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ORIGINAL PAPER

Integrating Work and Family Responsibilities: Experiences of Fathers of Children with Special Health Care Needs

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Abstract

Objectives Fathers face increasing demands to engage with family responsibilities without changes to workplace expectations. Research about these changes at home and in the workplace for employed fathers of children with special health care needs (SHCN) is limited, leaving fathers without necessary workplace, family, and community resources to better integrate work and family.

Methods An online survey collected data from 122 fathers who lived at least part-time with a child with SHCN under the age of 18 and were employed at least part-time. This study investigated the effects of workplace, family, and community resources on positive and negative work family and family work spillover.

Results Linear regression analyses revealed that access to workplace flexibility was positively correlated with negative work family spillover, and that use of workplace flexibility was positively correlated with negative family work spillover. Support from friends/neighbors was a significant predictor of negative family work and work family, and positive family work spillover.

Conclusions The study's findings illustrate that fathers of children with SHCN struggle to integrate work and family. Resources in the three micro systems of workplace, family, and community, are utilized by fathers to meet work and family demands. The study also highlights the positive spillover effects related to employment and family care for fathers of children with SHCN.

Keywords Fathers · Work family spillover · Children's special health care need · Community

Traditional gender expectations constructed the role of men and fathers as breadwinners, committed to financially support their families by immersing them selves in their careers and working long hours. This dedication to work is made possible because fathers in this traditional understanding do not have any responsibility for child care or family requirements (Acker 2006). These traditional gender expectations appear to shift, with men being expected to maintain their breadwinner role while at the same time engaging in care work at home (Aumann et al. 2011). These changing gender expectations might not always be accompanied by structural changes in the workplace leaving men struggling to keep up with these responsibilities at work and at home. This struggle to meet expectations at work and at home was termed the "the new male mystique" (Aumann et al. 2011). According to Aumann et al.'s (2011) research, 40% of fathers in the 2008 National Survey of the Changing Workforce (NSCW) reported some or a lot of work-family conflict compared to 34% in the 1977 survey. Fathers in 2008 surpassed mothers and indicated greater levels of work-family conflict (60% and 47%, respectively). Men were struggling to keep up with ideal worker norms demanded in the workplace while trying to manage changing gender expectations in the home (Venter 2011). For example, fathers in the 2008 NSCW spent an average of 1.2 h more engaged in child care and 1.1 h more in completing household chores compared to the 1977 NSCW, while maintaining on average 47 h of work per week in 1977 and 2008. Harrington et al. (2011) reported similar results in their study of 963 full-time employed fathers indicating a shift in attitudes towards active parenting with limited actual changes in work patterns. To date less attention has been paid to the experience of working fathers

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who care for a child with special health care needs (SHCN), since research is either focused on mothers as the primary caregiver (Al-Yogan and Cinamon 2008; Lewis et al. 1999; Powers 2003; Porterfield 2002), or does not identify participants' sex or gender at all (Brannan and Heflinger 2001; Brennan and Brannan 2005; Brennan et al. 2007; Brown 2014; Heiman 2002; Kuhltau et al. 2005). The question therefore remains how fathers who care for a child with SHCN experience the "new male mystique" at the intersection of work, family, and community resources.

In the United States, 19.4% of children are considered having special health care needs (NSCH 2016/2017). A special health care need is defined as any chronic physical, developmental, behavioral, or emotional condition that requires additional health services compared to children in the general population (McPherson et al. 1998). Families who care for children with special health care needs (SHCN) face additional family demands. For example, 15% of families with a child with SHCN provided 11 h or more a week in home health care compared to 4.3% of families not having a child with SHCN (NSCH 2016/2017). Additionally, 25.2% of families with a child with SHCN spent between one and 4 h each week coordinating care compared to 6.7% of families with no child with SHCN (NSCH 2016/2017). Caring for a child with SCHN can therefore be considered an exceptional caregiving responsibility. Exceptional caregiving responsibilities include any form of care that goes beyond traditional care expectations (Roundtree and Lynch 2006). Exceptional caregiving responsibilities are often emergency-driven, require lifestyle adjustments, and are time and cost intensive. Accordingly, Stewart et al. (2018) conceptualized dependent family care as a continuum with exceptional caregiving and typical caregiving responsibilities on opposite ends of the continuum.

In addition to theories of exceptional caregiving, the current study is based on Voydanoff's (2005a) theoretical model of the work, family, and community mesosystem. Her model assumes that families experience demands and resources in the three microsystems of work, family, and community, and the interaction of these demands and resources either supports work family facilitation or work family conflict. Families employ strategies within and between all three systems to support facilitation of work, family, and community roles and reduce conflict between work, family, and community roles. Facilitation and conflict in this current study were measured using the positive work family, positive family work, negative work family, and negative family work spillover scales (Grzywacz and Marks 2000). Negative spillover refers to conflict between different role expectations, while positive spillover refers to facilitation or enhancement when occupying different roles. The concept of spillover also pays attention to the directionality of role conflict or facilitation. For example, the demands at home spilling over into the work domain would be measured with the negative family work spillover subscale. Voydanoff (2005b, 2005c) also used this measure for testing her model of the work, family, and community interface, demonstrating the adequacy of this measure for the current study. Based on this theoretical conceptualization, the current study examines the influence of work, family, and community resources on negative and positive spillover for fathers with exceptional caregiving responsibilities.

Existing research demonstrates that exceptional caregiving responsibilities can increase the sense of work-family conflict or negative spillover experienced by parents of children with SHCN (Brown and Clark 2017; Sellmaier et al. 2016; Stewart 2013) and it can affect labor force participation (Brannan et al. 2018; Sellmaier et al. 2016). According to the National Survey of Children's Health (NSCH 2016/2017), 15% of families reported having to give up work or to cut back hours due to the child's health care needs. Negative effects on maternal employment have been found consistently across studies (Baker and Drapela 2010; Becker 2006; Brannan et al. 2018; Brennan and Brannan 2005; Porterfield 2002; Powers 2003; Sellmaier et al. 2016), but the effects on paternal employment are less clearly established. Busse-Widmann (2005) reported in her study of 580 German parents caring for a child with diabetes under the age of 6 years old that 4% of fathers reduced their work hours and 2% quit their job, compared to 33% of mothers making schedule changes and 21% quitting employment. Mothers of children with SHCN therefore appear to be disproportionately affected by disruptions in labor force participation compared to fathers of children with SHCN (DeRigne and Porterfield 2017). Mothers with more children with SHCN were also more likely to lose wages, but the same effect was not found for fathers (Earle and Heymann 2012). Most often fathers reported changing their patterns of work like changing shifts at work or becoming self-employed, followed by a reduction in hours, or a change in the type of work and their roles and responsibilities (Towers 2009; Venter 2011). The severity of the child's health care needs plays a critical role for workforce participation (Okumura et al. 2009; Schuh 2008; Sellmaier et al. 2016), in addition to gender. For example, mothers who reported that their children had more unstable and severe conditions were more likely to reduce or give up employment (Leiter et al. 2004).

