EFFECTS OF EARLY INTERVENTION ON FAMILY FUNCTIONING

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CHAPTER I

INTRODUCTION

In 1986, Congress passed the Education of the Handicapped Amendments of 1986 (Public Law 99-457) in the form of a formula grant to aid states in developing a comprehensive program of early intervention (Federal Register, 1989). The services outlined were to be for infants and toddlers aged from zero to thirty-six months of age and their families. The components of the law include state definitions of developmental delay, a central directory of information, timetables for serving eligible children, a public awareness and child-find system, evaluation and assessment, individualized family service plans, and a system of procedural safeguards.

One significant part of this new law is that it includes family training with counseling and home visits provided by counselors, social workers, and/or psychologists to assist the family in dealing with the special needs of the child. These services are provided for families to develop a heightened awareness or understanding of their needs, functioning, and how they relate to the child. The new public law found the family becoming the backbone of the Part H (infants and toddlers)

provision of the law. It should be noted that the new provision does mandate an assessment of child and family needs and family strengths related to meeting needs (Dunst, 1989). An assessment of marital relationships, family dysfunction, or family dynamics/stress is not included in the provision of the law. The model implicit in Part H of the law defines assessment and intervention as identifying child and family needs, locating formal and informal sources of support to meet those needs, and helping families use their resources and capabilities to obtain required resources in ways that strengthen child, parent, and family functioning (Dunst, 1989). Dunst (1989) pointed out that the model used predates Public Law 99-457 of October 8, 1986, and was first proposed by Hobbs, Dokecki, Hoover-Dempsey, Moroney, Shayne, and Weeks (1984).

Assessment of Families, Infants, and Toddlers

Public Law (P.L.) 99-457 accomplished several things. First of all, it reauthorized Public Law 94-142, the Education for All Handicapped Children's Act. Part B of P.L. 99-457 extended downward to identify and protect children three to five years old who have special needs. Part H of P.L. 99-457 provided a discretionary program for those children aged from zero to thirty-six months of age.

Under previous legislation, a child was to be evaluated by a team who could administer culturally fair

tests that were normatively based. Individuals who were familiar with the child's needs and capabilities were to be included in the assessment. From this assessment and determination for placement an Individualized Education Plan was written outlining strengths and weaknesses of the child as well as long and short term goals for the child in deficit areas.

Part H requirements of P.L. 99-457 are explicit in stating that a developmentally delayed infant or toddler and their family shall receive (1) a multidisciplinary assessment of unique needs and the identification of services appropriate to meed such needs and (2) a written Individualized Family Service Plan (IFSP) developed by a multidisciplinary team, including the family, defining child and family needs. Specific areas in which the child is assessed are cognition, speech/language, motor coordination, psychosocial adjustment, and self-help skills. The purpose of both family and child assessments is to come together in a statement of the specific early intervention services necessary to meet the unique needs of the infant or toddler and the family. Identifying and providing services to children in the zero to three age range is one part of the program that is more clearly defined than family assessment and provision. In addition to the aforementioned philosophy of a positive proactive stance toward family functioning, Dunst (1989) suggested that Congressional intent is very clear when it comes to

identifying needs and strengths. The needs and strengths of a family are to be identified from their standpoint and not from that of the professional. Hobbs (1975) stressed that the language of Part H reflects a needs-based rather than a service-based or categorical approach to assessment and resource acquisition. The model that this purveys is compensatory in nature. Part H of the law sees the role of assessment and service provision as helping families to identify needs as well as helping them locate formal and informal sources of support to meed those needs. As part of case management (resource coordination) services to the family, locating formal resources includes linking the family with professionals who could provide assistance to meet needs. It should be noted that informal resources to the family (such as church, community, friends, and relatives, etc.) are also a major consideration for help-giving.

To effectively understand what Congress had in mind when they designed Part H, needs and concerns need to be differentiated. A need was defined as something (e.g., a resource) that is desired or lacking but wanted or required to achieve a goal or obtain an outcome (Dunst, 1988). Needs identification is a complex process that involves the personal perception of what is and what ought to be, as well as viewing what can be implemented to correct the disparity. Dunst (1989) suggested that there is a difference between concerns and needs. Concerns are

conditions that recognize the disparity of what is and what ought to be, while needs are conditions that lead to recognitions that assistance, aid, or action will reduce any discrepancy.

From the early intervention point of view, an assessment of family strengths means finding those intra-family resources, competencies, and capabilities that can be used to mobilize extra-family resources to meet needs. This begins with the determination by the family that there is a need to be indicated or expressed. Determining intra-family resources involves asking the family to identify the different types of support available within the family unit, whether it be emotional, companionship, informational, or material. The ways in which these types of support are offered by family members within the family unit, along with the qualitative nature of social ties, can determine the amount or type of outside assistance sought.

Purpose of this Study

The idea of helping a family mobilize resources both formally and informally is the basis for this particular study. The purpose of this study is to see if early intervention support to families makes a difference in the way that they view their own strengths and capabilities. The focus is on what strengths, skills, and knowledge a family has concerning their resources and what their individual potentials can be with early intervention

support. Is the way in which they view their situation and their child(ren) influenced by a program of this nature?

In certain respects, this study is difficult to describe empirically due to the very nature of the program. The research question in this study involved the following: (1) Do early intervention services, as described, affect family functioning style over time, and (2) Are there gender differences as to how male and female caregivers perceive help? Do they differently perceive their own strengths affected during a time of intervention?

The null hypothesis approach to this descriptive study suggests that (1) early intervention services as described do not make a significant difference in the way that families perceive their strengths, and (2) is there a difference between male and female caregivers in their perception of strength?

Assumptions and Limitations of this Study

The study is limited by the number of families that were available in the geographical area being studied and by the fact that ethics dictate that all families with needs who qualify for this early intervention program be served, thus no control group for comparison was available.

CHAPTER II

REVIEW OF RELATED LITERATURE

Aspects that revolve around this particular study involve looking at social support, the prediction of coping behaviors and parenting difficulties, the effects and influences of stress and social support, the importance of networking relationships, helping models, the assessment of social support in the intervention process, gender differences, and a brief consideration of rural versus urban populations.

A Look at Social Support

The social support network influences what parents experience as part of their child rearing efforts and daily lives and is referred to as social support. People that families come in contact with either formally or informally make up the social support network. A priori benefit is realized within the family, but intervention benefits are always a potential and, hopefully, will be realized by the family. Cohen and Syme (1985a) and Sarason and Sarason (1985) stressed that it is now axiomatic to state that social support enhances the well-being of families as well

as lessening stress. Dunst and Trivette (1989) pointed out in an article that social support directly and indirectly influences family functioning and affects such things as family well-being (Patterson & McCubbin, 1983), the ability of a family to adapt to life crises (Moss, 1986), as well as parental styles of interaction and aspirations that parents have for themselves and their children. Child development and behavior is affected by the ways in which parents felt or believe they are competent to handle different situations. Dunst (1985) emphasized that social support networks are most successful when they are responsive to family identified needs. Indicated needs for support is necessary if the support is to have a positive influence and the greatest impact on family functioning. This is one positive argument for a needs-based approach of early intervention. The identification of case management resources from a family's perspective of need is formally reflected not only in the Individualized Family Service Plan that is eventually written after assessment and qualification for the program, but in the public law itself where family assessment is a requirement. Dunst (1985) provided a broad-based definition of early intervention that states early intervention is the provision of support to families of infants and young children from members of informal and formal social support networks that impact both directly and indirectly upon parent, family, and child-functioning. The concept is that early intervention

is the aggregation of many different types of aid to a particular family. Assessment of the family means identifying social support based on family needs that will affect the family in positive ways.

Since the provision of social support is so important from the perspective of the law and the early intervention program, the idea of social support can be operationalized more thoroughly in order to capture a broader view of the dynamics of these interactions. In a paper by Dunst (1989), they borrow from a number of conceptual frameworks (Barrera, 1986; Cohen, Meimelstein, Kamarck, & Hoberman, 1985; Tardy, 1985; Turner, 1983) to describe different components of support and their dimensional features. These frameworks of social support are represented by five different components: relational support, structural support, constitutional support, functional support, and support satisfaction.

Relational support includes organizations, persons, or groups that individuals might deem important to themselves and involve the very existence and quantity of relationships. Structural support refers to the quantitative aspects of the relationship engendered, including physical proximity to other network members, the duration and stability of contracts, frequency of contacts with network members, and reciprocity in social relationships. Constitutional support describes the actual need for help indicated and the match between that need and

the help provided. Dunst and Leet (1987) found that social support influences are greatest when they are indeed responsive to highly personalized family identified needs. Functional support refers to the types of amount of support available, whether these be emotional, instrumental (child care for instance), or material. The quantity of support, as well as quality of support, would be included here. The manner of support request and provision would be included in the definitions of support quality. Support satisfaction is the subjective measurement of how valuable the support is to the family as viewed by the family.

An understanding of these different components and how they could interact is helpful to see the holistic nature of early intervention as it relates to families in this compensatory model. Operationally, relational support is assessed in terms of the existence and quantity of social relationships; constitutional support is assessed in terms of the need for certain types of aid and assistance and the congruence between what is needed and offered; functional support is assessed in terms of the particular types of aid and assistance that are offered by personal social network members and the manner in which support is offered; and satisfaction with support is assessed in terms of the subjective evaluation of the degree to which one feels supported. This example is to show that support to families can be viewed in different ways, but it is for the purpose of helping a family identify needs in different

areas. At the outset, it should be re-emphasized that the assessment and mobilization of social support as part of early intervention practices must be done within the context of the family system and the family's indicated need for support. The family defines the need for service. A need for assistance is not assumed until the family has set forth such a need. This request for assistance might originate with one individual or with the family system. The social support facilitator helps the family crystallize the concern (Pilisuk & Parks, 1986).

