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# Paternal involvement in Autism parent training programmes: Barriers and child outcomes

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**Abstract**

Autism spectrum disorder (ASD) necessitates comprehensive family-centred interventions, yet fathers remain significantly underrepresented in parent training research and clinical practice. This cross-sectional mixed-methods research examined paternal participation barriers and associated child behavioural outcomes across six parent training programmes in Ireland. One hundred and four parent dyads ($N$ = 208 individual parents) completed structured questionnaires measuring engagement patterns, perceived barriers, and parenting self-efficacy. Child outcomes were assessed using the Aberrant Behaviour Checklist (ABC) and Vineland Adaptive Behaviour Scales at baseline, mid-programme, and programme completion. Semi-structured interviews were conducted with a purposive subsample of twenty-eight fathers to explore experiential dimensions of programme involvement. Quantitative findings indicated that work schedule conflicts (78.4%), perceived maternal primacy in caregiving roles (62.1%), and inconvenient programme timing (55.7%) constituted the most frequently endorsed barriers to paternal attendance. Hierarchical regression analyses demonstrated that higher paternal engagement predicted significantly greater reductions in child irritability scores (beta = -0.42, $p < 0.001$) and improvements in adaptive functioning (beta = 0.38, $p < 0.001$), controlling for baseline severity and maternal engagement. Qualitative thematic analysis revealed three overarching themes: navigating gendered caregiving expectations, desire for father-specific programme components, and the transformative potential of active participation. These findings underscore the clinical importance of restructuring parent training delivery to facilitate meaningful paternal involvement, with implications for programme scheduling, content adaptation, and workforce training in autism service provision.

**Keywords:** Autism spectrum disorder, Father involvement, Parent training, Paternal engagement, Child outcomes, Barriers

## Introduction

Autism spectrum disorder (ASD) represents a heterogeneous neurodevelopmental condition characterised by persistent differences in social communication and the presence of restricted, repetitive patterns of behaviour (Flippin *et al.*, 2011) [1]. Contemporary prevalence estimates indicate that approximately one in thirty-six children receive an ASD diagnosis, rendering it among the most commonly identified developmental conditions worldwide (Bearss *et al.*, 2015) [2]. The pervasive nature of these characteristics necessitates sustained family involvement in therapeutic and educational interventions, with parent training programmes emerging as an empirically supported approach for enhancing child outcomes across multiple developmental domains (Oono *et al.*, 2013) [3].

Parent-mediated interventions have demonstrated efficacy in reducing challenging behaviours, improving social communication, and strengthening adaptive functioning in autistic children (Bearss *et al.*, 2015; Oono *et al.*, 2013; Poslawsky *et al.*, 2015) [2, 3, 4]. Nevertheless, a persistent methodological and practical concern pervades this evidence base: the systematic underrepresentation of fathers in both research participation and clinical service delivery (Flippin *et al.*, 2011; Phares *et al.*, 2005) [1, 5]. Flippin and Crais (2011) [1] identified that fewer than twenty percent of participants in autism intervention research were fathers, a disparity that has shown only marginal improvement in subsequent years. This exclusion is particularly consequential given emerging evidence that paternal involvement in early intervention confers unique and additive benefits to child developmental trajectories (Perzolli *et al.*, 2021; Elder *et al.*, 2003) [6, 7].

The theoretical rationale for examining paternal contributions to autism parent training is well established. Ecological systems frameworks emphasise that child development is shaped by the interconnected influences of multiple caregiving relationships, with father-child interaction patterns operating through mechanisms distinct from maternal pathways (Lamb, 2010) [8]. Research examining father-child dyadic interactions in families affected by ASD has revealed that fathers demonstrate different patterns of physical engagement, verbal communication, and play-based interaction compared with mothers, suggesting that these com



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plementary influences merit specific attention in intervention design (Perzolli *et al.*, 2021; Potter, 2017) [6, 9].

Despite these compelling theoretical arguments, practical barriers impede meaningful paternal participation in parent training programmes. Previous investigations have identified work scheduling conflicts, gendered expectations regarding caregiving responsibility, and programme structures designed primarily around maternal availability as significant obstacles (Lashewicz *et al.*, 2019; May *et al.*, 2021; Hock *et al.*, 2012) [10, 11, 12]. Furthermore, whilst the emotional toll of raising an autistic child has been extensively characterised among mothers through examinations of fatigue, stress, and coping (Seymour *et al.*, 2013) [13], corresponding paternal experiences remain substantially less documented, though available evidence suggests that grief, uncertainty, and social isolation may interact with structural barriers to reduce engagement (Lashewicz *et al.*, 2019; Hastings *et al.*, 2005) [10, 14]. Preliminary evidence from father-focused intervention adaptations suggests that targeted modifications can successfully increase paternal attendance and satisfaction (Elder *et al.*, 2003) [7], though the downstream effects on child outcomes remain insufficiently characterised.

