

1.4.3. Resilience and Family Functioning in Mothers of Children with ASD

Ackerman and Franklin (1965) note that families have healthy functions which allow their members to orient their lives with the intended goals. They would not be affected by other people, not to mention the fact that any emerging problem would trigger cooperation by the family members to surmount the conflict or eliminate the source of the conflict. Not only do the members of the family accept each other but also have immense respect for each other's capabilities, weaknesses and strengths, which are garnered and summoned or leveraged to enhance growth and strength in the short- and long-term (Ackerman & Franklin, 1965).

According to McMaster family functioning model theory proposed by Epstein in 1987 (Miller, Ryan, Keitner, Bishop & Epstein, 1993), family system processes are the foundation of any family. Family functioning underlines a commitment to support the familial functioning including caregiving, communication, economic needs, safety, and child rearing (Feetham, 2005). Families have the main goal of providing crucial environmental circumstances for family members to improve and protect the varying social, psychological, and physical conditions. This fundamental function would be realized in cases where family members undertake particular basic tasks including catering for the material needs of people such as clothing, food and shelter; crisis tasks like assisting in case of family emergencies; as well as developmental tasks like fostering the growth and development of the members.

The concept of support from family functioning encompasses supportive relationships between community members, family members, friends and parents (Roberts & Feetham, 1982). Krysan, Moore, and Zill (1990) perceived a healthy and strong family as incorporating particular distinctive features. One of these features is adaptability, which encompasses the capacity to handle crisis or problems in a constructive and positive way. In addition, it must incorporate commitment, as well as clear and effective patterns of communication. Also, a healthy family must provide a conducive or supportive family environment through safeguarding a sense of belonging and fostering individual development of its members, demonstrating appreciation for all, as well as spiritual interconnectedness and social orientation and clearly defined roles (Krysan, Moore & Zill, 1990).

In a study carried out to examine the relative effects of child and different family functioning components in determining the parenting stress, Smith, Oliver,

and Innocenti (2001) demonstrated that family functioning components had more effect on parenting stress compared to child-related variables. However, there is no clarity regarding the degree to which family functioning variables such as communication or cohesion relate to the stress (Feldman et al., 1997). Johnson and colleagues (2011) conducted a study with 64 parents of children with ASD investigating the mediator effect of positive family functions on the relationship between parenting stress and mental health. Results indicated that positive family functioning had a mediating effect of stress and mental health, without supportive family functioning, both fathers and mothers are at risk for poorer mental health.

Krauss (1993) carried out a study that examined the concepts of cohesion and adaptability in families of children with developmental disorders. The study showed that for both mothers and fathers, a higher amount of parenting stress was related to poorer family functioning or decreased adaptability, and cohesion levels.

Although there are no studies investigating the direct relationship between family functioning and resilience, family functioning might have a significant role in safeguarding and determining resilience in family members given the importance of healthy family functioning in parents' various aspects of psychological well-being (Rea-Amaya, Acle-Tomasini & Ordaz-Villegas, 2017).

1.5 The Aim of Thesis

As the reviewed literature above indicates, investigate resilience in a relational and family context is recently common (Patterson, 2002a, 2002b; Walsh, 1998). The present study focused on the relationship between resilience in mothers of children with ASD and familial factors. Considering the findings of studies examining different familial factors separately, this study combined family

functioning, perceived social support and marital quality, and investigated their relationship to mothers' resilience. It was hypothesized perceived social support, marital quality and family functioning would predict mothers' resilience. In addition, mothers' age was controlled as a demographic variable considering the contradictory findings on the relationship between age and resilience in literature (Friborg et al, 2003; Lee et al., 2009). For example, some research has shown that resilience increases with age (Friborg et al, 2003). On the other hand, Lee and colleagues (2009) found that younger adults perceive themselves to have more resilient features. Furthermore, there are studies indicating that resilience is independent of the age variable (Boyraz & Sayger, 2011; Hystad et al., 2010).

1.6 Hypotheses

H1: Resilience will be associated positively with perceived social support, marital quality, and family functioning.

H2: Perceived social support would significantly predict resilience among mothers of children with ASD.

H3: Marital quality would significantly predict resilience among mothers of children with ASD.

H4: Family functioning would significantly predict resilience among mothers of children with ASD.

1.7 The Importance of Thesis

Despite having a child with ASD might be a major source of stress for family members, specifically for mothers; it is important to acquire appropriate coping mechanisms to maintain steadiness for both the parents and the development of the children (Peer & Hillman, 2014). According to the reviewed literature, mothers'

resilience underlines the capacity to cope with the challenges and overcoming the stress and burden related with having a child with ASD. The aim of this study is to investigate possible predictors of resilience among mothers of children with ASD. It is important to investigate resilience in mothers because mothers' promoted psychological well-being is highly associated with children's mental and behavioral development (Osborne, McHugh, Saunders & Reed, 2008). To our knowledge, there are no other studies investigating the relationship between resilience in mothers of children with ASD and familial factors directly in the Turkish literature. This study contributed to the literature by expanding the perspective on resilience in mothers of children with ASD by combining family-related factors, specifically, family functioning, perceived social support, and marital quality as possible predictors of mothers' resilience.

CHAPTER 2

METHOD

2.1 Participants

The sample of the current study consisted of mothers of children with ASD from special education institutes in Istanbul, Kırklareli, and Tekirdağ. The inclusion criterion for the study is that the mothers are married, and not being divorced.

2.2. Demographics

A total of 100 participants aged between 26 to 55 years (M_{age}=38 years old, *SD*= 5.22) from special education institutes in Istanbul, Kırklareli, and Tekirdağ are included in the study; 32 participants were in Istanbul (32%), 50 participants (50%), were in Kırklareli, and 18 participants (18%) were in Tekirdağ. Detailed demographic information about participants is presented in Table 2.1 and Table 2.2.

Table 2.1

Demographics of the Participants (Age and Marriage Year)

	Minimum	**Maximum**	**Mean**	**SD**
Age	26	55	38	5.22
Marriage Year	4	28	13	5.02

Table 2.2

Demographics of the Participants (Education Level, Work status, Number of children, Number of children with ASD, Order of children with ASD, Age of diagnosis)

	N	**Percentage (%)**
Education Level		
Literate	2	2
Primary School	13	13
Middle School	16	16
High School	41	41
University	27	27
Graduate	1	1
Working Status		
Working	26	26
Not Working	77	77
Number of Children		
1	32	32
2	57	57
3	9	9
4	1	1
Number of Children with ASD		
1	70	70
2	27	27
3	1	1
4	1	1
Order of Children with ASD		
1	70	70
2	27	27
3	1	1
4	1	1
Age of Diagnosis		
1	1	1
1,5	3	3
2	9	9
2,5	17	17
3	25	25
3,5	10	10
4	19	19
4,5	6	6
5	6	6
6	2	2
7	1	1

2.3. Measurements

2.3.1. Demographic Information Form

The demographic information form has been created for mothers of children with ASD. The form includes questions about the mother's age and education level. Additionally, there are questions about their children with ASD for example chronological age of the diagnosed child, when the child is diagnosed, and how many children have been diagnosed. Also, there is one question asking the duration of marriage (See Appendix B).