Before looking at what effective helping is, it is important to understand how case management is defined. The Federal Register (1989) identifies case managers as enablers and system advocates for families, who function in a facilitating role as needed to assist parents in obtaining services for their child and other family members. The case manager is by law expected to (1) coordinate all services, including those across agency lines, (2) assist parents in accessing services as outlined in the Individualized Family Service Plan, (3) coordinate the provision of early intervention services (e.g. medical services for others than diagnostic or evaluation purposes) that the child needs or is being provided, (4) facilitate the timely delivery of services, (5) continuously seek appropriate services and situations, (6) coordinate the performance of evaluations and assessments, (7) coordinate with medical and health providers and (8) facilitate and

participate in the development, review, and evaluation of the Individualized Family Service Plan.

The first Individual Family Service Plan as shown in Appendix A reflects intervention for a baby girl who was premature and whose parents were mainly concerned with a deficit in her motor development. Beginning with the family's concerns about the child, screening and evaluation in the appropriate areas revealed that she did have a developmental delay in gross motor development. A specific goal for this child at the time involved helping her to roll over from back to front position. The family had many resources available to them which they were already accessing and did not need more than direct therapy to the child and parent training in order to give continued stimulation to the child. Training of caregivers included parents, family (older brothers and sisters), and continued encouragement from the Resource Coordinator as regular home visits were made. According to the amount of involvement of the child and the actual needs of the family, only one goal for the child was determined appropriate by the family at this particular time. The Individual Family Service Plan is structured such that goals may be added or deleted on an ongoing basis with the Resource Coordinator, the family, and the therapist always collaborating to determine current needs.

Appendix B includes a statement of goals for a baby boy who has a condition of microcephaly. The parents are concerned about all areas of development and what they can expect developmentally in the future. They want to obtain as much information as possible on his medical condition. These areas of concern are reflected in goal statements that include the baby being able to recognize sounds, explore his environment, increase his gross motor skills, develop fine and oral motor skills, have continued growth monitoring, along with a need for a support group for the family. The goals statement of this second Individualized Family Service Plan reflects more involved and extended goals and coordination from different service providers including the Resource Coordinator in accordance with the actual needs of the family and child.

These two Individual Family Service Plan's and the goal statements that they represent emphasize the individuality of family needs and the program's sensitivity to those needs.

Since case management is such an important part of the early intervention program, along with various therapies to the child, various ways of approaching case management are recognized.

In a role-focused approach, the case manager carries out the definition of case management by exercising control over resources and services in a way that usurps client responsibility. The case manager sees to service provision

on behalf of the client and makes arrangements for the client. Case management practices that place major emphasis on the control functions of case management appear to do so because they consider clients as generally incompetent, unable to make informed decisions, and therefore receive services in only a passive way. Dependencies are thus created on the part of the case manager, and clients are deprived from learning to do for themselves.

The resource procurement approach to case management defines case management in terms of the relationships between the case management functions and meeting the needs of the client as a procedural goal, but it fails to acknowledge either the positive or negative outcomes of the ways in which resources mobilization occurs (Dunst, 1989). This role does recognize client involvement in deciding needs, but responsibility for helping to meet needs is still left to the case manager. Self sufficient or independent behavior on the part of the client is not promoted (Dunst, 1987, 1988).

A client empowerment approach does define functions, client outcomes, and procedural goals, but it is designed to enhance the client's capabilities in ways that enhance their own capabilities to negotiate different services that they need as well as obtaining resources. The client is encouraged to assume an active role in case management activities. In this approach the case manager views the

client as having existing strengths and stresses the client's ability to be enabled and empowered. This means providing opportunities to and giving authority to the client. The philosophy behind this approach is important because this study involves whether or not family functioning style is affected by this enabling type of case management approach.

The case manager that uses the enabling model (giving authority to) as described by Dunst (1989) views roles in these ways. Help-giver characteristics are those which are proactive and positive, assuming that clients have a capacity to become competent. Family strengths are built upon an active client participation which is encouraged. Case management functions are those which create opportunities for families to become capable and competent using enabling experiences that support and strengthen family functioning (Dunst, 1989). As far as needs/resource identification, families not only actively identify their needs, but take a part in mobilizing for the meeting of needs and play major decision making roles. Because of this, self efficiency and self esteem are enhanced. A family's sense of control is increased and the philosophy of enabling and empowering the family is better realized. The type of support rendered to the families in this early intervention study involved formal therapies and enabled proactive case management.

Prediction of Coping Behaviors and Parenting Difficulties

Friedrich (1979) conducted a study using the Questionnaire on Resource and Stress and found that one important variable which contributed to positive coping skills was the mother's feeling of security in the marital relationship. He reported that this had a significant bearing on her feelings as being capable to cope with her child's handicap. A relationship also existed between residence of the child (institutionalization versus being in the home) and sex of the child. Mothers with institutionalized children appeared to have more stress, as did mothers whose children were female. Marital satisfaction alone accounted for 70% of the predicted validity. It was not determined in this particular study what effect the handicapped child had on the marriage situation.

Ventura (1987) classified sources of stress in the area of parenthood into four areas which include new multiple role demands, spousal interaction (quality of time), provision of infant care that is adequate, and the variability of interaction with kin and other social networks previously available. Belsky, Lang, and Rovine (1985) reported that such stressors can alter marital relationships according to how they are dealt with. It should be noted that marital quality and the transition of marital quality is not consistently found (McHale & Huston,

1985). Although parenting at any level can be stressful, especially with a child who might have a special need, it is a source of great fulfillment also.

Pittman, Wright, and Lloyd (1989) from the University of Utah found several factors directly or indirectly influence parenting difficulty. These were the availability of privacy, the age and number of children in the family, and the income level. The number and age of children affect privacy to the degree that younger children are more demanding, where older children might be able to help more in the home. Income level was a significant predictor for men, even when they were not the sole earner (48%).

Implications for early intervention included an understanding that parenthood is a time of change with new and special needs that perhaps have never been experienced, much less dealt with before, and that the family social structure and needs expressed must be an important consideration as parents are not only given the opportunity but the authority to enhance their individual or family dealings with their special needs infant or toddler.

The Effects of Stress and Social Support

When considering the aforementioned work concerning ecological variables which influence family and personal functioning, Cochran and Brassard (1979) and Powell (1979) suggested that parental attitudes affect family

functioning, and that these support networks influence child socialization and familial interaction with the environment. Increased social support is credited with operating on different psychological levels which include intimate relationships, friendships, and less formal contacts. Cobb (1976) explained that social support networks provide the information that an individual needs to believe that he or she is cared for, loved, valued, and the member of a network that is mutually obligative. A study of the effects of stress and social support on mothers and premature infants by Crnic et al. (1983) yielded information that social support appeared to be a meaningful ecological variable that affected parental attitudes, mother-infant interactions, and infant development. Enhanced child-rearing attitudes are manifested in more positive behavioral patterns. Further studies by Weinraub and Wolf (1983) suggested that parental effectiveness of single and married mothers is enhanced by the availability of support and reduced by increase of stress. Social and emotional support was requested by many single parents as recorded in this particular study.

Dunst (1989) defined social support as satisfaction with various sources of support, and as the number of sources of support available to a particular family. They pointed out that Andrews and Whitney (1976) and Barrera and Ainley (1983) noted that perceived satisfaction of social support networks is a fundamental dimension of the overall

construct of social support. Barrera (1981) was cited as saying that satisfaction with support was a better indicator of emotional well-being than was network size. From a study involving the mediating influences of social support on personal, family, and child outcomes, Dunst (1989) suggested that social support can influence parent, parent-child, and child functioning.

The Importance of Networking

One of the important aspects of the Early Intervention Program is that of helping families and individuals who have developmentally delayed children access resources that they need formally as well as informally. Cognitive theories discuss parental coping in terms of the appraisal of stressful situations and the mobilization of coping processes. Coping processes include the accessing of utilitarian resources such as money and available community programs, health, energy, morale, social networks, general/specific beliefs, and problem solving abilities. Others recognize the importance of proactive networking skills by parents. In a study by Johnson and Sarason (1978), social support was seen to have a positive buffering effect. In other words, high stress families with good social support were able to cope better than did similarly stressed families with low social support. They found that mothers who were depressed and did not feel support in their marriages by their husbands or friends

were less able to reinforce appropriate behavior in their handicapped children. Crockenberg (1981) found that support was more greatly needed in times of increased stress and that low social support was associated with high resistance, high avoidance, and anxious attachment.

One of the main needs seen in an intervention program such as the Early Intervention Program is social support for individuals and families and help in networking with appropriate resources and individuals. Trivette, Deal, and Dunst (1986) linked effective networking to the specification of family needs, identification of sources of support and resources to meet needs, and staff roles in helping families access resources from their support networks. The Family, Infant, and Preschool Program (FIPP) in Morganton, North Carolina, is one such program that subscribes to this philosophy of family help by helping families identify their own needs, locate both formal and informal resources in order to meet those needs, and link families with those identified resources. The reasoning behind this is to enable and empower families in ways that make them more competent for the purpose of increased family, parent, and child functioning. As families are enabled to better network, they realize that opportunities created encourage family members to become more competent and independent with respect to their abilities to mobilize social networks to get needs met and attain desired goals (Trivette, et al. 1986). Empowering families means seeing

family members realize the capabilities that they have to bring into their lives and life situations the resources that they need for their benefit and the benefit of their child(ren).

