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Comparison of Attitudes Toward Disability, Resilience, and Sleep Quality Among Mothers of Children with High-Functioning Autism and Mothers of Children with Mild Intellectual Developmental Disabilities

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Editor	Reviewers
Christian Wiesner Professor at University College of Teacher Education in Lower Austria christian.wiesner@ph-noe.ac.at	**Reviewer 1:** Taher Tizdast Assistant Professor, Department of Psychology, Tonekabon Branch, Islamic Azad University, Tonekabon, Iran. Email: taher.tizdast@toniau.ac.ir **Reviewer 2:** Meysam Sadeghi Assistant Professor of Department of Cognitive Psychology, Higher Education Institute of Cognitive Sciences, Tehran, Iran. Email: m.sadeghi@icss.ac.ir

1. Round 1

1.1. Reviewer 1

Reviewer:

In the paragraph describing the autism group, the phrase “high-functioning autism spectrum disorder” requires an operational definition. Contemporary diagnostic systems do not formally recognize “high-functioning autism” as a separate diagnostic category, and the manuscript currently does not indicate whether this classification was based on IQ, adaptive functioning, language ability, support level, educational placement, or clinical judgment. The authors should specify the diagnostic criteria used, the professional responsible for diagnosis, any intelligence or adaptive-behavior thresholds applied, and the diagnostic framework, such as DSM-5 or DSM-5-TR, to ensure reproducibility.

In the paragraph describing the comparison group, the statement that children had “a formal diagnosis of mild intellectual developmental disability” should be supported by explicit diagnostic criteria. The manuscript should report how intellectual functioning and adaptive behavior were assessed, whether standardized intelligence testing was required, the approximate IQ range if applicable, which adaptive-functioning domains were evaluated, and whether diagnoses were based on DSM-5/DSM-5-TR criteria or national educational classifications. Without this information, the diagnostic comparability and internal validity of the groups cannot be adequately evaluated.

In the assumptions paragraph, the statement that "after correction of the extreme scores, skewness and kurtosis were within the acceptable range" requires methodological revision. The earlier description indicates that outlying observations were replaced with the overall sample mean. Mean substitution for genuine extreme observations can artificially reduce variance, alter covariance structures, inflate normality, and bias inferential statistics. The authors should identify the number and values of affected observations, justify why they were considered erroneous rather than legitimate extreme values, and preferably conduct sensitivity analyses using the original observations, robust procedures, or winsorization if scientifically defensible. Arbitrary replacement of observed data with the sample mean should not be used solely to satisfy normality assumptions.

Authors revised the manuscript and uploaded the document.

1.2. Reviewer 2

Reviewer:

In the sampling paragraph stating that "a combination of convenience and purposive sampling was employed," the use of different sampling strategies for the two groups introduces a potentially important selection bias. Mothers of children with autism were recruited mainly from treatment and rehabilitation centers, whereas mothers of children with mild intellectual developmental disabilities were purposively recruited from educational settings. These recruitment environments may systematically differ in service utilization, socioeconomic status, parental engagement, severity of child difficulties, and access to support. The authors should discuss this methodological asymmetry, report whether matching was actually performed, and provide statistical evidence that the two groups were comparable on the intended matching variables.

In the demographic Findings paragraph, the manuscript reports that "10 participants (33.33%) did not report child age" and that maternal educational information was also missing for 33.33% of the autism group. This degree of missing demographic information is substantial and requires explicit treatment. The authors should explain why missingness was so high in one group, report whether missing-data patterns differed significantly between groups, and discuss the possibility of nonrandom missingness. The manuscript should also clarify whether inferential analyses used all 60 cases and whether any study variables themselves contained missing observations.

In the demographic Findings paragraph, the two groups appear notably different in the distribution of child age, particularly because 63.33% of children in the mild intellectual developmental disability group were aged 5–7 years compared with 30.00% in the autism group, alongside substantial missing age data. Given that child age could influence maternal caregiving burden, acceptance, resilience, and sleep, the authors should formally test between-group demographic differences. If meaningful imbalance is present, child age and other relevant covariates should either be controlled analytically or acknowledged as potential confounders in interpreting the results.

In the Data Collection Tools paragraph describing the Attitude Toward Disability Questionnaire, the manuscript states that it measures "behaviors, perceptions, interpersonal interactions, feelings, and attitudes" and later reports five dimensions—affection and acceptance, embarrassment, frustration, disappointment, and overprotection—but does not provide essential scoring information. The authors should report the number of items, response scale, possible score range for each subscale, direction of scoring, whether any items are reverse-coded, and whether a total score is theoretically and psychometrically justified. This information is necessary to interpret the meaning of higher scores and the clinical relevance of the observed group differences.

In the paragraph describing the Connor–Davidson Resilience Scale, the manuscript states that "higher cumulative scores indicated a greater capacity for psychological adaptation," but the scoring description should be reconciled with the original CD-RISC scoring convention. The standard 25-item CD-RISC is commonly scored from 0 to 4 per item, yielding a total range of 0–100, whereas the earlier study description indicated responses from 1 to 5. Because the reported mean resilience score is approximately 90, the scoring method materially affects interpretation. The authors should verify the exact Persian version used, report its scoring range, and ensure consistency between the instrument description and the obtained scores.

In the paragraph describing the Pittsburgh Sleep Quality Index, there is a serious measurement issue requiring resolution. The manuscript appropriately describes the standard PSQI as comprising seven component scores and producing a global index,

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but the descriptive results report mean scores of 27.39 and 29.89. These values are impossible under the conventional PSQI global scoring range of 0–21. This discrepancy suggests that a nonstandard scoring system, a modified questionnaire, or an incorrectly identified instrument may have been used. The authors must verify the original data and instrument, state exactly how sleep quality was scored, provide the possible score range, and revise all interpretations accordingly. This issue affects the validity of one of the three principal outcomes.

Authors revised the manuscript and uploaded the document.

2. Revised

Editor's decision: Accepted.
Editor in Chief's decision: Accepted.

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