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# Marital Satisfaction, Social Stigma and Mental Health in Parents of Children with Autism Spectrum Disorder

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**Abstract**
Parents of children with autism spectrum disorder (ASD) frequently experience mental health challenges due to caregiving demands, social stigma, and marital challenges, which may adversely affect their mental health. The present study aimed to examine the relationship between marital satisfaction, social stigma, andmental health among parents of children with autism spectrum disorder. Using a correlational research design, data were collected over the course of the study through purposive sampling from parents whose children from 3 to 13 years of age were receiving educational, therapeutic, and early intervention services at public and private institutions of Faisalabad. The study employed a demographic information sheet, the Enrich Marital Satisfaction Scale Urdu Version ( Anjum, 2024), the Social Stigma Scale Urdu Version (Mazhar & Qurban, 2020), and the Depression Anxiety Stress Scale Urdu Version (Aslam & Kamal, 2017). Descriptive statistics were used to summarize participants' characteristics, while Pearson product–moment correlation, multiple regression analysis, and independent-samples t-tests were conducted to examine the proposed relationships. The findings indicated that greater marital satisfaction was associated with lower levels of social stigma and less mental health challenges. Social stigma showed a strong positive association with mental health problems and emerged as the most influential predictor of mental health outcomes. Furthermore, marital satisfaction and social stigma together accounted for a substantial proportion of variance in parents' mental health. No significant differences were observed based on parent gender, child gender, or sibling impairment. The findings emphasize the need for psycho-social interventions aimed at reducing social stigma and strengthening marital relationships to improve the mental health and well-being of parents raising children with ASD.

**Keywords:** Marital Satisfaction, Social Stigma, Mental Health, Parents, Autism Spectrum Disorder

## Introduction

Autism Spectrum Disorder (ASD) is a neurodevelopmental disorder that is marked by the consistent deficiency in social communication, interaction and repetitive behavior, interests (American Psychiatric Association, 2013). The unfairness of ASD and the related difficulties place great emotional, economic, and social pressures on parents, which in most cases hurt their matrimonial contentment, psychological state, and societal experiences (Karst and Van Hecke, 2012). Studies have always demonstrated that parents of children

with ASD have elevated levels of stress, depression, and anxiety than their counterparts whose children are developing normally or those parents of children, who have other developmental impairments. In addition to that, the stigmatization of ASD may represent a source of compounded psychological distress and adversely affect the dynamics within marriages. This paper discusses the interaction between marital satisfaction, social stigma, and mental health challenges among parents of children with ASD using the available literature to illustrate important findings and support interventions (Gray, 2002). Autism Spectrum Disorder (ASD) is an irreversible developmental disorder that is defined by the disability of the manner in which one communicates with other people, socializing and interpreting information (Brobst et al., 2009). It is called a spectrum, because it possesses a huge array of symptoms and abilities. Highly intelligent and autistic people are capable of functioning independently, and there are those with severe intellectual and developmental disabilities and in need of regular care (Sim et al., 2019). The primary symptoms of autism tend to be exhibited at an early age which is normally before the age of three. Characteristic are the lack of ability to maintain eye contact, language or speech delay, repetitive actions, flapping of hands or rocking, and being fixated on one thing or routine (Sim et al., 2019). Although the exact origins of autism are still unknown, it has been noted that a mix of hereditary and environmental variables may play a role. Although autism cannot be cured, a child with autism and his family can lead normal lives with early diagnosis and appropriate care (Hastings et al., 2005). Some therapies that may help children with autism acquire liferelated skills and realise their full potential include behavioural interventions, occupational therapy, speech therapy, and educational support. Even though autism is becoming more widely recognised, parents of autistic children still face many emotional, social, economical, and physical challenges. Despite the particular difficulties they frequently face, parents play a vital role in their children's development and well-being (Rivard et al., 2014). It takes a lot of empathy, comprehension, and persistence to raise a child with autism. Parents typically face numerous challenges in their day-to-day life, including both financial and emotional strains (Risdal & Singer, 2004). The problems do not only influence the mental state of the parents and their personal health, but it also influences the whole family system (Risdal & Singer, 2004).

Emotional stress is one of the most prevalent problems of parents. Following the diagnosis of autism in their child, most parents have a shock stage, denial, grief, or confusion (Botha & Frost, 2020). They might be sorrowful by the fact that their hopes of a normal childhood of their son or daughter are lost. Moreover, parents tend to feel guilty and some of them question themselves about whether they did something bad during the pregnancy or child upbringing. The day to day pressures of having to take care of a child with autism that might have problems with sleeping, eating, and communicating may cause mental fatigue, depression, and burnout (Schieve et al., 2007). Children with autism are also quite costly to treat and administer therapies. Special educational programs, occupational therapy, behavior therapy (including Applied Behavior Analysis), and speech therapy are usually expensive (Seligman and Darling, 2017). These services in most instances are not entirely covered by health insurance or government efforts mainly in those countries where developmental disorders are not well supported. Moreover, a parent, usually the mother, has to quit his or her job or even work less to take care of the child on a full-time basis. Such income loss further contributes to the economic stress and may cause economic instability. Autism is an expensive condition to have a child, and this can put off a lot of pressure on most families due to the high cost of raising an autistic child (Lovell et al., 2012). Parents with children with autism tend to experience social isolation. Their child can also behave in ways that are not easily understandable including sudden panics, repetitions, or inability to communicate, which can result in missing family dinners, going out or community activities (Mak and Kwok, 2010). It is a fact that many parents complain that they do not want to socialize because of the fear of being judged or misinterpreted by other people. Relatives and friends might not know what autism is or even give undesirable advice and this adds more stress to the parents. This isolation may also extend to the siblings whereby the siblings may feel neglected or humiliated with the way their sibling behaves in front of people. The whole family is likely to lose touch with their community and thus develop a sense of loneliness and helplessness (Mak and Cheung,

