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THE IMPACT OF THE DEVELOPMENTAL TRAINING MODEL ON STAFF DEVELOPMENT IN AIR FORCE CHILD DEVELOPMENT PROGRAMS

A DISSERTATION

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THE IMPACT OF THE DEVELOPMENTAL TRAINING MODEL ON STAFF DEVELOPMENT IN AIR FORCE CHILD DEVELOPMENT PROGRAMS

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BY

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DEDICATION

This dissertation is dedicated to the loving memory of my father, the late Reverend Albert Alfonso Edmonds, Jr. After three sons, he chose to name his fourth child and only daughter, "Candy," as he often told the story of how he viewed my arrival as a sweet treat from God. For as long as I can remember . . . he was my protector, my confidant, my friend, my biggest fan, my life coach and my knight in shining armor. Equipped with a Holy Bible and a *Reader's Digest*, he inspired a love of learning in me from a very young age. He was the first to ever call me "Princess" and in our 39 years together, not a day went by that he did not treat me as such. His physical body departed this world on November 30, 2009 but his teachings, his spirit and his love for his family, church and community live on forever which makes his earthly exit an even sweeter treat from God.

I love you, Eddie!!!

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ABSTRACT

In an effort to standardize training delivery and to individualize staff development based on observation and reflective practice, the Air Force implemented the Developmental Training Model (DTM) in its Child Development Programs. The goal of the Developmental Training Model is to enhance high quality programs through improvements in the training delivery methodology. DTM is built upon the framework of adult learning as a developmental process and relies on the program Training & Curriculum Specialist to observe, evaluate and deliver training based on the needs of the individual caregiver. Through the application of the DTM, child care employees are able to participate in their own professional development and use each training session as an opportunity to reflect over previous sessions while setting goals for the future. The factor examined in this dissertation was the impact of the implementation of the Developmental Training Model on staff development in Air Force Child Development Programs. This study identifies successes and challenges in staff training since the implementation. In particular, it found that the majority of caregivers felt positively about the impact on staff development but felt ongoing organizational support efforts had been insufficient to sustain perceived benefits. Likewise, input from various stakeholders pointed to a lack of skills and abilities among some Training and Curriculum Specialists combined with a need for increased professional development for this group had reduced potential impact of the new model. Additionally, time management and scheduling were cited as major concerns along with a lack of accessibility to a source for updated information on the Developmental Training Model. In general, the study respondents expressed a hope for continued use of the model and provided a number of suggested improvements to increase its effectiveness in Child Development Programs.

CHAPTER ONE: Introduction

Working families rely on a variety of child care arrangements to ensure children have a safe place to attend while parents are earning a living to support the family. According to Child Care Aware (2007), there are an estimated 12 million children under the age of five in some type of child care every week. Many times for those families not fortunate enough to have access to a caring and willing family member, friend or neighbor to provide their child care needs, child care is sought outside of the home in the form of child care centers. According to a 2007 report by the National Association of Child Care Resource and Referral Agencies (NACCRRA) estimated approximately 2.3 million individuals in the United States earned their living by caring for and educating children age five and under with just over half of these providing child care in formal settings, such as child care centers.

Kreader, Ferguson and Lawrence (2005) found that mentoring of caregivers sustained over time resulted in improved quality. In attempting to design any type of training program to meet the needs of early childhood education staff, intentionality is critical. The field of early childhood education is beginning to make great strides in staff development specifically targeted towards the unique needs of the staff working in the diverse array of program offerings. Gallagher and Clifford (2000) stated

> If we are to have competent staff, a wide array of personnel preparation programs (pre-service and in-service) are necessary, with considerable stress placed on upgrading the capabilities of persons now on the job through short-term training. There needs to be an agreement on a *career ladder* that would allow a person working in early childhood to continuously improve her or himself through personnel preparation. (p. 1)

The National Center for Children in Poverty estimates one-third of children of working mothers under age three spending approximately 35 or more hours in child care. Consequently, it is critical to examine not only facility and structural support issues but internal quality processes such as training as well. Likewise, examining turnover becomes of vital importance as well. Continuity of employees within any organization is typically quintessential to overall organizational effectiveness. As put forth by Stovel and Bontis (2002):

