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PERCEIVED SOCIAL SUPPORT AND PSYCHOLOGICAL DISTRESS AMONG PARENTS OF CHILDREN WITH AUTISM SPECTRUM DISORDER: MEDIATING ROLE OF PSYCHOLOGICAL FLEXIBILITY AND COPING, AND MODERATING ROLE OF CHILD'S THERAPY STATUS

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KEYWORDS	ABSTRACT
Autism spectrum disorder, social support, psychological flexibility, Coping, Psychological distress, Pakistan	Childhood with autism spectrum disorder (ASD) is associated with significant psychological distress in parents, but the effect of perceived social support in buffering the distress remains ambiguous, especially in Pakistan. The present study investigated the mediating role of psychological flexibility and coping styles (problem and emotion focused, avoidant) between perceived social support and psychological distress, as well as the moderation of this relationship by the child's therapy status. Twenty-five hundred (168 mothers and 82 fathers) parents of children who have ASD were recruited using purposive sampling, consisting of 119 children receiving therapy and 131 children not receiving therapy in a cross-sectional design. Parents filled out the Multidimensional Scale of Perceived Social Support, the Psy-Flex, the Brief COPE, and the Kessler Psychological Distress Scale (K10). Over half of the parents (54.8%) had very high distress. There was a strong, negative correlation between perceived social support and distress ($r = -.90$, $p < .001$). Psychological flexibility, problem-focused coping and avoidant coping partially mediated this relationship in PROCESS Model 4, while emotion-focused coping did not. Therapy status moderated the support-distress relationship ($\Delta R^2 = .007$, $p = .003$) with a stronger relationship in the parents of children not on therapy, and with no differences in distress or flexibility between the two groups. Support networks, psychological flexibility, and adaptive coping should be reinforced, particularly in families lacking therapy access, as interventions.
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Introduction

Autism spectrum disorder (ASD) is a lifelong condition that affects the development of the brain, characterized by impairments in social communication and by restricted, repetitive behaviors (American Psychiatric Association, 1994). The prevalence of ASD in the world is approximately 1 in 100 children and in Pakistan it is estimated that 350,000 children suffer with ASD (Zeidan et al., 2022; Furrukh & Anjum, 2020). Parents of such children also experience higher level of parenting stress than other parents (Zovko et al., 2024) and approximately 60% of the parents of children with ASD had scored more than cut off points for probable mental disorder (Nadeem et al., 2024). Perceived social support is the individual's appraisal of the support received from family, friends, and partner; it protects against such distress (Cohen & Wills, 1985; Zimet et al., 1988), but how it buffers distress is not clear (Abu Khait et al., 2023; Tindle et al., 2022). Psychological flexibility (ability to accept challenging experiences while being faithful to one's values) may be one pathway (S. C. Hayes et al., 2006), and coping (nonsociogenic responses to demands greater than one's resources) may be another (Lazarus & Folkman, 1984). The decision to provide therapy to the child may also affect the amount of informal support parents need (Demšar & Bakracevic, 2023). Hence, this mediating and moderating model was tested in the present study with the Pakistani parents.

Literature Review

In the transactional model, stress is triggered by a perceived lack of resources in relation to demands and the coping response determines the outcome of the stress (Lazarus & Folkman, 1984). Additional stress-buffering hypotheses come from the finding that social support buffers people by impacting on appraisal and promoting adaptive coping (Cohen & Wills, 1985); and the psychological flexibility model—how individuals can learn to endure challenging experiences without avoiding them (S. C. Hayes et al., 2006).

Working with children and their caregivers who have ASD, it is always correlated with reduced distress when caregivers perceive social support (Schiller et al., 2021). Higher depression, anxiety and stress were associated with lower satisfaction with support among Slovenian parents (Demšar & Bakracevic, 2023); and having less support from friends was associated with higher parenting stress among Croatian mothers (Zovko et al., 2024). But, daily demands did not mediate the relationship between stress and parents in Germany (Sartor et al., 2023).

