



LUND UNIVERSITY

Faculty of Social Sciences

Graduate School

SIMT17, Master's Thesis (Two Years) in
Gender Studies
Spring Term 2010
Supervisor: Magnus Lindgren

Parenting Children with Autistic Spectrum Disorder (ASD):

Gendered Social Construction of Parenting

Karelle N. Clark

Abstract

This paper will focus on a comparative analysis of the gendered social construction of parenting (mothering and fathering); in relation to possible relationship burdens faced by parents, in the process of care giving and administration of therapeutic mechanisms, to children diagnosed with Autism Spectrum Disorder (ASD). The gendered social construction of parenting and respective burdens will be addressed from a western theoretical perspective, and will outline various techniques that can be administered to achieve more productive lifestyles for autistic children and their families. Consideration will additionally, be given to the knowledge that not all western societies are homogeneous in composition.

Keywords Autism Spectrum Disorder (ASD), Gender, Sex, Treatment and Education of Autistic and related Communication-handicapped CHildren (TEACCH), Checklist for Autism in Toddlers (CHAT), Early Intensive Behavioral Intervention (E-IBI), Parenting, Family.

Table of Contents

1.0. Abstract.....2

2.0 Background.....4

3.0 Autism Spectrum Disorder (ASD)6

4.0 The Family and Gender Relations..... 11

 4.01 Familial Construction 11

 4.02 Assignment of Care-work 15

5.0. Gendered Socialization: Adaptation of Male and/or Female Roles 19

6.0 Maternal versus Paternal Expectations 25

 6.01 Balancing Marriage, Parenting and ASD 28

7. 0 Counteracting Problems: Communication and Stress & Anxiety..... 34

 7.01 Communication 34

 7.02 Stress and Anxiety 38

8.0 Early Intervention: Parental Input and the Individual (Child) 41

 8.01 Early Intensive Behavioural Intervention (E-IBI) 43

 8.02 TEACCH Program..... 45

9.0 Intervention Outcomes 49

10. Limitations and Prospective Directions 50

11. Conclusion..... 53

12. References 56

Parenting Children with Autistic Spectrum Disorder (ASD):

Gendered Social Construction of Parenting

2.0 Back ground

From the onset of this research paper, as a reader, it is necessary to recognize that the terms sex (biological species division) and gender (concept of being a man or a woman) will be used to “specifically distinguish biological differences from social/psychological” (Stanford Encyclopedia of Philosophy (SEP), 2008) differences in humans. This is important to note, because in common conversational language gender and sex are often treated interchangeably, and as such, gender should be notably differentiated from that of the biological term sex. Likewise, when reference is made within the text to western societies or the western context, it is specifically referring to European and North American perspectives. Moreover, gendered parenting differences will henceforth be analyzed within the context of the family based on the social roles, behavioural characteristics and positions adopted by western parents, as they undertake caring for their autistic child. The family unit will for the purpose of this paper refer specifically to the immediate family members -mother, father and siblings, while the sibling subgroup in turn, will refer to both child(ren) with ASD and non-afflicted brothers or sisters.

This research paper will serve to address specific questions directed towards the theme of how gendered socialization impacts the construction of mothering and fathering characteristics; and the impact such divergent male and female socialization have on a parent’s ability to execute care for a child diagnosed with ASD. This subject matter is of particular interest, due to my previous work assignment at a centre for children with ASD. While working as a teaching aid for children who exhibited varying degrees of symptoms within the autistic spectrum, certain observations were made regarding parental input in therapy of their offspring. Additionally, the relative lack of paternal input in daily care activities was a particular occurrence amongst this group of special needs children.

Amid one group of 20 children between the ages of two and thirteen, only 15% of the fathers actively engaged in the child care process outside of the home and immediately after therapy sessions, on a regular basis. The lack of paternal participation was particularly apparent when invitations were extended to both

parents/caregivers to accompany their children on field trips outside of the centre, and at socialization activities held internally, which showcased their children's educational aptitude (plays, show and tell day). This overt deficit in paternal involvement raised several mental 'flags' and fostered my interest as a researcher since the action of being a teacher aide, unintentionally situated me as a participant observer. From the standpoint of a participant observer, observations were made regarding the overall progress that could be and was achieved through the incorporation of behavioural modification techniques into the lives of these children. It was especially evident in order to ensure that such therapies maintained their long-term efficacy they also had to be incorporated into practice within the children's home environments. The involvement of both parents therefore, becomes a necessary asset, in order to ensure continuity in the child's learning. Additionally, this consistency needed to be administered in balance, incorporating both parental interaction and professional applications, with the primary purpose of this methodology being to maintain techniques learned in therapy throughout the course of the child's life span.

The cooperation of parents was therefore necessary to secure uniformity in therapy management; why then was there an absence of the paternal figure? This absence thus generated questions regarding the extent to which the mother figure would have to compensate for the absence of the father for intensive childcare. Furthermore, if the father was present within the home then, what role was he assuming, if he was not involved in childcare? Furthermore, how would exacerbated maternal burdens directly impact the marital situation; and the family unit as a whole? Combined, the previously mentioned observations fostered the chosen research concentration; and as such these concerns will be addressed in further detail throughout the progression of this paper. Resulting from the observation of the aforementioned questions, it became necessary as a researcher to address certain supplementary problematic areas prior to assessing the various burdens encountered by parents with regards to raising an autistic child. These are especially important to examine under the context of the societal structure, where the mother is more readily deemed the primary caregiver.

However, in order to do this, one must first evaluate what does it mean to be a family? Moreover, assessment must be made of what participatory roles are

required for the parents or caregivers involved in providing therapy for a child with ASD? This research paper will further address these subject areas, taking into consideration the gendered stereotypes associated with child care, the impact these stereotypes play on the construction of the family; and the relation both have regarding parental input in the process of administering different therapeutic approaches to a child with ASD.

3.0 Autism Spectrum Disorder (ASD)

Autistic spectrum disorder (ASD) is a mental health disorder which hinders an individual's aptitude for responding to visual and verbal stimuli; resulting in, delayed social integration skills, stereotypical repetitive behaviours and language abnormalities; specified in the triad of social impairments outlined by Wing & Gould (1979). Cohen & Volkmar (1997) denoted that there is no official cure for autism, but children diagnosed with this condition can be helped to extend their existing skills to compensate for their deficits in communication, cognition and behaviour (Carr, 2006). This in turn, provides both the child and his/her family with a means for both to achieve productive and fulfilling lives.

ASDs are "common in the general childhood population, and are both serious and lifelong" (Matson, Mahan & Matson, 2009, p. 868). ASD also represents one of the most challenging and prevalent childhood disorders; with occurrence rates increasing quite steadily. "The occurrence of ASD in 1 in 150 children" is "now considered the correct rate" (Croen et al., 2002; Fombonne, 1999; as cited by Matson et al., 2009); with "about 80 percent of them boys" (American Psychiatric Association, 2000; as cited by Passer, Smith, Holt, Bremner, Sutherland & Vliek, 2009, p. 831). Alloway & Gathercole (2006) describe ASD as a developmental condition associated with abnormalities in an individual's perception, cognition and emotional domains. Furthermore, the late Leo Kanner (psychiatrist) aptly described ASD as a disorder "characterized by extreme unresponsiveness to others, poor communication skills, and highly repetitive and rigid behaviour patterns" (Passer et al. 2009, p. 831). For a child to be diagnosed with ASD he/she must display symptoms of a total of six (or more) items from (1), (2), and (3), with at least two from (1), and one each from (2) and (3), as outlined by the Diagnostic and

Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM- IV-TR) (2000, p. 70)

- (1) “qualitative impairment in social interaction, as manifested by at least two of the following:
 - a) marked impairments in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body posture, and gestures to regulate social interaction
 - b) failure to develop peer relationships appropriate to developmental level
 - c) a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people, (e.g., by a lack of showing, bringing, or pointing out objects of interest to other people)
 - d) lack of social or emotional reciprocity (note: in the description, it gives the following as examples: not actively participating in simple social play or games, preferring solitary activities, or involving others in activities only as tools or "mechanical" aids)
- (2) qualitative impairments in communication as manifested by at least one of the following:
 - a) delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime)
 - b) in individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others
 - c) stereotyped and repetitive use of language or idiosyncratic language
 - d) lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level
- (3) restricted repetitive and stereotyped patterns of behavior, interests and activities, as manifested by at least two of the following:
 - a) encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus
 - b) apparently inflexible adherence to specific, nonfunctional routines or rituals
 - c) stereotyped and repetitive motor mannerisms (example, hand or finger flapping or twisting, or complex whole-body movements)
 - d) persistent preoccupation with parts of objects
- B. Delays or abnormal functioning in at least one of the following areas, with onset prior to age 3 years:
 - (1) social interaction
 - (2) language as used in social communication
 - (3) symbolic or imaginative play
- C. The disturbance is not better accounted for by Rett’s Disorder or Childhood Disintegrative Disorder.”

Approximately, 85% of the individuals who meet the criteria for autism are assessed as having idiopathic autism, according to Belleville, Menard, Mottron & Menard (2006) (Alloway & Gathercole, 2006, p. 213). Idiopathic autism specifically defines autism as being a disorder with “genetic etiology, without additional identifiable neurological or genetic pathologies” (Belleville et al. 2006; as cited by Alloway & Gathercole, 2006, p. 213). Kabot, Masi & Segal (2003) therefore noted that, the most widely accepted etiology for the occurrence of autism is that it is biological. On the other hand, it is imperative to note that although 85% of person’s diagnosed with autism are considered to have idiopathic autism, the remaining 15% who meet the criteria for having autism alternatively illustrate symptoms that are clinically “accompanied by a heterogeneous set of medical, neurological and neurodevelopmental disorders” (Volkmar, Lord, Bailey, Schultz & Klin, 2004; as cited by Alloway & Gathercole, 2006, p. 213). Resulting from autism’s display of varying levels of psychological functioning amongst those diagnosed with the disorder, the psychological disorder was subsequently changed to “autistic spectrum” (Belleville et al., 2006; as cited by Alloway & Gathercole, 2006, p. 213); in order to ensure that it accurately “encompasses the entire range of autistic symptoms” (Belleville et al., 2006; as cited by Alloway & Gathercole, 2006, p. 213). The spectrum thus, incorporates from the very minimal display of symptoms (high-functioning) to the very low functioning child who demonstrates echolalia, low intelligence quotient (IQ) and/or discernible stereotypical behaviours. Echolalia is characterized by a child’s repetition of the exact words that have been said to him/her by someone else, using the same intonation (Carr, 2006, p. 328); similar to that of when a parrot mimics a human.

For therapists, there are three main problem areas of development which children diagnosed with ASD usually demonstrate. These are referred to by professionals as the “triad of impairments” (Whitaker, 2001, p. 5), or the Wing’s triad, named after the researcher Lorna Wing. The triad’s categories consist of: “social interaction and understanding, all aspects of communication – verbal and non-verbal and flexibility of thinking and behavior, including problems with imagination” (Whitaker, 2001, p. 5). However, autism manifests itself in each child through variations in difficulties and levels of functioning. Carr (2006) noted that for children with ASD, social behaviour abnormalities usually manifest themselves

during infancy and include, but are not limited to, the absence of eye-to eye contact, lack of relationship reciprocity, attachment problems (inability to attach to parents) and delayed development of language skills. These difficulties are also especially noticeable with regards to the child's demonstration of awkward control over motor skills. It is for this reason that "each child will have his own profile of skills and abilities" (Whitaker, 2001, p. 5); which is assessed by his or her therapist in accordance with the child's distinctive personality traits. According to Passer et al. (2009), the brain-imaging studies that have been conducted on children diagnosed with autism show that autistic children have on average larger brains, which reflect "abnormal brain growth during the first year of life" (Passer et al. 2009, p. 833). Subsequent studies have also found that (younger) "siblings of autistic children are 200 times more likely to have the disorder than are children in the general population, and concordance is highest in identical twins" (Passer et al. 2009, p. 833). Furthermore, "children with disabilities are more likely to see their parents divorce than are other children, although the increased risk of divorce (3% to 6%)" (Risdal & Singer, 2004; as cited by Brobst, Clopton & Hendrick, 2008, p. 38) is in fact "smaller than many would expect" (Risdal & Singer, 2004; as cited by Brobst, Clopton and Hendrick, 2008, p. 38).

