Resilience in Families with an Autistic Child

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Abstract: The primary aim of this study was to identify characteristics and resources that families have that enable them to adapt successfully and be resilient despite the presence of an autistic child in the family. The study was rooted within the contextual framework of the Resilience Model of Stress, Adjustment and Adaptation of McCubbin and McCubbin (1996). Parents of 34 families whose children attend a special school for autistic learners in the Western Cape, South Africa completed self-report questionnaires and answered an open-ended question. Resilience factors identified in this study include higher socioeconomic status; social support; open and predictable patterns of communication; a supportive family environment, including commitment and flexibility; family hardiness; internal and external coping strategies; a positive outlook on life; and family belief systems.

Autism is a severely debilitating developmental disorder with potentially harmful effects on the entire family. It is a chronic disability that appears in all racial, ethnic, cultural and social backgrounds around the world and is more common than childhood cancer, cystic fibrosis and multiple sclerosis combined (Autism Society of America, 2003). A study conducted in the United States of America found that autism is now ten times more prevalent than it was in the 1980s (Blakeslee, 2003). Potentially, 270,000 South African children under the age of six are affected by autism (Autism South Africa, 2005). Furthermore, the number of children affected is rising by 10 to 17% per year (Autism Society of America, 2003). Because of the severity of the disorder, many families struggle to come to terms with their child’s diagnosis and to adjust to having a child with special needs in their home. The motivation for the present study rests on two factors, namely the increase in prevalence rates of the disorder and the potentially adverse effects the disorder may have on family functioning. Consequently, the aim of this study was to identify characteristics and resources that families have that enable them to adapt successfully.

The presence of an autistic child in the family may have adverse effects on various domains of family life, including the marital relationship, sibling relationships and adjustment, family socialisation practices, as well as normal family routines. Because of the demands associated with caring for an autistic child, parents do not have much personal time (Court Appointed Special Advocate (CASA) Programme, 2003). The result may be a weakened affectional bond between parents (Cantwell & Baker, 1984), depression, withdrawal of one parent from care-giving responsibilities, or even divorce.

Rivers and Stoneman (2003) noted that parental conflict and marital stress lead to behaviour problems, poorer adjustment, lower self-esteem and higher rates of depression in the siblings of children with autism. Other stressors for siblings include increased caretaking responsibilities, stigmatisation, the loss of normal sibling interaction (Dyson, Edgar, & Crnic, 1989), feelings of guilt and shame, and changes in family roles, structure and activities (Rodrigue, Geffken, & Morgan, 1993).

Family routines are often dictated by the autistic child and must often be changed at the last minute to accommodate the child’s needs. Other factors causing families to isolate themselves may include difficulty in finding a reliable person to look after the autistic child, and fatigue or loss of energy due to the constant burden of care giving (Sanders & Mor-
gan, 1997). Despite the challenges faced by the families of autistic children, some families are able to cope remarkably well, although others have considerable difficulty in dealing with these challenges.

**Family Resilience Theory**

In research on families over the last few years, there has been a shift from a deficit-based model towards a strengths-based model (Hawley & DeHaan, 1996), and the concept of resilience has been extended to include family resilience (Walsh, 2003). A family resilience approach aims at identifying those factors that contribute to healthy family functioning, rather than family deficits (Hawley & DeHaan; McCubbin, Thompson, & McCubbin, 1996). Definitions of family resilience encompass a number of common ideas. First, resilience appears to surface in the face of family difficulties or hardships (McCubbin et al.; Walsh), and inherent in resilience is the property of buoyancy.

In an attempt to illustrate and describe the complex notion of family resilience, McCubbin and McCubbin (1996) developed The Resiliency Model of Family Stress, Adjustment and Adaptation. The model distinguishes between two interrelated phases, namely adjustment and adaptation (McCubbin et al., 1996). The family’s level of adjustment depends on numerous essential interacting elements, namely the stressor and its severity; family vulnerability; established patterns of family functioning or family typology; resistance resources; appraisal of the stressor; and family problem-solving and coping strategies (McCubbin et al.).