The present research addresses three primary objectives: first, to quantify the prevalence and relative importance of barriers to paternal participation in autism parent training programmes across Irish service settings; second, to examine the relationship between paternal engagement levels and child behavioural and adaptive outcomes; and third, to explore fathers' lived experiences of programme involvement through qualitative inquiry. By employing a mixed-methods design, this investigation seeks to provide both generalisable quantitative evidence and contextually rich qualitative insights to inform the development of more inclusive parent training models.

## Material and methods

This mixed-methods research employed a convergent parallel design, collecting quantitative and qualitative data concurrently across six established autism parent training programmes operating within the Health Service Executive framework in Ireland. The research protocol received ethical approval from the University of Limerick Research Ethics Committee (Reference: 2023-04-17-EHS), and all procedures adhered to the Declaration of Helsinki guidelines for ethical conduct in human research.

Participants were recruited through purposive sampling from parent training programmes located across three health regions. Eligibility criteria required that participating families include a child aged between three and twelve years with a confirmed ASD diagnosis according to DSM-5 criteria, and that both parents or primary caregivers were available for data collection. Exclusion criteria encompassed single-parent households and families currently receiving additional intensive behavioural intervention beyond the parent training programme. The final sample comprised one hundred and four parent dyads ($N = 208$), representing a response rate of seventy-three percent from eligible families approached.

Quantitative data collection utilised a structured battery administered at three timepoints: programme entry ($T_1$), midpoint at twelve weeks ($T_2$), and programme completion at twenty-four weeks ($T_3$). The Aberrant Behaviour Checklist (ABC) was employed to assess child behavioural difficulties, with the irritability and hyperactivity subscales serving as primary outcome measures (Bearss *et al.*, 2015) [2]. The Vineland Adaptive Behaviour Scales, Third Edition (Vineland-3), provided standardised assessment of communication, daily living skills, and socialisation domains. Paternal engagement was operationalised through a composite measure incorporating attendance records, session participation ratings completed by programme facilitators, and a self-report Home Practice Compliance Scale developed for this investigation. Parenting self-efficacy was assessed using the Parenting Sense of Competence Scale. Perceived barriers were measured through a purpose-designed twenty-two item questionnaire, with items generated from existing literature and refined through pilot testing with eight fathers not included in the main sample.

Semi-structured interviews were conducted with a purposive subsample of twenty-eight fathers, selected to represent variation in engagement levels (high, moderate, low), child age, and programme location. Interviews lasted between forty-five and seventy-five minutes, were audio-recorded, and were transcribed verbatim. The interview schedule explored experiences of programme participation, perceived facilitators and barriers to involvement, impact on parenting practices and couple relationships, and recommendations for programme improvement.

Quantitative analyses employed hierarchical multiple regression to examine predictors of child outcome change scores, with paternal engagement entered as the primary predictor variable whilst controlling for baseline child severity, maternal engagement, child age, and socioeconomic status. Effect sizes were calculated using Cohen's d for between-group comparisons and partial eta-squared for regression analyses. Qualitative data were analysed using reflexive thematic analysis following Braun and Clarke's six-phase framework, with initial coding conducted independently by two researchers and themes developed through iterative discussion. Methodological rigour was enhanced through member checking, peer debriefing, and maintenance of a reflexive journal throughout the analytical process.

## Results

Demographic characteristics of participating families are presented in Table 1. Fathers' mean age was 38.7 years (SD = 5.4), with the majority employed in full-time occupational roles (82.7%). Children's mean age at programme entry was 6.3 years (SD = 2.1), with a male-to-female ratio of 3.8:1, consistent with established diagnostic patterns. No significant demographic differences were observed between programme sites (all $p$ values $> 0.05$).

Analysis of paternal engagement patterns revealed considerable variability across the sample. Based on the composite engagement measure, fathers were categorised into three groups: high engagement ($n = 34$, 32.7%), moderate engagement ($n = 41$, 39.4%), and low engagement ($n = 29$, 27.9%). High-engagement fathers attended a mean of 87.3% (SD = 8.2) of programme sessions, compared with 61.4% (SD = 11.7) for moderate-engagement and 28.6% (SD = 14.3) for low-engagement fathers.