Alternatively for parents, the process of diagnosis can be extremely challenging, since parents are often forced to come to terms with their child's unusual behaviour. Time after time, parents have initially viewed their child's atypical behaviour as being a phase the child will outgrow, so dealing with the truth of their child's diagnosis is usually accompanied by a grieving period. During the grieving period parents are compelled to acknowledge the loss of their 'normal child' and enter into the acceptance stage of coping with a developmentally challenged child (Carr, 2006). Resulting from the long-term health and developmental problems associated with ASD, the period of assessment and clinical diagnosis of the disorder is best analyzed as being a key family transition, accompanied by a lengthy process (Carr, 2006). As compared to raising children without mental and behavioural problems, parents with special needs children experience reoccurring "common themes", according to Barbarin, Hughes & Chesler (1985); Bristol, Gallagher, & Schopler (1988) (Brobst, Clopton & Hendrick, 2008, p. 38). This theme manifests itself through the negative consequences of decreased

father involvement in child care activities and increased family stress levels; within homes that have children diagnosed with ASD. The increased stress levels can be attributed to the fact that “parents of children with special needs may have to offer not only more time, energy, and resources for their child’s well-being but also offer these important qualities for a longer period” (Seltzer, Greenberg, Floyd, Pettee, & Hong, 2001; as cited by Brobst, Clopton & Hendrick, 2008, p. 38). Although every family’s structure is different, parents of children with mental disabilities do similarly experience heightened family stress; however, this stress manifests itself differently for each family unit and is dependent on both “external circumstances and individual family characteristics” (Dunst, Trivette, & Deal, 1988; Park, Turnbull, & Turnbull, 2002; as cited by Brobst, Clopton & Hendrick, 2008, p. 39). The external circumstances usually “include the family’s income level and the extent to which the individuals with disabilities are accepted and welcomed into community activities” (Dunst, Trivette, & Deal, 1988; Park, Turnbull, & Turnbull, 2002; as cited by Brobst, Clopton & Hendrick, 2008, p. 39). From the perspective of the parent, if the process of assessment and diagnosis occur too quickly, the parents may themselves reject this official diagnosis. Consequently, this rejection may spawn unproductive conflicts between the parents and mental health and/or education professionals (Carr, 2006), regarding suggested treatment options the family could adopt to foster their child’s future development.

Additionally, if parents within a home are experiencing relationship problems unrelated to the care of their child, this can cause additional strain on the family unit, especially if one parent has opted to leave the residence permanently. Caregiver burdens now often become the sole responsibility of the parent left within the home and can severely impact the attachment relationship that parent now has with his/her child; thus, upsetting the stable environment the child once had. A stable living environment is an important aspect to maintain because many children with ASD display the inability to transition or cope with changes that occur within their immediate environment. Sometimes if change occurs too rapidly (during or post-introduction) to a behavioural modification program, then techniques learned by the child may become null and void, with possibility of the child even reverting to previous, inappropriate behavioural fixations; which only creates further burdens for the family, siblings and caregivers alike.

Alternatively, Brobst, Clopton & Hendrick (2008) noted that although a large majority of research focuses on the difficulties encountered by parents in raising a child with special needs; in contrast, research has also been conducted which demonstrated more positive outcomes (Barbarin et al. 1985; as cited by Brobst, Clopton & Hendrick, 2008, p. 39). A prime example of this research is summarized in the data collected by Taanila, Kokkonen, and Jarvelin (1996), which “found that 70% of parents reported that a child’s illness or the birth of a child with a disability had not changed their relationship at all” (Brobst, Clopton & Hendrick, 2008, p. 39). Brobst, Clopton & Hendrick (2008) outlined that the occurrence of decreased satisfaction only visibly arose in homes where the couple’s relationship already had serious problems. They added that at that point the pressure caused by their child’s disability then further contributed to the couples’ “decreased marital satisfaction and possible divorce” (Brobst, Clopton & Hendrick, 2008, p. 39). In contrast, Havens’ (2005) research discerned that having a child with disabilities can for couples with satisfying relationships, even prove to “strengthen and enrich their relationships” (Brobst, Clopton & Hendrick, 2008, p. 39). Although, such couples do stand the risk of neglecting “their marriage when they have a child with a disability; parents are often aware of this challenge and are determined to keep their marriages strong” (Pelchat, Lefebvre, & Perreault, 2003, as cited by Brobst, Clopton & Hendrick, 2008, p. 39).

The following chapter will serve to discuss familial construction and the importance it holds in shaping western societies and its populace. Chapter 4.0 will also serve to address the evolution of this social institution (the family), in an attempt to further comprehend the shifts that have occurred in gender and power relation dynamics; and the influence those dynamics have had on the assignment of responsibilities surrounding care-work, between men and women.

4.0 The Family and Gender Relations

4.01 Familial Construction

Connell (2002) addressed the axiom held by the construction of a family, utilizing a premise outlined by Sigmund Freud (1900), which focused on the juxtaposition of humans to form emotional attachments. According to Connell (2002) Freud’s outlook advocated that when contemplating the human mind, it

should not be done solely from the examination of the individual psyche, but rather it should be analyzed based on the pattern of relationships formed inside the social institution of the bourgeois (middle class) family. Connell (2002) therefore suggested that the emotional relations brought about from the interaction of the family unit, is one of the preeminent entities that should be examined when trying to understand the dimensions of gender. The dimensions of gender are subsequently described by Connell as being directly affected by the family, given that the configuration of the family is customarily accompanied by the interweaving of power and the subsequent division of labour, which regularly occur between the father and mother figures within a household. Essentially, gender is used as the socially constructed institution through which we humans maintain order in our lives; based on divisions created between the sexes. The gender dynamics which exist within the sphere of the family are therefore also often discussed in association with male or female 'sex' roles and the respective power norms that have been socially assigned to either the male or female based on biology (Connell, 2005). It is for this specific reason that theorists such as Connell (2005) discussed concerns surrounding the formation of masculinity and femininity, from the standpoint that these terms are representations of internalized sex roles, generated as by-products of social learning or 'socialization'.

However, the transforms that have occurred within family formations over the last decade have markedly challenged the previously established norms, directed towards specific 'sex roles' assigned to men (breadwinner) and women (caregiver/nurturer). Connell (2005) noted that 'sex roles' are not finite and can be altered through changes in expectations, by means of education and the introduction of role models who perpetuate gender equality practices. These 'sex role' transformations are presently being demonstrated through the move being made by European and North American people to establish more modern family types; and as such have inadvertently reshaped the concept of parental contribution and the roles adopted by fathers and mothers, concerning undertaking of childcare duties. The apparent rise in single parent and same-sex parent families are just a few examples of how western societies have markedly challenged the previously instituted sex roles. Moreover, these newfangled family approaches have socially demonstrated the

ability by parents to smoothly incorporate androgynous parenting styles within their households; which was an almost non-existent concept less than a century ago.

Initially the term 'family' was derived from the concept of the family as being "nuclear, patriarchal and hierarchical, and members of the family were defined by their primary relationship to the conjugal couple" (Silva & Smart, 1999, p. 129). This definition of family meant that within a household, the family comprised of a male: the father and primary breadwinner, the mother: housewife and child caregiver, and the siblings: male or female children. Crompton (2006) argued that changes in approaches to practicing 'traditional' family were propelled through the intensification of industrialism in the late eighteenth century. Industrialization, through advancement in technical innovations contributed to the opening out of wage labour markets; thus, giving rise to significant changes in the structuring of modern families. The age of industrialization contributed not only to the institutionalization of social class, but also to the gendering of the labour market; which consequently, further augmented the gender hierarchy established during that time. The changes that arose allowed for the reduction in family members to that of conjugal units comprising of parents and children. Crompton (2006) noted that "production for use within the household became less important as families were transformed into units of consumption rather than production" (p. 2). Crompton (2006) additionally underlined that changes in family size and composition that arose during the 20th century were due to technological advances such as efficient contraception; in addition to, the shift in attitude towards gender roles and gender relations which accompanied the second wave of feminism. An increasing number of women were inspired to become members of the labour force, creating a transformation in "family formation and behaviour" (Crompton, 2006, p. 6). In England and Wales for example these changes are evident in the decline in fertility rates; "the Total Fertility Rate (TFR) has fallen from 2.9 in 1964 to 1.7 in 2000" (Crompton, 2006 p. 6).

Moreover, the traditional nuclear household has swiftly become a remnant of ancient times. As highlighted by Friedan, 1985, "fewer than 10% of families fit into traditional ideal of working father, stay at home mother, and children" (Carter & McGoldrick, 1989, p. 37). Many families today cannot afford to support children unless both parties are employed. Hewlett (1985) established that "29% of

households consist of couples with children under 18, compared with 44% in 1960” (Carter & McGoldrick, 1989, p. 37). In addition, “the number of married-couple and couple-with-children households has decreased steadily since 1970, and the number of single-parent households (mostly headed by women) has more than doubled” (Rawlings, 1983; as cited by Carter & McGoldrick, 1989, p. 37). It must also be noted that within the Western world (post 1980) the structure of the family notably shifted its structure from that of a solely heterosexual, nuclear family to incorporate into its structure same sex-headed (alternative) families, single parent families and divorced or separated family units.

In my estimation, change is an unavoidable trend within any society, it must be noted that not all of the changes occurring presently in the modern world should be deemed as negative factors which directly caused the ‘collapse’ of the traditional nuclear family make-up. Rather, such developments should be analyzed from the standpoint that although life has become faster paced, these changes have given rise to many complementary positive attributes, such as, greater gender equality amongst the sexes. Such changes have allowed individuals to now make conscientious choices with regards to the type of family unit they would like to belong to or who they even consider to be a family member; which was not a practice during olden times. The choice that is specifically being referred to in this instance is that of group of people who consider themselves family; but who are not biologically tied to each other. Thus, one can surmise that the circumstances of the present day world have indirectly constructed reasons for individuals to question the path we as a people should adopt in order to fulfill a true work-life balance within our daily lives. If both parents opt to work full time (as most often do in today’s world) then what time is left available for raising children and even maintaining healthy friendships and marriages? On the other hand, the shift from the former patriarchal, male breadwinner style of family unit with a stay at home mother, to the more modern styles of families arising today (divorced parents, single parents, same-sex parents, as so on) may also be deemed by some as a bi-product of rising accessibility to external care/domestic labour, ever increasing divorce rates, the expansion of education and career opportunities for women and longer and even more demanding work hours required by western employers (especially in North America).

Although sustaining a steady income has become an essential tool which parents utilize to ensure the wellbeing of their children; paid labour often becomes not only an additional life stressor, but can significantly reduce the amount of time that is left available for the care of children and other domestic work (house-keeping). One of the most regular activities that accompany parents engaging in longer work time outside the home is that of the burden of care being bundled onto the other spouse/parent who does not engage in the same lengthy amount of paid labour. Previous social norms publicized that care giving tasks were more often the responsibility allocated to the mother figure within the home. As parents, it is therefore necessary to establish a means of dividing the aspect of care work equally amongst each other; in order to, stave off undesirable marital and emotional stress, which can often become confounded when a family has a child born with a mental disorder such as autism.

4.02 Assignment of Care-work

Research conducted in the field of primatology by Smuts (1987); Smuts & Gubernick (1992); Whitten (1987) discovered that “even among non-human primates males and females have the same potential for nurturing.” (Silverstein, 1996, p. 17) Silverstein noted that for male baboons, gorillas and chimpanzees the extent to which they provided active care for their infants was dependent on variables such as temperament, ecology and demographics. She additionally hypothesized that observed differences in male and female parenting was more the outcome of conceptualized cultural edifices, rather than biological necessities; a supposition that is also capable of being transferred to the practices of human males and females. Silverstein (1996) affirmed that parenting research conducted by Lamb (1987) (utilizing western cultures) discovered that neither mothers nor fathers are inherent caretakers; rather both groups acquire their parental skills through “on the job” (Silverstein, 1996, p. 18) training. However, what resultantly happens is that mothers sooner or later spend a larger amount of time with their infants, which facilitates them with a greater sensitivity towards the needs of their child, versus that of fathers. Silverstein, additionally, highlighted that fathers seemingly become less competent than their wives, due to the lack of direct interaction they have with their

child; hence, creating the appearance that fathers' are less capable of care-work than mothers.

Daly & Rake (2003) characterized care-work as work conducted "with reference to the activities and relations involved in caring for the ill, the elderly and the dependent young" (Clark, 2009, p.6). This form of unpaid labour has for many decades been regarded as non-work since it does not incur monetary payment for tasks conducted; and, as such has been an area that has been and continues to be significantly taken for granted, within many western societies. One can therefore hypothesize that the reluctance by men to engage in a larger percentage of domestic and care work could be because of the perception made within societies that this form of work is not complemented by monetary rewards; which is a custom that has been privileged to men for many centuries. Although, care work remains significantly unseen since the majority of it is conducted behind closed doors, attention must be drawn to the fact that such care tasks do considerably assist in maintaining and strengthening kin and communities ties (Gerstel & Gallagher, 2001). As such, care-work requires more positive consideration, especially in homes where parents engage in more extensive child care responsibilities, commonly required of parents who have children with developmental problems. Responsible and loving fathers according to Silverstein (1996) are expected to enhance a child's development while neglectful or abusive fathers are likely to inhibit developmental outcomes. Therefore, the significance of "fathers should not be dismissed as peripheral to family life" (Silverstein, 1996, p. 12); and alternative methods should be socially implored to return and cultivate active paternal involvement within homes.

Silverstein (1996) advocated that when issues of balancing care roles crop up, one of the major impediments affecting equality of women (within the public sphere) is the failure of men to assume equal responsibility in the private world of the family. Douthitt, 1989; Googins, 1993; Hochschild, 1989; Juster & Staffer, 1985 argued that although perceptions regarding families are evolving into new models of role-sharing couples, empirical research however, proposes that wives are still responsible for two-thirds of housework, or between 13 and 17 hours more (per week) of child care and housework duties than their husbands (Silverstein, 1996). Empirical data surrounding women's roles have moreover, provided supporting

evidence signifying that feminine gender norms socialize woman to perform the double role of provider and nurturer within western homes (Silverstein, 1996). The idea of women automatically engaging in dual provider roles however is not always a task that is easily implemented in the real world; especially when the occupation a woman works in does not make allowances for flexible work schedules. Therefore, in order to fulfill this dual role, a woman may opt to relieve part of said burden by acquiring additional child care services, that is, a nanny or housekeeper to ensure those tasks are accomplished. If women are opting to relieve the burdens of housework by purchasing labour from the public sphere, then raises the concern of the outcomes that would be derived if care work is conducted solely by an individual outside of the family. Should parents then adopt alternative means of facilitating childcare even if in the face of risking alienation from their children? How then does this re-assignment of care duties impact a child's diagnosed with ASD; especially when parental input has become an integral part of many therapy regimens.

