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Examining the utilisation and usefulness of social support for mothers with young children with autism spectrum disorder

Laura Lee McIntyre and Mallory Brown

Department of Special Education and Clinical Sciences, University of Oregon Eugene, OR, USA

Abstract

Background—Social support has been described as a vital resource for families with children with disability. Although the benefits of social support have been described, little is known about the utilisation patterns in families of young children with autism spectrum disorder (ASD).

Method—In a community sample of 78 American families with children (2–6 years) with ASD, this study examined the utilisation and usefulness of social support. Child, family, and service variables related to social support were explored.

Results—Mothers of children with ASD reported using a combination of formal and informal supports, and these were perceived to be helpful. Sociodemographic variables, child behaviour problems, satisfaction with the autism diagnostic process, and access to information about ASD predicted social support utilisation.

Conclusion—Social support utilisation varies as a function of different child, family, and service variables. Understanding these variables may help professionals guide families in access to and use of social support.

Keywords

autism spectrum disorder; social support; early childhood; families

Introduction

Substantial evidence suggests that parents of children with autism spectrum disorder (ASD) experience more caregiving burden and stress than parents of children with other intellectual or developmental disability (e.g., Blacher & McIntyre, 2006; Eisenhower, Baker, & Blacher, 2005; Griffith, Hastings, Nash, & Hill, 2010; Schieve, Blumberg, Rice, & Visser, & Boyle, 2007). Previous research has implicated autism symptoms, such as deficits in social functioning (e.g., Baker-Ericzén, Brookman-Frazee, & Stahmer, 2005), as well as the presence of challenging behaviours (e.g., Lecavalier, Leone, & Wiltz, 2006; Osborne & Reed, 2009) in the heightened parenting stress in families of children with ASD.

Laura Lee McIntyre llmcinty@uoregon.edu.

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Although the extant literature may paint a bleak picture of parenting stress and ASD, not all caregivers of children with ASD experience negative impact and burden. Indeed, some mothers of children with disability report positive perceptions of their children with disability (Hastings, Allen, McDermott, & Still, 2002). Such positive perceptions of their children may also relate to parental wellbeing. For example, Blacher and Baker (2007) found that behaviour problems were associated with higher levels of maternal parenting stress; however, positive feelings toward their child moderated the effects on parenting stress. Hastings et al. (2002) found that parents' positive perception of their children with disability was associated with more social support. It follows that social support serves a vital function in parental coping and coping more broadly defined (e.g., in individuals with disability themselves; Emerson, Hatton, Robertson, & Baines, 2014).

Positive coping strategies in families of children with ASD are often associated with the presence of adequate social support (e.g., Gray & Holden, 1992; Mackintosh, Myers, & Goin-Kochel, 2005; Sivberg, 2002; Weiss, 2002). Henderson and Vandenberg (1992) identified a positive relation between family adjustment and social support, such that families reporting more social support reported better adjustment to having a child with an ASD. Similarly, hardiness (Weiss, 2002) and physical and emotional wellbeing (Trivette & Dunst, 1992) have also been found to positively relate to social support in families raising children with ASD.

The literature is mixed regarding the most effective forms of social support. Social support is categorised into informal and formal support. Informal supports are described as those that come from a network that may include family, friends, and parents of other children with disability. Informal supports play an important role helping caregivers reduce the feelings of isolation and helplessness often associated with raising a child with a disability (Cooley, 1994). Formal supports are provided through an organisation or agency, such as medical professionals, school staff, and day care providers (Boyd, 2002; Bromley, Hare, Davison, & Emerson, 2004; Schopler & Mesibov, 1984). Such supports are usually best provided on a cohesive continuum of support, rather than distinct and separate from one another (Cooley, 1994).