Figure 1 presents the barriers to paternal participation as reported by both fathers and mothers. Work schedule conflicts emerged as the most frequently endorsed barrier, reported by 78.4% of fathers and 71.2% of mothers. The perception that the mother serves as the primary caregiving figure was endorsed by 62.1% of fathers and 68.9% of mothers, suggesting mutual reinforcement of gendered caregiving norms within the family system. Programme timing was identified as problematic by 55.7% of fathers, whilst 48.3% reported that existing programmes lacked father-specific content relevant to their parenting experiences.

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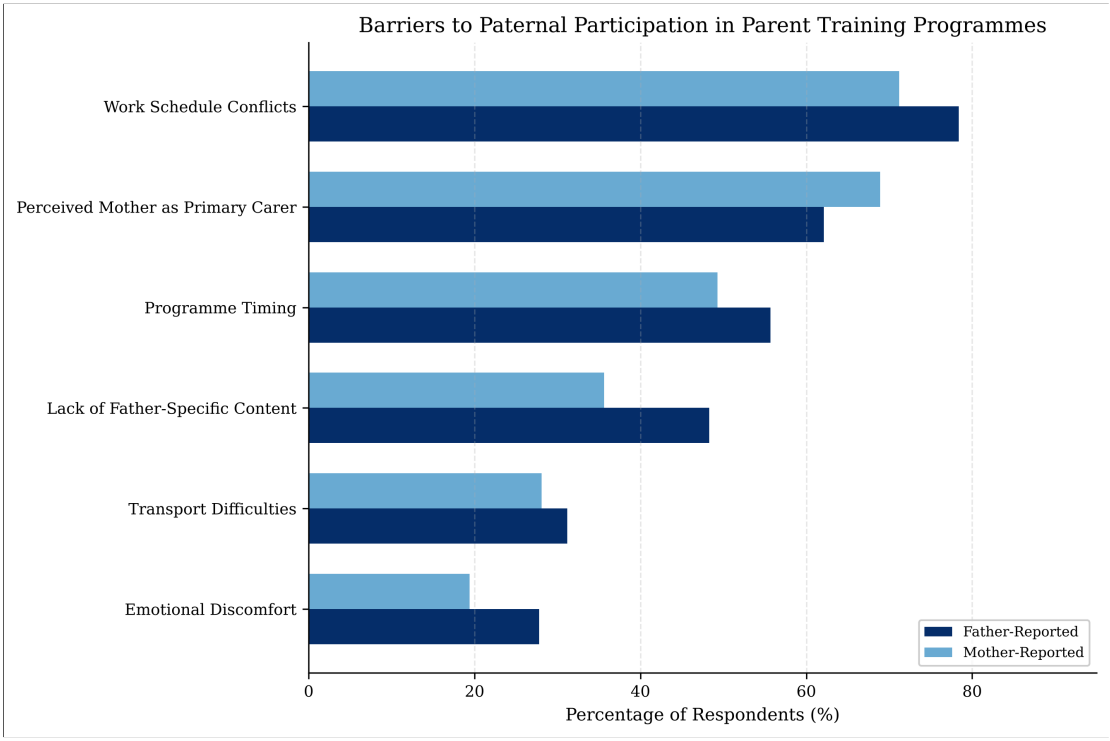



**Figure 1.** Barriers to Paternal Participation in Parent Training Programmes as Reported by Fathers and Mothers

Hierarchical regression analyses examining child behavioural outcomes are summarised in Table 2. After controlling for baseline ABC-Irritability scores, child age, maternal engagement, and socioeconomic status, paternal engagement emerged as a significant predictor of change in irritability scores from $T_1$ to $T_3$ (beta = -0.42, $p < 0.001$, partial eta-squared = 0.18). Similarly, paternal engagement significantly predicted improvements in Vineland-3 Adaptive Behaviour Composite scores (beta = 0.38, $p < 0.001$, partial eta-squared = 0.15). The trajectory of child behavioural change across assessment timepoints is displayed in Figure 2, demonstrating divergent patterns according to level of paternal engagement. Children whose fathers demonstrated high engagement showed a 49.4% reduction in ABC-Irritability scores, compared with 31.1% for moderate engagement and 15.8% for low engagement groups.