Theorist Talcott Parsons believed that the division of labour which was present within families between mothers (stay-at-home) and fathers (breadwinner) during the 1950's indeed served a specific role. This was resultant from the fact that during that time period such divisions acted as a stabilizing force within the family unit; which in due course was disseminated into the wider society (Jackson & Scott, 2002). However, it is apparent in present times that although the family unit does still contribute to the stable foundation of many western societies, the emphasis on specifically splitting paid labour (fatherly duties) and unpaid labour (motherly domestic/care duties) does not currently prove to be applicable to date. This is because parents are now required to both participate in the workforce due to increased financial burdens; and the more frequently occurring imposition of care duties to be supplemented through sources outside of the household; that is, private nanny/day care services or after school programs.

Furthermore, when comparing the ratio of women to men providing unpaid care, "women are twice as likely as men to be involved in providing both child care (31 per cent compared with 15 per cent) and care for ill or elderly adults (8 per cent as against 4 per cent)" (Daly & Rake, 2003, p.55). Folbre & Nelson, 2003 also noted that the practice of care-work has proven to be a beneficial resource to

Western societies such as the US; “between 40 and 60 percent of the total value of all US output is from nonmarket (unpaid) work” (Acker 2005, p.60). Moen (1989) furthermore highlighted that when comparing working men and women, working class mothers have a higher susceptibility to psychological distress; regardless of their engagement in paid employment or not; versus that of their male counterparts. In parallel to Moen’s assertion, Tangri and Jenkins (1986) furthermore expressed that a supportive father or boyfriend figure helps to promote a women’s sense of positive feeling concerning her decision to sustain a non-traditional career. This in turn acts as one of the single most important factors in averting stress for a working mother (Hoffman, 1989; as cited by Silverstein, 1996, p. 11). Silva and Smart (1999) additionally drew attention to presumptions made by other theorists and noted that with regards to housework the participation of men in domestic work has indeed risen as result of women opting to do less domestic work. However, this change has not occurred solely out of the personal choices of men, but rather through “a process of negotiation over a long period of time” (Silva and Smart, 1999, p. 51).

Active engagement by fathers in care-work is furthermore subject to the economic situation of the family itself. These economic influences can be further fragmented into two opposing categories: dual-earner and single-earner family types. As compared to single-earner households, in dual-earner families, mothers essentially adopt two major roles within the family unit: 1. monetary provider and 2. household/child care provider. This duality inevitably imposes on the mother a sense of “maternal role overload” (Crouter, Perry-Jenkins, Huston & McHale, 1987, p. 431). For dual-earner families it is therefore important for fathers make a greater effort to actively participate in family work, inclusive of child care, as it provides “an important social support for mothers” (Zur-Szpiro & Longfellow, 1982, as cited by Crouter et al, 1987, p. 431). On the other hand, studies have also shown that in single-earner families “the more a father works, the less involved he is with his child (McHale & Huston, 1984; Pleck, 1981; Robinson, 1977; Walker & Woods, 1976, as cited by Crouter et al, 1987, p. 432). Thorough assessment of the authority which both economic conditions pose towards men becoming “involved in the care of their children” (Crouter et al, 1987, p. 431) is a subject area that requires auxiliary in depth focus. This is because subsequent findings have demonstrated that fathers to

in fact “exert important influences on the social and cognitive functioning of their children (Parke, 1981; Radin & Russell, 1983, as cited by Crouter et al., 1987, 431).

Popular perceptions surrounding paternal input propose that sufficient father input is derived from their provision of financial maintenance to the family, and that the provision of financial support serves as adequate compensation for indirect interaction in child care duties. Nevertheless, one must not denigrate or dismiss the important outcomes that can arise for the family if a father does engage in tangible paternal contribution to child care. Lamb (1987) illustrated the significance paternal input can yield through one study conducted on pre-school youngsters. The study established that the children whose fathers’ were responsible for 40 – 45% of child-care responsibilities demonstrated higher cognitive competence and higher empathy towards their peers (Silverstein, 1996). Furthermore, a review of five studies performed to test the outcome of increased father involvement in the lives of their children, found that for these fathers the increased involvement provided them with corresponding increased self-confidence towards their personal parenting skills, increased satisfaction with their fathering role and increased overall paternal self-esteem (Silverstein, 1996). These results are especially important to note, since children with ASD require more effort on the part of their parents to help them acquire and maintain certain social behaviours and norms; and, since the research stated above outlines the importance of paternal input in the overall functioning of their children, it is therefore imperative to promote and maintain father participation in the treatment process and in care duties, within both the public and private spheres of family life.

The subsequent chapter will furthermore concentrate on the effects that gendered socialization practices have had on individual adaptation of ‘male’ and ‘female’ roles; and will additionally analyze how this type of social gendering constructs the adaptation of mothering and fathering techniques, by westerners.

5.0 Gendered Socialization: Adaptation of Male and/or Female Roles

Gender in uncomplicated terms can be described as a social product created by humans, and is reliant on people constantly “doing gender” (West & Zimmerman, 1987, p. 126). West & Zimmerman, delineated that the act of doing gender is in essence a complex combination of socially guided perceptual, interactional and

micropolitical actions that perpetuate specific expressions of masculinity and femininity (Jackson & Scott, 2002). Judith Butler (2004) addressed the perpetuation of femininity from the standpoint that femininity is fragile in construction; to the extent that it is necessary for women to constantly assume and reproduce femininity (Malacrida, 2009). Butler (2004) postulated that women employ this continuous duplication of femininity as *performative* acts, in order to strengthen the principles of femininity within the larger culture; and also to instill “women with a sense of themselves as ‘naturally’ gendered subjects” (Malacrida, 2009, p.102). Gender therefore should be gauged through the interaction of social factors as propagated within a larger social context. For many the act of engaging in gender has become a routine so embedded into the fabric of our societies, that it only becomes noticeable when “gender signs and signals are missing or ambiguous” (Lorber, 1994; as cited by Disch, 2009, p. 113); ergo, we cannot blatantly assess whether a person is male or female based on their mannerisms, clothing or even speech. Only then, when we cannot overtly identify typically male or female traits, that we consciously acknowledge ‘doing gender’ or recognize that we are enacting masculine or feminine traits.

Research carried out by Gerstel & Gallagher (2001) added support to West & Zimmerman’s gender arguments by recapitulating that issues surrounding personality differences assumed by girls and boys, may too be the end result of early, internalized socialization, fostered by the customs characterized by a respective society. The various early socialization techniques that have contributed to the differences in the societal roles adopted by men and women throughout western societies have been continuously debated by theorists such as Nancy Chodorow (1978) & Carol Gilligan (1982). Both Chodorow and Gilligan have argued that “early experiences, connection and nurturance characterize women's relationships, while separation and even distance characterize men's” (Gerstel & Gallagher, 2001, p. 198). This shared sentiment can be interpreted as a causal reason behind men and women differing in their ability to provide care for family members, especially children with special needs and the elderly. Chodorow (1978) & Gilligan (1982) advocated that women are taught socialization skills from an early age which instils specific emotions and tendencies towards feeling “responsible for nurturing and as they grow older assume their identity by providing care” (Gerstel & Gallagher,

2001, p. 198). In contrast, both theorists argued that as compared to women, “men learn to separate themselves and assume their identity through competition and detachment” (Gerstel & Gallagher, 2001, p. 198).

Looking through the lenses of early socialization of both boys and girls in relation to gendering, Philip Slater proposed that early socialization or preference of personality traits furthermore reinforced within children, stemmed from the relationship (positive) they developed with the person who was physically present in their lives. Slater noted that in cases where possibilities for personal identification were not available, the child would then engage in positional identification, subject to the perceived role or situation of another (Chodorow, 1999). A girl, Chodorow (1999) ascribed, derives her womanly nature from her mother, because of the bond developed between the two during the early stage of the child’s development. Alternatively, for boys they often have to develop their masculine gender identification and roles in the absence of a continual, personal relationship with their father; and the ever present trend today of the complete absence of an available male role model within the home. Therefore, for boys who are raised in father-absent homes their sense of what it is to be masculine is often attained from the cultural representation of masculinity and/or even the image portrayed by male role models within their society (Chodorow, 1999). The difference which therefore occurs in the interpretation and adaption of gendered roles amongst male and female children, is that for girls their identities are often embedded in the ongoing relationships they share with their mothers; which promotes the reproduction of care related work. While for boys, the development of a male identity is not as highly mediated by their relationship with their fathers but rather, is influenced by the culturally promoted ideology regarding masculinity; which decreases involvement in care work based on cultural norms (Chodorow, 1999).

The 2001, study conducted by Gerstel & Gallagher demonstrated the extent to which early gendered socialization skills are transferred from childhood into husband and wife relations with regard to care giving practices within the home. The results yielded from the random sample of 188 married respondents (86 percent Euro-American and 14 percent African American) found that 45 percent of the husbands in the study were less likely to provide assistance to their wives if they considered the household duties to be overtly feminine, such as preparing meals;

while 37 percent of the male participants were less likely to provide care for their children, versus 54 percent of their wives. These findings demonstrated the extent to which socially constructed norms associated with ‘male’ tasks versus that of ‘female’ tasks, even in present day societies still impact spousal participation, especially in the role of care giving. In contrast, the study also found that there were no significant differences displayed between wives and their husbands with reference to performing typically masculine tasks such as repairs or providing financial support. That is, masculine deemed tasks invoked more equal participation by both husbands and wives; whereas, more feminine tasks yielded lower participation from husbands. These findings further highlighted the noteworthy impact which socially constructed gender roles continue to play in fostering disparities amongst husbands and wives concerning the distribution of care giving, even in societies with a more prominent awareness of gender equality.

In contrast, theorists such as Barrie Thorne (1993) contended that through simple observation of children within a school setting, one can see how gendered differences can become purely situational. Such situational gender classifications are illustrated, for example, in simple “girls-chase-the-boys’ or ‘boys-chase-the-girls’” (Connell, 2002, p. 14) games, often enacted on the playing field. However, when those same boys and girls are placed within a classroom setting, such roles are removed, converting both groups into pupils on an equal learning plane; thus, eliminating the previously displayed gender divisions. It is for those reasons that Thorne (1993) deemed gender differences to be not just “something that simply exists” (Connell, 2002, p. 14) but “something that happens” (Connell, 2002, p. 14), and also something “that can be unmade, altered, made less important” (Connell, 2002, p. 14). One can therefore deduce that such reasoning could also be transferred to the “parallel processes” (Connell, 2002, p. 14) experienced by adults; although, it is a more common practice within western societies to markedly distinguish between gender boundaries.

Although gendered socialization appears to be one of the more notable contributors towards inequalities displayed by male and female parents; it should be outlined that it has not been conclusively found to be the sole cause for those male and female parenting differences. Alternate explanations for such disparities can also be attributed to male and female behaviours at adulthood. Some theorists dispute that

functions women and men attain within “different institutional positions, especially in jobs,” (Gerstel & Gallagher, 2001, p. 198) impact their ability to actively engage in parental duties. Campbell (1988); Gerson (1993); Hochschild (1997); Kanter (1977), argued that employment establishes and reinforces gendered expectations about which family member should give care; and additionally, “entail structures that allow workers the time, energy, and flexibility to actually give care” (Gerstel & Gallagher, 2001, p. 198); while providing “the income that family members may exchange with one another for giving such care” (Gerstel & Gallagher, 2001, p. 198). Therefore, in households where the father figure represents the breadwinner, the type of involvement he holds in the workforce can act as an agent in removing or diminishing his ability to engage in both the amplified care giving and therapeutic practices necessary when providing for a child diagnosed with ASD. This then further adds to the input and responsibility required of the mother who in modern, western societies is still vastly regarded as the family member responsible for childcare. In contrast however, theorists such as Scharz (1994) and Warner (1991) expressed the view that men whose wives are employed or who have female children, exert a greater level of sensitivity towards issues of gender equality and are even “more supportive of egalitarian feminist ideals” (Gerstel & Gallagher, 2001, p. 202), as compared to their unmarried or non-parent, male counterparts.

Issues regarding male input in the family and care giving can also be addressed from standpoints other than that of the perspective of gendered socialization. Gerstel & Gallagher (2001) noted that research conducted on housework and parenting suggested that men’s participation in unpaid family labour is subject to the actual structure of the particular family, and the external demands already imposed on the man. Milgram & Atzil (1988) provided support for this conjecture through their research findings regarding burdens and fairness experienced by parents of ASD children. From their standpoint, fathers’ deem it “entirely proper that they assume a smaller proportion of the overall parenting burden than mothers because of their occupational and financial responsibilities” (Milgram & Atzil, 1988, p. 416). The actual extent to which fathers assume duties is therefore dependent on “how they feel about their share is a function of conflicting pressures” (Milgram & Atzil, 1988, p. 416). Additionally, in “particular, existing literature suggests that wives, siblings, and minor children” (Gerstel & Gallagher, 2001, p. 200), also abet in determining

“men's domestic work” (Gerstel & Gallagher, 2001, p. 200); and the overall contribution towards the care of children, especially in families with a special needs child.