Family adaptation includes a series of adaptation-oriented components and resiliency processes (McCubbin et al., 1996). These incorporate (1) vulnerabilities, which may include additional life stressors and changes that undermine or restrict the family’s capacity to achieve a satisfactory level of adaptation; (2) resources, which consist of the psychological, family, and social resources that families utilise in the process of adaptation; (3) appraisal, which comprises the factors that give meaning to the changes in the family and play a role in establishing new patterns, eliminating old patterns, affirming old patterns, creating and utilising resources, as well as problem solving, coping and adaptation; (4) support, including intrafamily and family-community support processes that facilitate adaptation; and (5) patterns of functioning, which involves the elimination, modification and establishment of patterns of family functioning to bring about balance and harmony, as well as adaptation (McCubbin et al.).

Walsh (2003) formulated a process model of family resilience and highlighted family qualities that may reduce stress and vulnerability during crisis situations. It includes family belief systems, approaching hardships as a “shared challenge” (Walsh, p. 407), maintaining a positive outlook in adapting to stress, and preserving a shared confidence through an adverse situation. Furthermore, most families are able to find comfort, strength and guidance through connections to cultural and religious traditions (Walsh). Social and economic resources, including kin and social networks, friends, community groups and religious congregations, are important contributors to family resilience, particularly where the stressor is ongoing (Walsh). Communication processes that entail clarity of contents, open emotional expression, collaborative problem-solving and effective conflict management are vital for family resilience (Walsh).

Limited research has been documented that contributes specifically to the understanding of the resiliency process in families, or which identifies resiliency qualities associated with family adaptation in families faced with a chronic condition. This study, therefore, contributes to the field of research on resilience in families with an autistic child, and serves to recognise health and resilient potential in families where previously there may only have been decay.

**Method**

The aim of this study was to identify the characteristics and resources of families that enable them to be resilient despite having an autistic child in the family. A cross-sectional survey research design was used. Mixed methods were used to collect data from one parent of each participating family. Qualitative data were obtained by asking an open-ended ques-
tion, while quantitative data were collected through the use of various measuring instruments based on the Resiliency Model of Stress, Adjustment and Adaptation (McCubbin et al., 1996).

Participants and Procedure

Permission to conduct this study was obtained from the Western Cape Education Department and the respective governing bodies of the three facilities through which participants were recruited. A letter was then sent via two of the facilities to the families that qualified for the study based on the following criteria: (1) the family structure–two-parent families where both parents are present in the child’s life, (2) the age of the autistic child–not older than 10 years, and (3) the families should have known of their child’s diagnosis for a minimum period of 18 months. The questionnaires were sent with a letter explaining in detail the procedure to be followed in answering the open-ended question and completing the questionnaires. Due to the low response rate to the letters, those families who had not responded were contacted telephonically in order to provide additional information and to request their participation. This technique proved more successful, as the majority of families agreed to participate.

The third facility was a private organisation that caters primarily for the needs of children with developmental disabilities. In order to recruit families for the study, the researcher met with a group of parents at an informal gathering held at the organisation’s offices. After obtaining informed consent, ten questionnaires were handed out to those who were willing to participate and they were asked to return them to the facility offices at a later date.

Due to the small number of completed questionnaires received by the researcher, the decision was made to allow for the inclusion of single-parent families. An analysis of variance (ANOVA) revealed no statistically significant difference in scores between two-parent and single-parent families with regard to the dependent variable (family adaptation) \( F(1, 30) = 2.5480, p = 0.12 \).

In total, 34 families participated in the study: 16 from facility 1, 15 from facility 2 and three from facility 3. Twenty-four females and four males completed the questionnaires, while the remaining six parents did not indicate their gender. Most of the participating parents were aged between 34 and 43 \( (n = 28) \), with the mean age of the group being 36.21 \( (SD = 6.36) \). The mean age of the other parent \( (n = 25) \) in the family was 38.92 \( (SD = 5.31) \). Most of the families were two-parent families \( (n = 27) \), while four parents were unmarried, one was divorced, one was separated and one was widowed. The length of the parental relationship in most families \( (n = 23) \) was between seven and 13 years, with a mean length \( (n = 34) \) of 9.53 years \( (SD = 5.00) \). Thirty-one of the autistic children were male and three were female. The mean age of the autistic children \( (N = 34) \) was 6.48 years \( (SD = 2.16) \). Fifteen of the families had one other child apart from the autistic child, while 12 had no other children, five had two other children, and two families did not indicate whether there were other children. Most of the children \( (n = 25) \) had been diagnosed with autism between one and four years previously. The mean number of years since diagnosis \( (n = 33) \) was 3.24 years \( (SD = 1.90) \). Eighteen of the families were English speaking, 11 were Afrikaans speaking and five spoke another language at home. Four families were of a lower socioeconomic status, eight were of middle socioeconomic status and 21 were of a higher socioeconomic status. One parent did not indicate socioeconomic status.