> Research estimates indicate that hiring and training a replacement worker for a lost employee costs approximately 50 percent of the worker's annual salary--but the costs do not stop there. Each time an employee leaves the firm, we presume that productivity drops due to the learning curve involved in understanding the job and the organization. . . . Therefore, HR professionals must not address these situations lightly. Training and development practices, combined with other HR activity such as performance reviews, enable senior management to better understand the needs of their employees. (p. 304)

With regard to turnover in early childhood programs, a 2002 United States General Accounting Office (GAO) report to congressional requesters cited

> Caregiver education and training are also associated with better cognitive development in children. More highly educated or trained caregivers have been found to improve children's school readiness and language comprehension scores. In addition, low staff turnover is associated with children being more competent in language development. (p. 47)

Based on this knowledge, it is evident to the author of this study the reason child care

programs seek to provide increased and more meaningful training opportunities as a catalyst for attracting and retaining quality caregiving staff.

Statement of the Problem

As a Headquarters Family Member Programs Specialist providing staff assistance for military child care facilities located in the continental United States as well as the European and Pacific overseas theaters, the need for flexibility and creativity in terms of providing quality child care training takes on a whole new meaning. Current enrollment reflects an approximate 15% of the children in care reside in homes where parents are either a single military parent or dual military parents. In addition, a significant number of employees live in homes where the spouse or significant other has been deployed for thirty days or more to a remote location within the last 12 months.

With so many Air Force troops having deployed to various locations across the globe over the last five years, many children and several staff are living in extended family situations with friends of the family or nearby neighbors. In several cases, children have been placed with whichever family was willing to provide long-term care for them regardless of whether they had previous interaction or acquaintance with the family.

Individuals in positions such as childcare directors and training and curriculum specialists (trainers) represent what will be referred to as military childcare leadership throughout the course of this dissertation. For these individuals, the current military environment means assuming new roles such as primary disciplinarian, marriage counselor and family historian. In certain situations where children have a history of behavioral, medical or physical challenges, the role of liaison between guardians and the

child is often either the director or the trainer. Consequently, they are often responsible for informing the guardian and sometimes school administrators about the child's special needs and previous conditions. In addition, for most childcare leaders, mass deployments mean changing the way business has typically been done. For instance, instead of serving breakfast and lunch, an evening meal must be added to accommodate those children whose parents are working 12-hour shifts. In addition, parents working increased shifts mean changes in program budgets in terms of increased labor costs and program materials to support children spending longer periods of time in the program. Deployment of military members increases stress that employees may already be experiencing. Military childcare leadership must be able to keenly identify staff developmental readiness and recognize those fluctuations that may occur due to mental stress.

As a result of many of the aforementioned stresses facing military spouses, those spouses working in military childcare programs often leave the organization for a variety of reasons to include their perception of lack of training and poor support from childcare leadership. Despite the fact that military child care remains one of the highest paying vocations on an overseas base, and on several stateside bases, employee turnover still occurs. Because military spouses typically comprise approximately 75% of the military childcare workforce in bases located overseas, it is imperative that leadership look at the relationship between turnover and professional development. Placing a value on quality professional development will help ease the effects of the lack of continuity which eventually translates itself into financial losses for the program in terms of stress-related absenteeism and lost training dollars. Training models of yesterday that relied on staff to

self-educate and operate with little to no reflective practice are no longer adequate to support the needs of today's child care staff. The Developmental Training Model was designed to introduce reflective practice and goal setting into staff development processes. By basing training on direct classroom observations and providing staff with a chance to reflect on their individual and team performance, DTM provided a level of insight and individualization into staff development that did not previously exist. When implementing the DTM, *Air Force News & Views* article (2003) quotes Toni Koppen, Chief of Family Member Programs,

> The Air Force Developmental Training Model is a logical approach to staff training. Meeting adult learners at their levels and assisting them with actively participating in the learning process can only lead to improvement in job performance. (p.14)

Processes such as those embodied in the Developmental Training Model provide a more reflective, interactive and sequential development focus, which is better suited to the needs of the current child care workforce.