Research conducted by Crouter et al., (1987) also showed that the man's attitude towards parenting was moreover significantly manipulated, based on the actual structure of the family unit; that is, more non-traditional families, facilitated greater involvement by father's in the child care process. Furthermore, “a husband's love for his wife might make him want to help her with child rearing” (Huston & Ashmore, in press; as cited by Crouter et al. 1987, p. 432). In contrast, reviews conducted by Russell & Radin (1983) & Hoffman (1983), however, suggested that conflict within the marriage was also “associated with husbands' increased involvement in family work” (Crouter et al. 1987, p. 432). Similarly, Crouter et al. (1987) surmised that a number of fathers may even become more involved with their children's upbringing resulting from a continuous coercive exchange of negative marital interactions.

Although, care roles within most western societies denote the mother as the primary caregiver, households within which parental conflict is a reoccurring issue or the household contains the presence of an absentee mother, studies have shown that the father can in fact adopt a more significant role as the primary caregiver. However, McHale & Huston (1984) research illustrated that for the father to adopt a larger burden of care in the absence of a mother or female figure within the household is fairly dependent on the father's perception of his skills with regards to childcare. McHale & Huston (1984) study utilized a subsample of subjects in which the participants were all married with pregnant wives. The results yielded that if the father felt that he was more skilled in the area of care work, the more he engaged in activities regarding child care and leisure. Additionally, McHale & Huston (1984) highlighted that in projects which promoted parental education (specifically directed at fathers) resulted in greater paternal participation in childcare (Kotelchuck, 1976; Parke, Hymel, Power, & Tinsley, 1980; as cited by McHale & Huston, 1984). Such findings therefore can be directly linked to paternal involvement in daily therapeutic care for children with ASD. If fathers are given access to more in depth education regarding ASD and are taught skills to cope with the specific needs of their child, could in turn foster greater paternal input in the therapeutic process; alleviating

maternal burdens while encouraging fathers to remain active, constant factors in their child's life. Paternal (clinical) understanding therefore becomes converted into fundamental factor towards promoting more harmonious marital accord.

This chapter served to evaluate the manner through which gendered socialization techniques instilled from childhood influenced male and female adaptation of gender roles. In progression, it therefore becomes necessary to examine how these early socialization skills are further developed and transferred into adult expectations of what is meant to be a mother or a father; especially in the face of changing parenting practices.

6.0 Maternal versus Paternal Expectations

When examining the changes that have occurred within the 'family' and the effects this shift has had on modern families, a significant ongoing debate arose as to the influence parenting styles have on a child's social development. Lamb (1999) suggested that considerable speculation has been directed towards parenting styles as it correlates to child rearing; and highlighted that there still exists a "preoccupation with the superiority of "traditional" family styles and "traditional" parental roles." (Lamb, 1999, p. 1) Although there has been minute substantiation to conclude that "traditional families represent a pattern of family life that has been normative historically or cross-culturally" (Lamb, 1999, p. 1), there has been concern that this shift to non-traditional families could adversely affect a child's upbringing. However, this concern has not proved to be a deterrent towards the formation of non-traditional family structures, within western countries; and their apparent contribution and effect on rearing autistic children. Silverstein (1996) highlighted that contrary to cultural beliefs; research findings have not produced documented evidence of gender differences in competent parenting practices. However, Nichols (2009) noted that conflicts do still exist regarding these gender expectations. Whether these expectations are overtly or covertly expressed amongst parents, they are still particularly widespread; even when considering the present transitions that are transpiring regarding the culturally expected practices of parents.

Malacrida (2009) puts forward the argument that in spite of the normative belief that motherhood is a natural practice universal to all women, motherliness, much like other aspects of femininity, is rather a grouping of actions, behaviours and

actions that is learned and reproduced by social actors. Moreover, it can be argued that the philosophy of idyllic motherhood is preserved largely because of the practice of countless women who endeavor to achieve these goals. Additionally one belief that prevails proposes that when women as mothers manage to accomplish the enactment of idyllic mothering, then they experience an accompanying sense of success as women (Malacrida, 2009). However, it is significant to highlight that for some women realization of this goal can become a challenging feat to achieve, based on her particular family circumstance – for example: mothering a developmentally challenged child; and moreover, should not be interpreted as a failure on her part to be “an ideal, ever-available, selfless mother” (Malacrida, 2009, 103).

Accordingly, when analyzing a household comprised of both father, mother and child(ren) with ASD, it is particularly important to address the issue of whether gender differences that may exist in an unresolved manner, such as marital conflict, disagreements in parenting styles and/or participation in child care, in essence become amplified stressors; due to the greater, long term effort which is required for care of a special needs child. According to Chodorow (1999) for a mother the roles demanded of her can often be contradictory – for instance, within her marriage she may be expected to be passive and dependent in relation to her husband; while as a mother she may be required to be independent and energetic in relation to her children. Although women today are more financially independent and often invest more of their lives to the labour force as compared to their mothers (Chodorow, 1999), they nonetheless still contend with amalgamating conflicting dichotomies such as cross-gender (masculine) and same-gender (feminine) identities, into their daily lives. Such dichotomies are even on occasion expectations imbedded into the fabric of a society which perpetuate conflicting identity traits for mothers, and women alike. These conflicting dichotomies often become apparent when mothers attempt to portray a correct balance between feminine qualities (passive, emotional, caring) and masculine qualities (independent, dominant, unemotional) to their children. Women therefore often contend with greater emotional demands and the conflicting identity expectations of being a mother and a wife as compared to their male counterparts; whose physical or financial presence in the home is more customarily accepted as being a sufficient paternal role played within the family. Silverstein (1996) supported this contention and stated that women are often

socialized to contend with demanding dual roles, stemming from late 20th century fatherhood ideology. This ideology is reflected in the belief that active participation by mothers in daily child care is obligatory; whereas, nurturing and caretaking practices by fathers are discretionary.

Off-shooting from the notion of the father's role as a discretionary one, research findings put forward that the gender of a child acts as an additional determining factor influencing the level of input parents employ towards parenting. Katzev, Warner & Acock (1994) noted that "fathers with sons spend more time doing child care and participating in family outings than do fathers with daughters" (Gerstel & Gallagher, 2001, p. 200). Research findings such as these, according to Maccoby (1998) put forward that because of a father's desire to "toughen up" (Gerstel & Gallagher, 2001, p. 200) his male child, he is more likely to engage in bonding activities such as going on sporting outings and interaction through rough play with his son as opposed to his daughter. Although the father-son bonding has to a large extent proven to be beneficial to a male child, some theorists' dispute that such preferential treatment, particularly in two parent families, can disseminate opposing parental techniques, dividing the nature of care meted out to a male child versus that of a female child.

Disparity between parents regarding child rearing/bonding methods is another imperative aspect to evaluate, particularly in cases where the family has an autistic child. This is because a father of an autistic son may chose to relate to his son utilizing the same father-son bonding techniques he learned as a child from interaction with his father; but as a result of his son's mental disability may be unable to replicate that bond. This rejection may leave the father with a sense of defeat or frustration, and could in due course lead to the father retreating in entirety from parenting duties or displaying reluctance to interact directly with his child. The aforementioned retreat by the father figure can presumably create not only a rift between mother and father, because the mother is now charged with the task of assuming both androgynous parenting duties, while possibly trying to intermittently coax her partner into re-establishing his relationship with his child. Notation must be made that this coaxing by the mother is not always specific to a lack of paternal interaction with a male child, but encompasses also the type of relationship he may have with his female child. Such interruptions are often caused by the father's

inability to get the desired response he wishes from his autistic child, who unintentionally demonstrates attachment issues. As such, explorations into making the father a more active participant in ASD intervention programs, is necessary in order to counteract the frequency rate of father withdrawal from parenting practices and the subsequent positioning of the father as a spectator rather than a valuable player in his child's special care.

As previously mentioned, based on familial structure and demands surrounding maternal and paternal expectations, maternal and paternal contributions may differ significantly. However, it is important as parents to recognize the existence of these differences; in an attempt to attain a more equally beneficial balance between married life and parental obligations. The upcoming chapter will further address the issues associated with maintaining a balance between husband-wife and father-mother relations, and the implications these have on raising a child with ASD.

6.01 Balancing Marriage, Parenting and ASD

For many couples maintaining the correct balance between being a parent and being a partner can on occasion be a challenging feat to achieve. Harvey J. Locke found that amongst married couples, fewer wives than husbands reported concordance on family related problems such as, "finances, recreation, religion, affection, friends, sex, in-laws, time together, and life aims and goals" (Jackson & Scott, 2002, p. 209); in addition to reporting more serious marital difficulties. Jackson & Scott (2002) signified that the dissatisfaction in those areas experienced by wives as compared to husbands was not the major indicator of how unhappy the wife's concept of marriage was; but, was more accurately illustrated by the poor mental and emotional health experienced by married women as compared to their spouses and to that experienced by single women. Married women, Gurin, Veroff & Feld (1960), emphasized were found to experience a greater susceptibility to nervous breakdowns and psychological and physical anxiety, as compared to their spouses (Jackson & Scott, 2002). These were as a result of the impending inadequacies they felt within the confines of their marriage and the self blame they practiced towards their lack of overall adjustment (Jackson & Scott, 2002). Findings such as those expressed the degree to which married women in general experience mental and physical difficulties within their married life under normal circumstances. As such,

one can only fathom the heightened psychological distress that is possibly experienced by wives who have children with mental disabilities, such as ASD. This can subsequently become an exacerbated burden for a wife, since she now has to try and find an amicable balance between caring for her child and maintaining a healthy relationship between herself and her spouse; especially when trying to fulfill both personal and societal expectations.

According to Brobst, Clopton & Hendrick (2009) this balance becomes excessively demanding when additional time and personal effort is required from the parenting aspect, specifically when a family cares for a child or children diagnosed with ASD. Lieberman (1982) moreover noted that “mothers are at higher risk for breakdown and parenting burnout than fathers because of their heavier burden in parenting the handicapped child” (Milgram & Atzil, 1988, p. 416). In due course such burdens often transformed into diminished marital/relationship satisfaction within such homes. A study was conducted by Brobst et al. (2009) to assess just such a theory. Brobst et al. (2009) study compared 25 couples whose children had ASD with 20 couples whose children did not have developmental disorders. This research project structured its design to include comparisons for both stressor (child behavioural problems) and relational (relationship satisfaction) variables (Brobst et al. 2009). The results of the research indicated that “parents of children with ASD experienced more intense child behavior problems, greater parenting stress, and lower relationship satisfaction” (Brobst et al. 2009, p. 38). Additionally, the two groups observed in the study however did not differ in their ideas towards “perceived spousal support, respect for their partners, and commitment” (Brobst et al. 2009, p. 38).

A similar study was conducted earlier in 1988, by Milgram and Atzil also designed to assess the relationship difficulties parents incurred while trying to raise an autistic child. Milgram and Atzil’s study yielded supporting evidence and illustrated that parents who care for an autistic child not only face greater relationship burdens as compared to families without an autistic child; but also encounter a gendered inequality in the fairness of the division of care work within the home, as compared to other ‘normal’ families. The research conducted in this experiment utilized “46 parents of 23 autistic children (ages 7-14)” (Milgram & Atzil, 1988, p. 415). The parents were administered a sequence of self-report

measures in which they were required to assess the “overall parenting difficulty associated with raising their autistic child, number of parenting tasks performed primarily by each parent, division of overall parenting burden between father and mother, fairness of and satisfaction with this division, and personal life satisfaction” (Milgram & Atzil, 1988, p. 415). The results from this experiment “were consistent with a cognitive appraisal orientation to the stressor-stress reaction relationship” (Milgram & Atzil, 1988, p. 415). For the father figures the preeminent indicator for life satisfaction “was the absolute parenting burden they were assuming, and for mothers it was the relative burden” (Milgram & Atzil, 1988, p. 415). It must be highlighted that the latter set of findings were ascribed to the dissimilar roles adopted by men and women in the society, with regards to parenting. The conclusions derived from the research conducted by Milgram & Atzil (1988) further elevated the fact that even couples who generally ‘share’ parental duties, are still significantly affected by socially gendered care norms that not only impact their marital relations; but, become exacerbated when those parents are faced with caring for a child with autism. This increased relationship stressor was highly attributed to decreased participation by the father figure with regard to parent-child care and inclusion in intervention therapy methods.

Although, the above research demonstrated that emotional stress associated with raising a child with ASD appears to affect a mother more readily than a father, the research conducted did not specifically focus on psychological stress manifesting itself in fathers through alternate means. A father’s failure to understand why his autistic child displays such abnormal characteristics and his inability to have his child relate to him can also negatively affect a father, but the extent to which he experiences this anxiety could be rationalized as being somewhat dependent on the input of the mother. For fathers however, the manifestation of psychological stress can and sometimes does display itself in the form of the father engaging in alcohol abuse or developing other health problems such as high blood pressure, or even having a cardiac arrest; as opposed to depression which is more readily experienced by mothers of children with ASD.