2008). The awareness on autism is still minimal in most areas of the world. Its myths or misconceptions may include poor parenting or autism caused by vaccination and which some people believe in. This ignorance normally causes stigmatization and discrimination. Parents who don't comprehend the illness may face criticism from teachers, neighbours, or even members of the extended family (Kuhn & Carter, 2006). The family may feel pressured to hide the news since certain cultures view autism as a shame. This further complicates the ability of the parents to get the help and support they require (Kuhn & Carter, 2006). Among the behavioural problems that children with autism may exhibit include tantrums, self-harm, aggression, and a refusal to cooperate (Hastings et al., 2005). Usually, irritation, worry, or a lack of self-expression are the root causes of these challenging behaviours. Parents may find it difficult to effectively discipline their children when the conventional methods are ineffective. In some cases, the routines of the child may become hard, and even a slight change will trigger a significant emotional response (Sim et al., 2019). As an example, a new way to school or a toy that is lost can cause hours of suffering. The process of constantly changing their environment and their day to day schedules to prevent such triggers can be tiring to the parents (Sim et al., 2019). Another significant challenge is finding the appropriate school or learning environment for a child with autism. Many schools are ill-prepared for children with special needs (Rivard et al., 2014). Teachers may not be trained or resourced appropriately to manage autism associated behaviors. Parents often must fight for their child's rights, beg for special accommodations and participate in many meetings with educators and administrators. There are still some areas where there are no special education services, meaning that children with autism would simply not attend the regular school system. Even where there are programs they tend to have long waiting lists, limited places and poorly trained staff making access extremely challenging (Kuhn & Carter, 2006). Raising a child with autism really wears down the parents relationship over time. Research points out that these parents end up divorcing more often than folks in other families do (Brobst et al 2009). All that nonstop hassle from therapy sessions and money worries plus dealing with tough behaviors leaves couples with hardly any moments just for themselves. The brothers and sisters in the family deal with their own tough spots too. They can start feeling pushed aside or build up some bitterness and even wrestle with guilt over being the one without those issues. Sometimes they pick up bigger duties way too early on which messes with how they grow emotionally (Mak & Kwok 2010). Marital Satisfaction Marital satisfaction is an important aspect of family functioning, and parents with a child with ASD often report lower levels of relationship satisfaction compared to their parents of ASD children (Hartley et al., 2010). Stresses related to childrearing of a child with ASD (e.g., behavior problems, financial stressors and demands of caregiving) can create strain on the couple relationship yielding greater conflict and less intimacy. Preliminary research indicates that mothers-men and women are likely to be the primary caregiver, although it is increasingly men who are taking up this role (Poppleton et al., 2008) reported greater levels of stress than parents as a whole group with a consequent impact upon marital relationships (Ekas et al., 2010).

## Literature Review

Early research by Koegel et al. (1992) showed that homes with children with autism have significantly higher levels of stress, which typically results in increased marital conflict. Their research demonstrated that the prevalence of autism and its impact on social behaviour, everyday routines, and communication frequently necessitate continued parental attention and intervention. This increased need can lessen the time and energy couples have for each other, therefore lowering marital happiness. The longitudinal character of ASD, with lifelong caregiving responsibilities, can further strain partnerships (Koegel et al., 1992). In one of the first longitudinal investigations, Smith, Greenberg, and Seltzer (2012) followed 406 parents of adolescent and adult ASD patients over ten years to investigate marital satisfaction. Lai et al., 2015 discovered that parents of children with other disabilities were less likely to face marital instability than these ones were. Crucially, their research showed that marital dissatisfaction was predicted most by the extent of child behavioral issues rather than only diagnosis (Smith et al., 2012). Marital satisfaction is also greatly affected by the availability

and quality of the support systems. Weiss (2002) is of the opinion that formal supports, including respite care and parent training programs are of vital nature in reducing parental stress. Such services may help lessen the caregiving load when it comes to the number of times and how much the couple is burdened with care giving responsibilities. Unofficial aids like assistance of friends and families are also critical. Conversely, the lack of such supports may result in chronic burnout, social isolation and worsening of marital relationships (Weiss, 2002).