Unfortunately, compared to parents of children with other disabilities, Sanders and Morgan (1997) found that parents of children with ASD reported the greatest difficulty in obtaining social support within the community. Although it has been suggested that informal sources of support may be most beneficial to caregivers (e.g., Herman & Thompson, 1995), relatively little is known about the utilisation patterns and perceived helpfulness of various forms of social support used by parents of young children with ASD. Furthermore, research suggests there may be an important distinction between utilised and useful supports. Not all supports are created equal, as mothers who reported high levels of negative support (support that is available, but not useful) were more likely to experience increases in depression and negative affect, along with decreases in positive affect (Smith, Greenberg, & Seltzer, 2012). White and Hastings (2004) found that parents reporting greater levels of helpful, or useful, support also reported greater wellbeing, although it did not appear that the actual number of informal supports was associated with wellbeing. Similarly, Konstantareas and Homatidis (1989) found that, for mothers, the extent to which supports were useful was a better

indicator of stress, rather than the number of supports that were available. Yet, the present research is mixed, as Salisbury (1990) found that maternal stress levels were reduced by larger networks of social support, indicating that more supports may result in better outcomes for mothers. More research is needed to better understand the impact of utilised and useful supports on maternal wellbeing. Such information would be helpful for professionals who provide early intervention and support to families of young children with ASD, as it may help professionals prioritise the amount and type of supports recommended and provided to families.

It is also noted that various child-, family-, and service-related variables may influence both the utilisation and usefulness of social support. Working within an ecological systems framework (Bronfenbrenner, 1977, 1986), child and family variables are consistent with the microsystem in that the child may have proximal influence on developmental outcomes for children. Service variables are consistent with both the microsystem (e.g., school-based service hours) and mesosystem (e.g., parent satisfaction and involvement in the special education process). Social support may cut across systems in that the degree to which families are supported may be associated with both proximal and more distal outcomes for children.

Indeed, research has found a connection between social support and such micro- and mesosystem variables in families raising children with ASD. Bromley and colleagues (2004) found that child-related variables were related to social support utilisation, such that families accessing more supports tended to have younger children with greater language delays, less independent functioning, and poorer socialisation. Parent-related variables, including marital status and psychological wellbeing, were also associated with social support, such that single mothers and mothers reporting greater psychological distress reported less social support. Bromley and colleagues also found an association between service-related variables and receipt of social support. Families reporting greater satisfaction with their child's educational services reported greater support utilisation. A more thorough understanding of variables associated with the utilisation and usefulness of social support may help guide professionals in their work with families raising children with ASD.

The present study was part of a larger investigation of early identification and treatment of young children with ASD. Three research questions were addressed in the present study:

1. What forms of social support, both formal and informal, do mothers of children with ASD most commonly utilise?
2. Which forms of social support do mothers perceive to be the most helpful?
3. What child-, family-, and service-related variables predict social support utilisation?

Method

Participants

Participants were 78 mothers and their young children (2–6 years) diagnosed with ASD in two adjacent counties near a mid-size city in the northeastern United States (US). Mothers of

young children were the focus of the investigation because we were interested in understanding more about family experiences during early childhood, when early identification of ASD and early intervention occurs. Table 1 displays child and family demographics explored in the present study. Children were an average age of 4.63 years ($SD = 1.04$). On average, parents reported that their child was diagnosed with an ASD at 3.11 years old ($SD = 0.91$; range: 1.50–5.17 years). Approximately 80% of children with ASD were male. Consistent with the demographics of the region (United States Census Bureau, 2014), approximately 75% of the sample was White/Caucasian (see Table 1). The primary caregiver was the child's biological mother in all but two families in the sample. In one instance the primary caregiver was the child's father and in one instance the child's primary caregiver was a female relative. Mothers were an average age of 36 years and the majority was married or living with a partner (82%, $n = 64$). Slightly less than half of the mothers held 4-year college/university bachelor's degrees. Just over half of the mothers in the sample did not work, with the remaining working either full-time or part-time. Those who were employed worked an average of 32.27 hours per week. The majority of children (77%, $n = 60$) had siblings living at home. The average household size was four people, with an income of US\$57,346 ($SD = 33,066.57$, $Mdn = \$50,000$; range: \$10,000–\$105,000). Approximately 25% of the sample ($n = 20$) was low income, with 20.5% ($n = 16$) below the US federal poverty guideline and 5.1% ($n = 4$) near poor at 125% above the poverty guideline. According to the US federal poverty guidelines, a family of four with an income of US\$24, 250 would meet the federal poverty guideline (United States Department of Health and Human Services, 2015).