2.3.2. Multidimensional Perceived Social Support Scale - Turkish Version (MPSS)

The Multidimensional Perceived Social Support Scale (Zimet et al, 1988) was used to determine the participants' perceived social support (See Appendix C). The scale, which consists of 12 items rated on a 7-point Likert scale, has three sub-scales that ask for social support from family (item 3, 4, 8, 11), social support from friends (item 6, 7, 9, 12) and social support from a special person (item 1, 2, 5, 10). The total score obtained by summing up the scores of all items constitutes the social support score. The high social support score indicates that the social support perceived by the individual is high.

The validity and reliability study of the original scale was conducted by Zimet and his colleagues in 1988, and the internal consistency values for a social support from special person, family and friend subscales were .91, .87 and .85, respectively. The total reliability of the scale was stated as .88 (Zimet et al., 1988).

As a result of the validity and reliability analyzes of the Turkish version of the scale by Eker and Arkar in 1995, Cronbach's alpha coefficients were found as .89 for the whole scale, .85 for the family support subscale, .88 for the friend support subscale, and .92 for the special person support subscale (Eker & Arkar, 1995). On 2001, another reliability and validity analysis of the scale was conducted by Eker, Arkar, and Yıldız (2001) with 50 inpatient psychiatric patients, 50 patients who underwent surgical intervention, and 50 randomly selected patient visitors as normal group. Internal consistency values for a private person, family and friends were found as .89, .83 and .90, respectively. The total reliability of the scale was stated as .87 (Eker et al., 2001). In this study, Cronbach's alpha of the scale was calculated as .89.

2.3.3 The Resilience in Midlife Scale (RIM-S)

The Resilience in Midlife Scale was developed by Ryan and Caltabiano in 2009 to assess the psychological resilience of adults aged 35-60 (See Appendix D). This scale is a 5-point Likert-type scale (0-4) and consists of 25 items, and it consists of five factors. These are respectively; Self-efficacy, Family/ Social Networks, Perseverance, Internal Locus of Control, Coping and Adaptation. After the 6., 10., 12., 13., 17., 19., 20. and 23. items are reversed, a total resilience score is obtained by summing up the scores of all items. The resilience score ranges between 25 and 125. A high score on the scale means that the level of resilience is also high.

The scale was adapted to Turkey by Çakar, Karataş and Çakır (2014). In the validity and reliability studies conducted by Ryan and Caltabiano, it was found that the Cronbach Alpha value was .87. Its validity and reliability were tested in the adaptation study by Çakar, Karataş, and Çakır (2014) and the item total correlation coefficients ranged from .17 to .66. The internal consistency coefficient was found to

be .71, and the test-retest reliability was .85. In this study, Cronbach's alpha of the scale was calculated as .88.

2.3.4. Turkish Dyadic Adjustment Scale (DAS)

The Dyadic Adjustment Scale (DAS) was developed by Spanier (1976) to assess the quality of relationships as perceived by married or cohabiting couples (See Appendix E). The scale consists of 32 items and four subscales, which are Dyadic satisfaction, Dyadic cohesion, Dyadic consensus and Affectional expressions. The scale includes 2 yes-no questions and Likert-type questions with 5- to 7- point response formats. The marital quality score ranging from 0 to 151 is calculated through the sum of all items; higher scores reflect a higher perception of the quality of the relationships.

In the original form developed by Spanier (1976), the reliability coefficient for the total scale was .96 and for subscales; was ranging from .73 to .94. The Turkish validity and reliability study of the scale was conducted by Fışıloğlu and Demir (2000). The internal consistency reliability was .92, and also, the split-half reliability coefficient was .86. Also, reliability scores of subscales of the Turkish DAS were as follows; Dyadic satisfaction: .83; Dyadic cohesion: .75; Dyadic consensus: .75; Affectional expression: .80. In this study, Cronbach's alpha was calculated as .92.

2.3.5. Family Assessment Device (FAD)

The Family Assessment Scale was developed by Epstein, Baldwin and Bishop in 1983, in the United States, under the Family Research Program of Brown University and Butler Hospital in order to evaluate various aspects of family functioning (See

Appendix F). This scale is a 4-point Likert-type scale (1- totally agree, 2- agree to great extent, 3- agree a little, 4- disagree at all) and consists of 60 items and 7 subscales including problem solving, communication, roles, emotional response, showing interest, behavior control, and general functions. After the 1., 4., 5., 7., 8., 9., 11., 13., 14., 15., 19., 21. ,22., 27., 28., 31., 33., 34., 35., 37., 39., 41., 42., 44., 45., 47., 48., 51., 52., 53., 54., and 58. Items are reversed, the family functioning score was calculated through the average of all items; higher scores reflect and unhealthy family functioning. Theoretically, 2 is a distinctive number and average scores above 2 have been accepted as a sign of unhealthy family functioning (Bulut, 1990).

While McMaster Family Function Model was reduced to 53 questions for the Family Assessment Scale, questions were chosen randomly from each dimension and the internal consistency of each dimension was calculated with the Cronbach's Alpha coefficient. This process was continued until the alpha coefficient of each dimension was at least .70. The internal consistency (alpha coefficient) ranges from .72 to .92 in six dimensions. This shows that the internal consistency of the scale is high. The validity study of the scale was done by Epstein et al. (1983).

The adaptation study of the scale was conducted by Bulut (1990). For internal consistency analysis of the scale, Cronbach's alpha values were calculated separately for each sub-group from the responses of 67 subjects. Cronbach's alpha values were .80 for problem solving; .71 for communication; .42 for roles; .59 for emotional response; .38 for showing interest; .52 for behavior control; and .86 for the general function (Bulut, 1990). The internal consistency reliability was ranging between .72 and .92 (Bulut, 1990). The construct validity of the scale was evaluated by comparing the scores of the groups who were in the process of divorce and were not

in the process of divorce. It was found that the scale significantly differentiated these two groups. In this study, Cronbach's alpha of the scale was found to be .91.

2.4 Procedure

The participants were choosen from the Special Education and Rehabilitation Centers in Istanbul, Tekirdağ, and Kırklareli. Mothers who volunteered in participating were given the paper-and-pencil questionnaire set. The set includes Informed Consent Form (See Appendix A), Demographic Information Form, Multidimensional Perceived Social Support Scale Turkish Version, the Resilience in Midlife Scale, Turkish Dyadic Adjustment Scale, and Family Assessment Device. The mothers who accepted to participate completed the informed consent form and the other measurement instruments in 20 to 30 minutes. Some of the mothers filled out the questionnaires during the special education lesson of their children, and others were given the scales to fill them at their house, and all scales were handed directly to the researcher or the authorized persons in the institution where they served.

2.5. Data Analysis

Analyses were conducted through IBM SPSS Statistics 25.0. In addition to descriptive and frequencies of demographic variables; correlation, and multiple regression analysis were conducted.