Recent research has been on resilience and protective variables that help marital satisfaction to persist through the hardships of raising a child with ASD. Pakenham and Samios (2013) examined the role of meaning-making process, similar religious or spiritual beliefs, and adaptive coping strategies as factors that can make marital endurance and satisfaction. This study proposed that couples that are able to reframe their experience in a positive way, hopeful, and have a purpose in their caregiving experience more stable and fulfilling relationships (Pakenham & Samios, 2013). Another important factor is the quality of the relationship that existed between the couple before the diagnosis of the child. Baker-Ericzén et al. (2005) state that couples who have a good level of communication, share values, and can have emotional intimacy prior to the birth or diagnosis of the child have a better chance of withering the storms of ASD. On the other hand, parents whose relationships were not very good before might realize that the added burden of having a child with ASD breaks their relationship (Baker-Ericzén et al., 2005). Moreover, mental health challenges is strongly connected with marital satisfaction. Benson and Karlof (2009) established that an increased intensity of symptoms of depression in either one of the spouses was linked to a low marital satisfaction. Their study highlighted the need to treat the mental health challenges of parents and autism-related services. Mental suffering will cause distortion of perception about the partner, reduction of patience and hindrance of the effective problem solving all of which will have harmful impact on the marital satisfaction (Benson & Karlof, 2009).

Besides psychological well-being, financial stress has been found to be an important predictor of stress in such families. Rearing a child with ASD can be very expensive in terms of out-of-pocket expenses on therapies, treatments, and special education. Johnson et al. (2011) discovered that these parents were highly associated with financial hardship and low satisfaction in marriages. Financial stress would cause arguments, decrease access to good services and decrease access to recreation activities which would facilitate couples to bond (Johnson et al., 2011).

Marital dynamics are also influenced by the age and the stage of development of the child. According to a study conducted by Floyd and Gallagher (1997), marital satisfaction tends to be lower in the initial years of children existence especially during the period when the child is being diagnosed. With the parents adapting to the diagnosis and identifying coping mechanisms, marital satisfaction can either even or grow stronger with time. But transitions like the entry to school, adolescences as well as arrangements of adult services may reinstate stress and tension to the marriage union (Floyd & Gallagher, 1997).

**Hypotheses**

**$H^1$:** There will be a significant negative relationship between marital satisfaction and social stigma in parents of children with ASD.

**$H^2$:** There will be a significant positive relationship between marital satisfaction and mental health in parents of children with ASD.

**$H^3$:** There will be a significant negative relationship between social stigma and mental health in parents of children with ASD.

**$H^4$:** Marital satisfaction and social stigma will significantly predict the mental health in parents of children with ASD.

**$H^5$:** There will be a significant difference between male and female parents of children with ASD in terms

of study variables.

**$H^6$:** There will be a significant difference in male and female children with ASD in terms of study variables.

**$H^7$:** There will be a significant difference in the context of sibling's disability in parents of children with ASD in terms of study variables.

## Method

### Sample

The population of this study consisted of parents from different age group who had at least one child formally diagnosed with Autism Spectrum Disorder and were actively involved in the child's caregiving (Botha & Frost, 2020). The group was selected from several public and private facilities in District Faisalabad that offered clinical, therapeutic, or educational assistance to children with ASD. Mothers and fathers from a variety of socioeconomic and educational backgrounds made up the population. In the Faisalabad area, this distribution offered a varied sample of parents raising children with ASD. In this study, G-power method used to decide the sample size. A total of 116 parents were purposively selected from the overall population of parents. This proportion provided a strong basis for reliable generalization of findings S Wasay, MA Khan 2023).

### Instruments

#### Enrich Marital Satisfaction Scale (Anjum, 2024)

The ENRICH Marital Satisfaction (EMS) Scale (Fowers & Olson, 1993) was designed to provide a brief measure of marital quality that controls for marital conventionalization. It's comprising the Idealistic Distortion (5 items) and Marital Satisfaction (10 items) of the ENRICH Inventory (Olson et al., 1987). In this research, we used Urdu version of EMSS developed by Dr. Wahida Anjum in 2022. On the scale, high scores indicate high marital satisfaction and idealistic distortion, and low scores mean low marital satisfaction and idealistic distortion. The test-retest reliability of the Urdu-Urdu, English-English, Urdu English, and English-Urdu on the current sample was highly significant.

The magnitude of the relationship on all conditions was reported to be satisfactory. This test had a good level of Cronbach's alpha reliability coefficients, test-retest reliability, inter-item total correlation, factor loading, and psychometric properties of the Urdu-translated version of the scale. It included Likert-scale items (ranging from 1 = Strongly Disagree *to 5* = Strongly Agree), covering various dimensions of marital satisfaction, social stigma and mental health challenges (Anjum, 2024).

Thus, the EMS Scale provides a 1-item sampling of the 10 dimensions of marital satisfaction found to be most important by Fournier et al. (1983). Test-retest reliability and internal consistency were assessed for the EMS Scale. An internal dependability of.86 was found using Cronbach's alpha. Reliability between tests was.86. EMS Scale is a reliable and valid scale for the measurement of marital satisfaction.

#### Social Stigma Scale (Mazhar & Qurban, 2020)

The Social Stigma Scale (SSS) had 20 items that assessed social stigma among parents of special needs (3 categories of disabilities; Autism, Down syndrome, and intellectual disability. It consisted of 6 factors. The scale has significant validity and reliability. We used Urdu version which is developed by Dr. Maria Mazhar. A 5-point Likert scale, with 1 denoting strongly disagree, 2 disagree, 3 neutral, 4 agree, and 5 strongly agree, served as the basis for the Social Stigma Scale response format. Calculate each item's response to obtain the score; the final score is the sum of the responses. Mild = 20–40, Moderate = 41–60, and Severe = 61–100 are represented by scores ranging from 20 to 100 (Mazhar & Qurban, 2020).