The flexibility to adjust one's work schedule, in addition to supportive supervisors and coworkers has been found to be essential for reducing work-family conflict for parents caring for children with SHCN (Brennan et al. 2007; Brown 2014; Lewis et al. 2000b; Stewart 2013). Supervisory

support was found to reduce work-family conflict and work interfering with family life for caregivers of atypically developing children (Brown 2014). Supervisor support also seemed to reduce the chances of wage loss for fathers who cared for a child with SHCN (Earle and Heymann 2012). Families who experienced their organizations as more family supportive also reported lower levels of work interfering with family (Brown 2014). Stewart (2013) reported similar findings for workers with exceptional caregiving responsibilities, demonstrating the effects of coworker support, workplace culture, and schedule control on work-family conflict. The use of flexibility appeared to positively affect family-work conflict (Stewart 2013). However, benefits gained through adjustments in work schedules might be offset by the negative consequences of flexibility stigma, especially for fathers. Research about flexibility stigma demonstrated that fathers who did not follow traditional gender expectations and asked for flexible work arrangements faced more harassment in the workplace than fathers who followed more traditional gender expectations (Berdahl and Moon 2013). In Lewis et al.'s (2000b) qualitative study, fathers also reported trepidation to disclose that they have a child with SHCN since they feared negative repercussions. Workplace flexibility, and supportive workplaces are therefore crucial for fathers of children with SHCN, but not always accessible.

In addition to workplace supports, families of children with SHCN rely on family flexibility to meet workplace and care obligations (Brennan et al. 2007). Family flexibility refers to the flexibility within the family unit to address work or child care concerns (Emlen 2010). For example, married couples have greater family flexibility since they have someone with whom to share care responsibilities and care coordination. DeRigne and Porterfield (2010) found in their secondary data analysis that significantly more single mothers spent 7 h or more providing home health care (12.3% and 8.3%, respectively) and care coordination (14.6% and 8.4%, respectively) than married mothers, and marital status was found to be a significant predictor of family to work conflict for caregivers with exceptional care responsibilities (Stewart 2013). Married mothers of children with SHCN were significantly less likely to reduce work hours or stop work altogether than single mothers of children with SHCN (DeRigne and Porterfield 2010). Brown (2014) reported that the number of hours worked by the partner was a positive predictor of work family conflict for families caring for an atypically developing child. More hours worked can also be a family resource for families with exceptional caregiving responsibilities, since families with higher household incomes were found to have higher levels of family flexibility (Emlen 2010). In general, families of children with SHCN appeared to experience lower levels of family flexibility (Emlen 2010), and they tend to make up for a lack of workplace flexibility by following patterns of traditional single-earner families (Lewis et al. 2000a).

It is also critical to consider community supports such as support from friends and family, child care, school, after-school care, and health care. There is limited research specifically looking at community resources for fathers of children with SHCN, but Barnett and Gareis (2009) found in their study that employed fathers in the general population who experienced their children's schools and school activities as meeting their needs reported less stress and higher job role quality. The effect of school resources was especially pronounced for fathers with limited income and job flexibility. Despite the limited research investigating the effects of social supports for families of children with SHCN, there is some evidence that support received from family and friends positively affected work-family fit for these caregivers (Brennan et al. 2007; Lero et al. 2007; Stewart 2013). Research to date also demonstrated that caregivers of children with SHCN struggle with accessing adequate child care and school arrangements (Ceglowski et al. 2009; Emlen 2010; Jinnah and Stoneman 2007; Rosenzweig et al. 2008). Some of these challenges were due to a lack of qualified school personnel who are trained and supported to effectively deal with behavioral issues or other medical concerns (Ceglowski et al. 2009). Children with SHCN might also need after school care or summer programs at an older age including middle and high school years (Jinnah and Stoneman 2007). As a consequence caregivers reported receiving calls from schools to pick up their children (Rosenzweig et al. 2002) and indicated terminating child care arrangements due to safety concerns (Jinnah and Stoneman 2007). These challenges have been found to negatively affect employment and work-family fit (Brennan and Brannan 2005; Rosenzweig et al. 2002).

In addition to child care and school-based services, caregivers of children with SHCN are more likely to access health care services due to the child's medical needs. According to the National Survey of Children's Health (NSCH 2016/2017) 92.6% of children with SHCN had seen a doctor within the last 12 months, 20.2% visited the emergency room once, and 10.9% visited the emergency room twice in the last 12 months, compared to 84.4% of children without SCHN seeing a doctor, 13.8% visiting the emergency room once, and 3.5% visiting the emergency room twice. Despite this need for health care, 7.3% of caregivers of children with SHCN reported one or more unmet needs for health care (NSCH 2016/2017). Barriers according to this survey included a lack of available appointments, or struggles with transportation and child care. Accordingly, 26.7% of caregivers reported being sometimes frustrated and 7.5% being usually or always frustrated in their efforts to access services.

Existing research demonstrates that fathers in the general population experience higher levels of work-family conflict due to shifting responsibilities at home and shifting attitudes towards appropriate male gender roles combined with a lack of change in workplaces. Yet, work family conflict has not been studied widely for fathers who raise children with SHCN. Caregivers of children with SHCN more broadly reported greater levels of work-family conflict, more challenges in maintaining employment, and a lack of appropriate community resources. Given this context it is critical to learn more about the ability of fathers of children with SHCN to meet work and family demands using work, family, and community resources. Four research questions were addressed based on the existing literature and the theoretical model of work, family, and community interactions. First, what workplace, family, and community resources influence positive work family spillover for fathers of children with SHCN? Second, what workplace, family, and community resources influence positive family work spillover for fathers of children with SHCN? Third, what workplace, family, and community resources influence negative work family spillover for fathers of children with SHCN? Fourth, what workplace, family, and community resources influence negative family work spillover for fathers of children with SHCN?