Background and Significance

Although heralded by President Clinton as the "model for the nation" in the 1998 White House Symposium on child care, the military child care was once the last place anyone would look for guidance on establishing a quality child care system. According to Lucas (2001),

> At one time, it was known as the 'ghetto of American child care' with unsafe and unsuitable facilities, weak standards that were sporadically enforced, staff who were poorly trained and compensated with turnover rates at some centers as high

as 300%, and a general lack of oversight and attention from military officials. (p.129)

Since that time, the Military Child Care Act of 1989 was passed seeking to impart affordability, quality and availability of child care across all branches of the Department of Defense military child care system. Zellman and Johansen (1998) defined the MCCA as follows:

> The act was designed to address a variety of problems in military child care, including unmet demand, inadequate staff training and low retention, lack of developmental care, inadequate facilities, and uneven quality of care. To address these issues, the act required significant changes in Child Development Center (CDC) funding, operation, and personnel. It required the services to match fee dollars from parents with appropriated funds, to standardize fees based on total family income across services and installations, and to raise caregivers' pay while tying it to training milestones. Unannounced CDC inspections, the development of training materials for child care staff, and the hiring of a training and curriculum specialist at each CDC were mandated as well. (p. 3)

A 2002 report from the National Women's Law Center recalled the days prior to the Military Child Care Act of 1989,

> The military child care system was not meeting the needs' of the families it served. It was plagued by many of the same deficiencies as the civilian child care system today – unaffordable parent fees, extremely long waiting lists for care, and

> poor quality care, marked by a lack of comprehensive quality standards and high staff turnover of poorly trained, poorly compensated caregivers. (p. 1)

Conditions such as these called for a major overhaul of the military child care system. In response to mandatory requirements as set forth in the Military Child Care Act, leadership among the four service branches responded by enhancing provider compensation and training through a systematic approach. Park-Jadotte, Golin and Gault (2002), described the military child care programs as having historically high staff turnover rates with no method to ensure staff was properly trained. As a result, administrators implemented the caregiver pay program in response to the mandated MCCA, which required administrators to address the issue of staff quality. In a Kozaryn (2000) *Armed Forces Press Service News* article, Nancy Duff Campbell, co-director of the National Women's Law Center, remarked,

> Just a decade ago, child care in the military was plagued by problems that are all too familiar to civilian families today. Tens of thousands of children were on waiting lists for care. Military families could not afford care even if they could find it. Caregivers lacked training and were so poorly compensated that they didn't stay long in the field, and the quality of care suffered. (p. 1)

The 2002 National Women's Law Center report reflects on these changes,

> Recognizing that high-quality child care hinges upon a high-quality staff, the military increased provider compensation and training, and linked compensation increases to the achievement of training milestones. All workers are required to take some basic training before they can care for children and then successfully complete an extensive core training program within 18 months . . .. As a result of

these provisions, staff turnover has been dramatically reduced and staff morale and professionalism has been greatly improved. (p. 3)

Another vital portion of the Military Child Care Act of 1989 that had far reaching effects is the requirement to link pay to training. MCCA required military programs to establish a system that linked training and pay. This linkage of compensation to training provided Air Force child care programs a mechanism to attract and retain caregiving staff. However, this link existed only for the purpose of moving staff through the initial core modules. Once those were completed (typically 18 months following initial hire), the training program at many bases lacked standardization and was not always intentionally linked to promoting and advancing program quality. Perhaps most critical, the incentives previously linked to training usually dissipated following completion of the module program. Staff was often stuck in positions and saw very little room for growth professionally as well as in terms of position/rank. The implementation of the Developmental Training Model provided a method for staff to continue their professional development, to meet monthly with a training and curriculum specialist, and to engage in reflective practice and to help shape their own training needs. Unlike the previous training model, DTM included a mechanism for on-going communication between program leadership, the training and curriculum specialist and classroom staff. Another essential element to staff development, the DTM processes provides a method for caregiving staff to self-identify issues in their room, and discuss those as a small group while setting goals to improve classroom quality.

Prior to the implementation of the Developmental Training Model, the training program of the Air Force Child Development Centers was starting to lose the

effectiveness and impact it had once been lauded for in the late 1990s. In April 1997, military child development programs were recognized as the benchmark in child care for the nation. This recognition came through a White House Executive Memorandum, specifically citing the military child care training and wage packages which linked competency-based staff training requirements to wages as a cornerstone of the achievement. This acknowledgement by President Clinton that referred to the DoD child care system as a "model for the nation" came after almost a decade of work implemented as part of the Military Child Care Act. This proclamation has been touted in various articles, presentations and studies over the past 10 years and is often used when comparing standards of quality between civilian and military child care programs. However, by the beginning of the 21st century, that same training program lauded by the National Association for the Education of Young Children had become somewhat antiquated, overly generic and lacked observation-based objectives (L. Tomlinson, personal communication, July 12, 2007.)

