Parenting Styles and Parents' Perspectives on How Their Own Emotions Affect the Functioning of Children with Autism Spectrum Disorders

TING ZHOU*
CHUNLI YI*

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The grounded theory method was used to analyze the parenting styles used by caregivers to rear children with autism spectrum disorders (ASD) and to investigate parents' experiences regarding how to help their child overcome the symptoms. Thirty-two parents from 28 families of children with ASD in mainland China were interviewed. Analysis of interview transcripts revealed four patterns of parenting styles which varied in affiliation to the roles of caretaker and coach. Based on their experience, a sizable group of parents perceived that their own emotions influence the child's emotions and his/her symptoms. The results suggest the value of developing intervention programs on emotion regulation and positive parenting for the parents of children with ASD.

Keywords: Autism Spectrum Disorder; Parenting Style; Emotion Transmission; Emotion–Symptom Link

Autism spectrum disorder (ASD) is a pervasive developmental disorder which is characterized by impairment in social interaction and communication, severely restricted interests, and highly repetitive behavior (American Psychiatric Association, 2000).

children. For example, Brinker, Seifer, and Sameroff (1994) found that parental stress can predict the developmental level of children with intellectual disabilities. In another study using a sample that included children with physical disabilities, intellectual disabilities, and ASD, a strong relationship between mother-reported stress and children's progress in learning was reported (Robbins, Dunlap, & Plienis, 1991). In literature specifically about children with ASD, it has been found that parental stress impacts the effectiveness of early intervention (Osborne, McHugh, Saunders, & Reed, 2008a). Low self-efficacy among parents is also associated with less engagement in children's treatment (Osborne & Reed, 2010).

Although researchers have given much attention to parental stress and self-efficacy when parenting a child with ASD, parenting practices themselves seem to have been less explored. Existing research suggests that parents of children with ASD make more effort to stimulate the development of their special children and use more specialized parenting behaviors compared with parents of other children (Lambrechts, Van Leeuwen, Boonen, Maes, & Noens, 2011). In line with this, Tsai, Tsai, and Lotus Shyu (2008) found that such parents integrate the role of coach with their role as caretaker. The parents often act like coaches to help their children on speech, motor, and social skills. Such a dual role is considered to be an important feature of parenting in families of children with ASD (Hoogsteen & Woodgate, 2012; Tsai et al., 2008). Although these studies described features of parenting practice in families of children with ASD, they did not explore how parenting practices influence the child.

To summarize, although research to date has revealed that some parental factors, such as parental stress and parenting self-efficacy, might be associated with the functional improvement of children with ASD, few studies have systemically described approaches to parenting and parental perceptions of what in their parenting practice helps their children. To fill this gap in the literature, this study aimed to (1) obtain an in-depth understanding of parenting approaches in families with children with ASD and (2) learn about parents' experiences regarding how to help their children overcome their symptoms.

This study focuses particularly on families of children with ASD in mainland China. Although it has been more than 20 years since autism was first diagnosed in China, there is still a lack of information about and awareness of this disorder in the society and among family members. Shock and confusion are common reactions to first receiving the diagnosis (McCabe, 2008b). Because of the lack of formalized education programs and a comprehensive referral system, parents have to look for experts and select intervention programs by themselves (Clark & Zhou, 2005; McCabe, 2008a). Furthermore, as educational service resources are far from sufficient, many families who are unable to get access to such services teach their child at home (Huang, Jia, & Wheeler, 2012; Sun et al., 2013). Because of this situation, parents' attitudes, beliefs, and behaviors toward their child with ASD likely play a decisive role for the child's prognosis. Unfortunately, research on the parenting practices of parents of children with ASD in China is scarce. To our knowledge, this study is the first to investigate parenting styles in families of children with ASD in mainland China.

METHOD

Design

A grounded theory approach was selected for this study. This method involves generating new hypotheses and concepts about a particular phenomenon using an inductive and phenomenological strategy (Corbin & Strauss, 2008). Because there has been limited theoretical and empirical research on parenting children with ASD in mainland China, the grounded theory method was considered to be the most appropriate methodology for this study.