Measures

Seven self-report questionnaires were used to measure various potential resilience variables. All questionnaires were available in both English and Afrikaans. A biographical questionnaire was designed to collect information on family composition, marital status and duration of the parental relationship, the age and gender of family members, level of education, employment, income and home language. The family’s socioeconomic status (SES) was determined using an adapted version of the composite index derived by Riordan (cited in Tennant, 1996).

The dependent variable in this study is the family’s level of adaptation, given the chronic stressful circumstances. This was measured us-
ing the total score of the Family Attachment and Changeability Index (FACI8), adapted by McCubbin, Thompson, and Elver. It is an ethni-
cally sensitive measure of family adaptation and functioning that consists of 16 items to be
answered on a five-point Likert-type scale. FACI8 has two subscales, namely attachment and changeability. The internal reliability
(Cronbach’s alpha) of the total scale and the two subscales varies between .73 and .80 (Mc-
cubbin et al., 1996), while the alpha values obtained in this study for the total scale and
the attachment and changeability subscales are .75, .79 and .85 respectively.

The Family Hardiness Index (FHI), developed by McCubbin, McCubbin, and Thomp-
son, was used to measure the characteristic of hardiness, which refers to the internal
strengths and durability of the family unit. The FHI consists of 20 items to be answered on a five-point Likert-type scale. The overall
internal reliability (Cronbach’s alpha) of the FHI is .82, while the internal reliabilities for
the three subscales (commitment, challenge and control) are .81, .80, and .65 respectively.
The alpha values obtained in this study are .67 for the total scale, and .62, .54 and .82 for the
challenge, control and commitment subscales respectively. The validity coefficients range
from .20 to .23 for the variables of family satisfaction, time and routines, and flexibility
(McCubbin et al., 1996).

The Social Support Index (SSI), developed by McCubbin, Patterson, and Glynn, determines
the extent to which families find support in the communities in which they live. This in-
strument consists of 17 items to be answered on a five-point Likert-type scale. The SSI has
an internal reliability of .82, a test-retest reliability of .83 and a validity coefficient of .40
with the criterion of family wellbeing (McCubbin et al., 1996). A reliability analysis of the
data in this study yielded an internal reliability (Cronbach alpha) of .91.

The Relative and Friend Support Index (RFSI), developed by McCubbin, Larsen, and Olson,
consists of eight items to be answered on a five-point Likert-type scale. The RFSI assesses
the degree to which families make use of friend and relative support as a strategy to
manage stressors and strains. The internal re-
liability (Cronbach’s alpha) of the RFSI is .82,
with a validity coefficient (correlating with the
original F-COPES) of .99 (McCubbin et al.,
1996). The Cronbach alpha obtained in this
study was .82.

The Family Crisis Oriented Personal Evaluation Scales (F-COPES) was developed by McCub-
bin, Larsen, and Olson to distinguish problem-solving and behavioural strategies used by
families during times of hardship. The F-COPES consists of 30 items to be answered on
a five-point Likert-type scale. The F-COPES has five subscales, representing two dimen-
sions, namely internal and external coping strategies. Internal coping strategies are the
use of resources within the family to manage difficulties, while external coping strategies
are the behaviours the family engages in to obtain resources outside the family system.
The F-COPES total scale has an internal reliability coefficient (Cronbach’s alpha) of .77
and a test-retest reliability of .71 (McCubbin et al., 1996). The internal reliability coefficients
for the subscales derived from the data in this study are .50 (passive evaluation); .72 (rede-
fining the problem); .66 (seeking spiritual support); .70 (looking for social support); and
.53 (mobilising community resources).

The Family Time and Routine Index (FTRI), developed by McCubbin, McCubbin, and
Thompson, was used to explore the routines and activities used by families, and to evaluate
the value placed by families on these practices. This measure consists of 30 Likert-type items,
divided into eight subscales. The overall internal reliability (Cronbach’s alpha) of the FT
RI is .88, while the validity coefficients range from .21 to .34 with regard to family bonding,
family satisfaction, marital satisfaction, family celebrations and family coherence (McCub-
bin et al., 1996). The reliability coefficients obtained from the data in this study are .77 for
the total scale; .48 for the parent-child togeth-
erness subscale; .61 for the couple-togetherness subscale; .33 for the child routines sub-
cale; .78 for the meals together subscale; .70 for the family time together subscale; .83 for
the family chores routines subscale; .60 for the relatives connection routines subscale; and .44
for the family management routines subscale.