Prior to the implementation of the Developmental Training Program, orientation training for new child care staff at most Air Force child development centers consisted of approximately 40 hours of training often given in the form of handing the new staff member a 3-inch binder compiled of various reading materials and several videos to watch. Staff would be taken into a training room and given a large binder of Air Force regulations, policies and procedures to read on their own in preparation for the work ahead. This form of orientation often resulted in the new employee being left alone for hours at a time with an expectation to digest the material presented before them. After reading the material and watching videos on topics such as developmentally appropriate

practices and conducting observations, the staff member would then be released to complete a four-hour observation in a classroom. This observation was typically completed in a vacuum with no feedback or guidance on the experiences and interactions being observed. In addition, new staff received extremely vague guidelines on how to conduct the observation or what to expect while doing so. After completing the four-hour observation, staff would typically be deemed "trained" and subsequently released to begin working in a classroom with children. As a result, these individuals were poorly prepared for the work that lie ahead and consequently experienced feelings of frustration, confusion and isolation in their early days of employment. Likewise, these individuals did not have a strong foundation rooted in developmentally appropriate practice and often translated their orientation into their own teaching style in the classrooms (L. Tomlinson, personal communication, July 12, 2007).

Before implementing the Developmental Training Model, the Air Force relied on the Department of Defense module-training program to serve as the basis of staff development (K. Storc, personal communication, May 17, 2008). Since the early 1990s, the foundation of the Air Force Child Development Center training program had been the multi-series module program developed by Diane Trister Dodge that focused on the 13 functional areas of the Child Development Associate competency standards. The module training program consisted of four primary components: reading the module, completing the skill building exercises within it, completing a knowledge assessment and being observed in the classroom as part of a competency assessment. A typical administration of the modules would instruct staff to begin with Module 10 which addressed "Providing Positive Guidance," followed by Module 1 entitled "Keeping Children Safe" and then

Module 2, “Promoting Good Health and Nutrition” within the first six months of employment. Over the course of their next year and contingent upon continued employment, staff were required to complete the remaining 11 modules: “Creating and Using an Environment for Learning,” “Promoting Physical Development,” “Promoting Cognitive Development,” “Promoting Communication,” “Promoting Creativity,” “Building Children’s Self-Esteem,” “Promoting Social Development,” “Providing Positive Guidance,” “Working with Families,” “Being an Effective Manager” and “Maintaining a Commitment to Professionalism.” The training program was typically administered by a Training and curriculum specialist and monitored by a director (or assistant director) assigned to the child development center (K. Storc, personal communication, May 17, 2008). In addition to the module-training program, staff was required to complete annual child abuse prevention and positive guidance training. This training was administered as part of the orientation process before allowing caregivers to begin working with children and annually thereafter. Once the modules were completed, staff was required to maintain 24 hours of on-going professional development training each subsequent year. This 24-hour training was often completed on various recurring topics such as Family Style Dining, Medication Administration, Playground Safety, Parents as Partners, Smooth Transitions, Finger Plays, Effective Circle Time and other seemingly routine topics. Most of this training was administered year after year with no thought or regard for various provider developmental levels, interests or previous attendance. In addition, the training was typically held late in the evening or on a weekend in conjunction with a staff meeting, almost as an afterthought. In terms of scheduling, providers were mandated to attend and thus suffered lack of retention due to

conflicting feelings of resentment and boredom. Providers expected to gain very little new information from the training and thus gained very little (L. Tomlinson, personal communication, July 12, 2007).

Towards the latter end of the 1990s, program training had become somewhat outdated, labor-intensive and more directive than participatory. Senior management leadership determined annual training topics typically without any input from staff on what topics were needed and without any direct observation of staff performance to determine areas requiring additional professional development. In addition, although staff may have completed the mandatory module-training program, most were not taking full advantage of the learning opportunities presented by the modules. They appeared unable to translate the knowledge into practice. In most cases, once a module was complete, staff failed to open the book again which caused them to miss critical learning opportunities as well as deprive themselves of a vital resource. Very few staff revisited the content of the module and consequently lacked the ability to connect theory with what they were observing and practicing each day (K. Storc, personal communication, May 17, 2008.)

