



The Parenting Process from the Father's Perspective: Analysis of Perceptions of Fathers about Raising Their Child with Autism Spectrum Disorder

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There is an increasing awareness among early childhood professionals of the importance of father-child relationships in child development, and in supporting the father's identity so that he, like the mother, is a key figure in the child's life. There coexists a lag in empirical data on fathers of children with special needs, specifically autism spectrum disorder (ASD). Parents of young children with ASD report higher than average rates of stress and decreased self-efficacy with child rearing. Because ASD is the number one occurring developmental disability in the United States, with one in eighty-eight children (one in fifty-four boys) being diagnosed, there is a critical need for mental health programs to include fathers in the intervention process. The author sought to learn more about fathers of children with ASD and, more specifically, their perceptions about parenting, child rearing, and dealing with the diagnosis of ASD.

Key words: autism; children; fathers; parenting

Introduction

The following investigation builds upon a previous study in which the same research design and methodology were implemented with parents raising very young children with severe cerebral palsy (Vacca, 2006). The results of this study were based on a limited sample of families with very young children with a severe form of cerebral palsy. The limited sample size ($n = 5$) was due to a high attrition rate for families who had to leave the study because of job or domestic issues, or whose participation was delayed because the child with the disability tended to be hospitalized or medically compromised. Therefore, the establishment of a larger sample size was difficult to achieve.

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The published results of the earlier study highlighted the following preliminary phases that parents progressed through as a result of raising a child with a severe disability:

1. Normative phase (expecting a healthy child)
2. Self-study phase (self-blame for the birth of a child with a disability)
3. Acceptance phase (realization of the disability and embracing the child)
4. Determining quality of life phase (examination of marital relations, mental health)
5. Planning for the future phase (considering job changes, moving, future births)

The results also supported available models on families of children with special needs, and identified that raising a child with a disability affects family functioning and does so in repeating phases (Britner, Morog, Pianta, & Marvin, 2003; Lindblad, Holritz-Rasmussen, & Sandman, 2007).

The previous study consisted mainly of mothers ($n = 4$), however. Therefore, the author determined that more information from fathers was paramount. A father in this study shared an interesting impression that the raising of a child with cerebral palsy had to be better than raising a child with ASD. He stated, "At least my child looks at me, smiles, kisses me, says 'da' for Dad, and holds my hand."

The present study builds on this perception as well as the results, and aims to target fathers given the limited data about their perceptions about child rearing, especially for a child with ASD. The field of developmental psychology is increasingly emphasizing the importance of dual involvement of both mothers and fathers in the parenting process and in the early development of children (Borke, Lamm, Eickhorst, & Keller, 2007; Clarke-Stewart, 1978; Coley & Coltrane, 2007; Pancsofar & Vernon-Feagans, 2006; Pleck, 2007; Rohner, 1998). Just as there is a lag in research on fathers when compared to mothers in dealing with child development in general, there coexists a lag in empirical data on fathers of children with special needs (Vacca, 2006).

Research demonstrates that a majority of parents of children with special needs experience reactions to the diagnosis ranging from devastation and shock to denial, guilt, and shame (Barnett, Clements, Kaplan-Estrin, & Fialka, 2003; Hartley, Seltzer, Head, & Abbeduto, 2012; Wetchler, 2005). These results, although derived from interviews and surveys of families, consisted of unbalanced samples of parents, with mothers outnumbering fathers (Cabera, Tamis-LeMonda, Bradley, Hofferth, & Lamb, 2000; Guzell & Vernon-Feagans, 2004).

Generally, when asked to identify and prioritize their needs as individuals, fathers state that their needs encompass the areas of finances, shelter/housing, food, employment, transportation, counseling, employment training, family planning, legal assistance, and child support assistance. Similarly, Buckelew, Pierrie, and Chabra (2006) identified the following needs of fathers in their study of public health programs and the perceptions of fathers of very young children: ineffectiveness during labor; being in the way; disruption, discomfort, and exclusion dur-



ing the first few weeks of their child's life; and lack of recognition as a key player in the young infant's development. Alongside the needs expressed by fathers, specific barriers were expressed in child rearing and in participation in empirical studies such as residential status of the father or physical distance from the child, work responsibilities, marital conflict, or paternal depression (Donaldson, Elder, Self, & Christie, 2011; Flippin & Crais, 2011; Murray & McDonald, 1996; Navalkar, 2004).