With early intervention, families are provided services and ideally, best helped when they themselves help access services. This captures the true spirit of enablement and empowerment as it is described in previous contexts. Instead of families being placed in passive roles where professionals explain to them what is best for them, families are not only allowed in the decision making process, but are the focal point of the process. The focus of the program is the family and the program is family driven. As stated in Coordinating Services to Handicapped Children: A Handbook for Interagency Collaboration, the family should have greater opportunity to make choices, make mistakes, and engage the consequences of their own decision making process (Cornwell & Snyder, 1988). This study had particular significance for this particular research because it included families from rural areas. An individual, strength oriented approach is needed in areas where formal community resources are less available, and informal networks (friends, relatives, and community) are recognized as a strength.

Helping Models and Perspectives

The success of the Early Intervention Program is determined by the interaction of help-seekers and help-givers and how they relate to each other. The thread that runs through this explanation involves a philosophy of the family-centered approach to helping. Effective helping includes the individual's or family's perception of their need for help, the manner in which the help is offered, the source of help, the response costs involved in the accepting of help, and the sense of indebtedness that the recipient feels toward the help provider. These are some aspects of help-giving that should be taken into account if help is to be most effective. Most help-seeking models focus on perceptions of problems and needs, courses of actions taken to alleviate problems, and help-seeking itself. These ideas are based upon work done by Brickman, Rabinowitz, Karuza, Coates, Cohn, and Kidder (1982); Gross and McMullen (1983); and DePaulo (1983), respectively. Implications for a family-centered approach come from the above ideas. The family must first believe that they have a problem that needs to be alleviated. A problem or need is seen as a relative phenomenon, and may be defined as an individual's perception of the discrepancy between actual states of conditions and what is considered normative.

A study of Gross and McMullen (1983) explains that a potential help-seeker may accept the problem and do nothing, attempt to solve the problem alone, or seek help

from others. The process of help-seeking is referred to because it must be respected if help-givers are to most effectively help those who have identified needs. Gross and McMullen (1983) pointed out that the way in which perceived problems or difficulties are handled depends largely upon personal, social, or psychological costs to the individual or family. For example, if psychological or financial response costs for seeking help are too high, the individual or family will be less likely to seek help.

Dunst (1989) observed that as far as acting on advice and accepting help was concerned, help was best utilized when there was a match between the nature of help sought and the type of assistance provided. Positive influences could be seen when an aid was responsive to the help perceived or needed. As far as the Early Intervention Program is concerned, implications are that the program must be sensitive to the type of help desired in addition to professional opinion. A good example of this comes from a young mother who had a child with a particular developmental delay. When asked what she needed most at that particular time for her child or herself (various therapies for the child were already in place via another agency), she replied by saying that she needed to find other families in the community who had children with special needs. The need for a support group in this particular case emphasizes that informal support to an individual or family can be an important family resource as

well as formalized services. Another mother's need for respite care by a family or community member is expressive of a type of service that can be assessed informally, but the important idea is that the need is coming from the individual or family and not from the professional. These needs were perceived as being important along with formal physical/occupational/speech therapies provided to the child. The response costs were such that they could be met by relatives or other community members who could lend understanding in non-judgmental ways, and the individuals or families were ready and willing to accept this type of help. Because the need came from within themselves the value of the help was great and readily accepted.

In one particular model of help-seeking and social support developed by Dunst (1989), personal, familial, and situational factors are seen as determining one another. Sets of different characteristics together define an individual's subcultural patterns, and taken together are considered partial determinants of social support and help-seeking (Dunst, 1989). While coping mechanisms are included, help-giving and help-seeking are considered not only interdependent but reciprocal. Dunst (1989) pointed out that this model is based upon work done by Gross and McMullen (1983), Hall and Wellman (1985), House and Kahn (1985), and Wilcox and Birkel (1983), and that subcultural patterns, helping relationships, and coping mechanisms are seen as directly or indirectly influencing the full range

of a person's behavior. Early Intervention in turn must consider all of these facets to be most effective to the help-seeker. Help must not only match the perceived need, but it must be rendered in a way where the help-giver is not considered to be in a position that is higher than the help-seeker. As Dunst (1988) pointed out, powerful others can result in guilt and ambivalence.

Two ways in which models and perspectives to help-seeking and help-giving may be operationalized by the Early Intervention Program are through the Individualized Family Service Plan and resource coordination or case management. When the United States Congress enacted Public Law 99-457 on October 8, 1986, they installed the significant requirement for the IFSP which is to be a procedural tool for identifying and meeting infant and toddler and family needs. One major component of the IFSP is that of case management. The Education of the Handicapped Amendments of 1986 (Federal Register, 1986) defines case management as services provided to families of handicapped infants and toddlers to assist them in gaining access to early intervention and other services identified in the Individualized Family Service Plan. In coordinating services with families, care must be taken when viewing the approach and application of services toward them. Client decision-making abilities must not be usurped by the case manager who tries to assume too much responsibility for the client. Control of service provision must also be shared

with the client. When resources are procured, care must be taken that the client does not become a passive recipient of the services or resources as was aforementioned. The client must be allowed to become actively involved in the building of the program as well as the monitoring and determination of the services needed or rendered. Dunst (1987) defined effective case management as the act of enabling individuals or groups (e.g. a family) to become better able to solve problems, meet needs, or achieve aspirations by promoting acquisition of competencies that support and strengthen functioning in a way that permits a greater sense of individual or group control over its developmental course. Dunst (1989) provided a list of attitudes and behaviors that employ enabling experiences (opportunity-giving). These involve the case manager taking a proactive stance toward the family, emphasizing the family's responsibility for meeting needs and solving problems, assuming that all families have some capacity to understand, learn and manage events in their lives, and to build upon family strengths rather than deficits. Families and professionals may then learn to work together in a collaborative sense with a spirit of mutual respect and information sharing. The case manager and other help-givers can then work with the family, respecting their needs and desires for the betterment of the child and family.

Assessment of Social Support in the Intervention Process

Early intervention, although previously addressed based on child-based or center-based approaches, ideally comes into play when broader ecological considerations (Broffenbrenner, 1979) are made. When it is considered that social networks with which a family comes in contact are important and effects not only their child-rearing efforts, but their daily lives, it is less difficult to see how a holistic approach to family services becomes important. Social support refers to the need for aid and assistance (Cohen & Syme, 1985a; Dunst, 1989). Assessing social support means looking at the various aspects of the family and the environment in which they function. It includes examining needs that the family may have and what resources are available to meet those needs.

Early intervention then is a new program which contains new and old philosophies concerning care-giving. Help-giving can make a difference in the lives of infants and toddlers and their families but may be best approached in this holistic fashion that considers the infant or toddler functioning within a family that is in turn functioning within its total environment.

Along with this is the recognition by help-givers that the help-givers (families) need to play an active and vital role in realizing opportunities, that they have to make a difference in the way that they function, and that they

should be given the authority to play an active part in the process. Thus help-givers need to view help-seekers in new ways and in new roles. Professionals need to relinquish some of their authority to those help-seekers who have perhaps previously been viewed as helpless. The family needs to finally be allowed to make a difference in determining their own fate for their own betterment and the betterment of their child. The word normal finally becomes what is best or normal for that particular family in that particular situation, with help-givers being sensitive as outsiders to that family's real needs in their real situations.

Gender Differences

In examining the different aspects of family functioning, one important element under consideration is the difference between male and female perception of the family situation. Gender is more than an individual characteristic of females and males, and more than a role assumed by or assigned to women and men. Gender in families includes structural constraints and opportunities, beliefs and ideologies, actual arrangements and activities, meanings and experiences, diversity and change, and interaction and relations. The families involved in this particular study were twenty-five heterosexual couples, and a review of literature in the area of gender differences is particularly germane to married male-female caregivers.

Although gender roles in caregiving overlap, husband and wife roles appear to be sex-specific designations. In spite of this, stereotypical portrayals of women as more expressive and men as more instrumental have mixed empirical support. The consistency in the report of emotional distress is recorded in higher levels by women, though. Gender is only one facet of the complex caregiving process, as level of stressors and resources influence caregiving distress outcomes. In a study done on gender differences in spouse caregiver strain, (Coleman, Ganong, Clark, and Madsen, 1989) found that after exposing husbands and wives to the same level of stressors, gender difference reports were mixed. Wives reported significantly more health strain as a result of their caregiving, although their health was reported to be better overall than their husbands. Although wives were reported to be somewhat more caregiving for their husbands than husbands were for their wives in one aspect of this particular study (similar situations were observed), gender differences overall were not statistically significant for amount of stress reported.

A particular aspect that should be noted in the realm of gender differences, whether it be an overall perception of family strengths by an individual or parenting in particular, is that studies indicate that a person's behavior is influenced by the perception of self-efficacy (Bandura, 1977; 1982). People will not necessarily invest

in a particular activity if they do not perceive that they have the skills necessary as well as abilities to produce outcomes that have value. In a study on constructive and destructive parenting by Simons, Whitbeck, Conger, and Melby (1990), it was found that if the father perceived the child as difficult, his ability toward constructive parenting was undermined. In the same study, it was also found that the destructive parenting by the father was influenced by his wife's commitment to individualistic values. Marital satisfaction was given to be a stronger predictor of parenting for mothers than for fathers, and the wife's beliefs concerning the consequences of parenting influenced the parenting practices of her husband. This is interesting in light of the measurement of gender differences that were found in this particular study.