Participants

Participants were recruited via an advertisement posted on the corresponding author's blog, which mainly introduces popular science on child psychology. Inclusion was restricted to caregivers who took primary responsibility for the care of children diagnosed with ASD by a child psychiatrist. Families who expressed interest in the study were contacted to further verify the diagnosis of the child and to explain the study. Those who met the inclusion criteria were invited to participate in semi-structure interviews.

Twenty-eight families from four cities in mainland China participated in the interviews. In total, 32 parents participated in 28 interviews. Most of the participants were mothers (only two fathers were interviewed as primary caregivers), both parents from four families participated, and one aunt (father's younger sister) was interviewed as the primary caregiver of the child with ASD.

The mean age of participants was 36.69 (SD = 4.54) years. Their educational level varied among high school (4), college degree (16), master's degree (10), and doctoral degree (1). As listed in Table 1, the mean age of the children was 6.75 years (SD = 4.36). Twenty-seven out of 28 children were boys and only one was a girl. Twenty-three were the only child in their family and five had siblings. Most children had received more than one type of intervention, with applied behavioral analysis and sensory integration training being the most commonly used.

Data Collection

Eight groups of graduate students who were taking the course "Family Therapy" were trained to conduct the interviews. Each group was composed of two to three investigators. For each interview, one investigator was principally in charge of asking questions while the others took observational notes and asked additional questions to obtain details or to clarify participants' points. For the eight local families in Beijing data were collected by face-to-face interviews, and interviews by telephone were used for the 20 families located in other cities. Each of the interviews lasted 1–2 hours. Participants were asked the fol-

TABLE 1
Children's Demographic and Treatment Data

C	(	A /	)	G	(	A D /	)	(	B /	)	
1		17/10		Male		8/0			1/1		Sensory integration training
2		5/11		Male		3/0			1/1		Applied behavioral analysis
3		7/7		Male		4/0			1/1		Applied behavioral analysis
											Psychological counseling
4		6/2		Male		4/0			1/1		Applied behavioral analysis
											Sensory integration training
											Alternative therapy
5		9/6		Male		2/1			1/1		Sensory integration training
6		4/8		Male		2/0			1/1		Alternative therapy
											Physical therapy
7		22/6		Male		6/0			1/1		Applied behavioral analysis
8		9/6		Female		2/5			1/1		Applied behavioral analysis
											Speech therapy
9		2/6		Male		1/8			1/1		Alternative therapy
											Physical therapy
10		7/1		Male		2/6A86.8(anerapy)]TJ36.Applied behavioral analysisPhy4(integration)-|					

Rights of Human Subjects

This study was approved by the Institutional Review Board of the Psychology Department of Peking University. Before the interviews, participants were shown the consent

form which stated the main goals and methods of the study, their potential risks, and their right to withdraw from the study at any time. All the participants agreed to participate and none withdrew during the interviews. For confidentiality, identification information was eliminated and a number was assigned to each child before data analysis. Confidentiality was strictly kept by all investigators.

Data Analyses

Data were analyzed from the verbatim transcripts of tape-recorded interviews. Generally, we used analytic induction in data analysis, and a constant comparative method in the coding process. Three types of coding were involved: open coding, axial coding, and theoretical coding. The initial codes were generated from open coding in which units of meanings were derived from line-by-line analysis followed by integration and reduction in units (e.g., "assuming this is a life-time problem" was an initial code). When the formal codes were created, axial coding was performed to differentiate subcategories (e.g., "assuming this is a life-time problem" was put under the code "expectation adjustment"). Theoretical coding was finally used to identify relationships among categories (e.g., connection was made between "expectation adjustment" and "positive perception of the child"; Charmaz, 2006).