Procedure

To be included in the study, children (a) were reported by their primary caregiver to have a diagnosis of ASD, (b) were 6 years or younger, and (c) were living with their primary caregiver for a minimum of 1 year prior to the beginning of the study. Parents/caregivers of children with ASD responded to recruitment flyers distributed by local early childhood programs. Data were collected via in-home interviews and assessments. Participants received small monetary honoraria for their participation. Participating caregivers were informed about the study, signed consent forms that were discussed in person, and understood that information provided would be kept confidential. Participants had an opportunity to ask questions before they signed the consent forms. Participants were informed that they could skip any question without penalty and that participating in this study would not affect their child's education or medical services. This study received ethics approval from Syracuse University's Institutional Review Board (ethics approval #06–300).

Measures

Demographics and service history—A family demographics and service history sheet was created for the present study. Parent and child demographics were collected, along with a history of early intervention and current services. Variables of interest to the present study included service hours, sources of information, and satisfaction with the diagnostic process and services received. Specifically, parents were asked how many educational and therapeutic service hours their child received per week. When possible, this information was verified through a review of the child's individualised education plan (IEP) or individualised

family service plan (IFSP). In addition, parents were provided with a list of 10 sources of information and asked which sources they used for information about autism. Sources of information included teachers/school, therapists, paediatrician, internet, books/magazines, conferences, autism support groups, family members/friends, parenting groups, or other (parent-supplied answer). The number of sources of information was totalled. Parents were asked to use a 5-point scale (1 = *very dissatisfied*, 2 = *dissatisfied*, 3 = *neutral*, 4 = *satisfied*, 5 = *very satisfied*) to rate their overall satisfaction with their child's diagnostic process and satisfaction with their child's current services.

Adaptive behaviour—Researchers administered the survey interview form of the Vineland Adaptive Behavior Scales – Second Edition (Vineland-II; Sparrow, Cicchetti, & Balla, 2005) to assess the child's functioning in four domains: (1) Communication, (2) Daily Living Skills, (3) Socialisation, and (4) Motor Skills. The domains combine to yield an overall Adaptive Behavior Composite standard score, with a mean of 100 and standard deviation of 15. This measure was chosen because it is norm referenced and has well-established reliability and validity for the targeted age group (Salvia, Ysseldyke, & Bolt, 2007).

Autism symptomatology—Researchers used the Childhood Autism Rating Scales (CARS; Schopler, Reichler, & Renner, 1988) to rate children's symptoms of autism in 15 areas. Ratings on the CARS are made on 7-point scale reflecting numerical values of 1–4 (higher scores indicate more symptoms and greater impairment). Scores reflect the degree to which the child's behaviour deviates from that of a typically developing child of the same age. Scores on the 15 items are summed to form an overall score ranging from 15 to 60, which has corresponding cut-scores reflecting severity of symptoms (< 30 = no symptoms of autism, 30–36.5 = mild to moderate, 37–60 = severe). This measure was chosen because it is a commonly used measure of autism symptomatology. Additionally, the CARS is norm referenced and has adequate psychometric properties (Perry, Condillac, Freeman, Dunn-Geier, & Belair, 2005; Schopler et al., 1988).

Atypical behaviour—Researchers used the Temperament and Atypical Behavior Scale (TABS; Bagnato, Neisworth, Salvia, & Hunt, 1999) to assess atypical behaviours considered to be developmentally dysfunctional. The TABS is a 55-item checklist that contains items in four domains: (1) Detached (20 items), (2) Hypersensitive/Active (17 items), (3) Underreactive (11 items), and (4) Dysregulated (7 items). For each item, caregiver respondents indicate if the behaviour is present or absent (rated as “yes” or “no”) and whether they need help with the behaviour. Raw domain scores can be summed to form the Temperament and Regulatory Index (TRI) or total raw score, which can be converted to a T score ($M = 50$, $SD = 10$). Higher TRI scores are indicative of more atypical behaviour. This measure was chosen because it is a norm referenced and has adequate psychometric properties (Bricker, Davis, & Squires, 2004).