The Family Problem Solving and Communication Scale (FPSC), developed by McCubbin,
McCubbin, and Thompson, consists of ten items to be answered on a four-point Likert-
type scale. The FPSC has two subscales--incen-
diary communication and affirming communication. The reliability (Cronbach’s alpha) of the total scale is .89 and that of incendiary communication and affirming communication is .78 and .86, respectively. The reliability coefficients obtained for this study are .83 for incendiary communication, .87 for affirming communication, and .90 for the total scale. The test-retest reliability of the subscales, as well as of the total FPSC, is .86 (McCubbin et al., 1996).

The qualitative measure comprised an open-ended question regarding the family’s perspective of the qualities that have helped them to adapt to the presence of the autistic child. The question was: “In your own words, what are the most important factors, or strengths, which have helped your family to adapt to living with your autistic child?” The parents were thus required to respond in writing by giving their own personal account of factors that have facilitated their family’s adaptation.

**Data Analysis**

In analysing the qualitative data, a process of inductive reasoning was followed. Initially, preliminary codes were assigned to the data, after which the codes were refined in order to better depict the data (Lacey & Luff, 2001). These codes eventually become categories with which to identify various themes, which could then be used to report the results of the qualitative aspect of the study (Pope, 2000).

In order to identify possible independent variables that may be associated with the dependent variable (family adaptation), Pearson product-moment correlation coefficients were calculated. Multiple regression analysis was carried out in order to identify which combinations of independent variables could best predict family adaptation.

**Results**

In the comparison of the FACI8 scores of families with lower, middle and upper socioeconomic status, the ANOVA analysis indicates that those of middle and upper socioeconomic status adapted better. Except for one correlation (between family adaptation and incendiary communication), all other significant correlations were positive. Table 1 provides a summary of the correlations found between the dependent variable (family adaptation) and the various independent family variables. Only the results that are significant at a 1% level are presented.

According to Table 1, statistically significant correlations exist between family adaptation and the following variables: the occupation classification of the primary breadwinner, the age of the autistic child, the socioeconomic status of the family, social support, family problem solving and communication, affirming communication and incendiary communication (negative correlation), family hardiness (commitment, challenge and control), the coping strategy of passive appraisal, and family time and routines with the two aspects parent-child togetherness and family time together.

In order to identify which combination of independent variables would best predict the dependent variable (family adaptation), a best-subsets multiple regression analysis was carried out. Eighty-three percent of the variance is explained by the equation ($R = .9099$),

<table>
<thead>
<tr>
<th>Variable</th>
<th>$r$</th>
<th>$p$</th>
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<tbody>
<tr>
<td>Occupation classification of primary breadwinner</td>
<td>.56</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>Age of autistic child</td>
<td>.44</td>
<td>.02</td>
</tr>
<tr>
<td>Socioeconomic status</td>
<td>.53</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>Social support (SSI)</td>
<td>.45</td>
<td>.01</td>
</tr>
<tr>
<td>Family problem solving and communication (FPSC)</td>
<td>.65</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>Affirming communication</td>
<td>.68</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>Incendiary communication</td>
<td>-.57</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>Family Hardiness Index (FHI)</td>
<td>.76</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>Commitment</td>
<td>.59</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>Challenge</td>
<td>.71</td>
<td>&lt;.01</td>
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<tr>
<td>Control</td>
<td>.47</td>
<td>&lt;.01</td>
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<tr>
<td>Family Crisis Oriented Personal Evaluation Scales (E-COPES)</td>
<td></td>
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<tr>
<td>Passive appraisal</td>
<td>.59</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>Family Time and Routine</td>
<td>.44</td>
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<tr>
<td>Index (FTRI)</td>
<td>.44</td>
<td>.01</td>
</tr>
<tr>
<td>Parent-child togetherness</td>
<td>.54</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>Family time together</td>
<td>.52</td>
<td>&lt;.01</td>
</tr>
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with the identified factors being relative and friend support (RFS total score) \( (p = .02) \), family problem solving and communication (FPSC total score) \( (p = .000) \), seeking spiritual support as a coping style \( (p = .15) \) and passive appraisal as a coping style \( (p = .000) \).