Urban Versus Rural Populations

Although rural versus urban populations were not considered as a variable in this study, the families which took part in the study were from both urban and rural populations. These two types of populations represent a wide variety of values and beliefs. This includes cultural values about raising children, and parent's attitudes and perceptions about raising children affect parental behavior.

Considerations of families and the ways in which they perceive their own strengths might include the idea that

strong traditional beliefs of rural family systems may be explained by strong kinship ties (Straus, 1969). Although rural-urban differences may have decreased, limited association with outside groups can lead to a strengthening of already held values of the rural family. While rural families may depend upon familial tightly-knit structure to obtain resources, the urban family might look for the same kind of resources in a more diverse way.

Coleman et al. (1989) found that rural parents emphasize emotional development in their children more than urban parents. Urban parents emphasized social development more than did rural parents, both of the aforementioned to a significant degree. While no significant effect was found for physical development between rural and urban populations, rural families emphasized intellectual development over urban families to a significant degree. While there was not significant main effect for gender difference in this rural-urban study, it was found that fathers emphasized intellectual development more than mothers, while mothers stressed social development of children more than fathers.

The conclusion was that urban and rural parents hold different views of parenting. It is not known though whether this is due to environmental demands or differing values or a combination of the two.

CHAPTER III

METHODOLOGY

This chapter includes a discussion of the instrument used in this study as well as a description of the subjects, the procedures for evaluations, and the design of the study.

Instrumentation

The Family Functioning Style Scale was used to measure two aspects of family strengths: (1) the extent to which a family is characterized by different qualities and (2) the manner in which different combinations of strengths define a family's unique functioning style (Trivette, et al. 1986). Although the twenty-six items of this scale measure three different areas of interrelated functioning (family identity, information sharing, and coping-resource mobilization), five different distinct factors were identified and scored in the measurement of family strengths concerned with this study: commitment, cohesion, communication, competence, and coping.

In viewing family identity, five aspects of strength are identified. Among these are (1) commitment toward promoting the well-being and growth of individual family

members as well as that of the family unit, (2) appreciation for the small as well as the large things that family members do well, (3) the allocation of time that the family gives to itself to do things together, (4) the sense of purpose that a family has in order to continue through good and bad times, and (5) the congruence that a family has toward those things that it feels are important. All of these five family identity aspects are reflected in the time and energy that a family assigns to meet its needs.

Information sharing aspects include positive communication abilities as well as the family's ability to set rules and values to encourage desired behavior within the unit. The ways in which a family deals with positive and negative feedback within the system is a part of this information sharing network.

The coping-resource mobilization category includes (1) coping strategies of the family, (2) problem solving abilities used for resource procurement, (3) the ability for a family to see problems as a chance to learn and grow, and (4) the ability of a family to utilize resources inside and outside of the family unit to meet needs.

The scale is a self-report measure containing twenty-six items (see Appendix C). Each item is rated on a five point Likert-type scale by noting the degree to which the 26 statements are "Not-at-all-like-my-family" to "Almost-always-like-my-family". This scale was designed specifically for early intervention purposes and was

developed to tap those positive aspects of family that are consistent with commitment, cohesion, communication, competence, and coping.

Internal Consistency

Split-half reliability coefficients and coefficient alpha were .92 when a computation was made using the total number of scale items. When viewing coefficient alpha for the subscale items in each factor, the factor solutions were .84 for commitment, .85 for cohesion, .79 for communication, .79 for competence, and .77 for coping. The Family Functioning Style Scale (FFSS) appears to be an internally consistent instrument.

Construct Validity

Factor analysis using oblique rotation was used to analyze factor discernment of the various items. A scoring form is included (see Appendix D) and illustrates how the various items in the scale are assigned to the various five factors. Oblique rather than orthogonal rotation was used due to the idea that the factors are indeed interrelated. This five factor solution accounted for 60% of the variance. The variance accounted for by these five factors was roughly equally distributed. The indication is that the items in each of the factor categories are measuring equally important, though separate, aspects of family functioning style.

Criterion Validity

When the FFSS was being developed, the Family Hardiness Index was being developed and completed by McCubbin, Comeau, and Harkin in 1987. When 30 comparisons were made between these two scales, 28 were statistically significant. When comparing the five factor scores of the FFSS previously mentioned with the four subscale scores of the FHI, a canonical correlation of $r = .74$, $p < .0001$ existed. This suggests that both scales are measuring similar qualities in the area of family functioning style.

The FFSS originated in the Family, Infant, and Preschool Program (FIPP) in Morganton, North Carolina (Dunst & Trivette, 1989). FIPP is a part of the Northern Carolina Project, which would be classified as a state institution for the mentally disabled. The original participants from which data was collected were 105 parents of preschool aged children who were involved in FIPP. This program is an early intervention program for those residents in a region that surrounds Morganton. The sample included 64 parents of non-handicapped children and 41 parents who had children who were developmentally delayed or disabled. Eighty mothers and 25 fathers were involved in the original study, with 82 mothers or fathers completing the scale independently. Twenty-three scales were completed with the father and mother together.

Preliminary analyses were performed to ascertain the percentage of variance in item scores accounted for the three group contrasts (families of children with disabilities vs. families of non-handicapped children, mothers vs. fathers, and separately completed vs. completed together). The average percentages of variance accounted for in item scores were, respectively, 1%, 1%, and 2% for the three group contrasts. Given the fact that there was almost no covariation between the item scores and the group membership, the sample was considered homogeneous for conducting the reliability and validity analysis (Dunst, 1989).

Subjects

The subjects involved in this descriptive study were those who lived in a nineteen county area in a midwestern state. The nineteen county area that the families were selected from is illustrated by a map in Appendix E. Twenty-five heterogeneous couples participated in this study, each of whom had an infant or toddler that qualified for the early intervention program. By definition, a family qualified for the program by having a infant or toddler from zero to thirty-six months who had a developmental delay of 50% in one area of development or 25% delay in two areas. The areas assessed in the early intervention program are (1) cognition, (2) speech/language, (3) gross motor coordination, (4) self-

help skills (which include oral-motor and fine-motor skills), and (5) psychosocial adjustment. The primary caregivers in each family were represented by intact husband/wife couples with both primary caregivers living in the home. The primary caregivers (husband and wife) were given the scale when the child was first referred to the program as part of a family assessment process. The use of 25 families was arbitrary as the number of families assessed, but because all families referred to the program must be served if the child qualifies for the program, the use of a control group for this descriptive study was ethically unacceptable. The families assessed were those that entered the early intervention program during the months of August and September of 1991, and were assessed as they consecutively entered the program. Heterogeneous demography is represented in the study as some families were from what would be deemed larger populations while other families were from more rural, smaller locations.

Procedures

Families for this study were first identified by the eligibility of their child, as was aforementioned. This involved the referral of the child to the early intervention program by such sources as doctors, neonatal intensive care units, friends, or Public Health Departments. When the child was determined as eligible for the program, an Individual Family Service Plan (IFSP) was

written by the parent, the resource coordinator (case worker), and other professionals who would be directly or indirectly involved in the family's/child's program. This plan outlined services and needs of both family and child, and would enable the Resource Coordinator to assist the family in defining needs according to their own concerns. After the family qualified for the program, the FFSS was administered in person by the Resource Coordinator with the instruction, "Could you please take time to fill out this scale about your family's strengths. Your responses will help me get a better idea of what you consider your family's special capabilities". When a family had been in the program for six months, the FFSS was again administered to the same caregivers in the same way with the same explanation to the family.

Design

In this particular pre and post-test study, all subjects participated in both samplings. The intention was to see if families perceived the areas of commitment, cohesion, communication, competence, and coping differently after a six month period of early intervention services. Gender differences were considered as a variable in the analysis.

Because all subjects available were tested and two variables were in fact measured, this study lends itself to a two variable design. Due to the nature of the subjects

used and the particular way in which the study was arranged, the robustness of ANOVA was affected by the normality and the lack of random sampling. The null hypotheses for the gender variable and family functioning style attitudes were assumed to be independent, and that results would not be statistically significant when measured at a coefficient alpha of .05.

CHAPTER IV

RESULTS

In the particular sample used (n = 50), a one-way ANOVA was used to compare not only pre and post-test scores but gender differences that might exist. The significance level for this study was $p < .05$. These differences were measured and compared in the aforementioned areas of commitment, cohesion, communication, competence, and coping.

In examination of the table of means represented by Table I, it is seen that there was not only a change over time between the pre and post-test, but that female caregivers generally scored higher than male caregivers in each category with the exception of the competence pre-test. The total means for the pre and post-test reveals that females show more of an increase than did males overall. There was a difference in means between pre-test and post-test males and pre-test and post-test females.

Gender Differences

The first variable under consideration in this study was that of gender differences. This variable is identified as "sex" in the summary tables which follow, and

each summary table, whether pre or post, reflects whether there is or is not a significant difference between males and females at that particular time of testing.

TABLE I

COMPARISON OF TABLE OF MEANS

	Commit.	Cohesion	Commun.	Comp.	Coping	Total
			Pre-treatment			
Male	12.20	16.24	12.32	8.24	13.64	62.64
Female	13.60	16.56	15.00	7.72	15.68	68.56
			Post-treatment			
Male	14.20	17.16	15.96	8.80	17.04	73.16
Female	16.68	20.68	19.24	9.96	19.28	85.84

The pre-total score shown in Table II was $F(1,48) = 5.067$ and the post-total $F(1,48) = 36.67$. The critical F value $F(1,48) = 4.04$ when compared with obtained F values reveals that both pre and post-total results were statistically significant. This reflects the difference between males and females overall.