A sample of 351 adults showed that higher social support scores were associated with decreased avoidance coping and distress, and psychological flexibility (Tindle et al., 2022). Parents who were more satisfied with their support used more positive reinterpretation and less venting (Demšar & Bakracevic, 2023), and family support mediated the relationship between coping and distress experienced by professionals caring for Jordanian children with autism (Abu Khait et al., 2023). Psychological flexibility is also linked to mental health in parents of children with disabilities (Gur & Reich, 2023).

Parental stress is associated with the use of avoidant coping (Sartor et al., 2023; Zovko et al., 2024), while the associations with problem-focused and emotion-focused coping are less consistent (Vernhet et al., 2019). The overall coping did not correlate with distress in a Nepalese sample,

indicating that coping is a multi-dimensional construct and components of coping should be examined separately (Sharma et al., 2026).

When a child does not receive therapy, informal support could be most important, as parents who did not receive professional support were at a seven times higher risk to experience extreme stress (Sim et al., 2018) and parents whose children were in intervention reported no clinically elevated distress (Demšar & Bakracevic, 2023). Parents of children with ASD feel highly stressed and anxious (Zahid et al., 2025) and mothers feel that therapy is expensive and not much institutional support is available (Furrukh & Anjum, 2020).

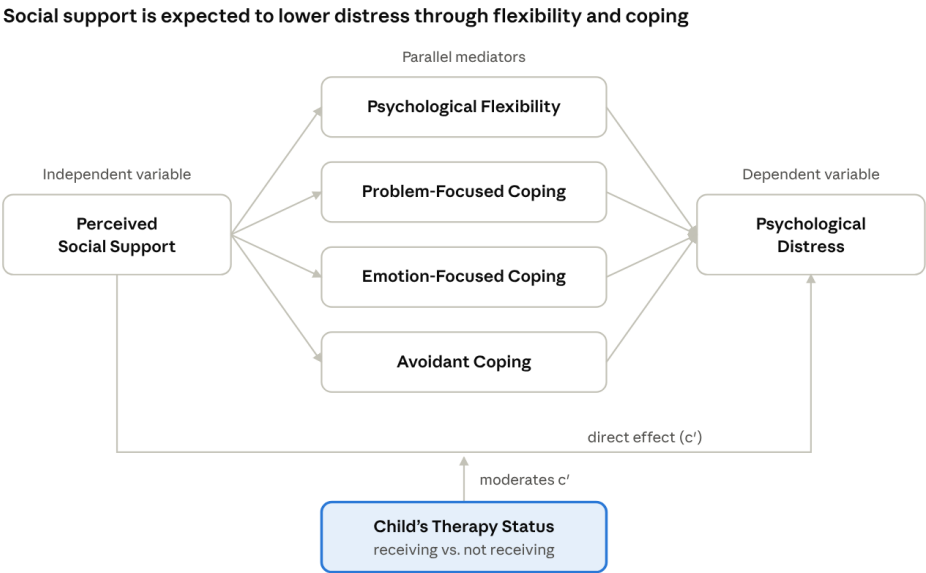
Rationale of the Study

There had been no prior study that examined the psychological flexibility and coping as parallel mediators between social support and distress in parents of children with ASD, and therapy status had not been tested as a moderator because most of the samples were recruited from parents already undergoing therapy (Demšar & Bakracevic, 2023; Zovko et al., 2024). Most of the Pakistani research has focused on description of distress and not its mechanisms (Nadeem et al., 2024; Zahid et al., 2025). The results can thus inform culturally appropriate acceptance-based and coping-skills interventions (Li et al., 2024).

Conceptual Framework

Consideration of these three theories led to the establishment of the present study's model, as shown in Figure 1 below. Perceived social support was the independent variable, psychological distress was the dependent variable, psychological flexibility and the three coping strategies were parallel mediators, and the status of therapy the child was in was a moderator of the direct relationship.