**Qualitative Results**

Thirty-three parents responded to the open-ended question and their responses were analysed in order to identify categories of family resilience. The following five broad categories emerged: (1) professional help/education—factors such as school and treatment programmes, knowledge of autism and advice from experts, (2) personal factors relating to the parents—this category included factors like maintaining a positive outlook, hope, commitment and patience, (3) social support from family, friends, the community and parents of other autistic children, (4) factors relating to the child—treating the child as normal, listening to the child’s needs, empathy for the child, recreational activities for the child, and (5) factors relating to the family unit—open communication, strong parental relationship, having other children in the household, and working together as a family.

The single factors reported most often by the parents as facilitating the adaptation process following the diagnosis of an autistic child were the school and treatment programmes (52%), knowledge of autism (45%), acceptance of the diagnosis (39%), support and involvement of extended family (39%), and faith in God (39%).

**Discussion**

The aim of this study was to identify resilience factors in families living with an autistic child. The parents reported that having other children in the home helped the family in the adaptation process. This supports Powers’s (2000) view that involving the siblings of children with autism in the day-to-day care of the disabled child, as well as in the child’s treatment programmes (Howlin & Rutter, 1987), leads to higher self-esteem and feelings of achievement in siblings and thus has a positive influence on the family’s adaptation.

The socioeconomic status of families appeared to play a role in the family’s adaptation, with families of middle and upper socioeconomic status being better adapted (see Table 1). This may be accounted for by the increased ability of middle- and upper-class families to afford better treatment for their autistic child. This finding is supported by positive correlations between both socioeconomic status and the occupation of the family’s primary breadwinner with family adaptation.

A family’s level of adaptation is associated with the extent to which families find support in the communities in which they live (SSI score). Social support is an important resource in alleviating the difficulties associated with having a chronic stressor, such as an autistic child, in the home, and promoting successful adaptation (McCubbin et al., 1996; Walsh, 2003). Social support has also been associated with positive family and child outcomes in families with an autistic child (Rivers & Stoneman, 2003). The results of the qualitative data support this finding.

Family adaptation is associated with the patterns of communication utilised by the family. It is enhanced by affirming communication, while it declines when incendiary patterns of communication are used (see Table 1). The quality of the communication in the family provides a good indication of the degree to which families manage tension and strain and obtain a satisfactory level of family functioning, adaptation and adjustment (McCubbin et al., 1996). Open communication was reported in the qualitative data \( (n = 4) \) as a factor that helped families to adapt to the presence of an autistic child.

Families with a supportive environment and a high degree of cohesion typically demonstrate higher degrees of commitment to and help and support for one another. Such families are also more likely to adapt successfully to the presence of a child with autism (Bristol, 1984). The parents in this study reported that being committed to helping their autistic child, working together as a family (family hardiness, commitment, seeing crises as challenges), and making their children their top priority were all family strengths contributing to better adaptation. Families who were willing to experience new things, to learn and to be innovative and active showed higher levels
of family adaptation. Such flexibility is an essential process in family resilience (Walsh, 2003). It involves the ability of families to adapt to the stressor through the reorganisation of patterns of family interaction to fit the new demands faced by the family (Walsh). Families with an internal locus of control show higher levels of family functioning than those who perceive their lives as being shaped by outside influences (hardiness–control). This finding concurs with those obtained by Bristol, and Henderson and Vandenberg (1992), who found that people with an internal locus of control are more likely to engage in behaviours to overcome the adverse effects of the chronic stress of raising an autistic child, and are thus more likely to achieve successful adaptation.

A healthy parental relationship leads to better adjustment in families with an autistic child (Rodrigue et al., 1993). This is confirmed by the parental reports in this study (see qualitative results). Powers (2000) argues that parents should not feel that they must be with their autistic child at all times and do everything for him/her. Rather, the child should be encouraged to develop skills that will enable him/her to function as independently as possible. The parents in this study shared this view and believed that making the child as independent as possible was an important step in the adaptation process.

Families that make use of the internal coping strategy of passive appraisal appear to exhibit higher levels of family adaptation (see Table 1, as well as results of regression analysis). Passive evaluation involves accepting the stressful situation (the presence of the autistic child) and not doing anything about it (McCubbin et al., 1996). This finding is interesting, as it would be logical to think that families would achieve higher levels of adaptation by actively pursuing solutions to the stressful situation. The participants in this study might have felt that they were doing all they could for their autistic child and therefore resolved to accept the situation. This finding supports that of Dyson et al. (1989) and Powers (2000), who state that acceptance of the child and his/her disorder is an important factor contributing to adaptation to that child.