**Depression Anxiety Stress Scale (Aslam & Kamal, 2017)**

The DASS-21 was developed in 1995 by Lovibond and Lovibond through the Psychology Foundation of Australia. Their aim was to create a brief but comprehensive screening tool that could identify clients struggling with anxiety, depression, or stress. In this research we used Urdu version of DASS. Urdu translation of the DASS21 was carried out by Naeem Aslam from the National Institute of Psychology, Quaid-i-Azam University, Islamabad, Pakistan. It asks about the client's experience over the past week. It uses a fourpoint rating scale to determine severity and identifies if an individual's experience is normal, mild, moderate, severe.The DASS-21 has three subscales: Depression, Anxiety, and Stress. Each subscale has seven items, and the client's responses are total by the provider to determine the measure's score. The DASS-21 is a condensed version of the DASS-42, a longer test that offers a more thorough evaluation of stress, anxiety, and depression. The overall scale reliability is .93 (Aslam & Kamal, 2017).

**Procedure**

To guarantee answer correctness and dependability, the researcher personally carried out the data collection procedure. Starting with formal petitions for approval from institutional heads and coordinators in charge of research operations, a methodical and ethical approach was taken. Written requests detailing the study's objectives, parameters, and ethical protections were supplied by the researcher. In accordance with institutional guidelines controlling research involving human subjects, approval was acquired.

The researcher presented herself to pertinent authorities at each institutional visit, outlined the study's goals, and indicated how it might advance the fields of psychology, special education, and mental health challenges. At every point, the voluntary nature of involvement and stringent confidentiality procedures were highlighted. Following clearance, the researcher had direct conversations with parents who fit the inclusion requirements. The researcher held a briefing session before distributing the questionnaires to provide clear and understandable explanations of the study's goals, importance, and methodology. Participants were made aware of their rights, which included the freedom to decline to participate or to leave at any time without facing any repercussions. Every participant gave their informed consent. Surveys were disseminated in encouraging settings, frequently with the help of institutional personnel. The researcher stayed on hand to answer questions, explain claims, and offer advice without swaying participants' answers. Throughout the procedure, extra care was taken to guarantee that participants felt appreciated and at ease. When literacy or comprehension problems emerged, further clarification was given to help participants while maintaining the autonomy of their answers.

**Results**

After scoring the each questionnaire according to statistical criteria. The data that were gathered used for statistical analysis for interpretation. The statistical package for social sciences were used for analysis (SPSS-26). First of all computed descriptive statistics to measure demographic characteristics of research participant. descriptive statistics used for variable measurement. Reliability analysis were computed to measure scale reliability. To check correlation among variable Pearson correlation were computed. To measure significance difference among variable independent sample t- test were computed. To measure predictive association among variable multiple regression analysis were computed.

**Demographics Information**

**Table 1** Demographic *Characteristics of Research Participants (N= 116)*

| Variable | Categories | f | % |
|---|---|---|---|
| Parent's Data | | | |
| Age | 24-29 years | 18 | 15.5 |

| | | | |
|---|---|---|---|
| | 30-35 years | 50 | 43.1 |
| | 36-41 years | 39 | 33.6 |
| | 42-47 years | 9 | 7.7 |
| Gender | Female | 57 | 49.1 |
| | Male | 59 | 50.8 |
| Qualification | Middle | 2 | 1.7 |
| | Matric | 26 | 22.4 |
| | Intermediate | 19 | 16.3 |
| | B.A/BSc | 32 | 27.5 |
| | BS/MSc | 20 | 17.2 |
| | M.phil | 7 | 6 |
| | PhD | 10 | 8.6 |
| Duration of Marriage | 4-9 | 65 | 56 |
| | 10-15 | 41 | 35.3 |
| | 16-21 | 8 | 6.8 |
| | 22-26 | 2 | 1.7 |
| Father's Profession | Job | 61 | 52.5 |
| | Partnership | 18 | 15.5 |
| | Business | 37 | 31.8 |
| Mother's Profession | Job | 37 | 31.8 |
| | Business | 10 | 8.6 |
| | Housewife | 69 | 59.4 |
| Caretaker | Mother | 72 | 62 |
| | Father | 8 | 6.8 |
| | Both | 36 | 31 |
| Family System | Nuclear | 57 | 49.1 |
| | Joint | 59 | 50.8 |
| Support System | No One | 58 | 50 |
| | Family | 51 | 43.9 |
| | Friends | 7 | 6 |

| | | | |
|---|---|---|---|
| | Society | 0 | 0 |
| Child's Age | 3-6 | 73 | 62.9 |
| | 7-10 | 32 | 27.5 |
| | 11-13 | 11 | 9.4 |
| Gender | Female | 46 | 39.6 |
| | Male | 70 | 60.3 |
| Birth Order | 1-2 | 99 | 85.3 |
| | 3-5 | 17 | 14.6 |
| Number of Siblings | 0-2 | 85 | 73.2 |
| | 3-6 | 31 | 26.7 |
| Sibling's Disability | Nothing | 106 | 91.3 |
| | Mental | 10 | 8.6 |
| Child's Diagnosis Age | 2-4 | 97 | 83.6 |
| | 5-8 | 19 | 16.3 |
| DSM Severity Level | Mild | 44 | 37.9 |
| Moderate | 38 | 32.7 | |
| Severe | 32 | 27.5 | |
| Profound | 2 | 1.7 | |
| Child's Any Other Disability | No | 99 | 85.3 |
| ADHD | 13 | 11.2 | |
| ID | 4 | 3.4 | |
| Access to Therapy | No Access | 2 | 1.7 |
| Difficult | 61 | 52.5 | |
| Easy | 53 | 45.6 | |

Note. f=frequency, %= percentage, ID= intellectual disability, ADHD= attention deficit hyperactivity disorder.