CHAPTER 3

RESULTS

In this chapter, the results of the study are presented in three sections. Firstly, the results of descriptive statistics are presented. The second section includes bivariate correlations between the predictor variables (Perceived Social Support, Marital Quality, Family Functioning) and the outcome (Resilience). In the third section, the results of multiple regression analyses are presented.

3.1. Descriptive Statistics for the Measures of the Study

Descriptive statistics of total participants showed that skewness and kurtosis values for each measure, except the family functioning score, were within the acceptable range (See Table 3.1). Therefore, A univariate outlier analysis was conducted to detect the outliers on the family functioning score. One outlier was detected and deleted from subsequent analyses. After deleting the outlier, the family functioning score was normally distributed (See Table 3.2). As the normality was fairly achieved, further analyses were conducted with 99 participants' scores.

Table 3.1.

Descriptive Statistics for Resilience Scores, Social Support Scores, Family Functioning Scores, Marital Quality Scores

	N	Min.	Max.	M	SD	Skewness	Kurtosis
Resilience	100	32	93	65.56	11.59	-.21	.52
Social Support	100	24	84	59.48	15.77	-.24	-.88
Family Functioning	100	1.22	3.46	1.90	.38	.95	2.00
Marital Quality	100	58	145	108.74	19.58	-.24	-.30

Table 3.2

Descriptive Statistics of the Resilience Scores, Social Support Scores, Family Functioning Scores, Marital Quality Scores After Eliminating A Univariate Outlier

	N	Min.	Max.	M	SD	Skewness	Kurtosis
Resilience	99	32	93	65.64	11.62	-.23	.53
Social Support	99	24	84	59.35	15.80	-.23	-.89
Family Functioning	99	1.22	2.94	1.89	.35	.47	.04
Marital Quality	99	63	145	109.25	19.00	.-15	-.45

3.2. Bivariate Correlations between Predictor Variables (Social Support, Family Functioning, and Marital Quality Scores), and Outcome Variable (Resilience Score) and Assumption Testing

Pearson's correlation analysis was conducted. As depicted in Table 3.3, all other variables have significant relationships with each other.

Table 3.3.

Bivariate Correlations among Predictor Variables (Social Support, Family Functioning, and Marital Quality), and Outcome Variable (Resilience) and Mothers' Age

	1	2	3	4	5
1. Resilience	-	.43***	.35***	-.53***	-.24**
2. Marital Quality	-	-	.32**	-.64***	-.15
3. Social Support	-	-	-	-.27**	.07
4. Family Functioning	-	-	-	-	.10
5. Age	-	-	-	-	-

Notes. * $p < .05$, ** $p < .01$, *** $p < .001$

3.2.1. Linearity

In order to examine the linearity assumption, the normal plot was composed. The straight line in Figure 3.1 represents the normal distribution and the points represent the observed residual.

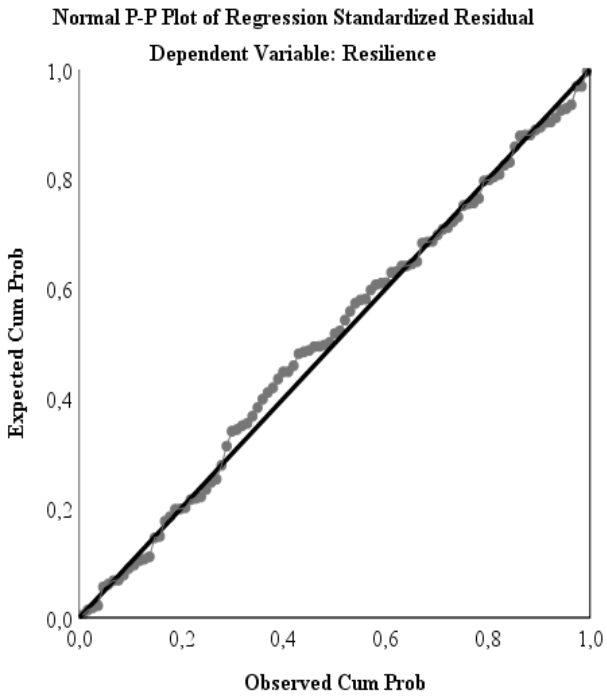

Figure 3.1. Normal P-P Plot of Regression Standardized Residual

3.2.2. Independent Errors

In order to test the assumption of independent errors of this study, the Durbin-Watson test was utilized. The value of Durbin-Watson is 1.93 which means that the error term is independent. Thus, the assumption of independent errors is not violated (Field, 2009).

3.2.3. Homoscedasticity

The scatter plot of regression standardized residuals against regression standardized predicted values was preferred to examine the assumption of homoscedasticity (Field, 2009). In addition, variance inflation factor (VIF) value ranged between 1.04 and 1.78, implying that there were no multicollinearity and

singularity in the data set (Field, 2009). The scatterplot of standardized predicted values vs. standardized residuals shows that the data met the assumptions of homogeneity of variance and linearity and the residuals were approximately normally distributed *(Figure 3.2).*