Figure 1: Conceptual Model of the Study



Hypotheses

1. Perceived social support would be negatively associated with psychological distress.
2. Perceived social support would be positively associated with psychological flexibility, problem-focused coping, and emotion-focused coping, and negatively associated with avoidant coping.
3. Psychological flexibility, problem-focused coping, and emotion-focused coping would be negatively associated, and avoidant coping positively associated, with psychological distress.
4. Psychological flexibility would mediate the relationship between perceived social support and psychological distress.
5. Coping strategies would mediate the relationship between perceived social support and psychological distress.
6. The child's therapy status would moderate the relationship between perceived social support and psychological distress, such that the negative relationship would be stronger among parents of children not receiving therapy.
7. Parents of children not receiving therapy would report higher psychological distress and lower psychological flexibility than parents of children receiving therapy.

Method

Research Design and Participants

A cross sectional correlational design was used. Twenty-five hundred Biological parents of children with ASD were recruited by purposive sampling from hospitals, autism centers, special schools and therapy clinics in Lahore and Sheikhpura, Pakistan. The receiving therapy group ($n = 119$) comprised of parents whose child had received at least one structured session of speech, occupational or Behavioural therapy each week over the previous 3 months, while the not receiving therapy group ($n = 131$) comprised of parents whose child had received no structured speech, occupational or Behavioural therapy over the previous 3 months. G*Power 3.1 ($f^2 = .15$, $\alpha = .05$, power = .80, 10 predictors) indicated a minimum sample of 118 (Faul et al., 2009).

Inclusion criteria. Mums and dads (biological parents) aged 18 years and older, who had lived with their child aged 3–18 years who was diagnosed with ASD at least 6 months prior by a psychiatrist, pediatricians or clinical psychologist. Exclusion criteria: Other caregivers; parents with a current psychiatric diagnosis or treatment; other children with a disability; child with a major medical illness; child with major life event in the last 6 months.

Measures

Demographic Sheet: Parent gender, child age, severity (Levels 1–3) and therapy status (1 = therapy, 0 = no therapy). No item was reverse scored on any of the scales.

The Multidimensional Scale of Perceived Social Support (MSPSS), 12 items, 7-point scale, range: 12–84 ($\alpha = .88$) measures social support from significant other, family, and friends. Urdu version was used for its (Akhtar et al., 2010).

The Psy-Flex is a 6 item version of the Psy-Flex (Gloster et al., 2021) ranging from 6 to 30 (reliability = .91) and rated from 1 (very seldom) to 5 (very often).

Brief COPE (Carver, 1997) is a 28 item instrument rated from 1 (I haven't been doing this at all) to 4 (I've been doing this a lot). Items were categorized as problem-focused coping (6 items: active coping, planning, instrumental support), emotion-focused coping (10 items: emotional support, positive reframing, humor, acceptance, religion), and avoidant coping (12 items: self-distraction, denial, substance use, Behavioural disengagement, venting, self-blame), with alphas of .84, .72, and .75 (Cooper et al., 2008).

Kessler Psychological Distress Scale (K10) (Kessler et al., 2002): This is a 10 item scale that measures distress over the previous 30 days on a 5 point scale from 1 (none of the time) to 5 (all of the time) with scores ranging from 10 to 50 ($\alpha = .93$). Scores of 10–15, 16–21, 22–29, and 30–50 indicate low, moderate, high, and very high distress (Andrews & Slade, 2001). Those scales that did not have an Urdu version were translated using forward-backward translation (Brislin, 1970).

Procedures and Ethical Considerations.

Parents were asked to read the booklet and took about 20 minutes to complete, after the departmental ethics approval and permission from the scale developers and institutions, parents were asked to give written informed consent, and items were read aloud to parents that could not read. Parents had the option to withdraw at any time and the data was anonymous and voluntary. All participants were debriefed and those that scored 30 or higher on the K10 were referred to psychological services.