Social support—Parents completed the Family Support Scale (FSS; Dunst, Jenkins, & Trivette, 1988) to assess the utilisation and helpfulness of various forms of social support, including their immediate family, relatives, friends, and others in the family's social

network, social organisations, and specialised and generic professional services. In addition, the scale provides two open items for parents to assess other sources of support not included in the 18 items. Parents rated each source of support on a 5-point Likert scale (1 = *not at all helpful*, 2 = *sometimes helpful*, 3 = *generally helpful*, 4 = *very helpful*, 5 = *extremely helpful*). A code of N/A was used if that source of support was not available to the family. A source of support was considered utilised if the respondent gave the item a numerical score, as opposed to a score of N/A. Items were considered helpful if respondents provided a score of 3, 4, or 5. A total helpfulness score was calculated by summing scores on all items. Separate total scores were calculated for family support, other nonfamily informal support, and formal support. Family sources of support included spouse/partner, relatives, parents, spouses' parents, spouses' relatives, and children. Other nonfamily informal sources of support included friends, other parents, spouses' friends, parent groups, social groups/clubs, and co-workers. Formal sources of support included family doctor/paediatrician, professional helpers, school/day care centre, early intervention, professional agencies, and church/minister. This measure was chosen because it is one of the most routinely utilised measures of social support in the reviewed literature and has well-established reliability and validity (Dunst et al., 1988; Frey, Greenberg, & Fewell, 1989).

Research design and data analyses

The study used a quantitative nonexperimental research design to analyse data and test the relations among variables (see Shadish, Cook, & Campbell, 2002). To address research questions 1 and 2, descriptive statistics were run in order to identify which forms of social support mothers reported as most utilised and most useful. For research question 3, bivariate correlations and independent samples *t* tests were run to identify child-, family-, and service-related variables related to key social support variables. Regression analyses were run to identify child-, family-, and service-related variables predictive of social support utilisation and usefulness.

Results

Parental report of the utilisation and helpfulness of various forms of social support are presented in Table 2. Findings indicated that the most utilised forms of social support were both informal and formal in nature. Family doctor or paediatrician, professional helpers, and spouse were reportedly utilised by 94.9%, 93.6%, and 92.3% of parents, respectively. Furthermore, supports that were reported to be most helpful also included both informal and formal forms of support. Professional helpers, spouse, and school or day care centre were reported to be helpful by 85.9%, 79.5%, and 74.3% of parents, respectively.

Correlations among social support utilisation and family, child, and service variables were examined to determine relations among social support and key demographics (see Table 3). Results indicate that utilisation and helpfulness of family support was related to child atypical behaviour, such that parents reporting more utilisation and helpfulness of family support had children with more atypical behaviour ($r = .32, p = .005$; $r = .25, p = .031$, respectively). The number of sources of information that parents utilised to obtain information specific to autism was related to both the utilisation and helpfulness of all forms

of social support, in that parents reporting a greater number of sources of information also reported greater utilisation and helpfulness of social support (see Table 3). Parental satisfaction with the diagnostic process and their child's current services were both positively correlated with the utilisation and helpfulness of formal supports. Finally, family gross annual income was positively associated with the utilisation and helpfulness of family support (see Table 3).

Families at or below the federal poverty line reported significantly less family support ($t = 2.03, p = .04$) than families living above the poverty line. Mothers married or living with a partner reported greater utilisation ($t = -3.45, p = .001$) and helpfulness ($t = -2.95, p = .004$) of informal support, as well as greater helpfulness of formal supports ($t = -2.05, p = .04$). Mothers working part-time reported significantly less helpfulness of informal supports, $F(2, 75) = 3.28, p = .04$. The utilisation of other informal supports differed significantly across father's employment status (unemployed, employed part-time, employed full-time), in that fathers employed part-time reported the most utilisation of informal support, whereas fathers currently unemployed reported the least utilisation of informal support, $F(2, 75) = 2.18, p = .04$.

Data were examined to check if they met the basic assumptions of normality, linearity, and homoscedasticity (Stevens, 2009). Univariate normality was assessed with histograms and normal probability plots, and all distributions approximated normal. The skewness and kurtosis values indicated that univariate normality was defensible. Multivariate normality and linearity were evaluated by creating scatter plots of all variables in relation to one another. Bivariate scatter plots were approximately elliptical, indicating that all combinations of variables were normally distributed and linearly related. Bivariate scatter plots also served as a graphical indication of homoscedasticity.