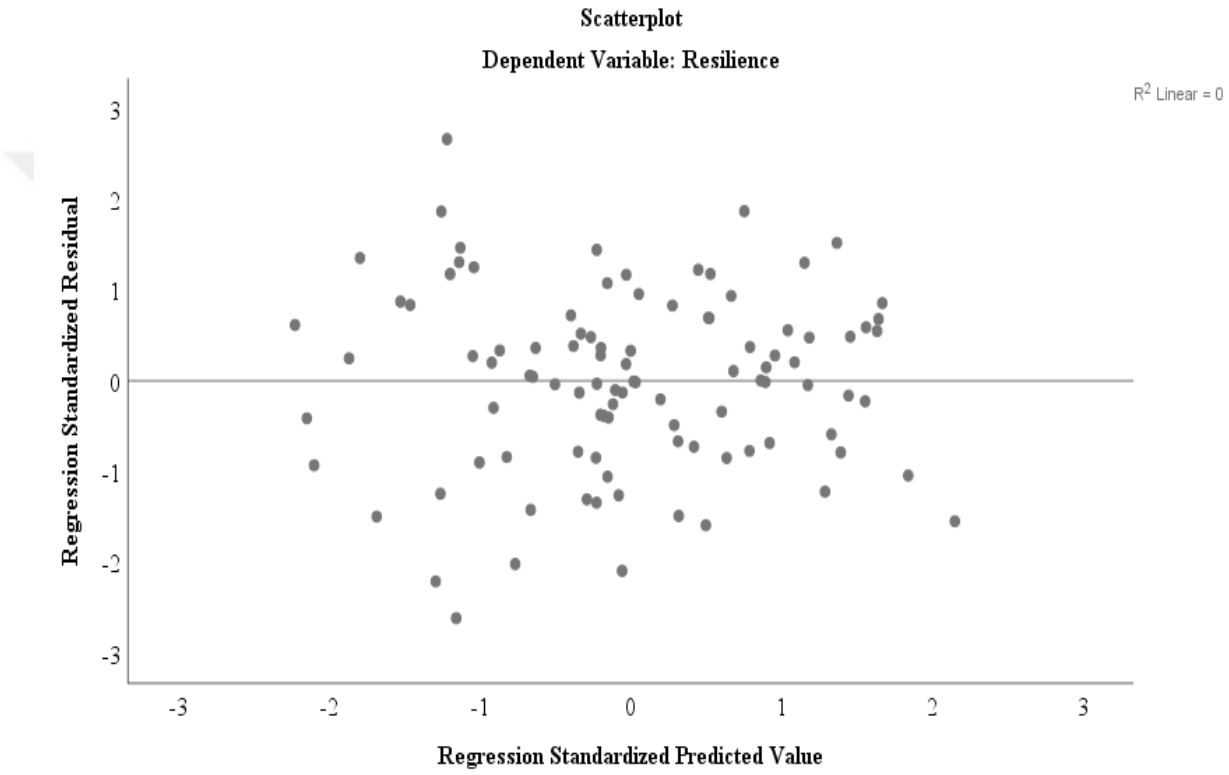

Figure 3.2. The scatter plot of regression standardized residuals against regression standardized predicted values

3.3 Analysis of Resilience scores according to Number of Children

The data were splitted into two groups, mothers with one child (N = 32) and mothers with two or more children (N = 57) in order to analyze whether there were differences in resilience scores between mothers of one child and mothers of two or more children.

An independent samples t-test was conducted to compare the total resilience scores of mothers with one child and mothers with two or more children.

There was no significant difference between the resilience scores of mothers with one child (M = 68.28, SD = 10.47) and mothers with two or more children (M = 64.89, SD = 12.45); t (87) = 1.30, p = .72.

3.4 Regression Analyses with the Resilience by the Predictors of Age, Martial Quality, Family Functioning, and Perceived Social Support

A hierarchical regression analysis was conducted in order to examine whether age, marital quality score, family functioning score and perceived social support score would be the predictors of resilience score.

In the first step of the regression analysis, the predictive effect of age on the resilience score was tested through the enter method. The model was found to be significant R^2 = .06, Adjusted R^2 = .05, F (1, 98) = 5.87, p = .017 (See Table 3.4). In the second step, after controlling the predictive effect of age, with the addition of social support, marital quality, and family functioning scores, the model was found to be significant, R^2 = .37, Adjusted R^2 = .35, F (4, 95) = 14.35, p = .000. Table 3.4

shows the details of the regression analyses. It was found that age, social support score and family functioning score significantly predicted resilience score.

Table 3.4

Hierarchical Regression Analyses for Variables Predicting Total Score of Resilience

	Unstandardized Coefficients		Standardized Coefficients		
	B	SE	ß	t	p
1 (Constant)	3.45	.34		10.11	.000
Age	-.02	.01	-.24	-2.42	.017 *
2 (Constant)	3.65	.58		6.32	.000
Age	-.02	.01	-.20	-2.47	.015*
Social Support	.08	.03	.24	2.72	.008*
Marital Quality	.05	.08	.08	.71	.481
Family Functioning	-.49	.13	-.39	-3.74	.000*

Notes. * $p < .05$

CHAPTER 4

DISCUSSION

The current study aimed to investigate the relationship between resilience in mothers of children with ASD and social support, family functioning, marital quality.

The results of the current study indicated that there were positive relationships between perceived social support, martial quality, family functioning, and resilience in mothers of children with ASD. Perceived social support and family functioning predicted resilience; however, marital quality did not predict resilience. It was also found that there was no difference between the resilience scores of mothers with one child and of mothers with two or more children. This result suggests that the number of children mothers have does not have an effect on mothers' resilience.

Mothers' age was negatively correlated with resilience; and also, was a predictor of resilience; implying that older mothers have lower resilience scores. This finding is in line with the finding of Diehl and Hay (2010) indicating that age might be a risk factor for becoming more vulnerable to the negative effects of stress. However, there are contradictory findings on the relationship between age and

resilience in the literature. For instance, Lundman and colleagues (2007) found a positive correlation between age and resilience.

Based on the literature about the relationship between resilience and social support, it was hypothesized that resilience of mothers of children with ASD would be predicted by mothers' perceived social support. This hypothesis was confirmed. Mothers who reported high levels of social support were found to score high on resilience and their perceived social support predicted their resilience level. This finding was consistent with that of previous studies. For instance, Sancakoğlu (2019) conducted a study with mothers of children with need of special education and found a positive correlation between mothers' resilience levels and perceived social support. Özbay and Aydoğan (2013) noted that social support is the most important factor affecting parents' resilience. Social support from society, neighbors, relatives and spouses have a positive effect on families' dealing with having children with developmental disability healthily and showing positive development. A supportive family environment will increase level of commitment and make it easier for the family to adapt more successfully to having a child with disability (Özbay, Aydoğan, 2013).

In addition, Ekas, Lickenbrock, and Whitman (2010) found that support from family brought a significant reduction in depression and maternal stress of mothers who have children with ASD. Tobing and Glenvick (2006) investigated the relationship between social support and maternal stress with 97 mothers of children with ASD; and found that social support was associated with low maternal stress. In another study conducted with parents of children with disability, there was a significant relationship between perceived social support scores and loneliness scores; and also, there was a significant negative correlation between loneliness

scores and perceived social support from friends and family (Sungur & Bozdoğan, 2011). Furthermore, in a study with mothers of 2- to 6-year-old children with ASD, the relationship between mothers' perceived social support and hopelessness was found to be negative; as the mothers' perceived social support level increases, their hopelessness level decreases (Ünlüer, 2009). Consequently, all these studies combined with the present one indicates that perceived social support for mothers' of children with ASD can buffer or protect negative consequences of stressful life events by reducing the level of stress and improving mental health.

Family functioning was another factor that was hypothesized to predict mothers' resilience in the present study. Confirming the hypothesis, the findings demonstrated that family functioning is a predictor of resilience in mothers of children with ASD. In literature, there are no studies investigating the direct relationship of family functioning on resilience in mothers of children with ASD. Thus, this study contributes to literature by showing that family functions such as healthy communication and clearly defined roles reported by mothers predict their resilience. This finding supported the idea that Family functioning is as a key factor in determining resilience in family members (Rea-Amaya, Acle-Tomasini, & Ordaz-Villegas, 2017). It is also consistent with Walsh's (2003) suggestion that mutual support, collaboration, and commitment induce increased family cohesion, which in turn contributes to more effective family functioning, and therefore also increases resilience in family members.

Families who have a child with developmental disorders are generally thought to experience more stress and adversity than other parents (Jones & Passey, 2005). However, many families with ASD overcome the challenges and adapt well to their environment (Drew & Norton, 1994). Successful adaptation enhances the

capacity to handle crisis or problems in a constructive and positive way, and consequently provides a supportive family environment. Kapp and Brown (2011) explored adjustment and adaptation to families living with ASD, and found that social support, spousal relationship, family time, togetherness, and routines are the most important resilience promoting factors with ASD. The findings of the present study indicating the relationship between resilience and social support and family functioning further extends Kapp and Brown's (2011) finding.