Data Analysis Plan

The data were analyzed using SPSS 27 and the PROCESS macro (version 5.0) (A. F. Hayes, 2013). All hypotheses were tested with Pearson correlations, except for Hypothesis 7, which was tested with an independent-samples t-test. The parallel mediators (Hypotheses 4–5) were tested with PROCESS Model 4 with 5,000 percentile bootstrap samples. Hypothesis 6 – parent gender, age of child, and severity of ASD was tested as a moderator with Model 1; and Hypothesis 5 – full model controlling for parent gender, age of child, and severity of ASD was tested with Model 5. In the moderating models the support was centred by itself and the indirect effect was significant if its 95% BC had been above 0. IV. RESULTS

Demographic Characteristics

Table 1: *Demographic Characteristics of the Participants (N = 250)*

Variable	<i>F</i>	%
Parent gender		
Father	82	32.8
Mother	168	67.2
Child's age (years)		
3–6	79	31.6
7–10	74	29.6
11–15	97	38.8
ASD severity level		
Level 1 (mild)	58	23.2
Level 2 (moderate)	118	47.2
Level 3 (severe)	74	29.6
Child's therapy status		
Not receiving therapy	131	52.4
Receiving therapy	119	47.6

Note. Child's age: $M = 8.95$, $SD = 3.83$, range = 3–15 years. ASD = autism spectrum disorder; f = frequency.

The mothers were the most common participants (67.2%), almost half of the children had Level 2 ASD (47.2%) and 52.4% of children were not receiving therapy (Table 1).

Descriptive Statistics and Reliability

Table 2: *Descriptive Statistics, Reliability, and Normality of the Study Variables (N = 250)*

Variable	<i>k</i>	<i>M</i>	<i>SD</i>	Potential range	Actual range	Skewness	Kurtosis	α
Perceived social support	12	55.86	9.70	12–84	34–81	0.19	–0.33	.97
Psychological flexibility	6	15.21	4.41	6–30	6–30	0.13	–0.12	.95
Problem-focused coping	6	13.59	2.58	6–24	7–20	0.05	–0.19	.82
Emotion-focused coping	10	22.34	3.81	10–40	10–35	0.36	0.24	.86
Avoidant coping	12	29.30	4.18	12–48	18–39	–0.04	–0.83	.83
Psychological distress	10	30.03	8.70	10–50	10–50	–0.12	–0.34	.97

Note. k = number of items; α = Cronbach's alpha.

There was good to excellent reliability ($\alpha = .82-.97$) and skewness and kurtosis were within ± 1 of normal, which is considered approximately normal (Table 2). Variance inflation factors (2.08–5.17) were not greater than 10. The mean distress score was very high on the K10; 54.8% of parents

indicated that their distress was very high, 27.6% high, 10.8% moderate and 6.8% low distress (Andrews & Slade, 2001).

Correlation Analysis

Table 3: *Pearson Correlations among the Study Variables (N = 250)*

Variable	1	2	3	4	5	6
1. Perceived social support	—					
2. Psychological flexibility	.76***	—				
3. Problem-focused coping	.74***	.58***	—			
4. Emotion-focused coping	.76***	.60***	.74***	—		
5. Avoidant coping	-.71***	-.59***	-.52***	-.46***	—	
6. Psychological distress	-.90***	-.79***	-.72***	-.70***	.71***	—

*** $p < .001$ (two-tailed).

Supporting Hypothesis 1, there was a negative correlation between perceived social support and distress ($r = -.90$). It was shown to be positively correlated with psychological flexibility ($r = .76$), problem-focused coping ($r = .74$), and emotion-focused coping ($r = .76$), while negatively with avoidant coping ($r = -.71$) supporting Hypothesis 2. Flexibility ($r = -.79$), problem-focused coping ($r = -.72$), and emotion-focused coping ($r = -.70$) were negative, and avoidant coping positively ($r = .71$), correlated with distress, supporting Hypothesis 3 (all $ps < .001$; Table 3).