When assessing the family construction from the perspective of coupled parents (mother and father) one of the most prevailing factors (as mentioned earlier), that occur within families with ASD diagnosed children is that of a decrease in

fathers' involvement in child care and greater stress in the family environment (Barbarin, Hughes, & Chesler, 1985; Bristol, Gallagher, & Schopler, 1988; as cited by Brobst et al. 2009, p. 38). Silva & Smart (1999) concentrated on the decrease in father participation from two angles: 1. Parent-parent relations and 2. Parent-child relations. From the perspective of the parents, their attitude towards family life is not only conducted through the relationship they have with their children but also the fact that "they relate to one another *as parents*, not simply as spouses (or partners)" (Silva & Smart, 1999, p. 102). Silva & Smart (1999), therefore described the relationship a mother has to a father, as differing from the relationship a wife has to her husband. More significantly, is the father's view on family life, as his relationship to his children, may exist solely as a result of the mothering skills provided by his wife. Work conducted by Kathryn Backett (1987) clarified statements made by Silva & Smart (1999) through her suggestions that the notion of fatherhood should not be regarded as being an autonomous relationship with the children but, as being a relationship "mediated through the behaviour of the mother" (Silva & Smart, 1999, p. 102).

According to Silva & Smart (1999), Backett's work also suggested that as mothers adopt a greater share of the responsibility with regards to childcare, the fathers in turn adopt a greater supportive role; thus minimizing his active participation in all facets of childcare. The adoption of a passive or non-present role in childcare and therapeutic regimes by fathers in homes with an autistic youngster, can significantly exacerbate the pressure faced by mothers and can further contribute to conjugal discord, ensuing from resentment that may arise between parents concerning the amount of time and consideration given by the other to assist in nurturing their child. Backett (1987), also surmised that for a father, a fitting father-child relationship was one in which the father had minimal physical interaction with his children (Silva & Smart, 1999). This sentiment can be interpreted from the standpoint that once a father had provided financial and emotional support to his spouse, he deemed himself as having fulfilled his share of the fatherly duties; with direct contact towards his child being achieved vicariously through the mother.

Backett (1987) findings therefore, consequently emphasized the major implication for families with special needs children, as father participation is greatly based on the father's relationship with the mother, since he is reliant on her to

conduct most of the emotional labour. This means that in households with children who have behavioural problems that require additional emotional and physical support on the part of the parents, the mother must therefore be capable of extending a more significant degree of wifely duties and childcare support; in order to, maintain her spouse's interaction with his special needs child. For a mother, continuously providing a doubled amount of care for both her husband and a child with ASD could become problematic, as she may opt to place more attention on caring for her child and neglect the relationship with her spouse. Redirection of wifely focus could obliquely act as a means of alienating a father from his family; and contributing to his subsequent absence from the home or his interest being redirected towards economic provision rather than that of emotional support. In contrast, Silverstein (1996) argued that if fathers were perceived (socially) as primary caretakers, as well as primary providers, then their relationship with, and responsibility to, their children would be defined independently of their relationships to the mothers. Silverstein (1996) therefore proposed that that the concept of paternal attachment, or father as nurturer, has the potential to change the general perception surrounding parental responsibility and should furthermore be scrutinized as an alternative means to transforming the status of father from a spectator to that of an active character within the lives of his offspring and within the home in general.

The recurring dynamic of the father as an outsider within such families alludes to the question of whether socially constructed gender roles determine degree of effort and dedication mothers and fathers are expected to adopt in administering (special needs) care to their offspring. Research conducted in 1988, by Milgram & Atzil is a prime example of the significance assumed by gendered roles. The results collected from this line of analysis conclusively determined that in families with ASD children, the “greater the parenting effort that mother reportedly makes, the smaller the effort reported by the father” (Milgram & Atzil, 1988, p. 419). The study conducted by Milgram & Atzil (1988) not only illustrated this perception but also provided supporting statistical data demonstrating that in instances where mothers gave greater input in parenting, the lesser the input that was provided by the father. The data collected reported that according to the fathers they did “about one third the parental care of the child ($34.57 \sim SD = 16.92$)” (Milgram & Atzil, 1988, p. 419); while the mothers confirmed the fathers' “estimates by reporting

independently that they themselves do about two thirds (66.09~ $SD = 16.85$)” (Milgram & Atzil, 1988, p. 419). However, the data also proved that the life satisfaction of the mother could be enhanced purely through “the father assuming a smaller, but fair, share of child care” (Milgram & Atzil, 1988, p. 422) duties.

Findings resembling these, according to Lieberman (1982), aid in clarifying “research literature on the importance of father's help in child care in general” (As cited by Milgram & Atzil, 1988, p. 422), and outlined one of the methods that could be implemented in homes in which parents care for an autistic child; to facilitate a reduction in “maternal psychiatric risk” (Bristol, 1983, in press; Bristol & Schopler, 1984; DeMyer, 1979; Zur-Szpiro & Longfellow, 1982; as cited by Milgram & Atzil, 1988, p.422). Additionally, in families that have special needs children it is especially important for the parent who is experiencing the greater amount of stress to “believe that he/she is appreciated and valued than to receive specific services or goods” (Milgram & Atzil, 1988, p.422). In order to ensure that maternal stress is kept at a minimum, it is therefore necessary for fathers to contribute routinely to childcare, to the extent that the mothers cannot openly distinguish “the discrepancy between how much mothers do and how much they think they ought to be doing” (Milgram & Atzil, 1988, p.422). When stress was kept at a minimum, the study showed that mothers actually reported a higher level of personal life satisfaction. The results collected by Milgram & Atzil (1988), also produced evidence which put forward that for parents of autistic children, their level of personal happiness increased, when they had less parenting to do, but subsequently that happiness presented itself at the expense of the other parent.

Even though the data collected demonstrated that mothers were the parent who actively fulfilled more of the care work within the home, there are two central outstanding issues that may not have been taken into consideration during the administration of this research project. The first is that of the participant mothers over estimating their mothering skills and contribution to care work. The second being, if future researchers opt to reproduce Milgram & Atzil (1988) study, changes in social parental norms (for example – the father nurturer phenomena) should be taken into consideration. As such, comparable future studies should account explicitly for both overstatement of skills by its female participants; and similarly with the under estimation of paternal skills by its male participants; as well. These

issues should be monitored in order to ensure the reliability of prospective results yielded by ASD research projects and behaviour modification programs.

Nevertheless, prior to addressing concerns regarding the significance parental input can bring about in ASD early intervention approaches, more in depth understanding must first be discussed concerning some of the specific developmental problems experienced by children with ASD.

7.0 Counteracting Problems: Communication and Stress & Anxiety

7.01 Communication

Communication challenges for autistic children noticeably appear under the two main categories of: verbal and non verbal communication. Whitaker (2001, p. 7) conveyed that autism creates “an enormously wide variation in the range of communication skills and strategies acquired by children with autistic spectrum disorders.” Whitaker also noted that, as many as one in four or five may by no means develop or express the ability to speak, or may be described as engaging in echolalia (mimicking of words). Non-verbal communication or inefficiency in expressing non-verbal skills is another major characteristic which hinders autistic children. For some children diagnosed with ASD, their limitation in participating in non-verbal practices is illustrated through the child’s inability “in learning to use pointing and gesture, which could otherwise be used to compensate for difficulties with spoken language” (Whitaker 2001, p. 7).

According to clinicians, researchers and educators alike, one of the more significant objectives they try to achieve with parents whose children are diagnosed with ASD is to design or integrate into the family’s daily routine, an effective method “to help them do better by their autistic child and only secondarily and incidentally to help them achieve greater satisfaction in their own personal lives” (Bristol, in press; Bristol & Schopler, 1983; DeMyer, 1979; DeMyer & Goldberg, 1983; Schopler & Mesibov, 1984; as cited by Milgram & Atzil, 1988, p. 415). The integration of such modification practices have become of vital importance since parents of autistic children, are according to McAdoo & DeMyer (1978), “themselves persons at risk for psychiatric and stress disorders” (Milgram & Atzil, 1988, p. 415); as compared to parents with non-autistic children.

With communication issues being a significant hindrance to children diagnosed with ASD, it therefore by proxy also becomes an impediment for the child's parents and family. For the child, frustrations in being unable to convey personal needs and wants can manifest itself through the exhibition of temper tantrums and incessant outbursts at inappropriate times. It is therefore important for both parents and child to formulate (with the help of a mental health professional) a beneficial method(s) of language (verbal and non-verbal), which suits the specific requirements of the child. This structure should be designed in a manner that is not only unproblematic for the child to grasp mentally but, should additionally be a set of exercises that could span varying social settings. If the communication exercise, such as use of picture flashcards or travel charts is able to be used in different social settings it could provide for the child a certain level of consistency regarding the exchange of verbal and non-verbal stimuli and reduce ambiguity in parent expectations; which is a dexterity other children are usually able to more readily grasp.

Whitaker (2001) conferred that when addressing verbal and non-verbal deficiencies in children with ASD, it is critical for parents to recognize that children with autism typically demonstrate unusual behaviours because they are unclear as to what behavioural responses are required of them based on a particular social setting. Unspoken expectations are especially difficult for them to comprehend and may trigger confusion or anxiousness within the child as a result. Methods of communication should for that reason be conveyed by parents or caregivers as clearly and precisely as is possible. Specific consequences regarding behaviour displayed within a particular social situation should also be done to ensure the child is clear on what are his or her 'do's and don'ts'.

Whitaker (2001, p. 26) has suggested a few language techniques that parents, under the guidance of their child's speech and language therapist could utilize in order to formulate more beneficial communication methods between themselves and their child with ASD.

- ***Matching your language to suit that of your child's level of understanding*** – Application of this practice should be done to counteract language that is expressed too complexly (above) the child's level of understanding.

- ***Catch your child's attention prior to giving an instruction*** – This ensures that the child is aware that he/she is being spoken to and it being asked to complete a certain task or behaviour.
- ***Be brief and relay things in a simple style*** – Simpler language can act as an aid for parents, since simple language is more likely to be understood by the child and can facilitate a more coherent response. This approach is particularly helpful when a child becomes vexed or anxious
- ***Give your child time*** - Parents should ensure that their child is given sufficient time to process the instruction given. Presenting multiple instructions before the previous instruction has been processed or completed by the child may cause mental overload and confusion for the child.
- ***Repetition usage*** – This does not refer to changing the structure of a sentence through the use of alternate words, but simply repeating the same task related words to ensure that the child has time to grasp what has been asked of him/her.
- ***Use of positive instructions*** – Parents should be specific in what task they want their child to do. For example: 'Eat your peas' should be used rather than 'Please do not play with your food'. Direct instruction would be a lot more helpful since it is easier for the child to understand.
- ***Being mindful of 'turn of phrase'***- Parents should limit the use of non-verbal behaviour and avoiding stating things indirectly to their child. For example: avoid asking a child to keep an eye on an object (toy), because this can result in exactly that action. Additionally, asking a child using phrases beginning with 'Would you like to...?', because these requests are usually accompanied by the child's answer of 'no'. 'No' answers can for parents then become a precursor to the development of a more difficult compliance situation by their child.

Regarding methods of counteracting communication deficiencies experienced by children with ASD, one alternative approach that can be used by parents is application of speech-generation devices (SDGs) into the home. SDGs are electronic devices that essentially provide a 'voice' for an individual who has little or no speech. The device utilizes the press of a button or the stroke of a switch to communicate needs, wants, opinions, and even emotions. SDGs were designed for the specific purpose of motivating and supporting speech, responsive language development and the growth of literacy, in children who exhibit significantly poor speech output; traits commonly displayed by children within the autism spectrum. Previous assessment of the success of SDGs, such as the one conducted by Thunberg, Sandberg & Ahlsén (2009), illustrated that the outcome from use of these devices has yielded an increased level of communication efficacy. If children with ASD are taught to use such communication devices, (the design employs pre-

programmed messages, consisting of short sentences or phrases and single words) the findings could be proven to not only enhance a child's ability to communicate his or her needs and wants to the parents; but, could also act in meliorating the occurrence of tantrums. For parents, this type of communicatory device could assist in quashing some of the parental anxiety which may arise, regarding unpleasant behaviours their child might often display in a public setting, when they are not able to acquire what they want. As a result of unpredictable behaviour, parents of children with ASD often shy away from invitations to public gatherings that may be extended to them and their child, as there may be apprehensions regarding whether their child's atypical behaviour will create an uncomfortable experience to other friends and family members who do not have children with ASD. SGDs can therefore add an element of assurance to parents that their child will have a means through which to communicate dissatisfaction or anxieties as is dictated by a marked social situation. It is therefore assumed that when parents are able to better relate/communicate with their autistic child, this in turn would help them relate better to each other as both parents and spouses. This is because excessive instances of blame and confusion could be kept to a minimum, since parents of children with ASD often blame themselves or their spouses for not managing unfavourable behavioural outbursts their child may partake in. This blame and confusion is especially evident for mothers, who often experience a sense of personal rejection, resulting from their inability to connect with and fully understand the quirks of their child.

Goldstein (2002) delineated that sign language is another effective method that can be utilized by professionals and families to enhance communication skills between themselves and their autistic child. Sign language usage is especially effective in cases where the child displays very limited communication skills. However, it must be noted that the practice of signing has significantly declined within recent years due to it being replaced by more popular communication methods such as the Picture Exchange Communication System (PECS) (Carr, 2009, p. 129). The Early Bird program is an example of a communication approach developed in the United Kingdom (UK), by the National Autistic Society, to help parents of autistic children, through the utilization of PECS. This program utilizes a couple of home visits, in which video feedback is used to assist parents in

strengthening appropriate communication proficiency and child management skills. Through this program, parents are taught how to correctly use PECS to successfully communicate with their autistic child (Carr, 2006). The PECS system is based on the principles of applied behaviour analysis and involves teaching children with ASD to exchange pictures for wanted items; with the anticipation of progression of these actions into more complex picture based sentences of requests, in the long term. Programs such as these provide parents with the tools necessary to actively engage their autistic child in social interaction through improved communicative methods, and are ideally hoped to decrease anxieties and frustration for both parents and child; in addition to counteracting some of the developmental deficits displayed by autistic children.