In the present study, marital quality was another factor expected to predict resilience of mothers of children with ASD.; however, this hypothesis was not supported. The findings indicated that the mothers' reported marital quality was not a predictor of resilience. However, there was a positive relationship between resilience and marital quality. Mothers who reported to have high satisfaction, cohesion and consensus in their marriages were found to have high resilience.

To our knowledge, there is no study which directly examined the relationship between marital quality and resilience in mothers of children with ASD. However, Davies and Cummings (2006) have suggested that a high-quality marriage may be compensatory for families with psychological distress. Olson and McCubbin (1983) suggested that high marital strength and satisfaction are critical requisite to predictions adaptation to a crisis situation. Furthermore, Bekhet, Johnson, and Zauszniewski (2012) indicated that low marriage quality is a risk factor that might compromise developing resilience in parents of children with ASD. Siman-Tov and Kaniel (2011) investigated the relationship between parental stress, parental resources, parental adjustment, and the child's ASD symptoms with 176 parents of children with ASD and found that there was a relationship between marital quality and ability to cope with stress (Siman-Tov & Kaniel, 2011). In families with

children with developmental disorders, a strong marriage may appear to function as the primary buffer against the stressors created by the care of a child with a developmental disorder. Consistent with these ideas and findings, the present study demonstrated that marital quality is positively related to mothers' resilience.

4.1. Clinical Implications of the Findings

Resilience was defined as an ability of an individual to adapt, recover, and access to productive and meaningful life through successfully coping after stressful events (Masten, Powell, 2007). In the literature of family and developmental disorder, having a child with a developmental disorder has been considered as a stressor; and resilience as a factor contributing to successful adaptation of families to care for a child with developmental disorder (McConnel & Savage, 2015). Accordingly, Bristol, Gallagher, and Schopler (1988) indicated that social support is positively correlated with enhanced personal adaptation. Also, Hilmann and Peer (2014) identified three resilience factors which are dispositional optimism, problem-focused coping, and social support. In the current study, it was suggested that individual factors associated with personal strength or weakness may be necessary but not sufficient to understand the whole construct of resilience. Based on this idea, the present study investigated the relationship between family-related factors (social support, family functioning, marital quality) and resilience in mothers of children with ASD. Current findings revealed that social support and family functions were significant predictors of resilience of mothers of children with ASD. They are significant to extend the perspective on the development of social support services for parents of children with ASD. Providing to these parents proper helping sources including psycho-education programs might increase their social skills and family

functions. Providing effective treatment models for ASD involving both child and family plays an important role for community mental health services and mental health professionals. Treatment methods aimed at improving the mental health of the mother will also be beneficial for children with ASD. In clinical applications, it is important to extend family-based programs together with the education of children. Also, psychological support programs for the difficulties which individuals, caregivers and family members face should be prepared by multidisciplinary works of professionals and government services.

Thus, analyzing relationship between environmental and family-related factors for mothers of children with ASD and their resilience may help to understand the importance of investigating and working on the difficulties that mothers live and their social support resources in clinical settings.

4.2. Limitations of the Study and Future Research

Firstly, the sample of the study consisted of mothers of children with ASD from Istanbul, Kırklareli, and Tekirdağ. Special education centers in these provinces were mostly located in low socio-economic status regions, and this makes difficult to generalize the findings of this study. Also, making contact with mothers in these special education centers were challenging as most of them did not want to participate in the study or even talk about their child diagnosed with ASD. Additionally, recruitment of the sample from special education centers may be considered as a limitation of this study. These mothers have more access to get support from special education teachers and psychologists of the schools, which might create a more reliable and constructed support system. Future research may

include mothers who are unable to access educational or social resources in order to be more exploratory for the families who are living with ASD.

Additionally, some of the participants filled out the questionnaires during the special education lesson of their children, and others were given the scales to fill them at their house. Therefore, some participants were not given the questionnaires directly by the researcher, and it is unclear the way how some participants perceive and understand questions, which may create a response bias.

Furthermore, this study did not attempt to analyze any causal relationship between variables as the design of the current study was correlational. Also, the relationship between mothers' resilience and child-related factors such as children's age, age of diagnoses, or the severity of the ASD symptoms (Level 1, Level 2, Level 3) were not examined in this study. These factors may have an effect on the mothers' resilience. For example, Ateş (2016) found that as the age at which the child was diagnosed with ASD increases, the parents' level of problem solving, communication, and emotional reaction increases.

ASD can coexist with other disorders, including mental retardation and ADHD (Zafeiriou, Ververi &Vargiami, 2007); and the presence of other developmental disorders comorbid to ASD in children can have an impact on mothers' resilience levels. However, in this study, whether the children who were diagnosed with ASD have also comorbid ADHD or mental retardation was not investigated, which creates a significant limitation to the current study.

In addition, although, this study was designed to conduct with specifically mother of children with ASD, fathers and other family members could have been included in order to obtain different aspects of familial factors. Further, qualitative

measurements and clinical interviews with mothers and other family members may be added in future studies.

4.3. Conclusion

The current study investigated the relationship between resilience, social support, marital quality, family functioning of mothers of children with ASD. Social support and family functioning were found to predict resilience, indicating that mothers who have more social support and have healthy family functions in their families are more likely to be more resilient.

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APPENDIX A

BİLGİLENDİRİLMİŞ ONAM FORMU

Bu çalışma, Bahçeşehir Üniversitesi Klinik Psikoloji Yüksek Lisans Programı öğrencisi Dilay Akcan tarafından yüksek lisans tezi kapsamında, Dr. Öğretim Üyesi Hale Ögel Balaban danışmanlığında yürütülmektedir. Çalışmada otizmli çocuk sahibi olan annelerin psikolojik dayanıklılıklarının algıladıkları sosyal destekle, evlilik kalitesiyle ve aile işlevselliğiyle olan ilişkisine bakılacaktır. Çalışmaya katılım tamamen gönüllülük temeline dayanmaktadır ve çalışma süresince katılımcılardan kimlik belirleyici herhangi bir bilgi istenmemektedir.

Araştırma yaklaşık olarak 25-30 dakika sürecektir. Lütfen soruların başındaki yönergeleri dikkatlice okuyunuz ve her soruyu size en yakın olan cevabı vererek yanıtlayınız. Araştırma içinde yer alan soruların doğru ya da yanlış cevapları yoktur. Vermiş olduğunuz cevaplar gizli tutulacak ve yalnızca araştırma amacına yönelik kullanılacaktır. Çalışmaya katılmaktan herhangi bir an vazgeçebilirsiniz veya çalışmayı yarım bırakabilirsiniz.

Katılımınız için teşekkür ederim.