Methods

Participants

The 122 fathers in this study were on average 42.49 years old (SD = 7.76), and identified predominantly as Non-Hispanic White (85.7%). The majority reported having a college degree with about one third reporting a bachelors and a fourth a graduate degree (see Table 1), which is reflected in an annual household income of between $60,000 and $119,000 for over half of the participants. Nearly all of the fathers were married or living with a partner (92%), and lived full-time with their child with SHCN (97%). Most fathers reported full-time employment (84%) with an average of 42.74 (SD = 11.10) hours a week, in contrast to their partners of whom 57% were employed with an average of 37.33 (SD = 13.89) hours a week.

Table 1 Demographics

Characteristics	Percent/mean (SD)
Fathers' employment	
Full-time	83.8%
Part-time	6.0%
Self-employed	10.3%
Fathers' race	
Non-Hispanic White	85.7%
Hispanic/Latino	10.7%
Asian/Pacific Islander	2.4%
Biracial/mixed	1.2%
Fathers' education	
Grade school or less	1.1%
Some high school	2.2%
Graduated from high school	11.0%
Some college	17.6%
Graduated from college	34.1%
Some graduate study	6.6%
Graduate degree	27.5%
Annual household income	
Under $30,000	6.7%
$30,000–$59,000	20.2%
$60,000–$89,000	24.7%
$90,000–$119,000	26.9%
$120,000–$149,000	6.7%
More than $150,000	14.6%
Fathers' relationship status	
Married	90.5%
Partners and living together	1.9%
Single	1.9%
Widowed	1.0%
Divorced	3.8%
Legal separation	1.0%
Child gender	
Female	42.8%
Male	57.2%
Number of children in the household	2.13 (1.12)
Child diagnosis	
Autism Spectrum Disorder (ASD) primary diagnosis	31.0%
Cerebral Palsy (CP) primary diagnosis	18.0%
Mental health	7.0%
Developmental disability	8.0%
Chronic physical disease	5.0%
Other	32.0%

$N = 105$

Procedures

Data for the current study were collected through a cross-sectional anonymous online survey of fathers employed at least part-time, who cared at least part-time for a child with SHCN under the age of 18. The survey was advertised across the United States through online family support groups, blog posts, social media outreach, and outreach to social service organizations working with families in general or fathers specifically. Participating fathers had the option of entering a gift card drawing of $25 as an incentive.

Measures

The online survey consisted of 65 questions and collected information about resources in the workplace, family, and community systems, in addition to demographic information about the father, spouse/partner, and the children, and several work-family measures.

Workplace measures

Questions about the father's work schedule and the impact of using flexibility on career advancement were based on the Support for Working Caregivers Interview Schedule (Brennan et al. 1999) and included work schedules of *standard full-time, flexible work hours, compressed work week, job sharing*, and *other part-time*. Questions about father's workplace flexibility and supervisory support were adapted from the National Study of the Changing Workforce 2008 (Aumann et al. 2011). Flexibility options included flexibility to make short-notice schedule changes, work from somewhere else than the workplace, and access to sick days. Overall access to flexibility, overall use of flexibility, and coworker and supervisor support, was assessed with one question for each item providing answer options of 3 (*low), 2 (medium)*, and 1 (*high)*. The items were reverse coded for data analysis.

Family measures

These questions focused on father's partner status, and the employment status of the partner and the number of hours worked, if applicable. Two questions were used to assess if one fathers were sharing responsibilities for child care and two if fathers shared responsibility for care coordination, giving options of 1 (*I do completely)*, 2 *(mostly I do)*, 3 *(equally shared)*, 4 *(mostly spouse/partner or other does)*, and 5 *(spouse/partner or other does completely*; Brennan et al. 1999). Questions measuring father's flexibility in their family schedule to address either work or childcare issues ranged from 1 (*no flexibility at all)* to 4 (*a lot of flexibility*; Brennan et al. 1999).

Community measures

Questions related to the community domain included a rating with 10 *(almost always helpful)* and 0 *(not at all helpful)*, which allowed fathers to rate the helpfulness of child care, after school care, school, public transportation, and health services. Fathers also provided an overall rating of the availability of community services to better integrate work and family including 1 (*high), 2 (moderate)*, and 3 (*low)*. The question was reverse coded for data analysis. A measure from the National Study of the Changing Workforce 2008 (Aumann et al. 2011) rated the level of support fathers received from friends and neighbors when they experience a problem ranging from 1 *(strongly agree)*, 2 *(agree)*, 3 *(disagree)*, to 4 *(strongly disagree)*. The question was also reverse coded for data analysis.

Work family spillover measures

Spillover was measured using four subscales (positive and negative family work and positive and negative work family spillover) developed for the National Survey of Midlife Development in the United States (MIDUS, 1995/1996). Questions for example include "Have the things you do at work helped you deal with personal and practical issues?" or "Has your job reduced the effort you can give to activities at home?" Fathers could rate these questions on a 5-point scale with 1 (*never*) and 5 (*all of the time*). The individual items for each subscale were added and the mean score was calculated dividing the total score by the number of items. The mean scores were used in the analysis. The scale had acceptable reliability with Cronbach's alphas of 0.68 for positive work family spillover, of 0.86 for negative work family spillover, of 0.68 for positive family work spillover, and of 0.71 for negative family work spillover.

Demographics

Descriptive measures included questions about the father's age, race, family composition, education, and household income. Questions also asked about the children's age, race, gender, disability, and how much the health issue affected the child's ability to do things measured on a 3-point Likert scale ranging from 1 (*very little)* to 3 (*a great deal*) adapted from the National Survey of Children with Special Health Care Needs 2009/2010.

Data Analysis

Data were collected with the Qualtrix© online survey software and directly imported into SPSS© for data analysis. Father's and child's race and gender were collected through open-ended questions, with fathers inputting their own descriptor. Terminology was adjusted across all responses for data analysis, in addition to computing the summary scores for the positive and negative work to family and family to work spillover scales by reverse scoring items if needed and adding item scores for the four different scales. Preliminary data analysis confirmed that the data were appropriate for conducting regression analyses. Descriptive analysis was used to better understand the demographic make-up of the participating fathers, their children, and household situation. Correlation analysis was employed to look for bivariate correlations between the different

independent variables and between the independent and dependent variables. All independent variables significantly correlated with the dependent variables were included in four separate linear regression analyses to assess the effects of workplace, family, and community resources on positive and negative work family and family work spillover.