**Table 2** *Mean and Standard Deviation of Demographics of the Respondents (N= 116)*

| Variables | *M* | *SD* |
|---|---|---|
| Parent's Age | 34.8 | 5.11 |
| Child's Age | 6.45 | 2.41 |
| Child's Disability Age | 3.73 | 1.10 |

Note. M= mean, SD= standard deviation.

**Table 3** *Normality Analysis of Study Variables (N= 116)*

| Variables | *Median* | *Mean* | *5% Trimmed Mean* | *Skewness* | Kurtosis |
|---|---|---|---|---|---|
| EMSS | 48.00 | 49.16 | 49.30 | .01 | -.29 |
| SSS | 81.50 | 76.42 | 77.56 | -1.16 | .79 |
| DASS | 35.00 | 32.12 | 32.36 | -.33 | -.91 |

Note. EMSS= enrich marital satisfaction scale, SSS= social stigma scale, DASS= depression anxiety stress scale.

**Table 4** *Reliability Analysis of Study Variables (N= 116)*

| Variables | *N* | *M* | *SD* | α |
|---|---|---|---|---|
| EMSS | 15 | 49.16 | 13.42 | .91 |
| SSS | 20 | 76.42 | 15.99 | .93 |
| DASS | 21 | 32.12 | 14.08 | .94 |

Note. EMSS= enrich marital satisfaction scale, SSS= social stigma scale, DASS= depression anxiety stress scale, N= number of items, M= mean, SD= standard deviation, α= alpha value.

**Table 5** *Correlation among Study Variables (N= 116)*

| Variables | *Mean* | *S.D* | *EMSS* | *SSS* | DASS |
|---|---|---|---|---|---|
| EMSS | 49.16 | 13.42 | _ | -.31*** | -.49*** |
| SSS | 76.42 | 15.99 | _ | _ | .64*** |
| DASS | 32.12 | 14.08 | _ | _ | _ |

Note. EMSS= enrich marital satisfaction scale, SSS= social stigma scale, DASS= depression anxiety stress scale, SD= standard deviation.

**Table 6** *Regression Analysis of Study Variables (N= 116)*

| Variables | p | *B* | *SE* | β | t | *95%CI* | |
|---|---|---|---|---|---|---|---|
| | | | | | | *Lower Bound* | *Upper Bound* |
| Constant | 12.99 | 6.82 | | 1.90 | .05 | -.529 | 26.523 |
| EMSS | -.34 | .07 | -.32 | -4.69 | .000 | -.489 | -.199 |
| SSS | .47 | .06 | .53 | 7.67 | .000 | .350 | .593 |
| R2 | .50 | | | | | | |

Note. EMSS= enrich marital satisfaction scale, SSS= social stigma scale, B= beta, SE= standard error, β= standardized coefficient beta, P= significance value, CI= confidence interval.

## Discussion

The current study looked at the relationship between mental health issues, social stigma, and marital satisfaction in parents of children with autism spectrum disorder (ASD). The results offer a comprehensive understanding of how social and relational elements work together to influence parents' mental health as they manage the challenges of raising an ASD child in a sociocultural setting. Overall, the findings provide context-specific insights pertinent to family systems and stigma-related processes, as well as supporting the suggested hypotheses and existing literature. The sample's demographics offer a crucial framework for interpreting the results. he mean age of parents indicated that the majority of participants were in early to middle adulthood, a developmental stage frequently marked by increased responsibilities related to career establishment, marital adjustment, and childrearing. Mental health challenges may increase when these normative stressors are combined with the challenges of raising a child with ASD. One noteworthy strength of the study is the nearly equal gender representation of fathers and mothers, which allows for meaningful gender-based comparisons and addresses a problem commonly seen in ASD research, where mothers are over-represented (Kuhn & Carter, 2006). Although no statistically significant differences were found, the equilibrium between nuclear and joint family systems provided a chance to investigate various caregiving contexts. A significant gap in social support networks and a crucial area for intervention are highlighted by the alarming fact that half of the parents said they had no trustworthy support person (Kuhn & Carter, 2006). Marital satisfaction showed a strong negative correlation with social stigma, which is in line with the first hypothesis. The psychological effects of social criticism may be mitigated by a supportive marriage, as evidenced by the lower levels of stigma experienced by parents who reported greater marital satisfaction. Strong marital ties improve coping abilities in high-stress situations, according to family systems and stress-buffering theories (Lovell et al., 2012). In order to lessen the internalisation of stigmatising societal beliefs, a cohesive marriage may promote emotional validation, joint problem-solving, and resilience. Previous studies showing that stigma has a major role in parental distress and social disengagement support these findings (Schieve et al., 2007; Rivard et al., 2014). Parents may be less prone to notice or internalise unfavourable social reactions when their marriages are marked by mutual understanding and emotional support. Therefore, it seems that marital contentment serves as a relationship resource that protects against stress brought on by stigma. The second hypothesis was also validated because there was a moderately negative correlation between marital satisfaction and mental health issues such stress, anxiety, and depression. The idea that marriage quality is a crucial factor in determining parental wellbeing is supported by the fact that parents with better marital satisfaction reported less psychological symptoms. This result is in line with previous research showing that parents of children with developmental disabilities experience less psychological discomfort when they have supportive marriages (Lovell et al., 2012). The findings highlight how crucial it is to consider parental mental health from a relationship perspective rather than as a personal issue. Spouses are frequently the main providers of both practical and emotional help when it comes to ASD caregiving. Parents may be more susceptible to psychological suffering when their marriages are disrupted. Strong marriages, on the other hand, may encourage emotional control, adaptive coping, and shared caregiving duties, all of which can lower stress levels (Lovell et al., 2012). social stigma showed a high positive correlation with mental health issues, supporting the third hypothesis. Significantly more symptoms of stress, worry, and sadness were reported by parents who felt more stigmatised. This result emphasises stigma as a powerful psychosocial stressor and is consistent with previous research highlighting the negative impacts of social marginalisation and judgement on parental mental health (Schieve et al., 2007; Rivard et al., 2014). By encouraging emotions of shame, loneliness, and powerlessness, stigma can worsen misery while also deterring parents from seeking out professional or social support. Internalising bad societal attitudes seems to be especially detrimental, increasing emotional strain and weakening psychological fortitude. These findings emphasize the necessity of addressing stigma at both individual and societal levels through psychoeducation, community awareness programs, and supportive counseling interventions (Schieve et al., 2007; Rivard et al., 2014). Regression