Dilay Akcan

Bahçeşehir Üniversitesi Psikoloji Bölümü

Yüksek Lisans Öğrencisi

Tez danışmanı: Dr. Öğretim Üyesi Hale Ögel Balaban

Bahçeşehir Üniversitesi Psikoloji Bölümü

Bu çalışmaya tamamen gönüllü olarak katılıyorum ve istediğim zaman yarıda kesip çıkabileceğimi biliyorum. Verdiğim bilgilerin bilimsel amaçlı yayımlarda kullanılmasını kabul ediyorum.

APPENDIX B

DEMOGRAFİK BİLGİ FORMU

Bu anket formu Bahçeşehir Üniversitesi Klinik Psikoloji Yüksek Lisans tez çalışması için "Otizm Tanısı Almış Olan Çocuklara Sahip Annelerin Psikolojik Dayanıklılıklarının, Algıladıkları Sosyal Destekle, Evlilik Kalitesiyle ve Aile İşlevselliğiyle Olan İlişkisinin İncelenmesi" amacıyla hazırlanmıştır. Soruları cevaplarken içten olmanız ve doğru cevaplar vermeniz araştırmanın niteliği açısından önemlidir. Verilen tüm bilgiler gizli tutulacaktır. Katılımınız için teşekkür ederim.

Yaşınız:

……

Eğitim Durumunuz:

……

Herhangi bir işte çalışıyor musunuz?

……..

Mesleğiniz?

…….

Kaç çocuğunuz var?

……

Otizm tanısı almış çocuğunuz kaç çocuğunuz var?

……

Otizm tanısı alan çocuğunuz kaçıncı çocuğunuz?

……

Çocuğunuz/çocuklarınız otizm tanısı aldığında kaç yaşındaydı?

……

Kaç yıllık evlisiniz?

…….

APPENDIX C

ÇBASDÖ

Aşağıda 12 cümle ve her bir cümle altında da cevaplarınızı işaretlemek için 1'den 7 'ye kadar rakamlar verilmiştir. Her cümlede söylenenin sizin için ne kadar çok doğru olduğunu veya olmadığını belirtmek için o cümle altındaki rakamlardan yalnız bir tanesini işaretleyiniz.

Bu şekilde 12 cümlenin her birine bir işaret koyarak cevaplarınızı veriniz.

Lütfen hiçbir cümleyi cevapsız bırakmayınız. Sizce doğruya en yakın olan rakamı işaretleyiniz.

1. **Ailem (örneğin, annem, babam, eşim, çocuklarım, kardeşlerim) bana yardımcı olmaya çalışır.**

   Kesinlikle Hayır 1 2 3 4 5 6 7 Kesinlikle Evet

2. **İhtiyacım olan duygusal yardım ve desteği ailemden (örneğin, annem, babam, eşim, çocuklarım, kardeşlerim) alırım.**

   Kesinlikle Hayır 1 2 3 4 5 6 7 Kesinlikle Evet

3. **Arkadaşlarım bana gerçekten yardımcı olmaya çalışırlar.**

   Kesinlikle Hayır 1 2 3 4 5 6 7 Kesinlikle Evet

4. **İşler kötü gittiğinde arkadaşlarıma güvenebilirim.**

   Kesinlikle Hayır 1 2 3 4 5 6 7 Kesinlikle Evet

5. **Ailem ve arkadaşlarım dışında olan ve ihtiyacım olduğunda yanımda olan bir insan (örneğin, flört, nişanlı, sözlü, akraba, komşu, doktor) var.**

   Kesinlikle Hayır 1 2 3 4 5 6 7 Kesinlikle Evet

6. **Ailem ve arkadaşlarım dışında olan ve sevinç ve kederlerimi paylaşabileceğim bir insan (örneğin, flört, nişanlı, sözlü, akraba, komşu, doktor) var.**

   Kesinlikle Hayır 1 2 3 4 5 6 7 Kesinlikle Evet

7. **Sorunlarımı ailemle (örneğin, annem, babam, eşim, çocuklarım, kardeşlerim) konuşabilirim.**

   Kesinlikle Hayır 1 2 3 4 5 6 7 Kesinlikle Evet

8. **Sevinç ve kederlerimi paylaşabileceğim arkadaşlarım var.**

   Kesinlikle Hayır 1 2 3 4 5 6 7 Kesinlikle Evet

9. **Ailem ve arkadaşlarım dışında olan ve duygularıma önem veren bir insan (örneğin, flört, nişanlı, sözlü, akraba, komşu, doktor) var.**

   Kesinlikle Hayır 1 2 3 4 5 6 7 Kesinlikle Evet

10. **Kararlarımı vermede ailem (örneğin, annem, babam, eşim, çocuklarım, kardeşlerim) bana yardımcı olmaya isteklidir.**

    Kesinlikle Hayır 1 2 3 4 5 6 7 Kesinlikle Evet

11. **Ailem ve arkadaşlarım dışında olan ve beni gerçekten rahatlatan bir insan (örneğin, flört, nişanlı, sözlü, akraba, komşu, doktor) var.**

    Kesinlikle Hayır 1 2 3 4 5 6 7 Kesinlikle Evet

12. **Sorunlarımı arkadaşlarımla konuşabilirim.**

    Kesinlikle Hayır 1 2 3 4 5 6 7 Kesinlikle Evet

APPENDIX D

YILMAZLIK ÖLÇEĞİ- (YETİŞKİN FORMU)

Aşağıda verilen cümlelere sizce doğruya en yakın olan seçeneği işaretleyiniz.

		0 **Kesinlikle katılmıyorum**	**1** **Katılmıyorum**	**2** **Kararsızım**	**3** **Katılıyorum**	**4** **Kesinlikle katılıyorum**
1	Yoluma ne çıkarsa üstesinden gelirim					
2	Amaçlarıma ulaşırım					
3	Hayatımın bir anlamı var					
4	Mali zorlukların üstesinden gelirim					
5	Arkadaşlarıma güvenebilirim					
6	Başarısızlıkta kolayca cesaretimi yitiririm					

7	Değişimi bir meydan okuma olarak görürüm					
8	Bir soruna çözüm bulabilirim					
9	Kendi hayatımı kontrol edebilirim					
10	Stresle kolayca baş edemem					
11	İhtiyacım olduğunda bana yardım edebilecek birisi var					

		0 **Kesinlikle katılmıyorum**	**1** **Katılmıyorum**	**2** **Kararsızım**	**3** **Katılıyorum**	**4** **Kesinlikle katılıyorum**
12	Ölümle baş edemem.					
13	Olaylar ümitsiz göründüğünde pes ederim.					
14	Yaşa bağlı vücutta oluşan değişiklikleri kabul ederim.					
15	Zor zamanları atlatabilirim.					
16	Zor zamanlarda aileme güvenebilirim.					
17	Değişen çalışma koşullarının üstesinden gelmek için donanımım yok .					

18	Kendime olan inancım işin üstesinden gelmemi sağlar.					
19	Planlara tam olarak uyamam.					
20	Bana olan şeyler üzerinde çok az etkim var.					
21	Hastalıkla baş edebilirim.					
22	Zorluklar beni kamçılar ve peşlerini bırakmam.					
23	Sevdiğim kişiler evi terk ettiğinde zorluk çekerim.					