Similar findings (although limited in availability) demonstrated commensurate results when examining families of children with ASD (Hastings et al., 2005). Whereas similar play interactions were noted with the parents who participated in the study, there were measurable elements of parental stress related to the difficulties of getting the child with ASD to engage in play, to socially interact with the parents and give eye contact, and to purposefully manipulate toys that were present.

Historically, research on families of children with ASD report stress in parents concerning the difficulties of not knowing how to get a child with ASD to look at them, smile at them in response to interaction, willingly hold their hand while taking a walk in the neighborhood, or respond reciprocally in verbal exchanges rather than merely echoing what the parents say (Rodrigue, Morgan, & Geffken, 1992; Seung, Ashwell, Elder, & Valcante, 2006). With ASD being the number one occurring developmental disability in the United States (one in eighty-eight children or one in fifty-four boys is diagnosed), there is a critical need for early intervention programs that involve direct intervention for both the child and the parents.

Children with ASD often demonstrate delays across all areas of development. When asked about what areas of development are not commonly seen in their child, parents typically indicate the lack of expressive language and appropriate play behavior, and limited (if any) face-to-face/eye contact. Traditional programs designed to teach such skills were often conducted in clinical settings; however, a growing body of research is emphasizing the importance of implementing interventions in home-based environments to provide a richer context for social interaction.

Another problem inherent in intervention programs is the overemphasis on training primarily mothers in intervention strategies, with the presumed expectation that the mothers in turn will train the fathers (Donaldson et al., 2011). As demonstrated in previous sections of this article, the exclusion of the father from intervention and the primary focus on the mother pose potential problems in encouraging paternal involvement in the home. Seung et al. (2006) found that, when fathers were involved directly in the intervention programs of their children with ASD, they reported higher amounts of self-confidence, overall competence, and marital satisfaction than fathers who were not involved in the intervention process.

The automaticity of the mother-child relationship is recognized as preeminent and overshadows the impact of fathers on child development (De Falco, Esposito, Venuti, & Bornstein, 2008; Flippin & Crais, 2011; Grossman et al., 2002). Buckelew et al. (2006) identified that 36 percent of children in the United States live apart

from their biological fathers, and the prevalence of single fathers increased exponentially (by 25%) between 1995 and 1998. In their study of 240 fathers of children between birth and five years, these authors found that the traditional societal roles were identified when fathers were asked to define their roles as fathers. The sample indicated the following perceived roles in child rearing (in order of priority): parenting (78% of respondents), role model (53%), pay the bills (44%), caregiver (41%), disciplinarian (39%), head of the house (39%), teacher (36%), mother's support (30%), providing transportation (29%), and no role as father (2%).

In examination of the available empirical studies and theories on attachment and child development, and in recognition of the typical pathways that parents and children take in the bonding process, what are the differences and similarities in parenting perceived by fathers of children with ASD? While awaiting the birth of their child, what roles do fathers predict they will fulfill once their child is born? What are their hopes, dreams, and expectations for their child? What changes in roles and expectations take place after the receipt of an ASD diagnosis for their child? And in what ways does the presence of ASD affect father-child interactions and attachment?

Overall, it is the intent of the author to provide readers with an often ignored perspective, that of the father, especially in the literature dealing with parents of children with special needs. It is hoped that, through the presentation of the results of this qualitative study, early childhood professionals will have a renewed sense of the impact of fathers on child development, strategies to encourage the participation of fathers in their children's lives, and ways to support the motivation for more fathers to participate in research studies.