Results

Fathers participating in this study had on average 2.13 (SD = 1.13) children with one of these children having SHCN (see Table 1). Children with SHCN were on average 7.47 years old (SD = 4.14) with a fairly equal distribution of male and female gender identities (57% male; 43% female). The children were also predominantly identified as Non-Hispanic White (74%), followed by Hispanic/Latino (13%), and mixed race (8%). The most often cited primary diagnosis was Autism Spectrum Disorder, with Cerebral Palsy being the second most reported diagnosis. Special health care needs also included mental health related concerns, developmental disabilities, and chronic physical conditions. Independent of diagnosis, 94.4% of fathers reported that the child's health issues affected the child *some* or *a great deal*.

Analyzing the level of workplace supports available to fathers, it can be noted that fathers in this sample reported fairly high levels of job related resources. For example, almost three quarters of fathers reported having access to sick leave (73.5%) and being able to implement short-notice schedule changes (73.8%). Over half of the fathers assessed their supervisors as highly supportive (52.4%), and almost half of them said the same thing about their coworkers (43.7%). Only 12% of fathers reported limited access to workplace flexibility. Despite these overall high to moderate levels of workplace supports, more than 50% of fathers somewhat or strongly agreed that the use of flexibility and their family responsibilities had impacted their careers.

Fathers also reported moderate to high levels of family flexibility. Most fathers indicated that their spouses were mostly responsible for care coordination (46.6%) and child care (48.1%), followed by equally shared care responsibilities (37.5% and 25.2% respectively). Consequently, 61% reported having some family flexibility to handle work and 64% to handle child care issues, with 23% and 24% respectively reporting a lot of family flexibility.

Access to community supports was not as prevalent in this sample, with almost half of the fathers rating the general availability of community services as low (44.4%). When analyzing the helpfulness of specific services, the average score for child care was 5.15 (SD = 3.39), for school 6.08 (SD = 2.87), after-school care 4.25 (SD = 3.52), public transportation 2.89 (SD = 3.04), and health care 6.12 (SD = 3.04). This indicates slightly above moderate scores for the helpfulness of school and health care, moderate scores for child care, and below moderate scores for after school care and public transportation. Support from friends and neighbors was higher rated with 52% of the fathers agreeing or strongly agreeing that they had the support from friends and neighbors that they needed.

Fathers' positive and negative work family and family work spillover scores were mid-range. The mean score for positive work family spillover was 11.63 (SD = 2.60), with a range of scores from 4 to 19 and the mean score for positive family work spillover was 9.06 (SD = 2.24) ranging from 3 to 14. The mean score for negative work family spillover was 12.44 (SD = 2.78) with a range from 5 to 20, and the mean score for negative family work spillover was 12.49 (SD = 2.39), ranging from 6 to 19. Fathers showed significantly higher levels of negative spillover than positive spillover ($t(95) = -3.49$, $p = .000$). Spillover scores of this sample were also compared to scores of men who participated in the nationally representative MIDUS study (Grzywacz and Marks 2000). Fathers caring for children with SHCN scored significantly higher on positive work family spillover ($t(93) = 3.68$, $p = 0.000$), and on both negative spillover scales ($t_{fw}(95) = 16.61$, $p_{fw} = 0.00$ and $t_{wf}(93) = 6.28$, $p_{wf} = 0.00$), and significantly lower on positive family work spillover ($t(95) = -5.05$, $p = 0.000$) compared to men in the MIDUS sample.

Bivariate Correlations between Work, Family, and Community Resources and Spillover

Bivariate correlation analysis was used to further explore significant relationships between the independent variables, and between the independent and dependent variables (see Table 2). All of the workplace resource variables were positively and significantly correlated. Therefore, fathers who reported more supportive supervisors and coworkers also reported more access to and use of workplace flexibility, and they were more likely to report access to work time and workplace flexibility, and to sick days.

Data analysis also demonstrated correlations between workplace and family supports, with fathers who indicated having more supportive supervisors also saying that they had more flexibility in their family to address both work and child care issues. Fathers with partners and with partners who were not employed were less likely to take on the main responsibility for child care and care coordination. Data analysis demonstrated similar connections between the community and work, and community and family microsystems. Fathers who stated in the survey that they had more supportive supervisors also experienced their community services as more helpful for integrating work and family, and greater helpfulness of services was positively