		0 **Kesinlikle katılmıyorum**	**1** **Katılmıyorum**	**2** **Kararsızım**	**3** **Katılıyorum**	**4** **Kesinlikle katılıyorum**
24	Yaşamımdaki olaylara nasıl tepki vereceğimi kontrol ederim.					
25	Kayıplar sırasında dini inançlar bana umut verir.					

APPENDIX E

ÇİFTLER UYUM ÖLÇEĞİ

Birçok insanın ilişkilerinde anlaşmazlıkları vardır. Lütfen aşağıda verilen maddelerin her biri için siz ve eşiniz arasındaki anlaşma veya anlaşmama ölçüsünü aşağıda verilen altı düzeyden birini seçerek belirtiniz.

	Her zaman anlaşırız	Hemen hemen her zaman anlaşırız	Nadiren anlaşamayız	Sıkça anlaşamayız	Hemen hemen her zaman anlaşamayız	Her zaman anlaşamayız
1. Aileyle ilgili parasal işlerin idaresi						
2. Eğlenceyle ilgili konular						
3. Dini konular						
4. Muhabbet-sevgi gösterme						
5. Arkadaşlar						
6. Cinsel yaşam						
7. Geleneksellik (doğru veya uygun davranış)						
8. Yaşam felsefesi						
9. Anne, baba ya da yakın akrabalarla ilişkiler						
10. Önemli olduğuna inanılan amaçlar, hedefler ve konular						
11. Birlikte geçirilen zaman miktarı						
12. Temel kararların alınması						
13. Ev ile ilgili görevler						
14. Boş zaman ilgi ve uğraşları						
15. Mesleki kararlar						

	Her zaman	Hemen hemen her zaman	Zaman zaman	Ara sıra	Nadiren	Hiçbir zaman
16. Ne sıklıkla boşanmayı, ayrılmayı ya da ilişkinizi bitirmeyi düşünür ya da tartışırsınız?						
17. Ne sıklıkla siz veya eşiniz kavgadan sonra evi terk edersiniz?						
18. Ne sıklıkla eşinizle olan ilişkinizin genelde iyi gittiğini düşünürsünüz?						
19. Eşinize güvenir misiniz?						
20. Evlendiğiniz için hiç pişmanlık duyar mısınız?						
21. Ne sıklıkla eşinizle münakaşa edersiniz?						
22. Ne sıklıkla birbirinizin sinirlenmesine neden olursunuz?						

	Her gün	Hemen hemen Her gün	Ara sıra	Nadiren	Hiçbir zaman
23. Eşinizi öper misiniz?					

	Hepsine	Çoğuna	Bazılarına	Çok azına	Hiçbirine
24. Siz ve eşiniz ev dışı etkinliklerinizin ne kadarına birlikte katılırsınız?					

Aşağıdaki olaylar siz ve eşiniz arasında ne sıklıkta geçer?

	Hiçbir zaman	Ayda birden az	Ayda bir veya iki defa	Haftada bir veya iki kere	Günde bir defa	Günde birden fazla
25. Teşvik edici fikir alışverişlerinde bulunmak						
26. Birlikte gülmek						
27. Bir şeyi sakince tartışmak						
28. Bir iş üzerinde birlikte çalışmak						

Eşlerin bazı zamanlar anlaştıkları, bazen anlaşamadıkları konular vardır. Eğer aşağıdaki maddeler son birkaç hafta içinde siz ve eşiniz arasında görüş farklılığı veya problem yaratıyorsa belirtiniz (Evet veya Hayır'ı işaretleyiniz)

	Evet	Hayır
29. Seks için çok yorgun olmak		
30. Sevgi göstermemek		

31. Aşağıda ilişkinizdeki farklı mutluluk düzeyleri gösterilmektedir. Orta noktadaki "mutlu" birçok ilişkide yaşanan mutluluk düzeyini gösterir. İlişkinizi genelde değerlendirdiğinizde mutluluk düzeyinizi en iyi şekilde belirtecek olan seçeneği lütfen işaretleyiniz.

[ ] Aşırı mutsuz [ ] Oldukça mutsuz [ ] Az mutsuz [ ] Mutlu [ ] Oldukça mutlu [ ] Aşırı mutlu [ ] Tam anlamıyla mutlu

32. Aşağıda belirtilen cümlelerden ilişkinizin geleceği hakkında ne hissettiğinizi en iyi şekilde tanımlayan ifadeyi lütfen işaretleyiniz.
[ ] İlişkimin başarılı olmasını çok fazla istiyorum ve bunun için yapamayacağım hiçbirşey yoktur.
[ ] İlişkimin başarılı olmasını çok istiyorum ve bunun için yapabileceklerimin hepsini yapacağım.
[ ] İlişkimin başarılı olmasını çok istiyorum ve bunun için payıma düşeni yapacağım.
[ ] İlişkimin başarılı olması güzel olurdu, fakat bunun için şu anda yaptıklarımdan daha fazlasını yapamam.
[ ] İlişkimin başarılı olması güzel olurdu, fakat bunun için şu anda yaptıklarımdan daha fazlasını yapmayı reddederim.
[ ] İlişkim asla başarılı olmayacak ve ilişkimin yürümesi için benim daha fazla yapabileceğim bir şey yok.

APPENDIX F

AİLE DEĞERLENDİRME ÖLÇEĞİ

AÇIKLAMA: İlişikte aileler hakkında 60 cümle bulunmaktadır. Lütfen her cümleyi dikkatlice okuduktan sonra, sizin ailenize ne derecede uyduğuna karar veriniz. **Önemli olan, sizin ailenizi nasıl gördüğünüzdür**. Her cümle için 4 seçenek söz konusudur (***Aynen Katılıyorum/ Büyük Ölçüde Katılıyorum/ Biraz Katılıyorum/ Hic Katılmıyorum***)

Her cümlenin yanında 4 seçenek için de ayrı yerler ayrılmıştır. Size uygun seçeneğe **(X) işareti** koyunuz. **Her cümle için uzun, uzun düşünmeyiniz.** Mümkün olduğu kadar **çabuk ve samimi cevaplar** veriniz. **Kararsızlığa düşerseniz, ilk aklınıza gelen doğrultusunda hareket ediniz.** Lütfen her cümleyi cevapladığınızdan emin olunuz.