Parallel Mediation Analysis

Table 4: *Parallel Mediation of Psychological Flexibility and Coping between Perceived Social Support and Psychological Distress (PROCESS Model 4, N = 250)*

Outcome and predictor	B	SE	t	p	95% CI
Psychological flexibility ($R^2 = .58$, $F(1, 248) = 347.95^{***}$)					
Perceived social support (a_1)	.35	.02	18.65	< .001	[.31, .38]
Problem-focused coping ($R^2 = .55$, $F(1, 248) = 300.11^{***}$)					
Perceived social support (a_2)	.20	.01	17.32	< .001	[.17, .22]
Emotion-focused coping ($R^2 = .58$, $F(1, 248) = 339.34^{***}$)					
Perceived social support (a_3)	.30	.02	18.42	< .001	[.27, .33]
Avoidant coping ($R^2 = .50$, $F(1, 248) = 246.56^{***}$)					
Perceived social support (a_4)	-.30	.02	-15.70	< .001	[-.34, -.27]
Psychological distress ($R^2 = .84$, $F(5, 244) = 261.07^{***}$)					
Perceived social support (c')	-.49	.05	-9.38	< .001	[-.59, -.38]
Psychological flexibility (b_1)	-.46	.08	-5.88	< .001	[-.61, -.31]
Problem-focused coping (b_2)	-.41	.14	-2.95	.004	[-.69, -.14]
Emotion-focused coping (b_3)	.01	.10	0.09	.932	[-.19, .20]
Avoidant coping (b_4)	.26	.08	3.39	.001	[.11, .41]
Total effect model: Psychological distress ($R^2 = .80$, $F(1, 248) = 1003.80^{***}$)					

Perceived social support (c)	-.80	.03	-31.68	< .001	[-.85, -.75]
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Note. *B* = unstandardized coefficient; *SE* = standard error; *CI* = confidence interval. ****p* < .001.

Table 5: Indirect Effects of Perceived Social Support on Psychological Distress through the Mediators (PROCESS Model 4)

Indirect path	Effect	BootSE	95% Boot CI	% of total effect
Total indirect effect	-.317	.049	[-.417, -.224]	39.5
Support → Psychological flexibility → Distress	-.160	.029	[-.219, -.104]	19.9
Support → Problem-focused coping → Distress	-.081	.028	[-.137, -.026]	10.1
Support → Emotion-focused coping → Distress	.003	.032	[-.061, .065]	—
Support → Avoidant coping → Distress	-.079	.023	[-.124, -.033]	9.8

Note. Percentile bootstrap confidence intervals were based on 5,000 resamples; an interval that excludes zero indicates a significant indirect effect. Total effect = -.803; direct effect = -.486.

All four mediators were significantly predicted by perceived social support (Table 4). The model explained 84% of the variance in distress, with psychological flexibility ($B = -.46, p < .001$) and problem-focused coping ($B = -.41, p = .004$) predicting lower distress, and avoidant coping predicting higher distress ($B = .26, p = .001$); emotion-focused coping was non-significant ($B = .01, p = .932$).

The total indirect effect was significant (effect = -.317, 95% Boot CI [-.417, -.224]; Table 5). A psychological flexibility indirect effect (-.160, 95% Boot CI [-.219, -.104]) was also in favor of Hypothesis 4. Problem-focused coping (-.081) and avoidant coping (-.079) were also significant mediators, while emotion-focused coping was not (.003, 95% Boot CI [-.061, .065]), which is partly consistent with Hypothesis 5. The mediation was partial because the direct effect was also significant ($c' = -.49, p < .001$).