**Table 1.** Demographic Characteristics of Participating Families

| Characteristic | Fathers (*n* = 104) | Mothers (*n* = 104) |
|---|---|---|
| Age, mean (SD) | 38.7 (5.4) | 36.2 (4.8) |
| Employed full-time, n (%) | 86 (82.7%) | 41 (39.4%) |
| Third-level education, n (%) | 62 (59.6%) | 71 (68.3%) |
| Child age, mean (SD) | 6.3 (2.1) | — |
| Child male, n (%) | 83 (79.8%) | — |
| ASD Level 1, n (%) | 38 (36.5%) | — |
| ASD Level 2, n (%) | 47 (45.2%) | — |
| ASD Level 3, n (%) | 19 (18.3%) | — |

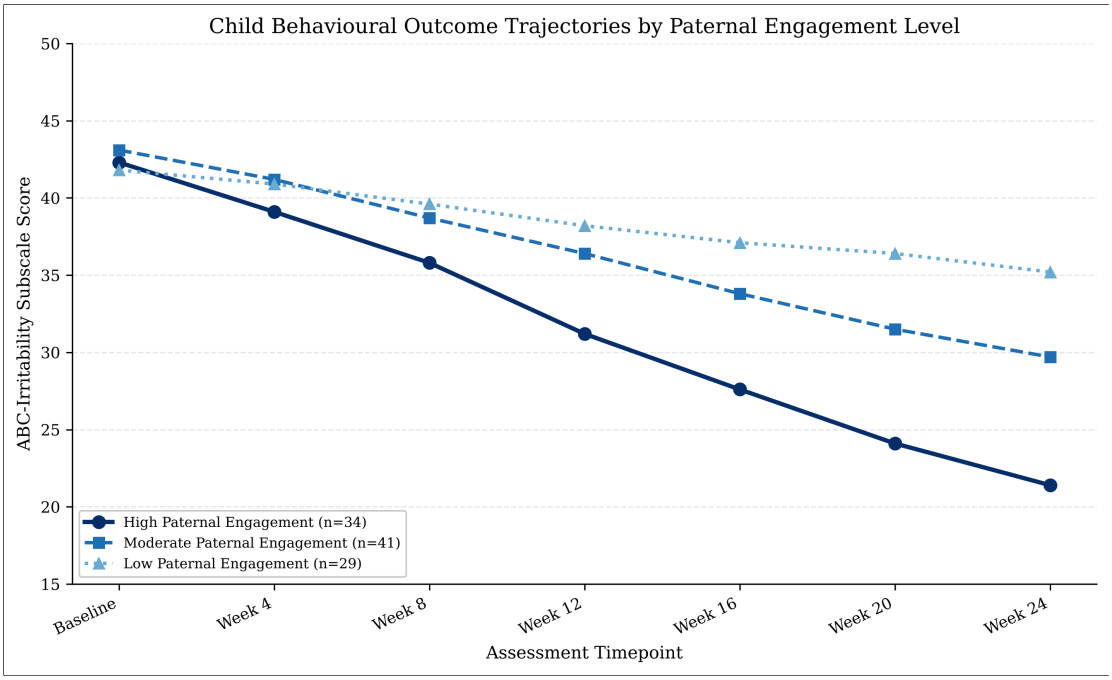



**Figure 2.** Child Behavioural Outcome Trajectories (ABC-Irritability) by Level of Paternal Engagement Over 24-Week Programme Duration

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Examination of paternal self-efficacy indicated significant differences between engagement groups at $T_3$ ($F(2, 101) = 14.73$, $p < 0.001$). Post-hoc comparisons using Tukey's HSD revealed that high-engagement fathers reported significantly greater parenting self-efficacy than both moderate-engagement (mean difference = 4.82, $p = 0.008$) and low-engagement fathers (mean difference = 9.31, $p < 0.001$). Additionally, the relationship between paternal engagement and child outcome improvement was partially mediated by gains in paternal self-efficacy, with the indirect effect accounting for approximately twenty-two percent of the total effect (Sobel test $z = 3.14$, $p = 0.002$).