CÜMLELER:	Aynen Katılı-yorum	Büyük Ölçüde Katılı-yorum	Biraz Katılı-yorum	Hiç Katılmı-yorum
1.Ailece ev dışında program yapmada güçlük çekeriz, çünkü aramızda fikir birliği sağlayamayız.	( )	( )	( )	( )
2.Günlük hayatımızdaki sorunların (problemlerin) hemen hepsini aile içinde hallederiz.	( )	( )	( )	( )

3.Evde biri üzgün ise, diğer aile üyeleri bunun nedenlerini bilir.	( )	( )	( )	( )
4.Bizim evde, kişiler verilen her görevi düzenli bir şekilde yerine getirmezler.	( )	( )	( )	( )
5.Evde birinin başı derde girdiğinde, diğerleri de bunu kendilerine fazlasıyla dert ederler.	( )	( )	( )	( )
6.Bir sıkıntı ve üzüntü ile karşılaştığımızda, birbirimize destek oluruz.	( )	( )	( )	( )
7.Ailemizde acil bir durum olsa, şaşırıp kalırız.	( )	( )	( )	( )
8.Bazen evde ihtiyacımız olan şeylerin bittiğinin farkına varmayız.	( )	( )	( )	( )
9.Birbirimize karşı olan sevgi, şefkat gibi duygularımızı açığa vurmaktan kaçınırız.	( )	( )	( )	( )
10.Gerektiğinde aile üyelerine görevlerini hatırlatır, kendilerine düşen işi yapmalarını sağlarız.	( )	( )	( )	( )
11.Evde dertlerimizi üzüntülerimizi birbirimize söylemeyiz.	( )	( )	( )	( )
12.Sorunlarımızın çözümünde genellikle ailece aldığımız kararları uygularız.	( )	( )	( )	( )
13.Bizim evdekiler, ancak onların hoşuna giden şeyler söylediğimizde bizi dinlerler.	( )	( )	( )	( )
14.Bizim evde bir kişinin söylediklerinden ne hissettiğini anlamak pek kolay değildir.	( )	( )	( )	( )
15.Ailemizde eşit bir görev dağılımı yoktur.	( )	( )	( )	( )
16.Ailemizin üyeleri, birbirlerine hoşgörülü davranırlar.	( )	( )	( )	( )
17.Evde herkes başına buyruktur.	( )	( )	( )	( )
18.Bizim evde herkes, söylemek istediklerini üstü kapalı değil de doğrudan birbirlerinin yüzüne söyler.	( )	( )	( )	( )
19.Ailede bazılarımız, duygularımızı belli etmeyiz.	( )	( )	( )	( )
20.Acil bir durumda ne yapacağımızı biliriz.	( )	( )	( )	( )
21.Ailecek, korkularımızı ve endişelerimizi birbirimizle tartışmaktan kaçınırız.	( )	( )	( )	( )
22.Sevgi, şefkat gibi olumlu duygularımızı birbirimize belli etmekte güçlük çekeriz.	( )	( )	( )	( )
23.Gelirimiz (ücret, maaş) ihtiyaçlarımızı karşılamaya yetmiyor.	( )	( )	( )	( )
24.Ailemiz, bir problemi çözdükten sonra, bu çözümün işe yarayıp yaramadığını tartışır.	( )	( )	( )	( )
25.Bizim ailede herkes kendini düşünür.	( )	( )	( )	( )

26.Duygularımızı birbirimize açıkça söyleyebiliriz.	( )	( )	( )	( )
27.Evimizde banyo ve tuvalet bir türlü temiz durmaz.	( )	( )	( )	( )

28.Aile içinde birbirimize sevgimizi göstermeyiz.	( )	( )	( )	( )
29.Evde herkes her istediğini birbirinin yüzüne söyleyebilir.	( )	( )	( )	( )
30.Ailemizde, her birimizin belirli görev ve sorumlulukları vardır.	( )	( )	( )	( )
31.Aile içinde genellikle birbirimizle pek iyi geçinemeyiz.	( )	( )	( )	( )
32.Ailemizde sert-kötü davranışlar ancak belli durumlarda gösterilir.	( )	( )	( )	( )
33.Ancak hepimizi ilgilendiren bir durum olduğu zaman birbirimizin işine karışırız.	( )	( )	( )	( )
34.Aile içinde birbirimizle ilgilenmeye pek zaman bulamıyoruz.	( )	( )	( )	( )
35.Evde genellikle söylediklerimizle, söylemek istediklerimiz birbirinden farklıdır.	( )	( )	( )	( )
36.Aile içinde birbirimize hoşgörülü davranırız	( )	( )	( )	( )
37.Evde birbirimize, ancak sonunda kişisel bir yarar sağlayacaksak ilgi gösteririz.	( )	( )	( )	( )
38.Ailemizde bir dert varsa, kendi içimizde hallederiz.	( )	( )	( )	( )
39.Ailemizde sevgi ve şefkat gibi güzel duygular ikinci plandadır.	( )	( )	( )	( )
40.Ev işlerinin kimler tarafından yapılacağını hep birlikte konuşarak kararlaştırırız.	( )	( )	( )	( )
41.Ailemizde herhangi bir şeye karar vermek her zaman sorun olur.	( )	( )	( )	( )
42.Bizim evdekiler sadece bir çıkarları olduğu zaman birbirlerine ilgi gösterir.	( )	( )	( )	( )
43.Evde birbirimize karşı açık sözlüyüzdür.	( )	( )	( )	( )
44.Ailemizde hiçbir kural yoktur.	( )	( )	( )	( )
45.Evde birinden bir şey yapması istendiğinde mutlaka takip edilmesi ve kendisine hatırlatılması gerekir.	( )	( )	( )	( )
46.Aile içinde, herhangi bir sorunun (problemin) nasıl çözüleceği hakkında kolayca karar verebiliriz.	( )	( )	( )	( )

47. Evde kurallara uyulmadığı zaman ne olacağını bilmeyiz.	( )	( )	( )	( )
48. Bizim evde aklınıza gelen her şey olabilir.	( )	( )	( )	( )
49.Sevgi, şefkat gibi olumlu duygularımızı birbirimize ifade edebiliriz.	( )	( )	( )	( )
50.Ailede her türlü problemin üstesinden gelebiliriz.	( )	( )	( )	( )
51.Evde birbirimizle pek iyi geçinemeyiz.	( )	( )	( )	( )
52.Sinirlenince birbirimize küseriz.	( )	( )	( )	( )
53.Ailede bize verilen görevler pek hoşumuza gitmez çünkü genellikle umduğumuz görevler verilmez.	( )	( )	( )	( )
54.Kötü bir niyetle olmasa da evde birbirimizin hayatına çok karışıyoruz.	( )	( )	( )	( )
55.Ailemizde kişiler herhangi bir tehlike karşısında (yangın, kaza gibi) ne yapacaklarını bilirler, çünkü böyle durumlarda ne yapılacağı aramızda konuşulmuş ve belirlenmiştir.	( )	( )	( )	( )
56.Aile içinde birbirimize güveniriz.	( )	( )	( )	( )
57.Ağlamak istediğimizde, birbirimizden çekinmeden rahatlıkla ağlayabiliriz.	( )	( )	( )	( )
58.İşimize (okulumuza) yetişmekte güçlük çekiyoruz.	( )	( )	( )	( )
59.Aile içinde birisi, hoşlanmadığımız bir şey yaptığında ona bunu açıkça söyleriz.	( )	( )	( )	( )
60. Problemlerimizi çözmek için ailecek çeşitli yollar bulmaya çalışırız.	( )	( )	( )	( )