Moderation Analysis

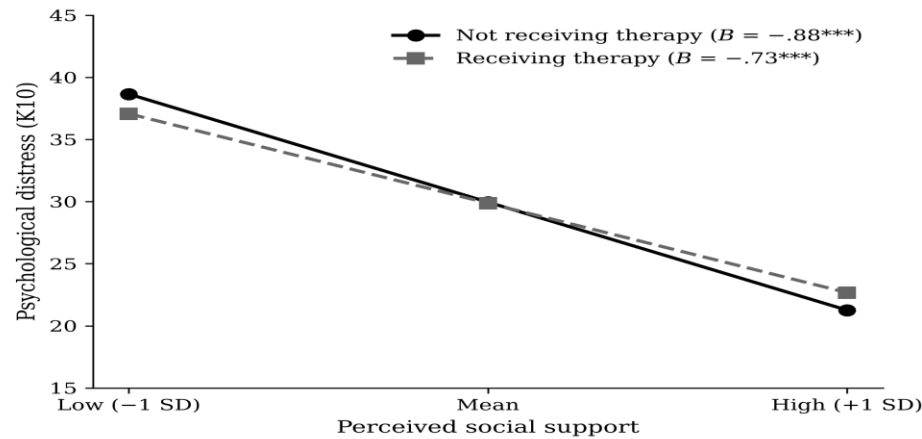
Table 6: Moderating Role of the Child's Therapy Status in the Relationship between Perceived Social Support and Psychological Distress (PROCESS Model 1, *N* = 250)

Predictor	B	SE	t	p	95% CI
Constant	30.08	.33	90.05	< .001	[29.43, 30.74]
Perceived social support	-.88	.04	-24.24	< .001	[-.96, -.81]
Therapy status	-.11	.48	-0.22	.826	[-1.06, .85]
Support × Therapy status	.15	.05	3.04	.003	[.05, .25]
Conditional effects of perceived social support					
Not receiving therapy (0)	-.88	.04	-24.24	< .001	[-.96, -.81]
Receiving therapy (1)	-.73	.03	-21.33	< .001	[-.80, -.66]

Note. Perceived social support was mean-centred. Therapy status was coded 0 = not receiving therapy and 1 = receiving therapy. $R^2 = .81$, $F(3, 246) = 347.49$, $p < .001$. Interaction: $\Delta R^2 = .007$, $F(1, 246) = 9.22$, $p = .003$.

The Support $\times$ Therapy status interaction was significant ($B = .15$, $p = .003$, $\Delta R^2 = .007$; Table 6). About Hypothesis 6, the negative B values suggest that parents had more distress when their children did not receive therapy than when they did receive therapy, with the former B value being stronger.

Figure 2: *Interaction between Perceived Social Support and Child's Therapy Status in Predicting Psychological Distress*



Note. Low and high values of perceived social support represent one standard deviation below and above the mean. *** $p < .001$.

Full Model with Covariates

Table 7: *Full Model Predicting Psychological Distress with Covariates (PROCESS Model 5, $N = 250$)*

Predictor	B	SE	t	p	95% CI
Perceived social support	-.55	.06	-9.54	< .001	[-.67, -.44]
Psychological flexibility	-.43	.08	-5.49	< .001	[-.58, -.27]
Problem-focused coping	-.37	.14	-2.68	.008	[-.65, -.10]
Emotion-focused coping	-.02	.10	-.015	.879	[-.21, .18]
Avoidant coping	.27	.08	3.60	< .001	[.12, .42]
Therapy status	-.23	.44	-.052	.602	[-1.09, .63]
Support $\times$ Therapy status	.11	.05	2.42	.016	[.02, .20]
Parent gender	-.49	.48	-1.01	.311	[-1.45, .46]
Child's age	-.13	.06	-2.29	.023	[-.25, -.02]

ASD severity	-.02	.31	-.008	.939	[-.64, .59]
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Note. Perceived social support was mean-centred. Parent gender was coded 1 = father and 2 = mother. $R^2 = .85$, $F(10, 239) = 135.91$, $p < .001$. Interaction: $\Delta R^2 = .004$, $F(1, 239) = 5.86$, $p = .016$. Indirect effects are reported in the text.