After determining that the key assumptions for linear regression (linear relationship, normality, and homoscedasticity) were satisfied, regression analyses were run to identify child-, family-, and service-related variables predictive of social support utilisation (see Table 4). Only variables with significant bivariate correlations were included in regression analyses. A linear regression was run to investigate the relations between significant demographic variables (number of sources of information, satisfaction with the diagnostic process, satisfaction with current services) and formal support utilisation. The overall equation was significant, accounting for a total of 29% of the variance in formal support. Among the demographic variables, number of sources of information and satisfaction with the diagnostic process contributed significantly to the prediction of formal support. Next, a linear regression was run to investigate the relations between significant child-functioning demographic variables (TABS TRI score, number of sources of information, gross annual income) and family support utilisation. The overall equation was significant, accounting for a total of 21% of the variance in family support. Of the demographic variables, TABS TRI score and gross annual income contributed significantly to the prediction of family support. Finally, a linear regression was run to investigate the relations between significant demographic variables (number of sources of information, father employment) and other informal support. The overall equation was significant, accounting for a total of 16% of the

variance in other informal support. Of the demographic variables, number of sources of information contributed significantly to the prediction of other informal support.

Discussion

Social support has been described as a vital resource for families with children with disabilities. Social support has been linked to positive coping strategies and reduced parenting stress, burden, and depression (e.g., Ello & Donovan, 2005; Gray & Holden, 1992; Sharpley, Bitsika, & Efremidis, 1997). Although the benefits of social support have been described, little is known about the utilisation patterns of supports in community samples of families of young children with ASD. This study examined the utilisation and perceived helpfulness of formal and informal supports as well as predictors of support utilisation.

Findings suggest that in a sample of mothers of children aged 2–6 years, both formal and informal supports were being utilised and perceived as helpful. Over 90% of primary caregivers relied on their spouse/partner as a source of support, with the majority of caregivers reporting that their spouse/partner was helpful. This finding is consistent with Herman and Thompson (1995), who identified positive support benefits associated with spouses.

In our study, mothers who were married or living with a partner reported greater utilisation and helpfulness of informal support, as well as greater helpfulness of formal supports. Some of this discrepancy may be accounted for by the instrument chosen to measure social support, as four of the 18 sources of support on the FSS are, by default of being a lone caregiver, not available (spouse, spouse's parents, spouse's relatives, spouse's friends). Thus, it is not surprising that informal supports are much less utilised by mothers without spouses. Further, families with two caregivers in the home may be better equipped to benefit from the myriad formal and informal sources of support available. With two caregivers in the home, formal supports may be more easily accessed due to reduced caregiving burden and increased time/ability to actually seek out such support. This information highlights the added importance of helping lone caregivers access and benefit from social supports. For example, these caregivers, in particular, may be directed to support groups as a means of expanding their social network.

Families reporting lower household incomes are also reporting significantly less family support. Yet it is these families who perhaps require more informal supports to alleviate some of the caregiving burden and defray childcare costs. Compared to mothers working full-time or those who are unemployed, mothers working part-time reported the least helpfulness of informal supports. Although unknown, it is possible that mothers working part-time did not fully benefit from employment supports (e.g., support from co-workers), perhaps due to occupational downgrading that is often associated with part-time employment for women. Gregory and Connolly (2008) state that “many women working part-time in low-paid occupations are qualified for, and have previously held, higher level, better paid jobs” (p. F1). On the other hand, fathers working part-time reported the most utilisation of informal support. Without knowing more about the individual circumstances that motivated mothers and fathers to work part-time in our sample, it is difficult to

determine why mothers and fathers received differential benefits from part-time employment. However, caution should be taken when interpreting these data as our sample size is small.

Although Herman and Thompson (1995) asserted that informal sources of support may be more beneficial to families, our findings suggest that formal supports were also viewed as helpful. Drawing on professional assistance during their child's early years may be especially beneficial to parents who are still navigating the service delivery system and adjusting to a recent diagnosis of ASD. Although the child's paediatrician was the number one utilised source of support, findings suggest that this source was helpful in less than 50% of cases. It is possible that parents sought out more specialised forms of care and support, making the general medical support available from their child's primary care physician less helpful.