Table 2 Correlations independent and dependent variables

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1 Schedule														
2 Access flex	0.054													
3 Use flex	0.002	0.494**												
4 Supervisor sup.	0.065	0.463**	0.232*											
5 Coworker sup.	0.072	0.373**	0.204*	0.606**										
6 Flextime	−0.056	0.532**	0.336**	0.398**	0.363**									
7 Flexplace	0.096	0.425**	0.277**	0.201*	0.210*	0.336**								
8 Sick days	−0.127	0.296**	0.220*	0.286**	0.088	0.261**	0.253*							
9 Empl. part.	−0.201*	0.065	−0.012	0.080	0.129	−0.007	−0.010	0.046						
10 Resp. childcare	−0.261*	0.023	−0.132	−0.053	−0.088	−0.061	−0.137	0.053	0.333*					
11 Resp. care coord.	−0.140	−0.021	−0.092	−0.043	−0.025	−0.053	−0.038	0.025	0.238*	0.774**				
12 Flex. work	−0.089	0.151	0.058	0.264*	0.188	0.185	0.035	−0.047	0.151	0.157	0.179			
13 Flex childcare	−0.064	0.196*	0.036	0.196*	0.123	0.081	0.066	0.109	0.131	−0.018	−0.018	0.621**		
14 Services	0.214*	0.116	0.009	0.260**	0.186	−0.003	0.158	0.119	−0.100	−0.079	0.086	0.285**	0.290**	
15 Friend sup.	0.129	0.206*	0.173	0.354*	0.245*	0.120	0.112	0.101	0.037	0.049	0.046	0.384**	0.231*	0.337**
16 Marital status	0.018	−0.049	0.061	0.050	0.048	0.012	0.186	−0.005	0.093	−0.423**	−0.284**	0.021	0.058	0.121
17 # children	0.084	0.187	0.256*	0.023	−0.075	0.159	−0.040	−0.141	0.157	0.084	−0.082	0.051	−0.097	−0.099
18 Age youngest child	−0.108	−0.047	−0.045	−0.010	0.105	0.064	0.028	−0.035	−0.014	−0.142	−0.110	0.004	−0.117	−0.076
19 Symptom level	−0.076	0.022	−0.039	−0.163	−0.069	−0.018	−0.196	−0.039	0.062	0.002	−0.069	−0.059	−0.098	−0.157
20 Education	0.016	0.188	0.040	0.107	0.089	0.295**	0.178	0.299**	−0.142	−0.052	−0.011	0.076	0.112	0.070
21 Father age	−0.078	0.092	−0.008	0.068	0.072	0.088	0.067	−0.095	−0.041	−0.193	−0.062	0.100	−0.075	0.006
22 Income	0.048	0.253*	−0.012	0.107	0.167	0.322**	0.511**	0.289**	−0.198	0.152	0.120	0.175	0.223*	0.112
23 Father race	−0.046	0.036	0.225*	0.011	−0.032	0.027	−0.162	0.169	−0.055	0.132	−0.001	0.057	0.061	−0.021
24 Childcare	0.173	0.310*	0.285*	0.210	0.162	0.107	0.212	0.197	−0.143	0.024	0.087	0.262	0.349**	0.556**
25 School	0.178	0.188	0.043	0.263*	0.252*	0.177	1.77	0.070	−0.137	−0.131	−0.146	0.335**	0.323**	0.406**
26 After-school care	−0.195	0.117	0.097	0.286	0.169	0.229	0.229	0.077	−0.212	0.046	0.022	0.444**	0.373*	0.348*
27 Pub. transp.	0.054	0.215	0.310	0.252	0.402*	0.135	0.135	0.163	−0.217	0.108	0.136	0.387*	0.435*	0.480**
28 Health care	0.048	0.201	0.045	0.382**	0.246*	0.057	0.057	0.140	−0.18	0.000	0.134	0.329**	0.381**	0.417**
29 Pos. W-F	0.136	0.238*	0.047	0.159	0.201†	0.151	0.118	0.181	−0.045	−0.050	−0.073	0.127	0.157	−0.089
30 Pos. F-W	−0.045	0.154	0.016	0.229*	0.206*	0.102	0.115	0.100	0.009	0.223*	0.280**	0.361**	0.255*	0.218*
31 Neg. W-F	−0.073	0.028	0.061	−0.031	−0.112	0.121	0.006	0.004	0.148	0.247*	0.156	−0.043	0.040	−0.148
32 Neg. F-W	0.101	−0.133	0.174	−0.202*	−0.152	0.025	0.054	−0.054	−0.138	−0.244*	−0.249*	−0.382**	−0.259*	−0.319**

Table 2 (continued)

	15	16	17	18	19	20	21	22	23	24	25	26	27	28
Marital status	−0.036													
# children	0.028	−0.034												
Age youngest child	0.019	0.232*	−0.259*											
Symptom level	−0.101	−0.149	−0.120	−0.020										
Education	0.020	−0.066	−0.097	0.022	−0.181									
Father age	−0.190	0.309**	−0.074	0.465**	−0.005	0.047								
Income	0.015	−0.190	−0.068	−0.125	0.047	0.352**	0.014							
Father race	0.071	−0.127	0.129	−0.099	0.051	−0.157	−0.213	−0.064						
Childcare	0.263	0.098	−0.047	−0.298*	−0.212	0.190	−0.069	0.157	0.026					
School	0.135	0.134	−0.078	0.150	−0.111	0.175	0.096	0.211	0.075	0.495**				
After-school care	0.291	0.200	−0.161	−0.003	−0.317	0.057	0.129	0.343*	0.000	0.886**	0.533**			
Pub. transp.	0.433*	−.136	−0.423*	−0.108	−0.008	0.264	−0.152	0.341	0.118	0.599**	0.350*	0.528*		
Health care	0.376**	−0.025	−0.119	0.059	−0.132	0.153	−0.104	−0.124	−0.094	0.312*	0.379**	0.326	0.338	
Pos. W-F	0.251*	0.051	0.083	0.042	−0.092	0.204†	−0.236*	0.042	0.015	0.034.	0.227†	−0.014	0.261	0.305*
Pos. F-W	0.473**	−0.082	−0.021	−0.065	−0.231*	0.116	−0.101	0.198†	0.102	0.303*	0.215†	0.312†	0.184	0.287*
Neg. W-F	−0.260*	−0.175	0.183†	−0.167	0.019	−0.101	−0.183	0.027	0.080	−0.075	−0.075	−0.210	−0.026	−0.103
Neg. F-W	−0.421**	0.118	0.108	−0.067	0.071	0.083	0.024	−0.037	−0.074	−0.133	−0.133	−0.271†	−0.176	−0.232*

1 = Schedule, 2 = Access to flexibility, 3 = Use of flexibility, 4 = Supervisor support, 5 = coworker support, 6 = Flextime, 7 = Flexplace, 8 = sick days, 9 = Employment partner, 10 = Responsibility child care, 11 = Responsibility care coordination, 12 = Flexibility work issues, 13 = Flexibility child care issues, 14 = Availability of services, 15 = Friend and neighbor support, 16 = Marital status, 17 = Number of children, 18 = Age of the youngest child, 19 = Symptom severity, 20 = Education, 21 = Father's age, 22 = Income, 23 = Father's race, 24 = Helpfulness childcare, 25 = Helpfulness school, 26 = Helpfulness after school care, 27 = Public transportation, 28 = Helpfulness health care, 29 = Positive work family spillover, 30 = Positive family work spillover, 31 = Negative work family spillover, 32 = Negative family work spillover

$N = 105$

†$p < 0.10$. *$p < 0.05$. **$p < 0.01$

correlated to increased family flexibility to address work and child care issues. When looking at the individual services, child care, school, after school care, public transportation, and health care services were all positively correlated with family flexibility. Support from friends and neighbors demonstrated similar patterns with workplace and family support. When looking at the demographic variables, severity of the child's symptoms was not correlated with any of the resources in the three systems, but more educated fathers were more likely to have access to sick days and flexible time schedules. Similarly, fathers in households with higher incomes reported greater access to flexibility including flexibility in schedule and workplace, and access to sick days.

Access to workplace flexibility and support from friends and neighbors were positively and significantly correlated to positive work family spillover. Father's age was negatively correlated. Support from supervisors and coworkers, reduced responsibility for child care and care coordination, flexibility in the family for work and child care issues, availability of services, and support from friends and neighbors were all positive predictors of positive family work spillover. The severity of the child's symptoms was a negative predictor of positive family work spillover. Fathers reporting less responsibility for child care also reported greater levels of negative work family spillover, and more support from friends and neighbors was related to lower levels of negative work family spillover. More supervisor support, less responsibility for child care and care coordination, more flexibility for work and child care issues, more supportive services, and friendships were correlated with less negative family work spillover.