After controlling for the covariates (Table 7), the results were unchanged: psychological flexibility ($-.148$, 95% Boot CI $[-.206, -.095]$), problem-focused coping ($-.073$, $[-.130, -.017]$), and avoidant coping ($-.083$, $[-.131, -.035]$) remained significant mediators, emotion-focused coping did not ($-.005$, $[-.065, .054]$), and the interaction remained significant ($B = .11$, $p = .016$). Only the child's age predicted distress ($B = -.13$, $p = .023$).

Differences by Child's Therapy Status

Table 8: Independent-Samples *t*-Test Comparing Parents by the Child's Therapy Status ($N = 250$)

Variable	Not receiving ($n = 131$)		Receiving ($n = 119$)		$t(248)$	p	95% CI	Cohen's d
	M	SD	M	SD				
Psychological distress	30.03	8.97	30.03	8.42	0.00	.996	$[-2.17, 2.18]$	0.00
Psychological flexibility	15.43	4.45	14.97	4.38	0.82	.410	$[-0.64, 1.56]$	0.10

Note. Levene's tests were non-significant ($p = .547$ for distress and $p = .924$ for flexibility), so equal variances were assumed. CI = confidence interval of the mean difference.

Parents in the two groups did not differ in distress, $t(248) = 0.00$, $p = .996$, $d = 0.00$, or psychological flexibility, $t(248) = 0.82$, $p = .410$, $d = 0.10$ (Table 8); Hypothesis 7 was not supported.

Discussion

The present study investigated the mediating role of psychological flexibility and coping strategies between perceived social support and psychological distress among the parents of children with ASD in Pakistan and the moderating role of therapy status of their children. Five hypotheses were supported, one was partially supported, and one was not supported. Most parents (54.8%) had very high levels of distress, similar to previous Pakistani studies (Nadeem et al., 2024; Zahid et al., 2025).

Hypothesis 1 was confirmed, in that parents who did not perceive support reported higher levels of distress. This was in line with the stress-buffering hypothesis (Cohen & Wills, 1985), a meta-analysis of Schiller et al. (2021), and research on Slovenian, Croatian and Canadian parents (Demšar & Bakracevic, 2023; Zaidman-Zait et al., 2017; Zovko et al., 2024). In Pakistan also concluded that the social support had a positive effect on the depression, anxiety and stress levels of mothers of children with ASD, due to the close bonding of extended families in childcare (Furrukh & Anjum, 2020). Support, however, did not mediate parental stress for German parents (Sartor et al., 2023), or emotional support, which was consistently associated with reduced stress for

Chinese parents (Liang et al., 2025). The very high correlation ($r = -.90$) may also in part be due to method similarity.

Support from a hypothesis was supported, with perceived support being correlated with psychological flexibility and problem-based and emotion-based coping and negatively correlated with avoidant coping. This is in accord with Tindle et al. (2022), Demšar and Bakracevic (2023), and Zaidman-Zait et al. (2017), whose findings were that internal resources such as optimism was positively tied to family support. Partner and friend support, however, had direct effects on outcomes, not indirect via internal resources (Ekás et al., 2010) and coping—not support—exerted the impact of daily demands on stress (Sartor et al., 2023).

Hypothesis 3 was supported. Psychological flexibility was most strongly associated with distress, in line with Gur and Reich (2023), Weiss et al. (2012), Sairanen et al. (2018), and Rickardsson et al. (2022). The positive correlation between avoidant coping and distress was consistent with the findings of Hastings et al. (2005) and Lai et al. (2015); and the negative correlation between problem-focused coping and distress was consistent with the findings of Smith et al. (2008). The negative correlation between emotion-focused coping and distress, however, contradicted findings of Dąbrowska & Pisula (2010) and Smith et al. (2008) who found that emotion-focused coping was associated with increases in stress or poorer well-being, and Vernhet et al. (2019), who characterized these findings as inconsistent. This difference might be due to the nature of the coping strategies used, as in this study, EF coping was represented mainly through adaptive coping style which is valued in Pakistan (Furrukh & Anjum, 2020).