Information seeking is a coping strategy often employed by the parents of autistic children. It enables the parents to take positive steps towards helping their autistic child (Rodrigue, Morgan & Geffken, 1990). In this study, the parents highlighted their knowledge of autism as a positive factor resulting in increased resilience. This coping strategy is adaptive, as it assists parents in learning how to help their child and prevents the use of maladaptive coping strategies (Rodrigue et al.).

Children with autism have a need for strict adherence to routines (Aarons & Gittens, 1999). Any disruption to their known routines often leads to panic, fear or temper tantrums (Sadock & Sadock, 2003). This aversion to changes in routines results in disruptions in family life, as the child may refuse to carry out any activities unless their specific routine is followed (Mash & Wolfe, 2002). Parents of children with autism have emphasised the importance of routines in the process of successful adaptation (Howlin & Rutter, 1987). Routines assist parents in organising their time so as to make time for the autistic child, their other children, their spouse and themselves. McCubbin et al. (1996) have also identified family routines as an important resource in the adaptation process. This is supported by the findings of this study, which suggest a positive correlation (see Table 1) between the routines and activities used by families and family adaptation. In terms of the qualitative data, only two parents reported that sticking to a basic routine was helpful in terms of achieving successful adaptation.

This study found that families that emphasise family togetherness showed higher levels of family adaptation (see Table 1, family togetherness). The Resiliency Model of McCubbin et al. (1996) highlights family celebrations and family time together as important resources that facilitate family adaptation. It is also important for parents to have time together for themselves, without any children, as this allows them to invest in their relationship (Bristol, 1984; Powers, 2000). Time away from the autistic child was reported as being important to the adaptation process by one parent in this study.

Parents reported that maintaining a positive outlook and remaining hopeful were factors that helped them to adapt to having an autistic child (qualitative results). The importance
of a positive outlook has been documented in resilience theory. Families become resilient when they actively pursue solutions to their problems, look beyond the hardships surrounding their situation, and focus on making the best of the options available to them (Walsh, 2003).

Faith in God was rated by the families in this study as an important factor contributing to adaptation. Bristol (1984) found that belief in God and/or adherence to clear moral standards mediates the family hardships by giving meaning and purpose to the sacrifices they make in caring for the autistic child.

Conclusions

The families that took part in this study were privileged in the sense that they all had access to educational services for their autistic child. The importance to the adaptation process and of having access to schools and other community resources is evident from previous research (Bristol, 1984; Powers, 2000), in resiliency theory (McCubbin et al., 1996; Walsh, 2003), and in the results of this study (see Table 1). Due to the limitations of the sample because of their homogeneity in terms of access to educational services, it is proposed that further research is undertaken to identify resilience factors in families that do not have access to such services. The majority of the families in this study was employed and had a high socioeconomic status, which means that it might be access to funds to invest in educational services, rather than access to the services themselves, that is the true mediating factor. It is further recommended that families from lower socioeconomic backgrounds be investigated in order to identify the factors that facilitate their adaptation to having an autistic child.

Several family qualities described by the Resilience Model of Stress, Adjustment and Adaptation (McCubbin et al., 1996) as being important in family adaptation were supported by this study. These include social support and the mobilisation of community resources, open communication, and family hardness, including commitment and an internal locus of control. The Resiliency Model, therefore, provides an effective contextual framework to understand resiliency factors specific to families with an autistic child.

This study is characterised by a number of limitations. Only 34 families took part, which calls for caution in generalising the results to all families with an autistic child in the home. A further limitation is the geographic location of the participants. All the families participating in the study reside in the Cape Town Metropolitan area, Western Cape Province, South Africa. This means that additional care should be taken in generalising the results, particularly with regard to families not residing in urban areas. People from rural areas are likely to experience greater difficulty in accessing educational services and may have a lower socioeconomic status than the families participating in this study.

The findings of this study serve a dual role in terms of their utility in facilitating family adaptation. Firstly, this study confirms that factors such as accessing social support, taking time away from their child, accepting the diagnosis, open emotional expression, family activities and routines, and family commitment are all important resilience factors. As such, they are beneficial for the child’s wellbeing and for successful family functioning. Secondly, the findings may be used to provide both professionals and parents with insight into how to create a family environment that will benefit the autistic child, without being detriment to the total family system.

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