**Table 2.** Hierarchical Regression Analysis Predicting Change in ABC-Irritability Scores ($T_1$ to $T_3$)

| Predictor | Beta | SE | *p*-value | Partial eta sq. |
|---|---|---|---|---|
| Paternal engagement | -0.42 | 0.08 | < 0.001 | 0.18 |
| Baseline ABC-I score | 0.51 | 0.07 | < 0.001 | 0.24 |
| Maternal engagement | -0.29 | 0.09 | 0.002 | 0.09 |
| Child age | -0.14 | 0.10 | 0.164 | 0.02 |
| Socioeconomic status | -0.11 | 0.09 | 0.221 | 0.01 |

**Table 3.** Facilitator-Rated Session Participation Quality by Paternal Engagement Group, Mean (SD)

| Domain | High Engagement | Moderate Engagement | Low Engagement |
|---|---|---|---|
| Active questioning | 4.2 (0.6) | 3.1 (0.8) | 2.3 (0.9) |
| Role-play engagement | 4.0 (0.7) | 2.8 (1.0) | 1.9 (0.8) |
| Home practice completion | 4.4 (0.5) | 3.3 (0.7) | 2.1 (1.1) |
| Strategy implementation | 4.3 (0.6) | 3.0 (0.9) | 2.0 (1.0) |
| Overall quality rating | 4.2 (0.5) | 3.1 (0.7) | 2.1 (0.9) |

Table 3 presents the distribution of facilitator-rated session participation quality across engagement groups. High-engagement fathers received higher participation quality ratings across all programme domains, including active questioning during didactic sessions, role-play engagement, and between-session practice completion.

Qualitative thematic analysis of father interview transcripts yielded three overarching themes with associated sub-themes. The first theme, "Navigating gendered caregiving expectations," captured fathers' experiences of societal and familial pressures that positioned mothers as primary therapeutic agents. Participants described encountering assumptions from both professionals and extended family members that the mother was the "natural" programme participant. One father articulated this tension: "There was this unspoken expectation that my wife would handle the programme sessions and I would keep everything else running at home. Nobody actually said fathers shouldn't come, but the whole setup assumed we wouldn't be there."

The second theme, "Desire for father-specific programme components," reflected participants' perception that existing programmes were designed with maternal perspectives as the default framework. Fathers expressed interest in content addressing their distinct interaction styles, including more active and physical play-based strategies. Several fathers noted that small-group discussions exclusively for fathers would have reduced their sense of being outsiders within predominantly female participant groups.

The third theme, "Transformative potential of active participation," described how fathers who maintained consistent engagement experienced meaningful shifts in their parenting identity and confidence. These fathers reported developing a more nuanced understanding of their child's sensory and communication needs, enabling them to contribute more effectively to the implementation of behavioural strategies within the home environment. Notably, several fathers described how their involvement created positive feedback loops within the couple relationship, with increased parental coordination enhancing the consistency of strategy implementation.

## Discussion

The present findings offer converging quantitative and qualitative evidence that paternal involvement in autism parent training programmes constitutes a clinically significant, yet substantially underutilised, resource for optimising child outcomes. The identification of work scheduling, gendered caregiving norms, and programme design limitations as predominant barriers accords with previous research in this domain (Flippin *et al.*, 2011; Lashewicz *et al.*, 2019; May *et al.*, 2021) [1, 10, 11], whilst extending the evidence base through the demonstration of dose-response relationships between paternal engagement and measurable child improvements.

The magnitude of the association between paternal engagement and child behavioural outcomes merits particular attention. The finding that high paternal engagement predicted a 49.4% reduction in irritability scores, compared with 15.8% for low engagement, suggests that father participation may represent a substantive moderating influence on intervention effectiveness rather than a merely desirable adjunct (Bearss *et al.*, 2015; Perzolli *et al.*, 2021) [2, 6]. The partial mediation of this effect through paternal self-efficacy gains aligns with social cognitive models of behaviour change, suggesting that programmes cultivating parental competence beliefs may amplify the benefits of increased attendance (Hastings *et al.*, 2005; Hock *et al.*, 2012) [14, 12].

Qualitative findings enriched these quantitative patterns by revealing the experiential mechanisms through which gendered expectations operate as participation barriers (Lashewicz *et al.*, 2019; Potter, 2017) [10, 9]. The pervasive assumption of maternal primacy in therapeutic caregiving, identified across professional, familial, and societal levels, suggests that structural programme modifications alone may prove insufficient without concurrent attention to the attitudinal frameworks of service providers and families. These observations resonate with broader sociological analyses of fathering identity construction within contexts of childhood disability (Lamb, 2010) [8].