Further, some of the least helpful supports rated by mothers included social groups/clubs, co-workers, and spouse's friends, which are all considered informal supports. Again, particularly at a young age and in close proximity to initial diagnosis, caregivers may rely more on experts who have a better understanding of the diagnostic implications and the medical/educational needs of the young child. In some cases, these individuals may not yet even be privy to the child's diagnosis, thus limiting their helpfulness specific to raising a child on the autism spectrum. As the child grows and the family becomes more familiar with their child's needs, parents may begin to rely more on these informal sources of support to manage the ongoing stress associated with raising a child with a disability.

When predicting social support utilisation, the number of different sources of information about ASD significantly predicted all forms of social support measured in this study: formal support, family support, and other nonfamily informal support. It is unclear if families independently sought out information on ASD or if information was provided through their social support network (e.g., professional helpers, family members, etc.). Nevertheless, families may benefit from both information and support, especially when the diagnosis and service delivery system are new and potentially overwhelming to families (Mansell & Morris, 2004).

When predicting utilisation of formal supports, the family's satisfaction with the child's diagnostic process also contributed significantly. Perhaps not surprisingly, those families that had positive experiences during the diagnostic process were also those who reported utilising formal supports. Furthermore, families that were dissatisfied with the diagnostic process, which is heavily influenced by professionals, may be less likely to seek out the support of those professionals again following receipt of diagnosis.

Although providing information and support to families with a child with ASD may be beneficial, a family's ability to adapt to a stressful situation is undoubtedly multifaceted. Seligman and Darling (1997) suggest that "the degree to which the family is in trouble may depend on how it conceptualises or reframes its life circumstance, how supportive family members are of each other, and how much social support is available outside the family" (p.

9). Professionals working with young children with ASD and their families may need to address all these areas in order to position the child and family for positive adaptation.

Limitations and future research

Although this study sheds light on the utilisation patterns of social support and allows examination of which sources were viewed as helpful, a number of limitations should be considered. First, this study included a sample of young children and their primary caregivers drawn from one geographical region of the US. Second, the sample was relatively homogeneous with respect to several demographic variables. Although there was diversity of annual income, the majority of caregivers were well educated and motivated to participate in this study. Third, children's diagnosis and service history were provided via parent report. When possible, parent reports were validated through a review of records; however, medical and educational records were not available for many of the participants. Finally, this sample of children may not represent all children on the autism spectrum given that children in the present study were identified early (age of diagnosis, $M = 37.37$ months; $SD = 10.93$) and all were receiving services. Indeed, because all children were diagnosed in early childhood and receiving early intervention services, these families may have experienced more positive outcomes than families whose children were not receiving early intervention services. These specific sampling characteristics, and size of the sample, limit the overall generalisability of findings.

Certainly, other variables not measured in the present study may help further explain utilisation and usefulness patterns in these families. Child-related factors, such as other developmental, medical, or physical concerns, are likely to influence a parent's utilisation of social supports, as they have the potential to limit or increase interactions with both formal and informal supports. Further, whether the child has a sibling or siblings in the home may influence the accessibility of some supports. In some cases, a greater caregiving burden as a result of multiple children in the home may preclude some parents from seeking out support. Alternatively, more children in the home may increase interactions with others, as doctor visits increase and interactions with other professionals (teachers, day care) are also likely to increase. Parent-related variables, such as depression, may also explain a family's use of social support. Indeed, Gray and Holden (1992) found that the most robust predictor of depression and anxiety in caregivers of children with ASD was low levels of social support.

Future research could examine intervention efforts to promote family utilisation of social support. Research on the utility of parent support groups is mixed at best and it remains relatively unclear what types of support work best and for whom (Hogan, Linden, & Najarian, 2002). Thus, in order to better serve families and children with ASD, professionals need a better understanding of what constitutes helpful support as well as a better understanding of how to facilitate support-based interventions. Further, additional information about how families establish and maintain networks of support and how these networks change over time is needed. Given that some of the present findings differ from past research, particularly regarding the helpfulness of informal versus formal supports, knowing which supports are helpful to whom at which developmental stages may help professionals tailor and target their support more efficiently and effectively. Further research

should also consider the support utilisation and usefulness patterns of other caregivers in the family system. Such knowledge may reveal which families are particularly vulnerable to poorer outcomes (low support utilisation and usefulness across both carers).