Workplace, Family, and Community Resources and their Effects on Positive and Negative Spillover

Stepwise linear regression analysis was employed to assess the impact of workplace, family, and community resources on positive and negative work family and family work spillover for fathers caring for children with SHCN (see Table 3). All independent variables significantly correlated in bivariate analysis were included in each of the four regression analyses. In a first step workplace variables were added, followed by family resources on step two, community resources on step three, and demographic controls in the final step.

Support from friends and neighbors was the only significant predictor for positive work family spillover before the addition of demographic variables. All independent variables taken together predicted 20% of variance in positive work family spillover.

Support from friends and neighbors was also a significant positive predictor of positive family work spillover. This predictor remained significant once all variables were entered in the model. The full model predicted 34% of variance in positive family work spillover.

Fathers who reported more flexibility in their families to address work responsibilities reported less negative work family spillover. This predictor did not remain significant once community resources were added, with support from friends and neighbors being a significant negative predictor of negative work family spillover. Older fathers, and fathers with greater access to workplace flexibility and more support from friends and neighbors reported more negative work family spillover. The full model predicted 37% of variance in negative work family spillover.

Use of workplace flexibility and support from friends and neighbors were both significant predictors of negative family work spillover after controlling for all the workplace, family, and community resources. Greater use of workplace flexibility predicted greater levels of negative family work spillover, and more support from friends and neighbors was a negative predictor of negative family work spillover. The full model predicted 39% of variance in negative family work spillover.

Discussion

This study aimed at addressing what workplace, family, and community resources influenced positive and negative work family and family work spillover for working fathers of children with SHCN. Results indicate that fathers used workplace, family, and community resources to mitigate the demands of work and care responsibilities supporting Voydanoff's (2005a) theoretical framework of work, family, and community microsystems as critical for integrating work and family demands.

Specifically, this study highlights the importance of community supports for fathers caring for children with SHCN. Fathers who rated services as more helpful also reported more positive family work and less negative family work spillover. Childcare and health care services were the specific services with significant correlations to positive and negative family work spillover and positive work family spillover. Unfortunately, in general community resources were experienced as not very helpful in integrating work and care demands; only a minority of fathers rated the availability of community resources as high, which aligns with current research (Ceglowski et al. 2009; Emlen 2010; Jinnah and Stoneman 2007; Rosenzweig et al. 2008). In addition to service supports, fathers also appeared to rely on support from friends and neighbors, with support from friends and neighbors being a significant predictor of all dimensions of work family and family work spillover. This finding is in line with existing research that demonstrates

Table 3 Stepwise linear regression of workplace, family, and community resources on spillover

		Positive W F Spillover				Positive F W Spillover				Negative W F Spillover				Negative F W Spillover			
Step	Predictor	R^2	*B*	*SE B*	β	R^2	*B*	*SE B*	β	R^2	*B*	*SE B*	β	R^2	*B*	*SE B*	β
1		0.09				0.08				0.08				0.08			
	Access workplace flexibility		0.22	0.51	0.06		0.15	.45	0.05		0.81	0.54	0.21		−0.77	.50	−0.22
	Use workplace flexibility		−0.14	0.44	−0.04		−0.14	.39	−0.05		0.14	0.47	0.04		0.90	.43	.027*
	Supervisor support		0.48	0.54	0.13		0.33	.48	0.10		−0.38	0.57	−0.10		−0.33	.53	−0.09
	Coworker support		0.64	0.48	0.18		0.64	.42	0.21		−0.81	0.51	−0.65		−0.18	.47	−0.05
2		0.12				0.20				0.16							
	Access workplace flexibility		0.41	0.54	0.11		−0.06	0.45	−0.02		0.53	0.56	0.14	0.26			
	Use workplace flexibility		−0.30	.045	−0.09		−0.07	0.38	−0.02		0.31	0.47	.09		−0.41	0.48	−0.12
	Supervisor support		0.39	0.55	0.10		0.29	0.47	0.09		−0.17	0.57	−.04		0.83	0.41	0.25*
	Coworker support		0.57	0.49	0.16		0.67	0.41	.022		−0.73	0.51	−.20		−0.18	0.50	−0.05
	Responsibility child care		−0.45	0.50	−0.17		0.03	0.42	0.16		0.88	0.51	.31t		−0.31	0.44	−0.09
	Responsibility care coordination		−0.04	0.41	−0.02		0.47	0.33	0.25		−0.34	0.40	−.83		−0.51	0.44	−.019
	Family flexibility work issues		0.47	0.55	0.12		0.56	0.47	0.16		−1.20	0.58	−29*		−1.03	0.50	−0.27*
	Family flexibility child care		−0.13	0.61	−0.03		0.23	0.52	0.06		0.72	0.63	0.16		−0.33	0.55	−0.08
3		0.18				0.32				0.28				0.39			
	Access workplace flexibility		0.40	0.53	0.11		−0.16	0.43	−0.05		0.63	0.53	0.16		−0.30	0.45	−0.08
	Use workplace flexibility		−0.53	0.46	−0.16		−0.25	0.37	−0.08		0.54	0.45	0.15		1.02	0.39	0.31**
	Supervisor support		0.37	0.54	0.10		0.15	0.44	0.05		−0.04	0.54	−0.01		−0.02	0.46	−0.00
	Coworker support		0.40	0.49	0.11		0.49	0.39	0.16		−0.51	0.49	−0.14		−0.11	0.41	−0.03
	Responsibility child care		−0.55	0.50	−0.21		0.02	0.40	0.01		0.90	0.49	0.32t		−0.53	0.42	−0.20
	Responsibility care coordination		0.01	0.40	0.01		0.47	0.31	0.24		−0.34	0.39	−0.15		−0.13	0.33	−0.06
	Family flexibility work issues		0.22	0.56	0.06		0.16	0.46	0.04		−0.69	0.56	−0.17		−0.57	0.48	−0.15
	Family flexibility child care		0.15	.61	0.04		0.47	0.49	0.12		0.50	0.61	0.11		−0.57	.52	−0.13
	Service support		−0.56	.46	−0.15		−0.01	0.37	−0.00		−0.08	.45	−0.02		−0.09	0.39	−0.03
	Support friends/neighbors		0.74	.35	0.28*		0.91	0.28	0.39**		−1.05	0.34	−0.38**		−1.01	0.29	−0.39***
4		0.20				0.34				0.37				0.39			
	Access workplace flexibility		0.58	0.56	0.16		−0.10	0.45	−0.03		1.06	0.53	0.28*		−0.21	0.48	−0.06
	Use workplace flexibility		−0.54	0.46	−0.16		−0.26	0.37	−0.08		0.51	0.43	0.14		1.02	0.39	0.30**
	Supervisor support		0.32	0.57	0.09		0.02	0.46	0.01		−0.20	0.53	−0.05		−0.08	0.48	−0.02
	Coworker support		0.45	0.50	0.13		0.56	0.40	0.18		−0.39	0.47	−0.11		−0.07	0.42	−0.02
	Responsibility child care		−0.72	0.52	−0.27		0.08	0.41	0.03		0.57	0.48	0.20		−0.56	0.44	−0.21
	Responsibility care coordination		0.10	0.41	0.04		0.42	0.32	0.22		−0.18	0.37	−0.08		−0.12	0.34	−0.06
	Family flexibility work issues		0.44	0.59	0.11		0.19	0.48	0.05		−0.16	0.57	−0.04		−0.48	0.51	−0.12