Several practical implications emerge from these results. Programme restructuring to incorporate evening and weekend session options, father-specific small groups, and content emphasising active play-based strategies could meaningfully reduce identified barriers (May *et al.*, 2021; Elder *et al.*, 2003; Schultz *et al.*, 2011) [11, 7, 15]. Furthermore, workforce development initiatives should address implicit biases among practitioners that may inadvertently communicate paternal dispensability in the intervention process (Flippin *et al.*, 2011; Phares *et al.*, 2005) [1, 5]. The economic argument for such restructuring is supported by the demonstration that enhanced paternal engagement amplifies programme effectiveness, potentially improving cost-effectiveness ratios for service providers.



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## Ethical considerations

This research received ethical approval from the University of Limerick Research Ethics Committee (Reference: 2023-04-17-EHS). All participating parents provided written informed consent prior to data collection, and participants were informed of their right to withdraw from the research at any point without consequence for their ongoing programme participation. Interview transcripts were anonymised through the removal of identifying information, and all data were stored in accordance with the General Data Protection Regulation (GDPR) requirements. Particular attention was given to ensuring that the research process did not inadvertently create pressure for paternal participation, with recruitment materials explicitly emphasising the voluntary nature of involvement.

## Limitations

Several limitations should be considered when interpreting these findings. The cross-sectional design of the quantitative component precludes causal inferences regarding the directionality of the relationship between paternal engagement and child outcomes, as unmeasured confounding variables may account for the observed associations. The sample was drawn exclusively from Irish parent training programmes, potentially limiting generalisability to healthcare systems with different structural characteristics. Self-selection bias may have influenced the composition of the qualitative subsample, with fathers who agreed to interview potentially representing more engaged or reflective participants. The composite engagement measure, whilst incorporating multiple indicators, has not undergone formal psychometric validation and may incompletely capture the multidimensional nature of paternal involvement. Finally, the absence of a randomised controlled design means that the observed differences between engagement groups cannot definitively be attributed to paternal participation per se, as these groups may have differed on unmeasured characteristics associated with both engagement and child outcomes.

## Conclusion

This research provides robust mixed-methods evidence that paternal involvement in autism parent training programmes is both inadequately supported within current service structures and significantly consequential for child developmental outcomes. The convergence of quantitative findings demonstrating dose-response relationships between paternal engagement and child behavioural improvements with qualitative insights into the experiential dimensions of father participation offers a comprehensive foundation for evidence-informed service redesign.

The identification of modifiable barriers, including work scheduling constraints, gendered programme design, and the absence of father-specific content, provides actionable targets for intervention at both structural and attitudinal levels. Critically, the mediating role of paternal self-efficacy in translating engagement into child outcomes highlights the importance of designing programmes that actively cultivate fathers' confidence in their parenting capacity, rather than merely increasing their physical attendance at sessions (Flippin *et al.*, 2011; Hastings *et al.*, 2005; Schultz *et al.*, 2011) [1, 14, 15].

The present findings carry implications extending beyond the immediate context of autism parent training. The demonstrated complementarity of maternal and paternal contributions to intervention effectiveness underscores the need for family systems perspectives in early intervention service design more broadly (Perzolli *et al.*, 2021; Lamb, 2010) [6, 8]. Service providers working across neurodevelopmental conditions may benefit from examining whether analogous patterns of paternal exclusion operate within their own practice contexts, and whether similar structural and attitudinal modifications could enhance programme outcomes.

Future research should examine the longitudinal stability of the paternal engagement effects identified here, particularly whether the divergent child outcome trajectories observed across engagement groups persist beyond the immediate post-programme period. Intervention research directly comparing standard parent training delivery with father-adapted programme formats would provide the experimental evidence required to justify the resource allocation necessary for widespread service modification. Additionally, investigations of paternal involvement across diverse cultural contexts would enhance the generalisability of the present findings, which are situated within an Irish healthcare framework (Lashewicz *et al.*, 2019; May *et al.*, 2021; Elder *et al.*, 2003) [10, 11, 7].

Taken together, the systematic inclusion of fathers in autism parent training represents not merely an equity consideration but a clinical imperative supported by evidence of meaningful outcome enhancement. The restructuring of programme delivery to accommodate and actively engage fathers warrants prioritisation within autism service development agendas, with the potential to substantially improve the effectiveness of existing evidence-based interventions for autistic children and their families (Oono *et al.*, 2013; Poslawsky *et al.*, 2015; Ingersoll *et al.*, 2011) [3, 4, 16].

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