In conducting this study, the author sought to learn more about fathers of children with ASD and, more specifically, about their perceptions about parenting, child rearing, and dealing with the diagnosis of ASD. The interview questions were organized around the following areas:

1. Parenting in the prenatal period
2. Perceived roles in being a father/parent
3. Reactions to the initial diagnosis of ASD
4. Factors influencing play and social interactions with their child as a result of ASD
5. Models illustrating the phases fathers go through in raising a child with ASD

The present investigation received institutional review board approval through Saint Joseph's University. Further, written informed consent agreements were distributed and received from all of the participants prior to data collection.

Method

Participants

A flyer requesting the participation of fathers whose children were enrolled in an ASD early intervention program (part of Part C of the Individuals with Dis-



abilities Education Act) in suburban Maryland and Pennsylvania was mailed to each family. Approximately two weeks were given for the return of the flyers. A total of thirty flyers were mailed out. The author of this investigation was familiar with two early intervention programs and therefore mailed the flyers to these programs. One program was identified in a suburban county in Maryland, and one program was identified in a suburban county in Pennsylvania. The investigator is well aware of selection bias of participation given the self-selection of programs and his familiarity with the programs. The reader should be aware that the scope of this study is pilot given the lack of studies investigating the perceptions of fathers of children with ASD about parenting. Therefore, it is the author's intent to use these preliminary results to conduct an in-depth investigation where more early intervention programs serving children with ASD are included from a larger, more representative group of fathers (i.e., in terms of race, socioeconomic status, and geographic region).

Following the deadline for returning the flyers, the return rate was very low (27%, $n = 8$). Follow-up phone calls were made to those fathers who did not return their flyers. A majority of fathers who responded to the calls indicated that their work schedule interfered with their ability to do an interview. Other fathers indicated a similar reason, and added that the high demands of their child with ASD were difficult and giving up an hour to talk was not possible. A very small number of fathers who were called ($n = 4$) stated that they did not feel comfortable talking about their child or autism.

All of the fathers who participated in the study were Caucasian. The mean household income of the group was \$53,620. All of the children had been participating in early intervention for eight months, since twenty months of age. Each child had a diagnosis of ASD prior to this investigation, following a multidisciplinary team evaluation by a child study team. Written consent was gathered from each father who participated in the study.

Setting

The present investigation involved individual, face-to-face interviews with the investigator and a given father (who indicated his interest in participation). Each interview was conducted in the home of the father. The fathers were asked to identify convenient days and times to participate in the interviews. The interview was a one-hour session completed in one evening.

Procedures

A semi-structured interview was conducted with the fathers. Each interview took place in the evening after work and following dinner with the family. Each interview lasted exactly one hour, and every father was interviewed using the same questions. As in the initial study with parents of children with severe cerebral palsy, the questions were grouped under specific development periods (i.e., prenatal and postnatal) and issues with parent-child interaction patterns. The following questions were asked:

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1. Prenatal period
 - a. Before your child was born, what did you perceive your primary role to be?
 - b. Before your child was born, what were your expectations for him or her?
 - c. What were your hopes and dreams for your child?
2. Postnatal period
 - a. What reactions have you had as a result of the news of your child's diagnosis of ASD and raising a child with a disability?
 - b. Discuss the ways in which the presence of your child's ASD has affected your interactions with your child.
3. Parent-child interaction patterns
 - a. What have been the greatest challenges you faced as a result of your child's ASD?
 - b. What have been the biggest problems or concerns that you have had in terms of interacting with and playing with your child as a result of his/her ASD?

Design

An ethnographic/qualitative approach was implemented in the present study given the limited data available on fathers of children with ASD. A qualitative design provides a pathway for future quantitative studies in which specific variables identified in the interviews can be examined more closely and regression analyses completed to identify relationships across gender, class, race, and geographic location of the family. Also, ANOVAs can be run and more advanced studies can be conducted to validate the initial developmental pathways parents of children with more severe disabilities go through as part of their adjustment to child rearing.