Three investigators (Chunli Yi, an experienced clinical psychologist and family therapist, Ting Zhou and Wenying Zhou, both graduate students) systemically reviewed the verbatim transcripts and did the coding. Data analysis was conducted simultaneously with the data collection. The coders each did open coding of five interviews individually and generated a comprehensive list of codes based on the data from the first 15 participants. Then meetings were held to discuss code clustering and consolidation. After several discussions, a codebook was developed to reflect themes common to most of the participants' data. The first 15 interviews were re-coded and remaining interviews were coded collectively based on this code book. Discussions were held when coders had different opinions. Memos were written to record possible links among themes implied by participants' descriptions. Theoretical coding was conducted collaboratively by the three coders, during which connections among themes were made.

The credibility of the data was enhanced by triangulation, that is, collecting data by different methods (interviews and observations). Confirmation of meaning with participants was done after verbatim transcripts were recorded and after the results were written up. A conformability audit was conducted by going back to the original transcripts and observation notes after the whole coding process was completed. Peer debriefing, in which impartial peers examined general methodology, was also utilized to improve overall trustworthiness (Lincoln & Guba, 1985).

RESULTS

Parenting Styles

Parenting styles were categorized into four types: training priority, relationship precedence, alternating, and letting alone (Table 2).

Training priority

The training-priority pattern refers to the style in which parents placed priority on skills training for their child. Parents whose data fit this pattern spent a lot of time training their child and had great expectations for progress. They spared no effort to find

Table 2

treatment resources and tried many methods. During the training process, they were usually highly demanding and strict. If the child did not concentrate or showed little improvement, the parent might punish the child: "If he performed awfully, I would beat him" (#3)[1] ; "Sometimes he made me so upset that I beat him." (#4) This kind of parent emphasized the coach role more than the caretaker role. One mother said, "I have to supervise him strictly 24 hours a day and do my utmost to train him." (#19)

The most salient emotion of these parents was anxiety, and they clearly described the relationship between anxiety and high demands in training. For example, one parent said, "I became very anxious and irritable after obtaining the diagnosis. I had to do something to make me feel better." (#19) Intensive training seemed to be a way to reduce parental anxiety. In the parents' descriptions, two kinds of cognition were associated with anxiety and intensive training. First, some parents acknowledged that they were still not able to completely accept the diagnosis, and they wanted to find evidence to confirm that their child was normal: "When she performed well, I thought the diagnosis was wrong." (#8) Second, although some parents said they had accepted the diagnosis, they were eager to see the child recover quickly, saying, for example, "We must get him to recover at a relatively young age. Otherwise, the prognosis is less promising." (#3) Because of the expectation of getting rid of the ASD label as soon as possible,

parents felt a sense of urgency and had high demands in training. In the training process, they seemed to have low tolerance for slow progress and were easily frustrated. Beating the children was a common reaction.

Relationship precedence

Letting Alone

The last type was labeled "letting alone," denoting a style in which parents had little hope for the child's improvement and had little motivation to participate in any treatment. Three parents (#5, #7, and #26) in the interviews showed this pattern relatively clearly. One parent said "We have no good ideas about how to help him, so we choose to let him be." (#7) Powerlessness and hopelessness seemed to be their typical emotions. Negative perceptions of the child seemed common among this type of parent: one father said, "He has no special abilities. Mechanical memory is meaningless and worthless." (#5) Obviously, these parents gave up the role of coach: as one mother said, "I used to teach him at home, but he frustrated me so much that I do not teach him anymore. (#26)" However, the role of caretaker was also weakened. One father who was not the primary caretaker even distanced himself from the child; the mother recounted, "My husband did not like to talk to the child and avoided opportunities to take the child out." (#26)

was in a low mood his symptoms became severe, while when I was relaxed he performed relatively well" (#19); "When adults, especially the mother, looked anxious, the child would be very anxious and exhibit many behavioral problems." (#23) The perceived influence of parental emotions on progress in training was also mentioned: "If I was in a good mood, she could finish the work. However, if I was anxious, she could not finish no matter how much time she spent" (#8); "My mindset had a great influence on the child. If I did not adjust my emotions, he would not make any progress in the training." (#18)

Perceived Feedback Loops between Parental Emotions and the Child's Emotions and Symptoms