TABLE II

SUMMARY TABLE OF PRE AND POST-TOTALS
FOR GENDER DIFFERENCES

Analysis of Variance for Pre-total

Source	Sum-of-Squares	DF	Mean-Square	F-Ratio	P
Sex	438.080	1	438.080	5.067	0.029
Error	4149.920	48	86.457		

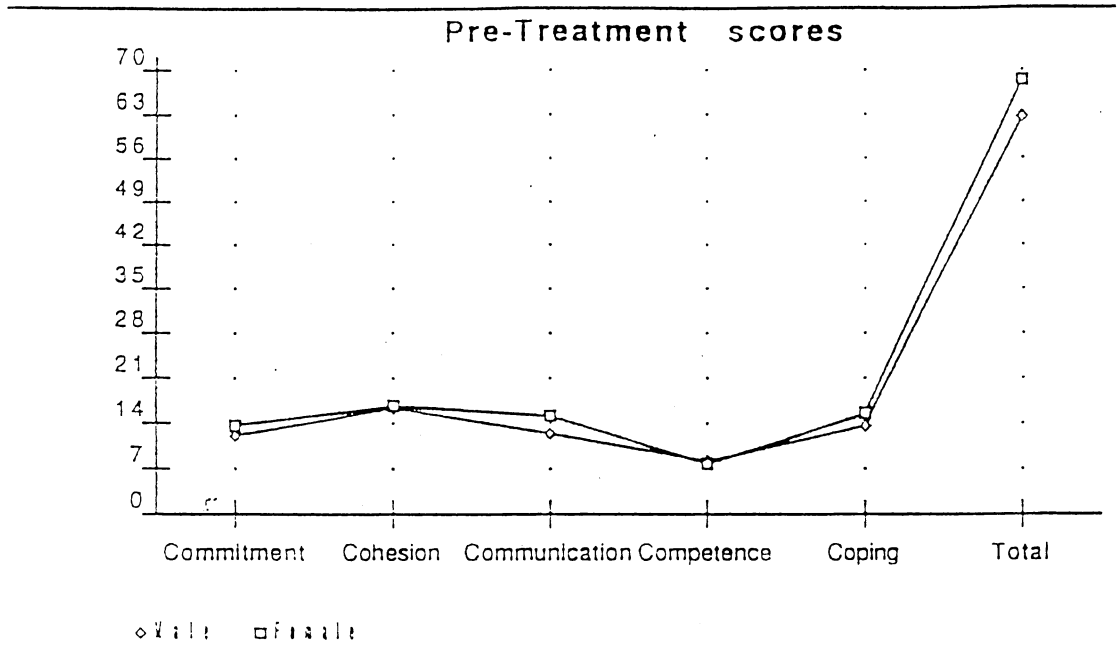
Analysis of Variance for Post-total

Source	Sum-of-Squares	DF	Mean-Square	F-Ratio	P
Sex	2009.780	1	2009.780	36.670	0.000
Error	2630.720	48	54.807		

A line graph presented in Figure 1 illustrates similarities and differences between individual factor and total scores.

Gender Differences for Commitment

Using the same df = 1,48 with a critical F ratio of 4.04, males and females on both pre and post-tests display statistically significant differences. The table of means in Table I reflects that females score slightly higher than males on both the pre and post-tests.



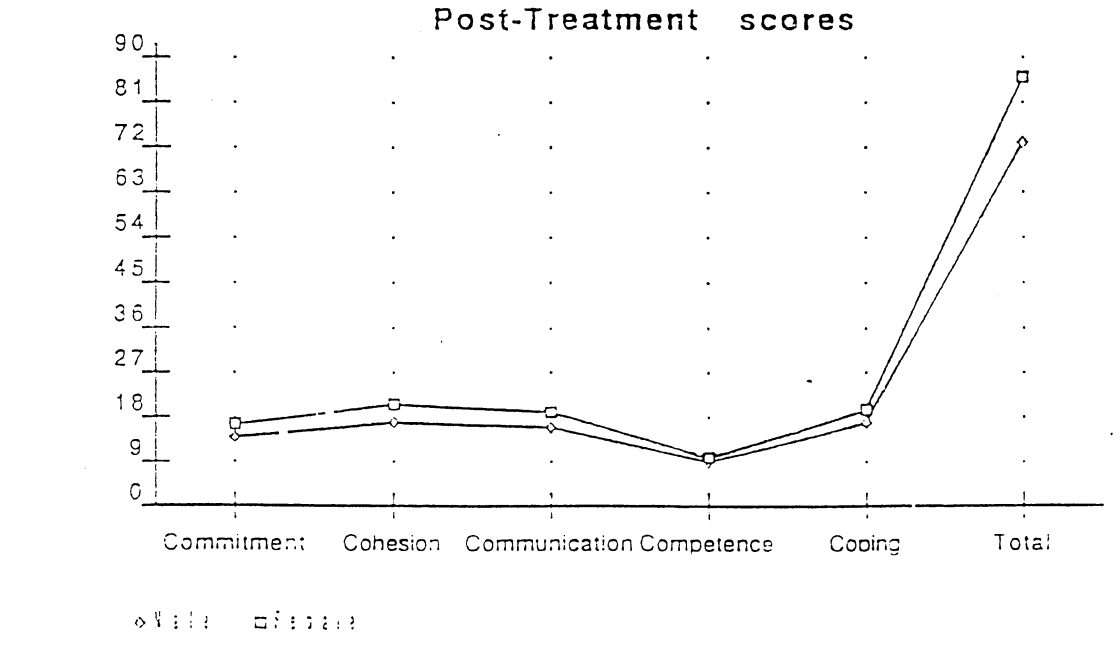


Figure 1: Line Graph Depicting Pre and Post-Treatment Differences in Gender

TABLE III

SUMMARY TABLE FOR PRE AND POST-GENDER DIFFERENCES IN COMMITMENT

Analysis of Variance for Pre-commitment

Source	Sum-of-Squares	DF	Mean-Square	F-Ratio	P
Sex	24.500	1	24.500	5.654	0.021
Error	208.00	48	4.333		

Analysis of Variance for Post-commitment

Source	Sum-of-Squares	DF	Mean-Square	F-Ratio	P
Sex	76.880	1	76.880	20.339	0.000
Error	181.440	48	3.780		

It should be noted in the total score results (Table II) as well as in the area of commitment, the null hypothesis would be rejected in that there is a statistically significant difference between male and female scores.

Gender Differences for Cohesion

In viewing the cohesion factor results, there was no significant difference between the males and females on this sex variable for the pre-test.

The post-test for cohesion, on the other hand, finds a statistically significant difference in this area.

TABLE IV

SUMMARY TABLE FOR PRE AND POST-GENDER DIFFERENCES IN COHESION

Analysis of Variance for Pre-cohesion

Source	Sum-of-Squares	DF	Mean-Square	F-Ratio	P
Sex	1.280	1	1.280	0.165	0.687
Error	372.720	48	7.765		

Analysis of Variance for Post-cohesion

Source	Sum-of-Squares	DF	Mean-Square	F-Ratio	P
Sex	154.880	1	154.880	31.395	0.00
Error	236.800	48	4.933		

Gender Differences for Communication

The communication factor that was measured by the FFSS finds in this sample a statistically significant difference between males and females on both the pre and post-test.

Referring back to the table of means in Table I, females scored higher overall in their recorded scores as to how they viewed the area of communication and its importance in their perception of family functioning style.

TABLE V

SUMMARY TABLE FOR PRE AND POST-GENDER DIFFERENCES IN COMMUNICATION

Analysis of Variance for Pre-communication

Source	Sum-of-Squares	DF	Mean-Square	F-Ratio	P
Sex	89.780	1	89.780	10.474	0.002
Error	411.440	48	8.572		

Analysis of Variance for Post-communication

Source	Sum-of-Squares	DF	Mean-Square	F-Ratio	P
Sex	134.480	1	134.480	22.451	0.000
Error	287.520	48	5.990		

Gender Differences in Competence

In the area of competence, a statistically significant difference was not found between males and females on the pre-test, but was recognized on the post-test. The table of means (Table I) reveals that this was (on the pre-test) the only factor where males scored a higher mean score than did females.

TABLE VI

SUMMARY TABLE FOR PRE AND POST-GENDER DIFFERENCES IN COMPETENCE

Analysis of Variance for Pre-competence

Source	Sum-of-Squares	DF	Mean-Square	F-Ratio	P
Sex	3.380	1	3.380	1.941	0.170
Error	83.600	48	1.742		

Analysis of Variance for Post-competence

Source	Sum-of-Squares	DF	Mean-Square	F-Ratio	P
Sex	16.820	1	16.820	14.690	0.000
Error	54.960	48	1.145		

For the final category considered for gender differences, the ANOVA summary table reveals that in the area of coping there were statistically significant differences between males and females on both the pre and post-tests. The table of means in Table I reveals a slightly greater increase in female scores than male scores for this category.

TABLE VI

SUMMARY TABLE FOR PRE AND POST-GENDER DIFFERENCES IN COPING

Analysis of Variance for Pre-coping

Source	Sum-of-Squares	DF	Mean-Square	F-Ratio	P
Sex	52.020	1	52.020	7.585	0.008
Error	239.200	48	6.858		

Analysis of Variance for Post-coping

Source	Sum-of-Squares	DF	Mean-Square	F-Ratio	P
Sex	62.720	1	62.720	12.977	0.001
Error	232.00	48	4.833		

Pre and Post-Test Comparisons

The second variable under consideration in this study was that of pre and post-test scores for males and females in order to see if there was any change in scores over time.