Ethnographic designs require the investigator to go into the environment of the participants, become part of the environment, and immerse into family functioning. Semi-structured interviews provide a nonthreatening context for information sharing. Participants in this forum tend to explain more or to make sense of the important events in their lives. Data trustworthiness can be evaluated to ensure construct validity of the interviews with the variables of investigation. Wolery and Dunlap (2001) recommend such exploratory designs in cases where there has been little previous research.

Data Analysis

Each interview was audiotaped and later transcribed. Each transcription was imported into a software program for qualitative data analysis (Qualitative Solutions and Research, 1997). This program is appropriate for its ability to identify themes in interviews similar to the type implemented in the study. Themes were analyzed across the areas addressed in the interview and the manner in which they related to the themes identified in available research. The author also compared the themes with those identified in the preliminary model for parents of children with



cerebral palsy. This model will be used as the focus of future studies with larger samples, examining perceptions of parents of children with disabilities.

Results

The first area addressed examined parents' initial perceptions of parenting during the prenatal and postnatal periods of their child's development. A coding system based on the work of Barnett et al. (2003) and Ziolko (1991) was used to aggregate the responses from the interviews. The common reactions to the news of a child's diagnosis at birth (as cited in Barnett et al.) were used to aggregate the interview data that addressed the prenatal period. It was the intention of the author to continue to compare the Barnett study with the perceptions of the parents participating in the present study, as well as those received in the original study (Vacca, 2006).

Perceptions in the Prenatal Period

Review of the results supports ongoing findings of parental perceptions of their unborn baby: elation, excitement, anticipation, and heightened hopes and expectations for health and happiness and a long life of success. One father stated, "our mindset was to do everything we could now 'socially' with our friends and each other now while we had the chance." Another father identified his hope that his baby would "have ten fingers and ten toes and that everything would look the way it was supposed to." Further, this father said he expected his baby to be normal just like his daughter was when she was born and that "she would be happy and healthy."

A compilation of other fathers' perceptions for their unborn babies included the following:

1. "My baby would be born ready to play and smile."
2. "He would be healthy and would be able to come home healthy and not have any sleeping problems."
3. "He will walk and do other things on time when he is supposed to."
4. "He will engage in sports and clubs when he gets to school."
5. "He will play sports and be able to run around with his friends."
6. "There are no development problems . . . I mean I hope he or she isn't born with like health issues and bad legs where he can't run or play with me."
7. "I hope that he won't have autism. All I see on TV and in magazines are things about autism. I would rather have a child with cerebral palsy than autism because at least he would talk to me and interact with me instead of just stare at the wall or move his hands in weird ways."

Along this line, about 25 percent of the fathers interviewed talked about not wanting their child to have autism. A majority of the fathers stated that they were "afraid" of having an autistic child because they would not know what to do.

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When the question of perceived role as a father/parent was the focus of discussion, the responses received were directly comparative to roles identified by Buckelew et al. (2006). The following lists the roles that were identified and the frequency with which they were identified (roles in italics were the same as those identified by Buckelew et al.):

1. *Breadwinner/provider* so that “my wife could stay at home” (88%)
2. Caregiver (75%)
3. Teacher (63%)
4. Organizer and head of the house (50%)
5. Playmate (25%)
6. Nurturer (12%)
7. *Helper* to “my wife” (12%)

One father stated the following in response to the question about anticipation as a parent:

You know I can’t say that I even thought about roles. I mean all I knew is that I would have to just kick in and be a dad, help my wife, and get things done around the house. I have never been a dad before so I didn’t sit around thinking about a title for myself. I thought about what my father did, and I wanted to do and expected to do as I thought about him. I guess when I look back at things I would say that I anticipated being the co-participant/the coleader with my wife. I would also be the primary breadwinner because I didn’t want my wife to work. And I anticipated being my child’s leader. I wanted to be a role model for him and be someone he could come to for problems and come to me when he wanted to play.