7.02 Stress and Anxiety

Matson et al. (2009) have underlined that for autistic children and their parents, another equally important psychological concern that affects both groups (especially in parent training programs), appears in the form of stress and anxiety. Two of the major ways stress and anxiety manifests itself are noted by Matson et al. (2009), as being as in the form of general anxiety; in addition to, other fears and phobias which contribute to stress and anxiety. One of the techniques utilized by professionals to help parents manage their autistic child's fear and anxiety, is the use of systematic desensitization exercises in which the child is exposed steadily to fearful stimuli (Matson et al. 2009). This approach utilizes the mother as a reinforcing agent and has helped in the rehabilitation of many autistic children; and in the long-term has promoted improved social cohesion for the child.

One must be aware that the child is not the only component experiencing nervousness and apprehension as a result of this disorder. Parents too, commonly experience heightened stress levels, in particular at the onset of their child's diagnosis. Diagnosis is regularly accompanied by shock, denial, emotional turmoil involving disappointment, anger and guilt, (Carr, 2006, p. 282) on the part of the parents. This psychological distress often stems from Leff & Walizer (1992) and Siegel (1997) assertion which underlined that providing care for an autistic child, presents "increased family stress and caregiver burden across the child's life span" (Stuart & McGrew, 2008, p.86). As expressed earlier in the text, parents may engage in a

grieving period while trying to mentally process the loss of the knowledge that their child is not 'normal' as they expected. Carr (2006) proposed that parents may unavoidably exhibit extreme worry regarding the education of their child, because of fears that their child's disability may cause their child to be ostracized by his/her peers; and/or from forming lasting friendships. Furthermore, Carr (2006) outlined that parental anxiety may become apparent or elevated due to concerns of who will care for their child in the unfortunate event of their death or injury. During this period of grief and acceptance transitioning it is therefore important that families receive the necessary guidance and encouragement from mental health professionals and other related parent support groups to ensure that disappointments are smoothly overcome; and are swiftly converted into acceptance and celebration of the achievements that can be accomplished despite of their child's ASD diagnosis.

Research has since established that "behaviorally oriented parent training procedures used with the general population, and to some extent with developmentally disabled populations" can prove to be "effective for parents of children with ASD" (Brookman-Frazer, Stahmer, Baker-Ericzen, & Tsai, 2006; as cited by Matson et al., 2009, p. 869). One of the most widely known training procedures used for young children with ASD is that of discrete trial training. It must be underlined that there has been only one research study, such as the one conducted by Lafasakis & Sturney (2007) that solely focused on depicting discrete trial training to parents. However, this approach under the guise of other E-IBIs do employ the premise of discrete trial training (Matson et al. 2009, p.870), and have proven to an effective tool for parents of children with ASD. Discrete trial training is a rigorous treatment regiment designed to aid people with developmental disabilities such as those associated with ASD. This type of training helps to minimize the level of stress and anxiety experienced by children in ASD, primarily because it focuses on teaching skills that autistic individuals do not possess naturally. The curriculum usually commences by teaching 'pre-learning skills', (for example, making eye contact with trainer and sitting), socialization dexterity (looking at others while talking and interacting with them), fundamental concepts (alphabet letters, numbers and colours) and safety skills (saying one's name, phone number and home address). During this stage trainers may also teach other language forms such as sign language or how to use communication devices (such as speech-

generating devices (SGDs) to children who are non-verbal. Re-enforcers may also be used in conjunction with the training in order to prompt more appropriate responses from a child. Incentives such as sweets or praise are often the frequent types used by trainers to achieve specific goals.

Aman (2005) re-iterated that ASD illustrates a broad and diverse spectrum of symptoms; in addition to behavioural challenges (Matson et al., 2009). Therefore, implementation of psychologically based methods across time and settings (for example, school and home) is a key treatment approach (Matson et al., 2009); which can confer not only therapeutic consistency over time for the child; but, also ensure that preventative/modification methods are not counteracted when the child is introduced to new activities or settings outside of the home and therapy sessions. Matson et al. (2009) thus inferred that the likelihood that parents would and could benefit from such training is noteworthy. Although ASD represents a challenging disorder to cope with for both a child and his or her associated family, early diagnosis and implementation of behavioural modification programs act as significant aids in counteracting the severity of several of the predominant symptoms. An example of one such behavioural modification program is that of the Early Intensive Behavioral Intervention (E-IBI) (Matson et al., 2009); which has proven to be highly essential and effective in modifying or eliminating many of the more severe symptoms (Matson et al., 2009).

Another useful alternative early diagnosis tool which is utilized by professionals is that of the Checklist for Autism in Toddlers (CHAT) published by Baron-Cohen et al. (1992). CHAT was designed to provide practitioners with a structured methodological guide for identifying autism in young children. The CHAT guide has essentially provided mental health and medical practitioners with a reliable method in identifying potential ASD traits in young children much earlier than in previous times. This program has allowed parents (who have what some may refer to as a 'difficult' child) to better understand why their child may display 'difficult' behavioural traits, is unable to communicate or appears unresponsive to others. The CHAT approach according to the National Autistic Society (2010) is designed in sections. Firstly, parents are asked questions related to nine items, and secondly, the last five items are answered through observations made by a health care professional. Each item looks at specific behaviours that if absent at the age of

18 months, puts the child at risk for a social-communicative disorder. These behaviours consist of attentions exercises (pointing and looking in the direction where their parent is pointing); and the use of pretend play. As compared to other diagnostic approaches the CHAT is an inexpensive and easily administered test, which can be given to a child as early as 18 months, as compared to other detection programs which are usually administered closer to three years of age. Therefore, the earlier a diagnosis can be made, the earlier intervention methods can be implemented and family distress reduced (National Autistic Society, 2010).

Early diagnoses can facilitate alleviating some of the stressors or anxieties parents and children may experience as a result of the atypical behavioural traits common to ASD. Likewise, for parents, stress reduction can be furthermore achieved through involvement in parent-headed support groups and family therapy sessions. Group therapies can allocate for parents whose children are diagnosed with ASD, a 'safe' space to share their personal experiences. Parent-headed support groups make available interaction between parents who share the same experiences; while providing a means to gain insight into alternative techniques that could be adopted to improve behavioural dilemmas. Group programs such as these also provide parents with the capacity to broaden their self-monitoring capabilities (observing thoughts and feelings), in addition to locating alternative means of solving problems associated with their child, while alerting them to the knowledge that they are not alone in the day by day struggles that ASD poses.

8.0 Early Intervention: Parental Input and the Individual (Child)

Carr (2006) underscored that one of the issues central to treatment of children with autism is whether they should be situated in schools designated for children with autism or whether they should be allowed an opportunity to be placed in mainstream educational institutions. Given that there is presently no comparative data surrounding which approach is most effective, decisions regarding the choice of institution for autistic children are therefore made based on ethical and realistic considerations (Carr, 2006). From the ethical standpoint, Carr denoted that children with autism deserve to be given an opportunity to sustain a normal lifestyle as possible, and as such should be given the chance to participate in mainstream education programs; once they are provided with additional support in the classroom

to cope with their mental and physical deficits. However, when contemplating the realistic considerations, coordinating the additional support that would be required in a mainstream setting (Carr, 2006) is not always feasible. Education professionals would therefore need to be provided with specialized training, resources and paraphernalia to effectively administer teaching to autistic children; and for education institutes could prove to exceptionally expensive, an expense which is not always financially covered by the state or allotted governing body.

It is for this reason when attempting to administer behaviour modification therapy or early intervention programs to a child diagnosed with ASD, preliminary information must initially be gathered in order to efficiently assess the requirements of the child in entirety. For a mental health professional this necessitates “gathering information and making sense of a family’s situation” (Horwath 2001, p.114), as these “are key phases in the process of assessment.” (Horwath 2001, p.114) Therefore, “gaining the family’s cooperation and commitment to the work is crucially important” (Horwath 2001, p.114). Mahoney & Wiggers (2007) accentuated the sentiment outlined by Horwath (2001), by stating that parents play an important role in early intervention programs. (Matson et al. 2009) Nichols (2009) additionally noted that although strong statements can be made regarding the positive outcomes derived from individual (child) therapy, equally strong claims can too be made towards the practice of family therapy.

Clarification must additionally be made between the constitution of individual and family therapy, as both facilitate differing approaches to treatment. Individual therapy focuses primarily on helping (for this paper focus is directed specifically to ASD treatment) a child overcome personal anxieties, and the implementation of personal behaviour modification practices. Family therapy on the other hand, focuses on positively altering the family structure. Although both therapeutic practices can aid in yielding positive outcomes for the child, individual therapy methods focus more on these practices being internalized by the child; thus acting as “the dominant forces controlling behaviour” (Nichols, 2009, p. 5). However, it is important to understand that individual therapy is not solely independent, and that it is also influenced by external factors such as the family unit. It is for this reason that therapists who work with autistic children, take into consideration the impact family members have on behaviour modification treatments; as the belief of many family

therapists is that “the dominant forces in our lives are located externally, in the family” (Nichols, 2009, p. 5). A rational deduction that can be made from Nichols (2009) assertion is that parental (and where possible, siblings) involvement is essential to ensuring that the improvements made during therapy sessions become a lasting effect across the child’s lifespan. This process can flourish in significance, seeing that when “every family member is changed and continues to exert synchronous change on each other” (Nichols, 2009, p. 5) warrants a more cohesive developmental environment for the child to grow as an individual. Utilizing parents or caregivers as primary therapists is as a result, one method that has become more widely employed by professionals, not only to enable the therapist to work with a larger number of clients, but also as a means of ensuring elevated participation and understanding of ASD amongst parents, in the long-term. Resulting from the varying personality traits and degrees of functioning associated with autism spectrum disorder this paper will henceforth, concentrate on the processes involved in and derived from the administration of two of the more prominently acknowledged early intervention approaches; that is, E-IBI therapies and the TEACCH program.

8.01 Early Intensive Behavioural Intervention (E-IBI)

Whitaker (2001) recapped that for parents and caregivers, one of the more common characteristics experienced, was their child’s inability to demonstrate interest in or avoid physical contact or interaction with others. This inability by a child diagnosed with ASD can prove to be disconcerting for parents and caregivers alike; however, through the implementation of consistent therapeutic practices such as Early Intensive Behavioural Intervention (E-IBI) therapies or the Treatment and Education of Autistic and related Communication-handicapped CHildren (TEACCH) programs, communication and behavioural problems can be improved. Programs such as these thus, provide parents with more cohesive means of counteracting their child’s atypical behaviours and can facilitate improved understanding of their child’s needs and wants.

Temper tantrums and other displays of inappropriate behaviour (slapping, spitting, throwing objects) are behavioural traits that can become embarrassing for parents or caregivers, especially when they occur within a public setting. Behaviours such as these can furthermore add to the anxiety and apprehensions

parents feel with regards to partaking in events that occur outside of the home. The more frequent the outbursts the more likely the parents are of withdrawing from accepting invitations to socialize (children birthday parties or play dates) and can lead to the social isolation of the family from neighbours and even extended family members. The end product of such social isolation can inadvertently contribute toward many additional emotional and physical disorders including alcohol abuse, heart attacks, anxiety and even violence amongst parents; thus, operating as a catalyst towards marital discord and/or divorce.

Carr (2009) suggested that when parents consider enrolment in early intervention programs they should try to ensure that such treatments commence before the child is three years of age and should strive to maintain a minimum of 25 hours of therapy per week on an annual basis; as this can yield the most effective outcomes. However, one must keep in mind that depending on the family's situation, early diagnosis can occur later than what is specified by these programs. In order for intervention programs to reap the most benefits for the child in question, the particular intervention therapy should be designed with its emphasis on achieving the individual goals of the child, and should take into account the specific deficits and needs of the child. Such considerations would facilitate a smooth progress of effective rehabilitation and regulation of problem areas. As a supplementary preventative measure parents can also elect to (based on recommendations made by their child's therapist) administer pharmacological treatments to their child, for example: selective serotonin reuptake inhibitors for repetitive behaviour, stimulants to counteract hyperactivity and inattention (des Portes et al. 2003; McDougle et al. 2006; Scahill & Martin, 2005; as cited by Carr, 2009) . Parents can also implement a regimented diet for their child which ensures that their child's food intake is that of a gluten-free (*gluten is found in wheat and rye*) and casein-free (*casein is found in milk*) (GF/CF) diet .

Programs such as E-IBIs consequently become essential support programs for families because they give the child a means through which he/she can better express personal needs and wants parents or caregivers. E-IBI therapies are for that reason designed to address the needs of children with ASD, through the style of one on one teaching techniques, associated with the following areas:

- Behavioural difficulties
- Non-responsiveness

- Limited attention span
- Obsessive or repetitive behaviours
- Overall difficulties in learning.

Practice in these areas, in turn assists in decreasing the display of unnecessary emotional outbursts in the form of temper tantrums and screaming, especially in public places, by the child. These early interventions programs are therefore strategically designed to coach both parent and child in methods addressing how to use more constructive methods of communication for the accomplishment of goals. These goals are accomplished through teaching of systematic processes in which tasks for example - going to the bathroom or asking for food, are achieved through use of gestures, touch or picture charts; in order to achieve more desirable exchange of end results.