analysis showed that marital satisfaction and social stigma together accounted for a significant amount of the variance in parental mental health outcomes. Interestingly, social stigma turned out to be the stronger predictor, indicating that society attitudes and perceived judgement may have a greater impact on parental mental health than marital circumstances alone. The widespread and outward form of stigma seemed to have a more noticeable negative impact, even though marital satisfaction had a protective effect. This result is in line with earlier studies that showed stigma to be a major factor in carer distress (Mak & Cheung, 2008). The findings imply that even solid marriages might not be enough to completely offset the detrimental psychological impacts of social stigma.

**Conclusion**

The demographic representation of the 116 participants is the necessary background on which all other results should be projected. This was not a uniform group; instead, it was a certain segment of the population of parents of ASD children with its peculiarities. The mean age of the typical parent in this study was 34.83 years with a SD of 5.11; most of the parents (76.7) were between the age of 30 and 41. This implies a cohort that is in a key life phase, one that is usually juggling between the growth of the career and strict family roles. The gender balance was almost balanced (Female = 49.1, Male = 50.8), which is one of the strengths of the study because it provides the possibility of making meaningful gender comparisons, which was not the case years ago as most attention was paid to mothers. The parents had a very varied educational background including middle school, middle school and to the doctoral degrees. Nevertheless, the biggest single sample had a BA/BSc (27.5%) meaning that the sample is relatively educated. This affects their access to information, their capacity to negotiate health care systems and maybe, their socio-economic status. Most of the participants (91.3) had been married between 4 and 15 years implying that they were families in the early and middle cohort of their marriage, an age that was usually challenged by the needs to raise their young children, not to mention having a child with special needs. The family setup was nearly balanced (49.1/50.8) in terms of nuclear and joint structures and provided a special chance to investigate the disparate effects of these residential systems. One of the most dreadful and alarming results was that 50% of the parents (n=50) have no individual who they can rely on. Such overwhelming sense of unsupportedness highlights a major weakness of this sample, and it can be thought that a huge number of these parents are experiencing their difficult path without any support. It was found that the mother was the primary care giver to the child in a whopping 62 percent of the cases with fathers being the only care giver in only 6.8 percent of the cases. The occupations of fathers were mainly Jobs (52.5%), business (31.8%), so most of the fathers were in salaried jobs. Meanwhile, most mothers were housewives (59.4) and 31.8% were employed and 8.6% in businesses. This financial system has a tendency to leave one financial burden to the father and the mother with the heaviest caregiving responsibility, a situation that may introduce two different stressors to the partners that may overlap and conflict. The study children were also mainly young with an age mean of 6.45 years (SD = 2.41) and most of them (62.9) fell in the range of 3-6 years. It is an era of active intervention and diagnosis condensation. The majority of children were boys (60.3) as the prevalence rate of ASD diagnosis is higher among boys. In families (0-2 siblings) there was a significant majority of first (85.3) or second-borne (73.2). The median age of diagnosis was 3.73 (SD = 1.10), which was within normal ranges as far as diagnostic schedules are concerned but the standard deviation was low, indicating that there was minimal variation in the diagnostic age, the majority of children were diagnosed during toddler and early preschool stages. The ASD severity, according to DSM, was spread in mild (37.9%), moderate (32.7%), and severe (27.5%) severities, with a small percentage in the profound (1.7%). This distribution shows that this sample involves a broad range of functional challenges. Although the majority of children did not have any other disability (85.3%), the most prevalent comorbidity was Attention Deficit Hyperactivity Disorder (ADHD) (11.2%). Another important, but final conclusion was related to the access to therapy that over half of the parents (52.5) mentioned as being difficult and indicates that there is a major barrier at the systemic

level of accessing the necessary services to children. The psychological and social obstacles of raising a children with autism spectrum disorder (ASD) are complex and frequently influenced by cultural beliefs as well as family relationships. H1 is built in the premise that marital satisfaction acts as a key protective element for parents, giving emotional support and resilience against external stresses, including perceived societal shame. Social stigma, defined as the internalised feeling of societal judgement, marginalisation, or ostracism, has been generally recognised as a crucial factor to parental distress (Schieve et al., 2007; Rivard et al., 2014). The hypothesis proposes that higher levels of marriage happiness lessen the vulnerability of parents to feeling stigmatised, as a supportive marital connection can work as a psychological buffer, increasing coping capacities and emotional stability.