Perceptions in the Postnatal Period

The second part of the interview focused on questions that related to perceptions following the diagnosis of ASD. The participants were asked to share the impact of the diagnosis on perceived roles and child interaction patterns. Review of the responses indicated that they were very similar to those Barnett et al. (2003) identified. A majority of fathers indicated their first reactions to the diagnosis were denial, confusion, and disbelief. A father in the present study identified the following:

I remember when I heard the diagnosis. I immediately turned to my wife, who began to cry and say ‘No it can be that.’ I didn’t have time to feel anything. My main reaction was to hold my wife and try to listen to what it all meant for us as parents. It wasn’t until later that my reaction was denial. Frankly I was pissed.

Another father said the role he felt was “supporter” and “advocate.” He stated, “The need to be a supporter went through the roof. I knew I needed to be the main advocate to everybody to figure out what to do and to know what is going on.” He



stipulated, "the need to step up to the plate and fulfill all the roles I thought of before he was born was critical." Overall, several fathers endorsed the primary role to be supporter following the diagnosis. Another father added the following:

You have to come to the realization that you have to believe what someone is telling you about your child. In our case it was the evaluating psychologist. Then you just need to accept things and immediately decide what you have to do to reverse things and make it all better for us and for our child so that things can go back to normal. Basically, you have to just buckle down and think of all of the things you can do to take this thing away from your child that has him hidden from the world. I don't mean hidden physically . . . he will probably ride a bike if he wants to. It's the social thing. You need to do tons of things to make him normal socially. I just want him to know that I am his father. I want him to have a friend, too.

Five of the fathers already had a child, and their primary reaction to the diagnosis was being unprepared. Almost unanimously these fathers said that once they recovered from the shock of the diagnosis they "felt relieved" because at least they knew early and that services could be secured and implemented right away. All of the fathers stated that after they heard the term *autism* they knew things would be a lifelong process. This would end up being an ongoing process that would require stamina, time, and many changes to the family and to each other.

Parent-Child Interaction Patterns

The final phase of the interview focused on the challenges associated with child interactions as a result of ASD. Initially, the fathers identified that they had already had to adapt to playing with their child before the diagnosis was given. One father said:

I already had to do things differently with my child because he wasn't playing with his toys or me in ways that looked normal to me. After the diagnosis I spent most of the time thinking about the future. I knew play would be different because it had been a while before we had him diagnosed.

This quote captured what many of the fathers identified. This was the fact that changes were already in place in terms of interactions, and that this was a primary reason for making the referral for the evaluation.

The changes in interaction patterns focused primarily on how to play with the child in calm play situations such as reading books, playing with toys one-on-one, or singing to the child while he/she was sitting on the father's lap. As noted in former evaluations of parent-child interactions, all of the fathers in the present study stated that they continued to play rough with their child and be physical with their child. One father supported this by saying:

Throwing him up in the air, wrestling with him, and some other roughhousing was the only way I could get him to smile and laugh and say something.



The hardest thing for me was trying to figure out how to get him to do the same thing when we sat down for calm things like doing puzzles or playing with clay.

One theme of responses that emerged from the interview was the resounding thought that things had to be done correctly if the child was going to be okay. One father stated clearly, "Hey look, I still don't know what this autism thing is and what it is all about. But I do know things are not normal and so I just want to do things the therapists tell us to do, and I want to do them correctly to make him normal again." Many fathers agreed, yet stated that this feeling dissipated over the months after they realized that the scope of intervention was not to necessarily take the autism away but rather to help the child communicate and interact in ways that felt comfortable and safe and in ways where others would understand the child.

Discussion

The present investigation examined the perceptions of fathers of young children with ASD, the factors associated with this diagnosis in the identity of the father as a parent, and the social interactions between the father and his child. The study builds on the results of the author's former study examining parental perceptions of parents of children with cerebral palsy. Although the present study has a limited sample size, the results provide support for those found in the study on cerebral palsy about the barriers that prevent optimal father involvement in empirical investigations.