In viewing the total means for pre- and post-test female scores (68.56 and 85.84 respectively), it is noted that there was an almost 20 point increase between the two measurements. The increase in scores was statistically significant ($F = 558.058$, $p < 0.000$). The male total mean scores also increased over a six month period from 62.64 to 73.16. This F-ratio was also statistically significant ($F = 129.631$, $p < 0.000$). The five factors that were measured will be examined in order to discuss pre and post-test differences which may exist.

In the area of commitment, female mean scores increased from 13.6 to 16.68 from pre to post-test measurements. The observed F-ratio for this particular comparison was 71.291 ($p <0.000$). Again, the critical value of $F(1,48)$ for an alpha level of .05 was 4.04. Rejection or non-rejection of the null hypothesis was considered using this value. Male mean scores for commitment ranged from 12.2 to 14.2 for pre and post-tests with an observed F-value of 44.44 ($p < 0.000$). This expressed a statistically significant difference for male results. The null hypothesis would be rejected for this factor.

In the area of cohesion, female mean scores rose from 16.56 to 20.68 with an observed F-ratio of 126.298 ($p < 0.000$). Male mean scores on the cohesion factor increased from 16.24 to 17.16 with an observed F-ratio of 6.69 ($p < 0.016$).

The communication factor of the FFSS saw an increase in female mean scores from 15 to 19.24 with a statistically significant F-ratio (observed) of 133.895 ($p < 0.000$). Male mean scores rose from 12.32 to 15.96 with a statistically significant F-ratio of 88.567 ($p < 0.000$).

The competence factor revealed an increase in female mean scores from 7.72 to 9.96 with an observed F-ratio of 78.075 ($p < 0.000$). Male mean scores on the pre and post-tests rose somewhat from 8.240 to 8.80 with a statistically significant difference of an observed F-ratio = 10.361 ($p < 0.004$).

The final category, that of coping, revealed pre and post-test increases for both males and females with female mean scores increasing from 15.68 to 19.28 (observed F [1,48] = 149.538) and male mean scores rising from 13.64 to 17.04 with an observed F-ratio of 93.73 ($p < 0.000$).

The findings of mean scores and F-ratios as recorded by this instrument in a pre and post-test situation reveal that there were generally statistically significant increases over time as males and females previewed their strengths of family functioning style in these areas of the FFSS.

CHAPTER V

CONCLUSION

Developing a method of family assessment is indeed a challenge in and of itself due to several aspects. First, family assessment is something that should be considered because meeting family needs in this family-centered, home service-based approach to helping is built into the public law. Another important aspect of family assessment is that in this compensatory model the professionals that help a family enter the home situation while not seeking family pathology or dysfunction. Learning what a family needs in order to best function for them without being intrusive is a major key to helping for the Early Intervention Program. Early Intervention should be one way of educating family in a very non-judgmental way. A third aspect of family assessment that is challenging is the fact that it is not clearly defined as to how these families involved in early intervention programs are going to be assessed. The very nature of the word assessment creates a picture of the family being given a test in order to see how they measure up or compare as if in a testing situation, when the reality of the program is working with infants and toddlers and their families in ways that not only help them but

teach them to access resources. Early intervention then is one way of helping these families to learn skills that they in turn may use over time in order to be better equipped for whatever their futures bring.

The samples of individuals that participated in this study were 25 families that were referred to the early intervention program and whose children qualified for services. Built into this early intervention program was resources coordination or case management for the purpose of lending support and education to these families in addition to the support and education provided by various therapists. The 25 families (represented by male and female care-givers in each family) were given the FFSS when they entered the program and again were given the instrument at the end of a six month period of time in order to ascertain as to whether their perceptions of their own family strengths changed as a result of intervention services. Part of what this measured was not only what was done for them but what they themselves learned to do. The area that the FFSS measured were commitment, cohesion, communication, competence, and coping. The families which participate were chosen in succession over a one month period as they entered the program in lieu of being selected randomly from a larger population and randomly assigned. It was aforementioned that due to the nature of this program, all families referred to the program were served for legal and ethical reasons, thus no control group

could be sued in this particular descriptive study. Families participated who resided in the northwest quadrant of a midwestern state, and the sample used remained intact over the six month period of time between pre and post-testing.

Data for measuring family strengths as portrayed in the FFSS was recorded using mean scores from the pre and post-tests of the FFSS along with summary tables illustrating a one way ANOVA examining gender differences and pre and post-test differences. The purpose of generating this kind of information was to examine whether or not males and females in a particular family perceived family strengths or qualities differently according to the five factors measured on the scale and to examine whether or not there was a change in perceived family strengths over time.

In the preparation of this study, it was recognized that the study would be descriptive in nature based upon the limitations of design and population sample used. Although the particular instrument used for measurement (the FFSS) had not been extensively used in pre and post-test situations, reliability and validity of the instrument appear to be robust. The use of the FFSS in further pre and post-tests situations for early intervention would give an even more realistic picture of how the scale responds in light of the needs of the families of this population (early intervention participants).

In an analysis of this study, it appears that females scored higher than males in the areas measured on pre-treatment scores with the exception of competence. Competence includes the family's perceptions about their own abilities to access the resources that they need. In the post-test mean scores, females showed higher overall scores in all areas. When gender differences as a variable were considered, it appeared that there were statistically and practically significant differences between males and females. In this particular study the null hypothesis would be rejected for both variables measured. The results of the mean score differences and ANOVA findings were encouraging. In the context of this study it was recognized that females generally scored higher than males on the items given, and that over time the family's skills or perceptions in these five areas measured by the FFSS increased or were enhanced.

In the realm of hypothesis testing, we can recognize that there was a statistically significant difference, but that there were also many uncontrolled variables that may have accounted for or contributed to the change in perceptions of family strengths that were not necessarily due to early intervention support. Considering the complexities of the family milieu, an inadequate presupposition would be that any one program or factor contributed alone toward the total enhancement of the family situation. A more appropriate view might be that

the early intervention program contributed by way of helping the family to feel more adept toward their own capabilities and strengths which is the program's primary focus.

The concept of family assessment is fairly new from this early intervention standpoint, and the use of the FFSS in order to determine the way in which a family perceives their own strengths and weaknesses appears to be a non-threatening way to gain information from those families who wish to participate in this kind of assessment. Care should be taken in further use of the instrument by way of establishing with families that it is for the purpose of helping them access resources and finding out what their strong points are. Motives for use are important in that no family assessment, particularly in the context of early intervention program, should be for the purpose of seeking pathology or dysfunction. Family assessment should be used for the purpose of enabling and empowering the family to help itself for the betterment of the family and the child.

The findings of this study should be considered in the context of the family-centered approach where support meets in not only service to the child but also where parents, families, and children are provided support and education in this home-based program.

BIBLIOGRAPHY

Andrews, F., & Whitney, S. (1976). Social Indicators of Well-Being. New York: Plenum.

Bandura, A. (1982). "Self-efficacy mechanism in human agency." American Psychologist. 37:122-147.

Bandura, A. (1977). Social Learning Theory, Englewood Cliffs, NJ: Prentice-Hall.

Barrera, M. (1981). Social support in the adjustment of pregnant adolescents. In B. Gottlieb (Ed.), Social Networks and Social Support. Beverly Hills, Ca.: Sage. 69-96.

Barrera, M., & Ainley, S. (1983). The structure of social support: A conceptual and empirical analysis. Journal of Community Psychology. 11, 133-143.

Barrera, M., Jr. (1986). Distinctions between social support concepts, measures, and models. American Journal of Community Psychology. 14, 413-445.

Belsky, J., Lang, M.E., & Rovine, M. (1985). Stability and change in marriage across the transition to parenthood; A second study. Journal of Marriage and the Family. 47, 855-865.

Brickman, P., Rabinowitz, V., Karuza, J., Coates, D., Cohn, E., & Kidder, L. (1982). Models of helping and coping. American Psychologist. 37, 368-384.

Bronfenbrenner, U. (1979). The Ecology of Human Development. Cambridge: Harvard University Press.

Cobb, S. (1976). Social support as a moderator of life stress. Psychosomatic Medicine. 38, 300-314.

Cochran, K.M. & Brassard, J.A. (1979). Child development and personal social networks. Child Development. 50, 601-616.

Cohen, S., & Syme, S.L. (Eds.). (1985a) Social Support and Health. New York: Academic Press.

Cohen, S., Meimelstein, R., Kamarch, T., & Hoberman, H. (1985). Measuring the functional components of social support. In I.G. Sarason & B.R. Sarason (Eds.). Social Support: Theory, Research, and Applications (pp. 73-90) Dedrecht, The Netherlands: Martinus Nijhoff Publishers.

Coleman, M., Ganong, H., Clark, J. Mary, & Madsen, R. (1989). Journal of Marriage and the Family. 51 (May): 329-335.

Colletta, N. (1981). Social support and the risk of maternal rejection by adolescent mothers. Journal of Psychology. 109, 191-197.

Cornwell, J.R. & Snyder, K.D. (1988). Rural community networking in partnership with families. Rural Special Education Quarterly. 9(3), 23-26.

Crnic, A., Greenberg, M., Ragozin, A., Robinson, N., & Basham, R. (1983). Effects of stress and social support on mothers of premature and full-term infants. Child Development. 54, 209-217.

Crockenberg, S.B. (1981). Infant irritability, mother responsiveness, and social support influences on the security of infant-mother detachment. Child Development. 52, 857-865.

DePaulo, B. (1983). Perspectives on help-seeking. In B.M. DePaulo, A. Nadler, & J. Fisher (Eds.), New Directions in Helping: Vol. 2. Help-seeking. (pp. (3-12). New York: Academic Press.