Table 3 (continued)

Step	Predictor	Positive W F Spillover				Positive F W Spillover				Negative W F Spillover				Negative F W Spillover			
		R^2	B	$SE\ B$	β	R^2	B	$SE\ B$	β	R^2	B	$SE\ B$	β	R^2	B	$SE\ B$	β
	Family flexibility child care		−0.15	0.67	−0.03		0.38	0.54	0.10		−0.18	0.63	−0.04		−0.71	0.57	−0.17
	Service support		−0.58	0.46	−0.16		−0.04	0.37	−0.01		−0.14	0.43	−0.04		−0.11	0.39	−0.03
	Support friends/neighbors		0.59	0.37	0.22		0.90	0.40	0.38**		−1.39	0.35	−0.50***		−1.07	0.31	−0.41***
	Symptom severity		−0.09	0.49	−0.02		−0.48	0.40	−0.13		−0.32	0.49	−0.07		−0.21	0.42	−0.05
	Father's age		−0.05	0.04	−0.17		0.01	0.03	0.03		−0.11	0.04	−0.34**		−0.01	0.03	−0.05

N varies

*$p < 0.05$. **$p < 0.01$. ***$p < 0.001$

the importance of social support for caregivers of children with SHCN (Stewart 2013) and for caregivers of adults with disabilities (Hilbrecht et al. 2017) in addressing work-life integration. Interestingly, support from friends and neighbors was also positively correlated with coworker and supervisor support, which could indicate that the boundary between workplace and community is fluid (Kossek et al. 2006), with coworkers or supervisors also being considered friends.

Workplace resources were also relevant for fathers in this study, which is well documented for fathers in the general population (Aumann et al. 2011; Hammer et al. 2005; Hill et al. 2013; Nomaguchi 2012). Greater levels of supervisor and coworker support were correlated with greater levels of positive family work spillover, and supervisor support was negatively correlated with negative family work spillover. Interestingly, access to workplace flexibility was a positive predictor of negative work family spillover and use of workplace flexibility was a positive predictor of negative family work spillover. Fathers who experienced more demands at home were therefore more likely to use flexibility options, demonstrating the importance of workplace resources to meet care and family obligations. But fathers with greater access to workplace flexibility also reported more negative work family spillover. This could be related to flexibility options contributing to boundary management struggles (Kossek et al. 2006). For example, some fathers might prefer clear boundaries between work and family roles, and certain flexibility options such as telecommuting might not align with this preference creating a sense of work stress for the individual father. This relationship between access to flexibility and negative work family spillover for fathers could also be an indicator of flexibility stigma (Berdahl and Moon 2013), especially since fathers reported higher levels of access to workplace flexibility than actual use of workplace flexibility. Fathers therefore might be reluctant to use flexibility out of fear of negative repercussions associated with flexibility stigma (Venter 2011). Consequently, more than half of the fathers reported negative impacts of flexibility use on their career. As discussed in previous research (Hammer et al. 2005; Nomaguchi 2012), this study shows the importance of organizational support in addition to the mere availability of workplace and work time flexibility policies, since supervisor and coworker support was positively correlated with access and use of flexibility, and with flexibility in schedule and workplace. Similar to fathers in the general population (Allen 2001; Grzywacz and Marks 2000), fathers with more years of education were more likely to have access to sick days and schedule flexibility. Interestingly, fathers who reported less responsibility for child care reported more negative work family spillover. This could mean that either stress experienced in the workplace might keep fathers from

being involved in their children's care, or that these fathers internalized traditional gender expectations of ideal workers and therefore experienced stress from more highly valued work expectations.

In addition, these findings suggest that workplace and community resources were not sufficient to solve the work family puzzle (Emlen 2010). Almost half of the households had only one working parent, and in households with dual working parents the employed partner worked on average fewer hours than the employed father. Employment status of the partner was also correlated with responsibility for child care and care coordination, with partners who were not employed full time being more likely to take on greater responsibilities for both child care and care coordination. A similar effect was found for marital status. Therefore being married or having a partner who was not employed full time can be considered a family resource that allows fathers to spend less time on care-related tasks (Brown 2014; Lewis et al. 2000a; Stewart 2013). It is also important to note that fathers experienced negative work family and family work spillover even when they were not primarily responsible for child care and care coordination. This is a critical addition to the existing research about families caring for children with SHCN, since research so far has focused its attention on mothers as primary providers of child care (Al-Yogan and Cinamon 2008; Lewis et al. 1999; Powers 2003; Porterfield 2002, Sellmaier et al. 2016) or has not identified gender in the samples at all (Brannan and Heflinger 2001; Brennan and Brannan 2005; Brennan et al. 2007; Brown 2014; Heiman 2002; Kuhltau et al. 2005). Symptom level of the child was not a significant predictor in this analysis, but it was negatively correlated with positive family work spillover, providing some support that caring for a child with special health care needs can add stress and responsibilities that might spillover into the work realm. As suggested in previous research (Sellmaier et al. 2016), attention therefore needs to be paid to symptom levels not just diagnosis more generally.