As shown in the review of research for this article, although prior studies investigating parent-child relations examine relations among both mothers and fathers, the majority of results that are reported are based on the participation of mothers. As seen in the present investigation, reasons identified by fathers for not participating included job, family obligations, or personal feelings. Researchers need to continue to think through their efforts to recruit fathers in light of their obligations. The value that fathers bring to research on children is critical, and they shed light on the parent-child dyad from both parents' perspectives. Available research shows that, when fathers are included in the lives of their children and in the intervention program for their children with special needs, they tend to report higher levels of marital satisfaction, high self-esteem and confidence, and higher competence as a parent.

Analysis of the findings of the present study provides support for four of the five phases identified in the original study on cerebral palsy:

1. Normative phase
 - a. Excitement and joy;
 - b. Anticipation for future friendships and recreational activities;
 - c. Health and well-being;
 - d. Success in life.



2. Acceptance phase
 - a. Assimilating facts and impressions;
 - b. Adapting perspectives about child outcome;
 - c. Overcoming confusion and limits in knowledge and taking action;
 - d. Recognizing the permanency of the situation and advocating for the child;
 - e. Taking on additional roles and assuming primary roles in the family;
 - f. Providing extensive support to mothers and adapting personal lifestyle.
3. Determining quality of life phase
 - a. Realizing that life can go on, goes on, and will go on;
 - b. Adapting personal and marital lifestyles to include the child with ASD;
 - c. Learning how to reach out for supports;
 - d. Recognizing patterns of play that can remain the same and those that need adaptation;
 - e. Finding newer ways of playing and interacting with the child;
 - f. Remaining steadfast in supporting spouses/partners and oneself;
 - g. Embracing the child for who he or she is versus who he or she was expected to be.
4. Planning for the future phase
 - a. Locating resources for the child and family;
 - b. Finding services that include all members of the family;
 - c. Enrolling in intervention and taking advantage of the early diagnosis;
 - d. Remaining positive as much as possible, and ongoing to support the child and family.



The responses received in the interviews identified themes that were commensurate with the identified phases. All but the acceptance phase had support from the responses.

Results obtained by examining the responses about perceived role(s) as a father generally supported those identified in prior research, with breadwinner, caregiver, teacher, and head of household ranking the highest. In terms of expectations during the prenatal period and as the normative phase indicates, fathers in this study reported their resounding need for their child to be healthy and happy throughout life.

The results of this investigation, including the parenting model presented here, support the cyclical nature of raising a child with special needs. In many respects, parents of children with ASD experience similar feelings to parents with children with cerebral palsy following the diagnosis, and undergo reflective thinking about their lives and the changes that are needed to accommodate the child's disability and its effects on the family system. However, a major difference expressed by fathers of children with ASD is a higher incidence of concern about mental health (social skills) of the child versus the primary concern of physical health that was raised in the study on cerebral palsy. This resounding theme of impaired social



interactions was preeminent when the fathers discussed their concerns. One father supported this profoundly by saying:

You know you expect a normal, healthy child who will walk and talk and laugh and so on. Then you get a child with autism and you say, "OK well, let's ask and answer some key questions: Is he healthy physically? Yes. Can he see, hear? Yes. Can he walk? Yes. Can he run and jump and swing on a swing? Yes. Can he talk to me? No. Does he look at me like in the eyes? No. Does he come up to me and say, 'Daddy throw me the ball'? No. Will he hold my hand like he really wants to or laugh at me when I get silly? I'm not sure." See all of the questions with noes, these are what makes having a child with autism suck. And this is why I'm sure many fathers don't want to talk about it, especially to a researcher. No offense but they probably see you as they saw the psychologist when the diagnosis was given.

The profound dialog offered here was shared in many forms and in many parts of the interviews by all of the fathers. However, the one common theme that was clear is that they do (did) what they saw necessary to preserve the family unit, support their spouse, and attend to their child. Another father offered the following: "You just accept it and, like riding a bike up a steep hill, you put your head down and pedal like crazy. You don't look up or stop pedaling till you get to the top; then you can look around and rest for a second before the next hill."