8.02 TEACCH Program

As formerly mentioned, another equally beneficial approach that has been utilized by parents and clinicians alike, in counteracting atypical behavioural traits displayed by autistic children, is that of the techniques administered through the TEACCH program. The TEACCH program was developed in the early half of the 1970s by Eric Schopler, Ph.D., with the purpose of providing scientific evidence to demonstrate that autistic children were not suffering from psychosomatic illnesses as believed by many during that period. TEACCH provides effective services to families with autistic children regarding diagnostic assessments, social and recreational interactive groups, parent training and support group services and one-one counseling services for more high functioning autistic clients. Additionally, the TEACCH program has been used to train teachers, care providers and professionals from varying scientific disciplines at both national and international levels.

Schopler's design illustrated that parents play an important role in the treatment of their children and as such should be included as collaborators in the education of their autistic child. The results gathered by Schopler and colleagues in the administration of the TEACCH program during the early 1970s, yielded significant advancement in the field of autistic research and was subsequently distributed state wide in North Carolina, United States (US); with most of its clinical services still presently remaining free to North Carolina residents. The TEACCH approach aims to provide its clients with developmental skills; in addition to,

facilitating them in the attainment of basic human needs such as self confidence, self-efficacy and a sense of security, to name a few. According to Carr (2009) TEACCH also aims to make the world intelligible to the autistic child through the program's acknowledgement of deficits (social cognition and communication) and the structuring of its activities to capitalize upon the strengths of the child (unique special interests, visual processing abilities and favourable rote memories). In an attempt to achieve the goals outlined by the TEACCH approach, the program inspired the construction of an intervention approach referred to as "Structured Teaching."

The principles of Structured Teaching include:

- Understanding the culture of autism.
- Developing an individualized person- and family-centered plan for each client or student, rather than using a standard curriculum.
- Structuring the physical environment.
- Using visual supports to make the sequence of daily activities predictable and understandable.
- Using visual supports to make individual tasks understandable. (TEACCH, 2010)

One of the most prominent issues encountered by families with autistic children presents itself during the early development stage of the child life and is experienced through the child's general inability to connect with his or her parent and other family members. Early diagnosis and intervention therefore becomes vital to families, since understanding the nature of autism is essential to parents and the child; in order to promote cohesion and foster productive living for both the child and his or her family. With this notion in mind, the TEACCH approach provides families with Home TEACCHing Sessions and the TEACCHing Together Group, as a means of initiating the practice of structured teaching methods during the earliest stages of the child's development. This manner of grouping was designed to diminish the gap that often occurs at the commencement of official school-based education curriculums and/or prior to the child's formal clinical ASD diagnosis. Although official diagnosis is not required for a child's enrollment in the program, the children who are usually accepted into these groups are generally below the age

of three and a half years. TEACCH Together Groups were designed with a two part focus:

1. The assessment of the child's personal needs and overall capabilities.
2. The use of the programs attitude towards using parents as secondary therapists.

The second focus of the TEACCH Together Groups encourages parents and/or caregivers to make available in depth knowledge of their child and family history. In addition parents are allowed to shadow TEACCH staff during sessions, and provide staff members with necessary feedback on techniques and their child's overall receptiveness. The active participation included in the focus of the groups therefore allows parents to gradually implement these structured actions into the daily routine of their child. If parents consistently practice with their child and other siblings the principles highlighted in the Structured Teaching approach defined by TEACCH, could effectively act as an support system that reduces the anxiety and confusion many parents/families experience prior to their child's enrollment in a formal behavioural modification programs.

According to TEACCH (2010) some of the most significant program goals of sessions include:

- *Inclusion of structure to the environment to improve understanding and attention.* This is achieved by creating a small area within the home that mimics the classroom setup for the child and parent to use while participating in school like activities, for example: colouring, drawing and reading.
- *Advancement of transition skills through designing and utilizing visual transition systems.* This goal is achieved through the initial establishment of a suitable goal for the child and is taught using visual aids associated every phase towards completing the goal. A specific object is usually implemented to let the child know that for example, potty training has begun. An object usually related to the toilet may be presented to the child, serving as the transition aid; while guiding the child to the appropriate location for a toilet training session. A picture of the toilet on a flashcard, presented to the child serves as visually preparing the child for the task at hand and alerting him/her

to the location of the task. An accompanying toilet training chart can be used, with which the child could place a matching flashcard to display his or her completion of the task. This visual association system essentially promotes more effective communication between parent and child, by providing the child with a constant method of recognizing the connection between his or her behaviour and the toilet training process, up to the final completion/accomplishment of the goal.

Additional accompanying curriculum goals included in sessions:

- *Amplification of engagement through the use of strengths and interests*
- *Fabrication of strong, positive learning routines*
- *Establishment of independent animated communication through exchange systems*
- *Active parent participation in all teaching sessions, to share ideas, pose queries, and become trained in applying the principles of Structured Teaching.*

Under the TEACCH program, the Home TEACCHing Sessions are also accessible to parents of children with ASD. This home-based service program is specifically directed towards parents with very young children and family units. These sessions are conducted on a weekly basis, over a 12 week period; with a TEACCH staff (teacher) during home-sessions with both the parents and child. The home sessions are designed to match the individual needs of each child participant, based on the child's development at that time. A specific curriculum of activities is devised with its' primary focus directed towards developing the young child's capability to be taught, comprehend and attend utilizing Structured Teaching techniques. Carr (2006) specified that for the TEACCH program to effectively work parents need to employ highly structured work routines with their children. The same time and work environment should be used on a daily basis and should be conducted in an environment that is free of external distractions. Moreover, tasks that have been completed should be set aside in a specified tray marked finished. The highly structured nature of this approach capitalizes on the affinity that autistic children have for sameness and their resistance to erratic transitioning (Carr, 2006).

9.0 Intervention Outcomes

Research was conducted to ascertain supporting data regarding promising outcomes derived from previous studies in which parents were trained as primary therapists in early intervention programs. Two corresponding research documents were subsequently located outlining possible outcomes from the use of parents as the primary therapist; that is, Sheinkopf & Siegel (1998) study and Horner, Carr, Strain, Todd & Reed (2002) meta-analyses review. Matson et al. (2009) argued that many early intervention programs need to increase the parent's position at the central role of the treatment; since a parent is more likely to impact the learning aspect of their child, over that of an external participant (therapist). Matson et al. (2009) also emphasized that when parents are used as the primary therapist, mental health professionals are now able to significantly increase the number of patients and families that they can facilitate.

An excellent example of one such an approach was described by Sheinkopf & Siegel (1998), in which they “trained 11 parents to implement applied behavior analysis for their pervasive developmental disordered preschoolers. Results of treatment were compared to 11 other matched preschoolers with pervasive developmental disorders” (Matson et al. 2009, p. 871). During the study an average of 27 hours of treatment was administered per week for a period of 20 months to the treatment group. The results yielded “at post-test, children in the treatment group received higher scores on IQ tests, and displayed far fewer symptoms of autism” (Matson et al. 2009, p. 871) than that of their counterparts in the study. Horner et al. (2002) assessments also yielded salient data regarding the effectiveness of behavioural intervention programs (Carr, 2009). Horner et al. (2002) review of five formerly conducted systematic reviews and meta-analyses of behavioural intervention programs (inclusive of nine controlled studies of behavioural interventions using children with ASD under age eight), ascertained that in cases of aggression, self-injury, tantrums and repetitive behaviour, behavioural interventions proved to be 90% effective in reducing the appearance of these difficult mannerisms, within 60% of the cases reviewed (Carr, 2009). As a result, over the last two decades intervention programs have become increasingly popular in usage concerning behaviour modification strategies for autistic children, with some being more effective than others.

10. Limitations and Prospective Directions

It is essential to underline that many of the research studies discussed throughout this text, directed towards researching families, parental relations and/or parenting children with ASD were conducted in the 1980's; and, although they yielded significant data, are not reflective of the many changes that have occurred within families and western societies over the last two decades. The changes in parental input, especially with fathers from the Scandinavian context are a prime example. In Scandinavian it has become visually apparent that more men are in fact engaging in a larger percentage of the care work, such as taking their child to their place of employment, re-arranging work schedules and/or participation in paternal leave; in order to, spend more quality time at home with their young/new born children or even that ensuring they are available to provide care when their spouses have to spend longer hours at the office. Connell (2002), characterized that it has been possible for western men to now engage in such care activities without trepidation of loss of wages, through the introduction of paternal leave programs, for example the 'Father's Quota' initiative implemented by the Norwegian government. This program has in actuality, encouraged some 70 percent of eligible men (Connell, 2002) to accept their entitlement, thus allowing them to be present to provide care during the first month of their child's life. (Gender Equality Ombudsman, 1997; as cited by Connell, 2002) Paternal leave agendas (when used appropriately) have given women a greater opportunity to have their spouse/partner present to assist in caring for their new born (if a first time parent) or be of assistance to care for their other children, during the initial month of their child's birth; which can often prove to be an excessively stressful time for both new and experienced parents alike.

Options such as being a stay at home mother or father, in today's world are not always feasible and as summarized before, the father often becomes the spouse who opts to remain full time in the workforce to financially support the family, thus inadvertently leaving the mother to stay at home to care for the young child or children. In western countries, such as Norway and Sweden, where parents are allowed up to one year parental leave after childbirth, with earning related benefits (Duvander, Lappegård, & Andersson, 2010), dividing parental leave equally can serve to be a beneficial asset to the spousal relationship, especially if the family has a child born with special needs. Having the sanctioned convenience of alternating

parental duties can also serve to foster a healthier work-life balance amongst parents. This is because such leave entitlements provided by the state facilitate parents with a sense of financial security (previously not an option) and permits them to stay at home for an extended period of time to supply child care and assist in other domestic duties; as is deemed necessary to a particular family. Such incentives, with the only requirement being that parents do not take leave simultaneously (Duvander, Lappegård, & Andersson, 2010) not only provide additionally monetary encouragement for men to support their partners in domestic care duties, but also provides the mother, with an opportunity to return to work, with the security that her spouse or partner is supplementing care within the home.

In a similar vein, this “shift by men under the age of fifty to partake in a more gender-equal model of family life” (Connell, 2002, p. 85) is supported by the data collected in a national study of men in Germany conducted by Zulehner and Volz (1998) (Connell, 2002, p. 85). Zulehner and Volz (1998) study found that German men below the age of fifty were in fact twice as often more likely than their counterparts over age fifty to reject ‘traditional’ norms, and advocated gender equality within their families. Although such changes are not indicative of all western societies, it does provide a level of evidence that more men are moving away from the former style of the traditional parenting role which identified the father as the primary ‘breadwinner’; to sharing in a more equally balanced family lifestyle between care work and paid labour, with their partner.

Moreover, despite the fact that the discourse surrounding parenting has been extensively explored, it must be outlined that such studies are accompanied by certain limitations which still require addressing. These limitations exist because the majority of research conducted on this subject matter focuses primarily on the parental relationship of married couples; while little research has been concentrated on the dynamics experienced between single parents, divorced or separated parents and gay and lesbian parents; and the relationships they hold with their children. Prospective clinicians studying the parenting phenomena should therefore, attempt to make future investigation more reflective of the societal changes occurring to date. Studies should furthermore be restructured to include utilizing more non-traditional family and parenting arrangements, such as single father families; which have become prominent features within western societies, over the last decade.

Restructuring study designs would serve to ensure that the outcomes derived from future studies are more conclusive, reliable; in addition to, being representative of the ongoing changes being experienced by today's parents.

Furthermore, Hewlett (1991) indicated that to a large extent the manner in which parenting data have been previously collected by researchers has also been skewed by the biases of the researchers themselves. (Silverstein, 1996) These biases have occurred resultant from the choice of design used by cultural anthropologists in field observations of "mother-oriented theories of infant and child development." (Silverstein, 1996; p. 17) Field studies such as these are designed within the context of mother-child observations that ensue prior to night fall. These studies therefore all together fail to see the relationships and interaction that transpire between fathers and children; which must be highlighted more frequently occur during early evenings. Silverstein, (1996) conferred that father-child interactions commonly come about during the evening time; resulting from fathers regularly being at a place of employment during the daytime, when parent-oriented studies are usually conducted by researchers. Researchers accordingly, need to streamline trial designs to make the experiments more time flexible, in order to provide fathers with more chances of participating.

Supplementary to this, a large segment of father based research has also only examined fatherhood during the early stages of a child's life, for example- during pregnancy, immediately after birth and/or in early infancy. Likewise, more in depth inquiries need to be made by clinicians into the developments that come about during later nurturing periods of a child's life. Additionally, it is for this reason that Matson et al. (2009) argued that although lifelong management models of parenting treatment appear practical, researchers still do not have significant data regarding the "maintenance properties of early intensive behavioral interventions over an extended period of time." (Matson et al., 2009, p. 873) The findings from these forms of experimentation become especially important more than ever when analyzing adjustments that have occurred within the family structure, post-ASD diagnosis; and the end products that amass, well into the child's adulthood. Utilization of reformatted studies designs that take into consideration fathers from varying western social contexts (cross-culturally, racially, ethnically, and socioeconomically), could serve to advance the configuration of already existing behavioural modification and

family-oriented programs directed children with autism. In turn, this could serve to ensure that the data and outcomes generated from such programs provide more effectively conclusive preventative methods and knowledge surrounding parental and family involvement in ASD treatment programs, and the sustainment of overall marital and familial wellbeing/unification.