DePaulo, B., Nadler, A., & Fisher, J. (Eds.). (1983). New Directions in Helping. Vol. 2. Help-seeking. New York: Academic Press.

Dunst, C.J. (1985). Rethinking Early Intervention. Analysis and Intervention in Developmental Disabilities. 5, 165-201.

Dunst, C.J. (1987, December). What is effective helping? Paper presented at the Plenary Session "What is Helping?" held at the Fifth Biennial National Training Institute of the National Center for Clinical Infant Programs, Washington, D.C.

Dunst, C.J. (1988, March). Enabling and empowering families: Ceveats, considerations and consequences. Keynote presentation made at the Early Intervention: Innovations in Service Delivery Conference, Danbury, Ct.

Dunst, C.J. & Leet, H. (1987). Measuring the adequacy of resources in households with young children. Child: Care, Health, and Development. 13, 111-125.

Dunst, C.J. (Ed.) (1989). Family-centered assessment and intervention practices. Family Systems Intervention Monograph. 1, Number 1. Morganton, North Carolina: Family, Infant and Preschool Program, Western Carolina Center.

Federal Register, (Thursday, June 22, 1989 Rules and Regulations Vol. 54, No. 119, p. 2-6312).

Federal Register, 99-860, p. 8. 1986.

Friedrich, W.N. (1979). Predictors of the Coping Behavior of Mothers of Handicapped Children. Journal of Consulting and Clinical Psychology. 47(5), 1140-1141.

Gross, A.E., & McMullen, P.A. (1983). Models of the help-seeking process. In B.M. DePaulo, A. Nadler, & J. Fisher (Eds.) New Directions in Helping. Vol. 2. Help-seeking (pp. 45-70). New York: Academic Press.

Hall, A., & Wellman, B. (1985). Social networks and social support. In S. Cohen & S.L. Syme (Eds.). Social Support and Health. (pp. 23-43). New York: Academic Press.

Hobbs, N. (1975). The Futures of Children. San Francisco: Jossey-Bass.

Hobbs, N., Dokecki, P., Hoover-Dempsey, K., Moroney, R., Shayne, M., & Weeks, K. (1984). Strengthening Families. San Francisco. Jossey-Bass.

House, J.S., & Kahn, R.L. (1985). Measures and concepts of social support. In S. Cohen & S.L. Syme (Eds.). Social Support and Health. (pp. 83-108) New York: Academic Press.

Johnson, J.H., & Sarason, I.G. (1978). Life stress, depression, and anxiety: Internal-external control, a moderator variable. Journal of Psychosomatic Research. 22, 205-208.

McCubbin, H.I., Comeau, J.K., & Harkinm J.A. (1987). Family inventory of resources for management. In H.I. McCubbin & J.M. Patterson (Eds.). Systematic Assessment of Family Stress, Resources, and Coping. (pp. 67-69). St. Paul, Mn: Family Stress and Coping Project.

McHale, S.M. & Huston, T.L. (1985). The effect of the transition to parenthood-on the marriage relationship: A longitudinal study. Journal of Family Issues. 6, 409-433.

Moss, R.H. (Ed.). (1986). Coping with Life Crisis: An Integrated Approach. New York: Plenum Press.

Patterson, J.M., & McCubbin, H.I. (1983). Chronic Illness: Family stress and coping. In C.R. Figley & H.I. McCubbin (Eds.). Stress and the Family: Vol. 11. Coping with Catastrophe. (pp. 21-36). New York: Brunner-Mazel.

Pilisuk, M. & Parks, S.H. (1986). The Healing Web: Social Networks and Human Survival. Hanovers, NH: The University Press of New England.

Pittman, J.F., Wright, C.A. & Lloyd, S.A. (1989). Predicting parenting difficulty. Journal of Family Issues. 10(2), 267-286.

Powell, D.R. (1979). Family-environment relations and early childrearing: the role of social networks and neighborhoods. Journal of Research and Development in Education. 13(1), 1-11.

Folkman, S., Schaffer, C., & Lazarus, R.S. (1979). Cognitive processes as mediators of stress and coping. In V. Hamilton & Warbuton (Eds.). Human Stress and Cognition. (pp. 265-298). New York: Wiley.

Sarason, I.G., & Sarason, B.R. (Eds.). (1985). Social Support: Theory Research and Application. Dordrecht, The Netherlands: Martinus Nijhoff Publishers.

Simons, A., Whitbeck, L., Conger, R., & Melby, J. (1990). Husband and Wife Differences in Determinants of Parenting: A Social Learning and Exchange Model of Parental Behavior. Journal of Marriage and the Family. 375-392.

Straus, M.A. (1969). "Social class and farm-city differences in interaction with kin in relation to societal modernization." Rural Sociology. 34, 477-495.

Tardy, C.H. (1985). Social support measurement. American Journal of Community Psychology. 13, 187-202.

Trivette, C.M., Deal, A., & Dunst, C.J. (1986). Family needs, sources of support, and professional roles: critical elements of family systems assessment and intervention. Diagnostique. 11, 246-267.

Turner, R.J. (1983). Direct, indirect, and moderating effects of social support on psychological distress and associated conditions. In H.B. Kaplan (Ed.) Psychological Stress: Trends in Theory and Research (pp. 105-135). New York: Academic Press.

Ventura, J.N. (1987). The stresses of parenthood re-examined. Family Relations. 36, 26-29.

Weinraub, M. & Wolf, B.M. (1983). Effects of stress and social supports on mother-child interactions in single- and two-parent families. Child Development. 54, 1297-1311.

Wilcox, B.L., & Birkel, R.C. (1983). Social networks and the help-seeking process: A structural perspective. In A. Nadler, J.D. Fisher, & B.M. DePaulo (Eds.). New Directions in Helping: Vol. 3. Applied Perspectives on Help-seeking and Receiving. (pp. 235-253). New York: Academic Press.

APPENDIXES

APPENDIX A

INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP)

PREMATURE BABY GIRL

Issued 9-20-91 EI - 16

SOONERSTART: OKLAHOMA EARLY INTERVENTION PROGRAM

Individualized Family Service Plan (IFSP)

Child's Name Baby Girl Parent Name(s) Mom and Dad

Child's Date of Birth 3-10-92 Age 3 (Months)

EIU Code Somewhere in Oklahoma Interim IFSP Date

Full IFSP Date 6-10-92

Resource Coordinator Sherri Coordinator

Transition Planning Timeline 3-94 Transition Planning Date Initiated

Scheduled IFSP Review Dates:

6 Months 12-92 Date Completed

1 Year 6-93 Date Completed

Other Date Completed

Other Date Completed

Other Date Completed

IFSP / Evaluation Team Members:

NAME	TITLE	ROLE
	Parent	Parent
	Resource Coordinator	Case Management Serv.
	Physical Therapist	provider

IFSP, Page 2

Child's Strengths: She is alert and interacts well with people. She engages in smiling behavior. She attends to sounds and voices well.

Family's Strengths As Related to Enhancing Their Child's Development. (This part is done only with the concurrence of the family.):

The family has a good informal support network with family and friends. The family exhibits a positive outlook. Parents and child have achieved a good attachment.

Family's Resources and Support Sources/Services: Church, friends, extended family

Family's Resources for Transportation (if applicable to services needed by their child): Family has an automobile

Date / Number	Family's Outcome Statement	Responsible Persons	Family/Teach Course of Action (Addressing the Outcome Statement)	Review by Family: Date	Review by Family: Progress Code	Summary/Comments
6-10-92	Baby Girl will learn to roll over	Physical Therapist Parents Family Resource Coordinator	Mom will arrange toys to encourage her to roll P.T. will strengthen trunk muscles through direct therapy and parent education.			
# 1	Baby Girl will begin propping when placed on her stomach.	Physical Therapist Resource Coor. Family Parents	During weekly home visits the Resource Coordinator will provide information encouraging exploration.			
#						
#						

Progress Codes: 1 = Accomplished 2 = Still a Need 3 = No Longer a Need

Issued 9-20-91

Issued 9-20-91

Date	EI SERVICES DELIVERY SUMMARY (Include the frequency, intensity, method, location, initiation date(s), and anticipated duration date(s) for each EI Service)	Signatures
6-10-92	Physical Therapy: 1 hour/month, direct therapy and parent education, homebased, beginning 6-17-92.	
6-10-92	Resource Coordination: 1 hour/week, parent support, homebased, beginning6-17-92.	

APPENDIX B

INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP)

MICROCEPHALY BABY BOY

Second Individualized Family Service Plan with more extensive services for Baby Boy

Date / Number	Family's Outcome Statement	Responsible Persons	Family/Teach Course of Action (Addressing the Outcome Statement)	Review by Family: Date	Review by Family: Progress Code	Summary/Comments
6-10-92 # 1	Baby Boy will make sounds when presented with familiar objects.	Speech Pathologist parents Resource Coordinator Friends	Speech Pathologist will present information on encouraging vocalizations Parents will reinforce and imitate his sounds.			
6-10-92 # 2	Baby Boy will begin exploring his environment.	Child Development Specialist Parents Resource Coordinator	Child Development Spec. will present information on encouraging exploration. Parents will arrange toys just out of his reach to encourage movement.			
6-10-92 # 3	Baby Boy will learn to crawl.	Parents Physical Therapist Resource Coor.	The Physical Therapist will provide exercises on pushing to prone with parent education. The P.T. will provide direct therapy to increase upper body strength.			