Given the ongoing increase in the incidence of ASD, with current estimates indicating that one in eighty-eight children in the United States has ASD, education systems, mental health agencies, and other related programs need to provide a family systems venue for support, intervention, and outreach. This venue has to include efforts to address all family members and to allow them to receive help and invitations to participate in support groups and research studies so that other families going through similar issues can benefit (Kayfitz, Gragg, & Orr, 2010). The goal of this approach with families would focus on the following:

1. Family and child well-being, attachments, and interactions
2. Parental support and resources
3. Marital support
4. The sensitive parent-child unit
 - a. Helping parents (including fathers) with child interactions
 - b. Identifying newer ways of playing and interacting
 - c. Interpreting behaviors and cues given by the child as communication
 - d. Developing communication systems to aid in parent-child interactions
5. Overall mental wellness for all family members

This support is just as critical for parents of children with ASD as it is for any family of a child with special needs. This comprehensive approach supports the three-tiered model of intervention developed by Barnett and colleagues (2003) to



guide the work of all family care professionals: social process (focusing on family and spousal supports), emotional process (addressing cycles of denial, acceptance, grief, and emotions), and cognitive and behavioral process (coping skills and overall parenting techniques).

Conclusion

The fields of mental health and education are inundated with legislative efforts to get kids ready to learn by the time they enter kindergarten. However, school readiness efforts typically focus on the traditional aspects of learning such as knowledge of concepts and numbers, and the ability to read letters and words. What they do not stress is the equally important skills set related to children's ability to cope with daily school and life demands. There is also a gap in guidelines to assist families of children with special needs, especially children with ASD. Many families of children with ASD or other special needs often find themselves lost in the shuffle and overlooked in the current educational and mental health system because of the lack of guidelines designed exclusively for them (Flippin & Crais, 2011). Furthermore, fathers are all too often overlooked as a viable partner in the process, and results show that involved fathers lead to success all around for the father, the child, and the family. As stated in Vacca (2006): "This is why mental health systems need to respond readily to the needs of families and children with special needs [especially in the autism population given the incidence] to ensure that no child is left behind."

References

- Barnett, D., Clements, M., Kaplan-Estrin, M., & Fialka, J. (2003). Building new dreams: Supporting parents' adaptation to their child with special needs. *Infants and Young Children, 16*(3), 184.
- Borke, J., Lamm, B., Eickhorst, A., & Keller, H. (2007). Father-infant interaction, paternal ideas about early child care, and their consequences for the development of children's self recognition. *The Journal of Genetic Psychology, 168*(4), 365–379.
- Britner, P., Morog, M., Pianta, R., & Marvin, R. (2003). Stress and coping: A comparison of self-report measures of functioning in families of young children with cerebral palsy or no medical diagnosis. *Journal of Child and Family Studies, 12*(3), 335–348.
- Buckelew, S., Pierrie, H., & Chabra, A. (2006). What fathers need: A country-wide assessment of the needs of fathers of young children. *Maternal and Child Health Journal, 10*(3), 285–291.
- Cabera, N., Tamis-LeMonda, C., Bradley, R., Hofferth, S., & Lamb, M. E. (2000). Fatherhood in the twenty-first century. *Child Development, 71*, 127–136.
- Clarke-Stewart, K. A. (1978). And Daddy makes three: The father's impact on mother and young child. *Child Development, 49*, 466–478.