The results of this study also align with Voydanoff's (2005a) theoretical concept of micro systems interacting and building mesosystems of resources and demands. For example, service availability and support from friends and neighbors were correlated with flexibility in the family to address work and child care issues. The microsystems of community and family can be therefore considered a mesosystem with families using boundary-spanning strategies to find the best match between work, family, and community resources and demands. Similar to community and family resources, workplace and family resources appear to interact as well and fathers used workplace strategies to increase family flexibility. For example, fathers who did not work standard full-time hours were more likely to take on more responsibility for child care and fathers who experienced supervisors as more supportive reported more flexibility in their family schedule to address work and child care issues. Greater use of workplace flexibility also correlated with greater family flexibility to address child care issues. Fathers of children with SHCN might select more supportive workplaces knowing that they need workplace flexibility to address the increased family demands (Brennan et al. 2007; Stewart 2013; Brown 2014) and to balance the lack of resources in school and child care (Ceglowski et al. 2009; Rosenzweig et al. 2008). Additionally, the current study confirms Lewis et al.'s (2000a) findings about strategies employed by families with exceptional caregiving responsibilities. Most fathers in the current study fell within the modified single earner or the one-and-a-half earner family strategy. Both of these strategies are considered to provide higher degrees of family flexibility to supplement a lack of resources and flexibility both at work and in the community. Work and family strategies therefore are being employed to respond to family demands and to mitigate a lack of community or workplace resources, demonstrating how the three microsystems interact (Voydanoff 2005a). This issue has also been analyzed through a perspective of work, family, and community resource ecologies, and the moderating relationships between these ecologies (Sellmaier 2019).

Fathers in this study also reported higher levels of negative work family and family work spillover and lower levels of positive family work spillover when compared to men interviewed in the MIDUS study (Grzywacz and Marks 2000). This lends further support to initial studies showing that those fathers caring for children with SHCN face additional challenges in integrating work and family demands (Darling et al. 2012; Sellmaier 2019; Towers 2009; Venter 2011). Being a parent was found to increase negative family work spillover for men in the MIDUS study compared to men without children. Further research is therefore needed to distinguish the negative effects on family work spillover of parenthood more generally and of parenting a child with SHCN more specifically. The authors also reported a positive trend-level association of parenthood with positive family work spillover for men in the MIDUS study, which appears to run counter to the findings of this study. In contrast, the greater level of positive work family spillover for fathers with SHCN shows that employment is not only a source of stress but also a source of respite from the demands at home (Lewis et al. 1999). Being employed provided positive experiences that sustained fathers in meeting their responsibilities at home, and positive experiences at home sustained fathers in meeting their work obligations. Working and caring for children with SHCN therefore needs to be also conceptualized as protective factors. Future research therefore should pay more attention to the positive effects of employment on workers with exceptional caregiving responsibilities.

Limitations

This study is limited in its ability to generalize findings to the larger population of working fathers caring for children with SHCN. The survey was distributed nationwide but the use of an online survey and the use of convenience sampling limit the generalizability of findings. Furthermore, participants were not racially diverse, and most fathers reported a college education, and fairly substantial levels of workplace and family resources. The type of disabilities represented in this study and fathers self-selecting to participate in this study influences the findings as well. Despite these limitations, the study provides an important starting point to better understand the experience of working fathers caring for a child with SHCN. Future research should include more diverse samples of fathers regarding race, income, and education, since access to workplace resources is influenced by demographic and socio-economic factors (Glauber 2008; Grzywacz and Marks 2000; Nomaguchi 2012). Research needs to continue to examine the interactive effects between workplace, family, and community microsystems. Sampling children across different age groups and disability categories could increase understanding of the availability of resources across the family lifespan, especially since community supports are often modeled after the needs of typically-developing children (Jinnah and Stoneman 2007). This current research does not provide a comparison of work family integration for fathers and mothers, but it demonstrates the importance of paying attention to the needs of family members even if they are not primarily responsible for child care. Future research should expand on these preliminary findings to compare experiences of work life fit for both mothers and fathers. Investigating the effects of work, family, and community demands and resources within the couple unit could be especially fruitful, since a reliance on family flexibility can potentially increase conflict and stress between partners and for fathers. As fathers in Venter's (2011) qualitative study reported, fathers might feel guilty for not equally contributing to child care or feel stressed from juggling work and care demands when equally sharing care responsibilities. It can negatively affect the overall household income and women's lifetime earning and retirement benefits, if they reduce work hours or give up employment altogether. Additionally to within couple comparisons, follow-up studies need to compare the impact of workplace, family, and community resources and demands on both fathers of children with SHCN and fathers of typically-developing children to shed further light on the distinct needs of these different groups of care providers.

This study reiterates the need for workplace supports such as supportive supervisors and coworkers, and for flexibility in the workplace and work schedule. It highlights that employers need to address flexibility stigma to retain qualified personnel, since access to flexibility is moot if fathers do not feel safe to actually use it (Thompson et al. 1999). Broader educational messaging might be helpful to raise awareness of the needs of working fathers and of the effects of flexibility stigma on employment and individual well-being. For example, family supportive supervisor behaviors, which include emotional, and instrumental support, creative work family management, and role modeling has been shown to affect work-family conflict, and positive spillover (Hammer et al. 2009). Previous research has similarly argued for employers to train supervisors in these family supportive behaviors to improve organizational and individual outcomes (Kossek et al. 2018).

The lack of support experienced by professional services, calls for an expansion of community services to better support families caring for children with SHCN. This is not only restricted to health care or behavioral health services, but includes adequate and high-quality child care, K-12 schooling, and after-school care. This could include providing after-school care or summer programs for middle school and high-school students with specific health care needs (Jinnah and Stoneman 2007). This could also mean training child care providers, teachers and school personnel to more effectively address behavioral issues so parents do not have to leave work to respond to behavioral emergencies (Rosenzweig et al. 2002) Service providers also need to examine when and how they deliver services to allow working parents to maintain employment, while accessing the services relevant for the well-being of their children. For example, providing services integrated into the school setting, providing after-hours care, or online services could be possible solutions that would allow working fathers greater involvement in the care of their children (Gopalan et al. 2010; van de Luitgaaden and van der Tier 2018).

As shown in this analysis, fathers of children with SHCN struggle with integrating work and family demands even if they are not primary care providers. They rely on workplace and family flexibility and the support from friends and neighbors to address positive and negative spillover. Learning more about these fathers' struggles is critical to more effectively support them in their workplaces, families, and communities. This will not only support father's work-life integration, but also allow them to be an effective parent and partner, and a productive employee and community member.

Compliance with Ethical Standards

Conflict of Interest The author declares that she has no conflict of interest.

Ethical Approval Research involving human subjects: All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee (Portland State University HSRRC Proposal # 143207) and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed Consent Informed consent was obtained from all individual participants included in the study.

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