Descriptive and inferential statistical methods, including Pearson correlation, were utilised to explore the association between these variables. The results supported H1 with a weak-to-moderate negative association ($r = -0.31$, $p < .001$). This research reveals that parents having better marriage happiness reported lower levels of perceived social stigma, suggesting that a strong marital dyad can alleviate the psychological impact of society judgement. These results highlight the importance of environmental and relational elements in comprehending the psychological health of parents of children with ASD. The protective role of marital happiness underscores the need for family-centered therapies that increase spousal support and communication. Additionally, changing cultural perceptions and raising understanding about ASD may lessen external stigma, improving the resilience and well-being of parents. Elevated psychological stresses, such as melancholy, anxiety, and general distress, are linked to parenting a child with autism spectrum disorder (ASD) and are impacted by family dynamics and outside societal circumstances. H2 suggests that marital pleasure has a direct association with parental mental health difficulties, serving as a protective or risk-modifying factor. While lower marital satisfaction is predicted to be linked to higher levels of mental health issues among parents, a robust and supportive marriage is thought to lessen psychological suffering (Lovell et al., 2012). This hypothesis resonates with the broader theoretical concept that parental well-being is integrated within relational contexts, where the quality of spousal support promotes coping mechanisms in high-stress caregiving environments (Botha & Frost, 2020). To ascertain the relationship between these factors, statistical analysis, such as Pearson correlation, were performed. Results indicated a significant moderate negative correlation ($r = -0.49$, $p < .001$), indicating that higher marital satisfaction was related with lower levels of depression, anxiety, and stress among parents. This revealed that the quality of marital connection is a key driver of psychological resilience and well-being in parents of children with ASD. The findings highlight how crucial it is to focus interventions for families impacted by ASD on marital relationships. Programs that increase spousal communication, collaborative problem-solving, and emotional support may lessen the psychological burden of caregiving. Furthermore, these results imply that family-centered, as opposed to individual-focused, mental health support for parents should address relational aspects as fundamental contributors to parental mental health. Among the stormy waves of difficulties posed by ASD, the stable and satisfactory collaboration seems to be the lifeboat, correcting the psychological burden and creating the sense of resilienc (Lovell et al., 2012). The mental health of parents raising children with autism spectrum disorder (ASD) has been found to be significantly impacted by social stigma. H3 hypothesis that higher perceived social stigma will relate to increased mental health issues, including depression, anxiety, and stress, among parents. The theoretical rationale arises from the concept that social judgement, isolation, and negative society attitudes exacerbate the emotional load of caregiving, hence worsening psychological suffering (Schieve et al., 2007). Stigma may also inhibit parents from seeking social support or accessing critical resources, thus increasing vulnerability to mental health difficulties (Rivard et al., 2014). Pearson correlation analysis revealed a statistically significant positive correlation ($r = 0.64$, $p < .001$), indicating that as perceived social stigma increased, so did levels of depression, anxiety, and stress among parents. This substantial link underlines the deleterious influence of public judgement on parental mental health and underscores the psychosocial issues experienced by carers within stigmatising situations.