Progress Codes: 1 = Accomplished 2 = Still a Need 3 = No Longer a Need

Issued 9-20-91

Second Individualized Service Plan with more extensive services for Baby Boy continued

Date / Number	Family's Outcome Statement	Responsible Persons	Family/Teach Course of Action (Addressing the Outcome Statement)	Review by Family: Date	Review by Family: Progress Code	Summary/Comments
6-10-92 # 4	Baby Boy will learn to eat with a spoon and accept different food textures.	Parents Occupational Therapist Nutritionist Resource Coordinator	Occupational Therapist will use brushes to desensitize mouth. Nutritionist will provide information on food textures and nutritional value.			
6-10-92 # 5	Baby Boy will have growth monitored	Nurse Parents Resource Coordinator	Nurse will chart height and weight. Nurse will monitor health status. Resource Coordinator and nurse will provide information on infection prevention, immunizations and normal growth.			
6-10-92 # 6	Parents will attend Early Intervention Family Support Meetings	Parents Resource Coordinator	Resource Coordinator will provide date, location and topic of meeting.			

Progress Codes: 1 = Accomplished 2 = Still a Need 3 = No Longer a Need

Issued 9-20-91

APPENDIX C

FAMILY FUNCTIONING STYLE SCALE

Listed below are 26 statements about families. Please read each statement, then circle the response which is most true for your family (people living in your home). Please give your honest opinions and feelings. Remember that your family will not be like ALL the statements given.

How is your family like the following statements:	Not at all like my family	A little like my family	Sometimes like my	Usually like my	Almost always
1. We make personal sacrifices if they help our family	0	1	2	3	4
2. We agree about how family members should behave	0	1	2	3	4
3. We believe that something good comes out of even the worst situations	0	1	2	3	4
4. We take pride in even the smallest accomplishments of family members	0	1	2	3	4
5. We share our concerns and feelings in useful ways	0	1	2	3	4
6. Our family sticks together no matter how difficult things get	0	1	2	3	4
7. We can ask for help from persons outside our family if needed	0	1	2	3	4
8. We agree about the things that are important to our family	0	1	2	3	4

		Not at all like my family	A little like my family	Sometimes like my	Usually like my	Almost always
9.	We are willing to "pitch in" and help each other	0	1	2	3	4
10.	We find things to do that keep our minds off our worries	0	1	2	3	4
11.	We try to look "at the bright side of things"	0	1	2	3	4
12.	We find time to be together	0	1	2	3	4
13.	Everyone in our family understand the "rules" about acceptable ways to act	0	1	2	3	4
14.	Friends and relatives are willing to help whenever needed	0	1	2	3	4
15.	Our family is able to make decisions about what to do when we have problems or concerns	0	1	2	3	4
16.	We enjoy time together	0	1	2	3	4
17.	We try to forget our problems or concerns for a while when they seem overwhelming	0	1	2	3	4
18.	Family members are able to listen to "both sides of the story"	0	1	2	3	4
19.	We make time to get things done that are important	0	1	2	3	4

	Not at all like my family	A little like my family	Sometimes like my	Usually like my	Almost always
20. We can depend on the support of each other whenever something goes wrong	0	1	2	3	4
21. We talk about the different ways we deal with problems and concerns	0	1	2	3	4
22. Our family's relationships will outlast our material possessions	0	1	2	3	4
23. We make decisions like moving or changing jobs for the good of all family members	0	1	2	3	4
24. We can depend upon each other	0	1	2	3	4
25. We try not to take each other for granted	0	1	2	3	4
26. We try to solve our problems first before asking others to help	0	1	2	3	4

APPENDIX D

SCORING FORM

SCORING FORM

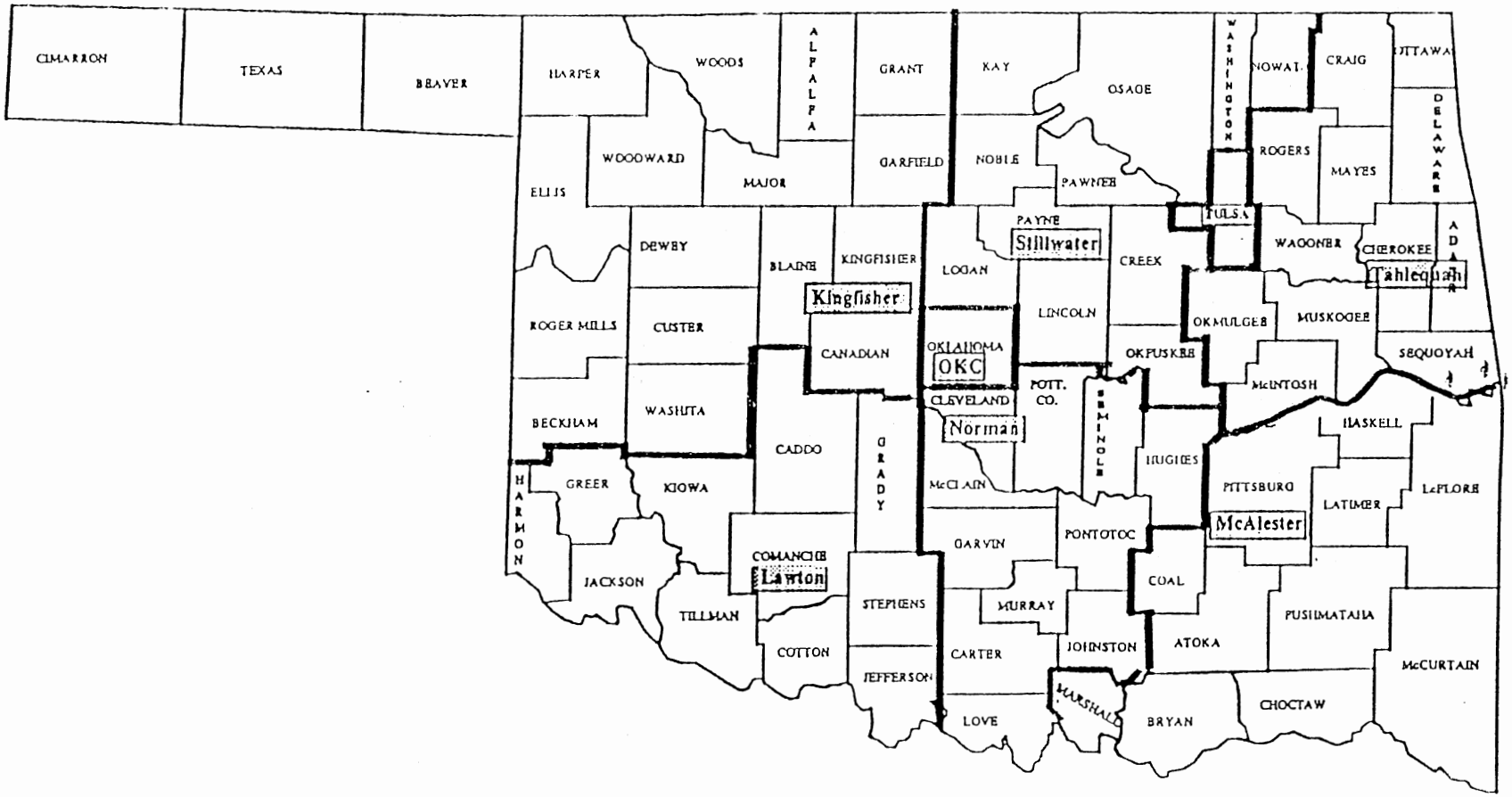
ITEM	Commitment	Cohesion	Communication	Competence	Coping
1		☐		☐	
2					
3			☐		
4		☐			
5			☐		
6		☐			
7					☐
8			☐		
9	☐				
10					☐
11					☐
12	☐				
13					☐
14					☐
15					☐
16	☐				
17			☐		
18			☐		
19	☐				
20				☐	
21			☐		
22		☐			
23		☐			
24		☐			
25	☐				
26				☐	
Subscale Score / Total Possible	/ 20	/ 24	/ 24	/ 12	/ 24

APPENDIX E

PROPOSED EARLY INTERVENTION REGIONS

AND SITES

OCTOBER 1990


CIMARRON
TEXAS
BEAVER
HARPER
WOODS
ALFALFA
GRANT
KAY
OSAGE
WASHINGTON
NOWATA
CRAIG
OTTAWA
WOODWARD
MAJOR
GARFIELD
NOBLE
PAWNEE
ROGERS
MAYES
DELAWARE
ELLIS
DEWEY
BLAINE
KINGFISHER
LOGAN
PAYNE
Stillwater
CREEK
TULSA
WAGONER
CHEROKEE
ADAIR
Tahlequah
ROGER MILLS
CUSTER
Kingfisher
LINCOLN
OKMULGEE
MUSKOGEE
CANADIAN
OKLAHOMA
OKC
OKFUSKEE
SEQUOYAH
BECKHAM
WASHITA
CLEVELAND
POTT. CO.
McINTOSH
Norman
HASKELL
HARMON
GREER
KIOWA
CADDO
GRADY
McCLAIN
HUGHES
PITTSBURG
LATIMER
LeFLORE
McAlester
GARVIN
PONTOTOC
COMANCHE
Lawton
JACKSON
TILLMAN
STEPHENS
MURRAY
COAL
PUSHMATAHA
COTTON
CARTER
JOHNSTON
ATOKA
McCURTAIN
JEFFERSON
MARSHALL
BRYAN
CHOCTAW
LOVE

VITA

John S. Umble

Candidate for the Degree of

Doctor of Philosophy

Thesis: EFFECTS OF EARLY INTERVENTION ON FAMILY FUNCTIONING

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