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Table 1.Child and family demographics ($N = 78$).

Demographic	<i>M (SD)</i>	<i>n</i>	%
Child-related			
Age in years	4.63 (1.04)		
Sex (Male)		63	80.77
Race (White/Caucasian)		59	75.64
Vineland-II composite	70.92 (11.85)		
CARS total score	37.71 (7.81)		
TABS total score	56.35 (11.78)		
Parent-related			
Mother's age in years	36.21 (6.43)		
Father's age in years ($N = 75$)	38.41 (6.94)		
Mother's employment			
Full-time		25	32.05
Part-time		13	16.67
Not employed		40	51.28
Father's employment ($N = 75$)			
Full-time		61	81.33
Part-time		3	4.00
Not employed		11	14.67
Mother's marital status			
Married or living with partner		64	82.05
Lone carer		14	17.95
Household income/year in USD	\$57,346 (33,067)		

Note. CARS = Childhood Autism Rating Scale; TABS = Temperament and Atypical Behavior Scale; USD = United States Dollars.

Table 2.Sources of support reported as utilised or helpful ($N = 78$).

Source of support	Utilised <i>n</i> (%)	Helpful <i>n</i> (%)
Family doctor or paediatrician	74 (94.9)	36 (46.2)
Professional helpers	73 (93.6)	67 (85.9)
Spouse	72 (92.3)	62 (79.5)
Friends	69 (88.5)	44 (56.4)
Relatives	67 (85.9)	37 (47.4)
School or day care centre	66 (84.6)	58 (74.3)
Parents	63 (80.8)	40 (51.3)
Early intervention	61 (78.2)	52 (66.7)
Other parents	60 (76.9)	31 (39.7)
Spouse's parents	58 (74.4)	37 (47.4)
Professional agencies	58 (74.4)	37 (47.4)
Spouse's relatives	55 (70.5)	23 (29.5)
Spouse's friends	51 (65.4)	21 (26.9)
Children	48 (61.5)	37 (47.5)
Parent groups	43 (55.1)	32 (41.0)
Co-workers	38 (48.7)	18 (23.2)
Social groups/clubs	34 (43.6)	22 (28.2)
Church/minister	32 (41.0)	14 (18.0)

Table 3.

Bivariate correlations of social support and child, service, and family variables.

Demographic variables	Total formal support	Total family support	Total other informal support
Child variables			
Vineland-II ABC standard score	-.22	.17	-.05
CARS total score	.10	-.12	.04
TABS TRI score	-.06	.32 **	-.001
Service variables			
Total service hours	.07	-.10	-.05
Number of sources of information	.46 **	.25 *	.43 *
Satisfaction with diagnostic process	.28 *	.04	-.08
Satisfaction with current services	.25 *	.21	.13
Family variables			
Gross annual income	-.03	.31 **	.20
Mother employment	-.15	-.05	.13
Father employment	-.07	.00	.25 *
Mother highest grade completed	-.13	.10	.08
Father highest grade completed	-.05	.11	.12

Note. Vineland-II ABC = Vineland-II Adaptive Behavior Composite standard score; CARS = Childhood Autism Rating Scale; TABS TRI = Temperament and Atypical Behavior Scale Temperament and Regulatory Index; formal support = family doctor/paediatrician, professional helpers, school/day care centre, early intervention, professional agencies, church/minister; family support = spouse/partner, relatives, parents, spouses' parents, spouses' relatives, children; other informal support = friends, other parents, spouses' friends, parent groups, social groups/clubs, co-workers.

*
 $p < .05$

**
 $p < .01$

Table 4.

Linear regression results for child, service, and family variable predictions to social support utilisation.

	R^2	β
Predictors of formal support	.29 ***	
Number of sources of information		.42 ***
Satisfaction with diagnostic process		.25 *
Satisfaction with current services		.12
Predictors of family support	.21 ***	
TABS TRI score		.30 **
Number of sources of information		.19
Gross annual income		.23 *
Predictors of other informal support	.16 ***	
Number of sources of information		.35 **
Father employment		.16

Note. TABS TRI = Temperament and Atypical Behavior Scale Temperament and Regulatory Index.

*
 $p < .05$

**
 $p < .01$

 $p < .001$