The findings emphasise the important necessity to address social stigma in programs aimed for families impacted by ASD. Clinicians and practitioners should provide supportive environments where parents can discuss experiences of stigma and acquire adaptive coping techniques. Additionally, community-based activities and awareness campaigns targeting social beliefs about ASD may reduce stigma and enhance family well-being. Overall, this theory supports the idea that social stigma is a significant predictor of mental health health issues in parents and should be given top priority in ASD caregiving research and practice. It appears that one of the main factors that can lead to such psychological burden of such parents is internalization of negativity in the society (Schieve et al., 2007).The regression model (Table 6) was also very significant and showed a considerable 50 percent ($R^2 = 0.50$ ) of the variance in parental mental health challenges (DASS scores) was explained by the combined explanatory influence of marital satisfaction and social stigma. This is an incredibly large number of psychosocial studies, which implies that both of these aspects take center stage in the explanation of the mental health challenges of this demographic. The two variables were both statistically significant unique predictors. The more significant predictor ( - 0.53, p = -.001) was social stigma in comparison with marital satisfaction ( -0.32, p = -.001). This implies that although a good marriage is protective, the destructive impact of perceived societal judgment is a little more pronounced independent effect to the extent of depression, anxiety and stress levels. The psychological distress change by 0.47 units with a one unit increase in social stigma, whereas distress was reduced by 0.34 units with a one unit increase in marital satisfaction, other variables being held constant (Mak & Cheung, 2008). Unlike much of the extant literature where higher levels of distress were usually found to be more prevalent among mothers, this paper did not show statistically significant differences between mothers and fathers on any of the quantified variables: marital satisfaction (EMSS: *t(114) = -0.50, *p =.61), social stigma (SSS: *t(114) = 1.56, *p =.12), or psychological distress (DASS: *t(114) = -0.09, *p =.9 These comparisons (with Cohen coefficients of 0.09, 0.29, and 0.01, respectively) proved that the unsignificant differences were not simply an effect of sample size but were actually a lack of significant difference in this cohort. This critical observation indicates that the psychological burden of the responsibility to care after a child with ASD, using the psychological variables assessed, is equally distributed between both sexes in this sample. The maternalistic approach to caregiver burden description might require changes to consider the equally influential role of fathers (Kuhn & Carter, 2006). There were no significant differences between mothers and fathers of children with ASD of girl and boy sex on marital satisfaction (EMSS) or social stigma (SSS). With mental health challenges (DASS) there was no significant trend among the parents, however, the mean score was found to be greater in parents of girls (M=34.89) than of boys (M=30.30). This medium effect size (Cohen) d = 0.33 indicates that this could be a significant practical difference that warrants further research in larger samples and which could be unique social issues or diagnostic delays of girls with ASD. Sibling with any disability did not provide statistically significant differences in marital satisfaction, social stigma and psychological distress. Nonetheless, the team of participants who had a disabled sister had a greater mean score on the DASS (M=36.40 vs. M=31.71) but the effect size was small-median (d=0.34). This means it is not statistically significant in this sample but the cumulative psychological cost of taking care of more than one child with special needs might have a heavier psychological cost which would most likely have been statistically significant in a larger study. Mourya et al. (2016) examined 51 mothers of children with intellectual disability (ages 3–15) and found that greater activity limitation in children was significantly associated with higher perceived stigma and restricted social life among parents. The study further showed that parental stigma strongly predicted their social withdrawal. These findings highlight how child-related factors and stigma jointly influence parental wellbeing and social functioning (Mourya et al. 2016).

## Limitations

The greatest drawback is the adoption of a cross-sectional design. Information was gathered at one moment in time which enables determination of relationships but not to make conclusive statements on causality. As

an example, we can argue that low levels of marital satisfaction are related to high levels of psychological distress, but we do not know whether psychological distress is the cause of relationship issues, whether relationship issues are the cause of psychological distress, or whether there is a co-relationship over time. These family experiences are dynamic and changing and cannot be captured through a fixed snapshot. The sample of 116, though sufficient to conduct the statistical analysis, is still quite small and probably was selected based on a particular geographical or clinical setting (based on the demographic characteristics). This restricts the extrapolation (external validity) of the results. The findings might not have universal applicability on parents who belong to various cultures, rural, or significantly different socioeconomic groups. The high level of education of the sample, including the relatively high level, might not be a reflection of the whole number of parents of children with ASD. It was based on the study of parents of children with ASD as a single group. Despite recording the severity levels, the analysis did not delve much on how the outcomes could vary among parents of children with profound ASD and mild ASD. Moreover, the lack of the control group, parents of typically developing children or children with other disabilities, as well as makes it hard to determine what results are specific to the ASD experience and what ones are shared by the parenting experience of a child with special needs, in general.

**Recommendations**

Based on the findings of the present study, the following practical and researchoriented recommendations are proposed to improve outcomes for families of children with autism spectrum disorder (ASD):

- Adopt family-centered intervention approaches: Clinical practice should move beyond child-focused interventions and incorporate regular counseling and psychoeducational sessions involving both parents. Structured couple-based programs should be developed to enhance communication, collaborative caregiving, conflict resolution, and emotional intimacy. Strengthening the marital dyad may serve as a critical protective factor against psychological distress.
- Integrate routine mental health screening for parents: Brief, validated screening tools for depression, anxiety, and stress (e.g., DASS-21) should be routinely administered to both mothers and fathers during their child's clinical or therapeutic visits. This practice may normalize discussions around parental mental health and support early identification and intervention.
- Address perceived social stigma in clinical settings: Clinicians should create a supportive and nonjudgmental environment in which parents can openly discuss experiences of stigma. Therapeutic interventions should include psychoeducation on stigma, adaptive coping strategies, and reframing societal attitudes toward ASD.
- Promote peer support and community advocacy: Parents should be encouraged to participate in peer-led support groups to reduce isolation and validate shared experiences. Mental health professionals and service providers should also engage in community education initiatives to challenge misconceptions about ASD and reduce stigma at a societal level.

**Directions for Future Research**

- Employ longitudinal research designs: Future studies should use longitudinal approaches to examine changes in marital satisfaction, perceived stigma, and mental health outcomes across different stages of child development and family life cycles.
- Utilize micro-longitudinal and daily diary methods: Daily diary or experience-sampling methodologies may provide insight into the immediate effects of daily stressors, stigma experiences, and spousal interactions on parental mental health.
- Incorporate qualitative methodologies: Qualitative studies are recommended to gain deeper understanding of parents' lived experiences and to complement quantitative findings.

- Expand sample size and diversity:Replication with larger, geographically, culturally, and socioeconomically diverse samples is needed to enhance external validity and determine whether the observed relationships are universal or culturally specific.

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