11. Conclusion

Beyond the difficulties experienced by parents in upholding a healthy balance between married life and caring for an autistic child, is the pertinent question of whether there is a place in modern societies for men as caregivers? Segal (1989) asked a similar question – Is there a future for men? Segal asked this question to outline that fact that although changes have occurred within traditional families, men still continue to dominate in many societies. (Silverstein, 1996) Consequently, this domination continues to impact the ability for women and children to lead better lives; since the interaction between the two is essential to constructing symbiotic (family) relationships. Silverstein (1996) duly assessed that complete equality for women can only be achieved when the traditional perceptions of mothering and fathering are discarded and the notion of family is socially restructured. For this reason, “our concept of the ‘normal’ family must come to include whatever combination of adults and children choose to live together, regardless of sex, gender, or biological relationship to each other.” (Silverstein, 1996, p. 31) Mothering and fathering should in future be viewed as responsibilities that are equally born by parents and should incorporate comparable divisions in financial and nurturing practices; in an attempt to ensure the positive social progression of men and women, and as members of a family unit.

Acknowledgement must be made marking the fact that behavioural modification approaches directed towards the domain of autism have undergone considerable restructuring. This is because such therapy approaches have realised the importance of parental training as an affirmative means of facilitating and incorporating greater parental involvement in the behavioural rehabilitation of children diagnosed with ASD. As a result, the implementation of such techniques “parents are able to develop skills, largely within the domain of applied behavioral analysis; which result in more effective treatment for their children” (Matson et al.

2009, p.872); in the long-term. The implementation of more effective or consistent treatment methods for children with ASD in turn has also transformed itself into a vital tool towards preserving the psychological wellbeing of parents whose children are born with developmental disorders. For the reason that exacerbated parental stress, depression and sense of failure often present themselves as psychological impairments for parents with autistic children, as mentioned throughout this discourse. Exhaustive assessment of associated research material has also provided sufficient substantiation that mothers more often experience psychological distress than fathers. This is usually because mothers time and again associate their inability to create attachment bonds with their young child (a problem commonly exhibited by children with ASD) as a personal failure in mothering skills. That opinion, in conjunction with pressures affixed by socially gender norms, often facilitates the occurrence of the aforementioned psychological stressors in the lives of mothers as compared to their male counterparts.

Although the mother has been throughout history the designated nurture, societal changes over the last two decades have provided evidence supporting the reality that fathers should not be dismissed nor categorized as insufficient or non-beneficial components in the provision of childcare within western households. Silverstein (1996) reinforced the suggestion that fathering is a key component in achieving full equality for women. She additionally stressed that the popular societal tendency of limiting fathering to the provider role within the family has been central to the problem concerning male privilege; and as such has unavoidably contributed to the societal subordination of women as a whole. Fathering, therefore, is an area of research that professionals should further scrutinize, taking into consideration that fatherhood in recent times has undergone several advantageous transformations; and should be considered as one of the fundamental components in achieving and maintaining concrete and inclusive equality for women.

Conclusively, analysis of this discourse has as well offered beneficial reinforcing data delineating that the position of fatherhood is indeed changing; despite, the prevalent popular perception of western women as the primary social nurturers. It is significant to accentuate that although a number of western fathers are engaging more actively in the care aspect of their children's lives, this change in fathering practices has occurred under two distinct categories – father-

provider/nurturer versus the absentee father. We are aware that much research has been conducted within the last decade regarding the importance of parental participation and inclusion in the administration of therapy to children with ASD; however, one reoccurring trend that still remains prevalent throughout the various studies discussed is the relatively minimal participation or incorporation of the father figure into research studies by clinicians. A significant short coming of those research models can furthermore be criticized from the stance that researcher biases unequivocally have influenced experiment designs to the extent that the studies more often than not routinely replicate the assignment of father involvement to mere 'spectator' roles in care/therapy and during the course of parent-oriented studies regarding autism. Further investigations are therefore required by researchers regarding the outcomes that could be yielded from paternal contribution (utilizing existing intervention programs), especially during longitudinal clinical assessments. One recommendation that could be made to clinicians to ensure that prospective experiment models assign fathers' contribution as a pertinent factor during studies is to situate fathers as primary caregivers, rather than mothers; which is the more frequent practice chosen. Likewise, probable data gathered from father based experiment approaches should be deemed as auxiliary research designs that could yield notable data associated with autism research within the scientific realm.

Although within the societal sphere the practice of fathering and mothering has in present times made considerable headway towards more equal distributions in the degree to which emotional support is given to children by both mothers and fathers; in order to secure that this trend continues to evolve positively, westerners need to consciously persist in replicating such gender equality attributes at the individual level, if it is to effectively transpire into a norm at the nationwide level. Constructive replication not only postulates that potential generations will exhibit a more natural acquisition of equality in gender and parenting norms in the future, but will also help to make movements towards transforming some of the existing unequal perceptions surrounding the societal roles currently allocated to mothers and fathers.

References

- Acker, J. (2005). *Class questions: feminist answers*. USA: Rowman & Littlefield Publishers, Inc.
- Alloway, T. P. & Gathercole, S. E. (Eds.). (2006). *Working memory and neurodevelopmental disorders*. New York, Sessex: Psychology Press.
- Brobst, J. B., Clopton, J. R. & Hendrick, S. S., (2009). Parenting children with autism spectrum disorders: the couple's relationship. *Focus Autism Other Dev Disabl.*; 24:38. Retrieved from <http://foa.sagepub.com/cgi/content/abstract/24/1/38>.
- Carr, A. (2006). *The handbook of child and adolescent clinical psychology: a contextual approach*. (2nd ed.) London: Routledge
- Carr, A. (2009). *What works with children, adolescents and adults? A review of research on the effectiveness of psychotherapy*. London & New York: Routledge
- Carter, B. & McGoldrick, M. (1989). *The changing family life cycle: A framework for family therapy*. (2nd ed.) Boston: Allyn and Bacon.
- Chodorow, N. J. (1999). *The reproduction of mothering: psychoanalysis and the sociology of gender*. (2nd ed.) London: University of California Press
- Clark, K. (2009). *Doing Family Lesbian-Headed Families versus Heterosexual Families: Consequences of Class, Labour and Sexuality on Modern Western Families*. Unpublished manuscript, Lund University, Sweden.
- Connell. R. W. (2002) *Gender*. Cambridge: Polity Press.
- Connell. R. W. (2005) *Masculinities*. (2nd ed.) Cambridge: Polity Press.
- Crompton, R. (2006). *Employment and the family: The reconfiguration of work and family life in contemporary societies*. UK: Cambridge University Press.
- Crouter, A. C., Perry-Jenkins, M., Huston, T. L. & McHale, S. M. (1987). Process underlying father involvement in dual-earner and single-earner families. *Developmental Psychology*, 23:3, 431-440. Retrieved March 8, 2010 from <http://psycnet.apa.org/journals/dev/23/3/431.pdf>.
- Daly, M. & Rake, K. (2003). *Gender and the welfare state: care, work and welfare in Europe and the USA*. Cambridge, UK; Malden, MA: Polity Press, in association with Blackwell Publication.

- Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision [DSM-IV-TR] (2000). *Diagnostic criteria for 299.00 autistic disorder*. (4th ed.) USA: American Psychiatric Association.
- Disch, E. (2009). *Reconstructing gender: a multicultural anthology*. (5th ed.) New York: McGraw-Hill.
- Duvander, A. Z., Lappegård, T., & Andersson, G. (2010). Family policy and fertility: fathers' and mothers' use of parental leave and continued childbearing in Norway and Sweden. *Journal of European Social Policy*, 20, 45-57. Retrieved from <http://esp.sagepub.com/cgi/content/abstract/20/1/45>
- Freeman, A. & Reinecke, M. A. (2007). *Personality disorders in childhood and adolescence*. Hoboken, New Jersey: John Wiley & Sons, Inc.
- Gerstel, N. & Gallagher, S.K. (2001). Men's caregiving: Gender and the contingent of care. *Gender and Society*, 15:2, 197-217. Retrieved from <http://www.jstor.org/stable/3081844?origin=JSTOR-pdf>
- Horwath, J. (2001). *The child's world: Assessing children in need. Great Britain*: Atheneum Press, Gateshead, Tyne and Wear.
- Jackson, S., & Scott, S. (2002). *Gender: A sociological reader*. London: Routledge.
- Kabot, S., Masi, W., & Segal, M. (2003). Advances in the diagnosis and treatment of autism spectrum disorders. *Professional Psychology: Research and Practice*, 34, 26-33.
- Lamb, M. (1999). *Parenting and child development in "nontraditional" families*. Lawrence Erlbaum Associates, Inc. New Jersey
- Malacrida, C. (2009). Performing motherhood in a disablist world: dilemmas of motherhood, femininity and disability. *International Journal of Qualitative Studies in Education*, 22, 99-117. Retrieved from <http://dx.doi.org/10.1080/09518390802581927>
- Matson, M. L., Mahan, S. & Matson, J. L. (2009). Parenting training: a review of methods for children with autism spectrum disorders. *Elsevier Ltd: Research in autism spectrum disorders*. 868-875. Retrieved from http://www.sciencedirect.com/science?_ob=MIimg&_imagekey=B83X1-4VVN510-1-1&_cdi=33801&_user=745831&_orig=search&_coverDate=12%2F31%2F2009

&_sk=999969995&view=c&wchp=dGLbVzz-

zSkWA&md5=3e389d9af5b66eabe5a71801bd3523cd&ie=/sdarticle.pdf

- McHale, S. M., & Huston, T. L. (1984). Men and women as parents: *Sex role orientations, employment, and parental roles with infants*. *Child Development*, 55, 1349-1361.
- Milgram, N. A. & Atzil M. (1988). Parenting stress in raising autistic children. *Journal of Autism and Developmental Disorders*, 18:3, 415-424. Retrieved from <http://www.springerlink.com/content/p471511382q7p534/fulltext.pdf>
- Nichols, M., (2009). *The essentials of family therapy*. (4th ed.) Boston, MA: Pearson Education Inc.
- Passer, M., Smith, R., Holt, N., Bremner, A., Sutherland, E. & Vlieg, M. (2009). *Psychology: the science of mind and behaviour*. London: McGraw-Hill; New York: McGraw-Hill Higher Education.
- Person, E.S., Cooper, A. M. & Gabbard, G. O. (2005). *Textbook of psychoanalysis*. London, England: American Psychiatric Publishing, Inc.
- Pilgrim, D. & Rogers, A. (2005). *A sociology of mental health and illness*. (2nd ed.) UK and New York: Open University Press
- Sheinkopf, S. J. & Siegel, B. (1998). Home-based behavioral treatment for young children with autism. *Journal of Autism and Developmental Disorders*, 28, 15–23.
- Silva, E. & Smart, C. (1999). *The new family?* London: Sage Publications Ltd.
- Silverstein, L. B. (1996). Fathering is a feminist issue. *Psychology of women quarterly*, 20:1, 3-37. Retrieved from <http://www3.interscience.wiley.com/cgi-bin/fulltext/119954535/PDFSTART>
- Stanford Encyclopedia of Philosophy (SEP). (2008). Feminist Perspectives on Sex and Gender. *Published May 12, 2008*. Retrieved March 28, 2010 from <http://plato.stanford.edu/entries/feminism-gender/>
- Stuart, M. & McGrew, J.H. (2008). Caregiver burden after receiving a diagnosis of an autism spectrum disorder. *Elsevier Ltd: Research in autism spectrum disorders*. 86-97. Retrieved from http://www.sciencedirect.com/science?_ob=MIimg&_imagekey=B83X1-4SP4B69-2-3&_cdi=33801&_user=745831&_orig=search&_coverDate=01%2F31%2F2009

&_sk=999969998&view=c&wchp=dGLbVtb-
zSkWb&_valck=1&md5=f2d0b62b68c8a5dc27e84b983da3738c&ie=/sdarticle.p
df

The National Autistic Society. (2010) *Checklist for Autism in Toddlers (CHAT)*.

Retrieved from <http://www.nas.org.uk/nas/jsp/polopoly.jsp?a=2226&d=1419>

Thunberg, G., Sandberg, A. D & Ahlsén E. (2009). Speech-generating devices used at home by children with autism spectrum disorders: A preliminary assessment.

Focus Autism Other Dev Disabl., 24, 104. Retrieved from <http://foa.sagepub.com/cgi/content/abstract/24/2/104>

TEACCH (2010) Division TEACCH: *Early childhood services programs*. Retrieved from <http://www.teacch.com/intervention.html>

West, C., & Zimmerman, D. (1987). Doing Gender. *Gender & Society*, 1, 125.

Retrieved May 5, 2010 from <http://gas.sagepub.com/cgi/content/abstract/1/2/125>

Whitaker, P. (2001). Challenging behaviour and autism: *Making sense-making progress: a guide to preventing and managing challenging behaviour for parents and teachers*. The National Autistic Society. London: Stephen Austin & Sons Ltd.

Wing, L., & Gould, J. (1979). Severe impairments of social interaction and associated abnormalities in children Epidemiology and classification. *Journal of Autism and Childhood Schizophrenia*, 9, 11-29. Retrieved from <http://www.springerlink.com/content/q176p00t265712j1/>