It seems that the four patterns of parenting were related to differences in the nature of the emotion–symptom link. On the basis of participants' descriptions, a vicious cycle seemed to emerge in the training-priority pattern: parents' anxiety, anger, and frustration made the child stressed and therefore exhibit more symptoms. In turn, the child's problems made parents more anxious: as one mother said, "My emotions enter into a vicious cycle: his retrogressing makes me stressed and my bad mood makes him even worse." (#22) On the contrary, emotions in the relationship–precedence pattern seemed to exhibit a virtuous cycle: under the influence of parental relaxation and positive parenting, the child was more relaxed, showed fewer symptoms, and made greater progress. Parents were encouraged by the improvement of the child and became highly efficacious and relaxed. As one mother said, "I found my positivity did have an influence on my child's behavior. His progress made me feel hopeful and really relaxed." (#10) Some parents who fit the alternating pattern did not report any factors that help overcome the child's symptoms, with one mother saying that "his problems come out at random." (#13) Some of them did mention the emotion–symptom link, but claims such as "[I] can not control my emotions" (#17) were typical. One parent who fit the letting alone pattern observed emotional transmission between parent and child (#26), but the other two had no ideas about factors that helped their children (#5 and #7).

DISCUSSION

Taking care of a child with ASD means great stress and difficulty for the parents. Consistent with previous research on parental stress, parents in this study reported intense negative emotions such as anxiety, hopelessness, anger, and powerlessness after the diagnosis and in daily interactions with the child. The results revealed parental emotions were associated with parenting cognition and behaviors. For example, the great anxiety of parents in the training-priority group was usually related with failure to adjust expectations regarding prognosis, and it motivated them to push their child into intensive training. In contrast, parents exhibiting the relationship–precedence style relieved such anxiety by adjusting their expectations, and they were more tolerant of the child's problems. Furthermore, parents perceived that their own emotions seemed to influence the emotional reactions of the children as well as their symptoms. This observation is in line with the results of research in samples of children without disabilities and those with physical disabilities

self-differentiation should be able to adjust their own psychological status rather than tying their experience to their children's behavior (Nichols & Schwartz, 2004). If parents adjust their own mindset, they may have more positive perceptions of the child and more tolerance for his/her symptoms. And if parents can maintain a positive attitude then the child can experience their unconditional love, which might be helpful in lessening the impact of the autism on the child.

In line with this reasoning, we believe that helping parents with their emotional regulation is a good initial intervention for the families of children with ASD. Decreasing anxiety should be a central goal. It would be helpful to work on anxiety-related cognition to make parents adjust their expectations, take a positive view of the child, and find meaning in their caretaking practice. Social support is also an important resource for relieving stress (Ingersoll & Hambrick, 2011). For these parents in mainland China, because social ser-

Hastings, R. P. (2002). Parental stress and behaviour problems of children with developmental disability. Journal of Intellectual and Developmental Disability, 27(3), 149–160.

Hastings, R. P., & Beck, A. (2008). Practitioner review: Stress intervention for parents of children with intellectual disabilities. Journal of Child Psychology and Psychiatry, 45(8), 1338–1349.

Hatamzadeh, A., Pouretemad, H., & Hassanabadi, H. (2010). The effectiveness of parent – child interaction therapy for children with high functioning autism. Procedia – Social and Behavioral Sciences, 5, 994–997.

Hewitson, L., Potts, A., & Barnhill, K. (2012). Maternal parenting stress and aberrant behavior in children with autism participating in a multi-disciplinary program providing medical care, dietetic support, educational assessment and family resources. Neuropsychiatrie de l'Enfance et de l'Adolescence, 60(5 Suppl), S206.

Hoogsteen, L., & Woodgate, R. L. (2012). Centering autism within the family: A qualitative approach to autism and the family. Journal of Pediatric Nursing, 28(2), 136–140.

Huang, A. X., Jia, M., & Wheeler, J. J. (2012). Children with autism in the People's Republic of China: Diagnosis, legal issues and educational services. Journal of Autism and Developmental Disorders, 42(11).

Ingersoll, B., & Hambrick, D. Z. (2011). The relationship between the broader autism phenotype, child severity, and stress and depression in parents of children with autism spectrum disorders.