- Coley, R. L., & Coltrane, S. (2007). Commentary: Impact of father involvement on children's developmental trajectories: New findings Panel for the National Fatherhood Forum. *Applied Development Science, 11*(4), 226–228.
- De Falco, S., Esposito, G., Venuti, P., & Bornstein, M. H. (2008). Fathers' play with their Down syndrome children. *Journal of Intellectual Disability Research, 52*, 490–502.
- Donaldson, S., Elder, J., Self, E., & Christie, M. (2011). Fathers' perceptions of their roles during in-home training for children with autism. *Journal of Child and Adolescent Psychiatric Nursing, 24*(4), 200–207.
- Flippin, M., & Crais, E. R. (2011). The need for more effective father involvement in early autism intervention: A systematic review and recommendations. *Journal of Early Intervention, 33*(1), 24–50.
- Grossman, K., Grossman, K. E., Fremmer-Bombik, E., Kindler, H., Scheuerer-Engelisch, H., & Zimmermann, P. (2002). The uniqueness of the child-father attachment relationship: Father's sensitive and challenging play as a pivotal variable in a 16-year longitudinal study. *Social Development, 11*(3), 307–331.
- Guzell, J., & Vernon-Feagans, L. (2004). Parental perceived control over caregiving and its relationship to parent-infant interaction. *Child Development, 75*(1), 134–146.
- Hartley, S. L., Seltzer, M. M., Head, L., & Abbeduto, L. (2012). Psychological well-being in fathers of adolescents and young adults with Down syndrome, Fragile X syndrome, and autism. *Family Relations: An Interdisciplinary Journal of Applied Family Studies, 61*(2), 327–342.
- Hastings, R., Kovshoff, H., Ward, N., degli Espinosa, F., Brown, T., & Remington, B. (2005). Systems analysis of stress and positive perceptions in mothers and fathers of pre-school children with ASD. *Journal of ASD and Developmental Disorders, 35*(5), 635–644.
- Kayfitz, A., Gragg, M., & Orr, R. (2010). Positive experiences of mothers and fathers of children with autism. *Journal of Applied Research in Intellectual Disabilities, 23*(4), 337–343.
- Lindblad, B. M., Holritz-Rasmussen, B., & Sandman, P. O. (2007). A life enriching togetherness—meanings of informal support when being a parent of a child with a disability. *Scandinavian Journal of Caring Sciences, 21*(2), 238–246.
- Murray, J., & McDonald, L. (1996). Father involvement in early intervention programs: Effectiveness, obstacles, and considerations. *Developmental Disabilities Bulletin, 24*(2), 47–57.
- Navalkar, P. (2004). Fathers' perception of their role in parenting a child with cerebral palsy: Implications for counseling. *International Journal for the Advancement of Counseling, 26*(4), 375–382.
- Pancsofar, N., & Vernon-Feagans, L. (2006). Mother and father language input to young children: Contributions to later language development. *Journal of Applied Developmental Psychology, 27*, 571–587.





- Pleck, J. (2007). Why could father involvement benefit children? Theoretical perspectives. *Applied Developmental Science, 11*(4), 196–202.
- Qualitative Solutions and Research. Non-numerical Unstructured Data Indexing Searching and Theorizing: QSR NUD*IST (1997) [computer software].
- Rodrigue, J., Morgan, S., & Geffken, G. (1992). Psychosocial adaptation of fathers of children with ASD, Down syndrome, and normal development. *Journal of ASD and Developmental Disorders, 22*(2), 249–263.
- Rohner, R. (1998). Father love and child development: history and current evidence. *Current Directions in Psychological Science, 7*(5), 157–161.
- Seung, H., Ashwell, S., Elder, J., & Valcante, G. (2006). Verbal communication outcomes in children with ASD after in-home father training. *Journal of Intellectual Disability Research, 50*(2), 139–150.
- Vacca, J. (2006). Parental perceptions of raising a child with a severe physical disability: Implications for mental health providers. *Best Practices in Mental Health: An International Journal, 2*(1), 59–73.
- Wetchler, J. (2005). Reflections from a single father of a teenage daughter with mental retardation. *Journal of Feminist Family Therapy, 17*(2), 65–78.
- Wolery, M., & Dunlap, G. (2001). Reporting on studies using single-subject experimental methods. *Journal of Early Intervention, 24*, 85–89.
- Ziolko, M. (1991). Counseling parents of children with disabilities: A review of literature and implications for practice. *The Journal of Rehabilitation, 57*(2), 29.



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