Hypothesis 4 was accepted, with the psychological flexibility being the largest indirect effect (approximately 20% of the total effect). For parents who felt supported, they seemed to be able to embrace and accept challenging experiences more readily and to act on their values. This was consistent with Tindle et al. (2022), and comparable to Weiss et al. (2012) who also found that acceptance partially mediated the relationship. But Sairanen et al. (2018) confirmed that only experiential avoidance, not defusion or mindfulness, accounts for parental stress, indicating that not all flexibility processes are equally important.

Hypothesis 5 was partially supported. Problem-focused and avoidant coping mediated the support–distress relationship, which agreed with Sartor et al. (2023), Zovko et al. (2024), Hastings and Johnson (2001), and Dunn et al. (2001). This relationship did not go through the emotion-focused coping mechanism, which was found by Demšar and Bakracevic (2023) and Pottie and Ingram (2008) to be protective. Emotion-focused coping correlated strongly with the problem-focused coping ($r = .74$) and therefore its unique effect may have been captured by the other mediators, which is more consistent with the results of Dąbrowska and Pisula (2010) and those of Vernhet et al. (2019).

Hypothesis 6 was confirmed, with more supportive parents for children not receiving therapy. This was in line with the stress-buffering hypothesis (Cohen & Wills, 1985) and with Sim et al. (2018), particularly in Pakistan where there is limited and expensive therapy (Furrukh & Anjum, 2020).

The interaction was weak ($\Delta R^2 = .007$), and support continued to be protective in the case of the parents of the child on therapy, as found by Hastings and Johnson (2001) and Liang et al. (2025). Therefore, a synergistic relationship between professional and informal support seemed to be present.

Hypothesis 7 was not confirmed, because there were no differences in distress and flexibility between the two groups. It ran counter to the previous findings of Sim et al. (2018), Demšar and Bakracevic (2023) and Schwichtenberg and Poehlmann (2007) which correlated therapy or more therapy hours with decreased parental distress. But other studies have also reported high depressive symptoms in mothers in therapy programs (e.g., Schwichtenberg and Poehlmann, 2007) and Hastings and Johnson (2001) reported that stress was largely based on psychological factors. This may be attributed to the financial and time requirements of therapy in Pakistan and also the simple yes/no answer for therapy status. The only covariate predicting distress was child's age. The non-significant effect of the severity of ASD conflicted with the findings of Hastings and Johnson (2001) and Zaidman-Zait et al. (2017) and reinforced the findings of Pottie and Ingram (2008).

Implications

Acceptance-based programmes could be particularly beneficial for these parents, as, to date, there is evidence of parental distress being reduced through acceptance-based programmes (Li et al., 2024). For coping skills training to be effective, it should reinforce problem-focused coping and minimize avoidance. The autism services should include families, form parent support groups, focus on families that do not have access to therapy and routinely assess parents for distress.

Strengths and Limitations

This was the first study to employ parallel mediation using psychological flexibility and coping, and moderation using therapy status among parents of children with ASD in Pakistan. It applied reliable measures ($\alpha = .82 - .97$), bootstrapped confidence intervals and controlled for covariates. However, because of the cross-sectional design, causal inferences could not be made, and the associations may have been biased upwards by self-report measures. Lahore and Sheikhpura were sampled purposively, mothers comprised two thirds of the sample, the sample was dichotomized in terms of therapy, and the K10 cut-off scores have not been validated in Pakistani parents.

Suggestions for Future Research

Future studies should utilize longitudinal or intervention design, including rural parents and more fathers, determine the type and intensity of therapy, and validate the Urdu Psy-Flex and K10 which include religious coping as an individual coping strategy.

Conclusion

Perceived social support was closely linked with decreased psychological distress among pediatric ASD parents of Pakistan, in part due to increased psychological flexibility, problem-solving coping and decreased avoidance coping. Both groups did not differ in overall distress but were more protective when the child was not receiving therapy. Enhancement of support networks, psychological flexibility, and adaptive coping strategies therefore might decrease distress among these parents.

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