Purpose of the Study

As a Family Member Programs Specialist for the Air Force, the author of this study finds it is crucial to identify the successes and challenges since implementation of the Developmental Training Model (DTM). Because the military childcare system has not been thoroughly researched in terms of training initiatives, it is a very worthwhile research topic that will help fill a void in the current literature in terms of what elements comprise the Air Force child development staff training program. A multi-case study of

the DTM provided an opportunity to investigate the impact of new training format on a wide variety of stakeholders to include front line direct care staff members, Training and curriculum specialists and program management such as directors and assistant directors.

In addition, the research will have future ramifications for training within the military childcare system as a whole. Specifically, this research study will shed light on whether the Developmental Training Model is a more effective delivery system for meeting staff development needs. It will also provide insight as to the challenges of implementing such an approach to determine whether it is feasible for further implementation across the Department of Defense and/or other child care agencies to include the civilian sector. While the Developmental Training Model was initially implemented in Air Force child care programs to provide a more effective method of identifying and responding to staff training needs, the question still remains unanswered as to whether or not this was successful. Still to be determined is whether or not the DTM has improved communication between the Training and curriculum specialist and the classroom staff and if using the DTM increases the ability to identify training needs and respond appropriately. Traditional training in the form of large group information dissemination has been the status quo since the early 1990s. The effects of utilizing smaller groups and emphasizing more reflective practice through the utilization of DTM remain to be fully seen. The purpose of this study is to take a closer look at the impact of the 2003 Air Force implementation of the Developmental Training Model, which will be achieved through a multi-case study of four Air Force base Child Development Program locations. This model transformed the traditional training program from primarily large group sessions focusing on a stagnant list of annual recurring training needs to an

observation-based, individualized, participatory mechanism that allowed for goal setting as well as reflective practice on classroom performance (K. Storc, personal communication, May 17, 2008). Frede (1995) cites teaching at its best involves teachers who generate questions, gather data, test hypotheses, and draw conclusions that guide their interactions with students. Her study found that one of the factors that lead to quality programs are "processes that help teachers respond to individual children" such as reflective teaching practice. In several of the programs Frede studied, the quality factor noted reflects many of the aspects of the Developmental Training Model which provides staff with time to meet and discuss observations of children, a forum to plan accordingly and an opportunity to receive targeted training as described by Wilson (2004). Wilson further reasons, "It is through collaborative interactions (between trainer and teachers, and among teachers within each classroom team) that teachers can reflect on, reorganize and consequently reconstruct their knowledge" (p. 2).

In an attempt to provide a more comprehensive training program that provided both large and small group interaction as well as a continuum of professional developmental goals based on provider's individual developmental levels, the Air Force wholeheartedly embraced the Developmental Training Model which only one year prior had been deployed throughout the Pacific Air Forces Command. Although the program was by all accounts overwhelmingly successful at those eight bases where it was piloted, no empirical studies regarding outcomes or impact had been accomplished. Those members directly responsible for implementing and instituting the new training format had articulated much of the conjecture surrounding the success of the program. Very little, if any, information or first-hand accounts from actual caregiving staff or program

management regarding the impact of the DTM had been documented or substantiated (L. Wilson, personal communication, March 11, 2006,).

Recognizing that the intent of the Developmental Training Model was both timely and poignant for sustaining quality in Air Force Child Development Programs, it is pertinent to assess how the implementation has affected staff intentionality in the classroom. Schweinhart (2003) puts it all in perspective by stating, "In order for teachers to engage in the practices that contribute to children's long-term development, they need to learn these practices through systematic in-service curriculum training and supportive curriculum supervision" (p. 7). According to Wilson (2004), "the assumption is that through the *DTM* process teachers will develop increased ownership of their own professional development, become more reflective about their practice, develop skills in problem solving, and consequently more consistently provide exemplary programming to children" (p. 8). In order to maintain the national respect garnered when the military childcare system was propelled as a model for the nation by former President Bill Clinton (Kozaryn, 1997), it is imperative that the successes and challenges of implementing the DTM be assessed more thoroughly in an effort to provide continued enhancements to the process.

No official studies on its effects on program quality have been completed to date and this remains to be seen. This study will specifically examine the impact on staff development of the implementation of the Developmental Training Model in Air Force child development programs. This multi-case study offers a methodological approach that supports the in-depth exploration at the "ground" level that is needed to thoroughly examine aspects such as the challenges and needed resources for the Air Force to

adequately support further implementation. Specifically this study explores the following questions related to the implementation of the Developmental Training Model:

Research Questions

1. How do employees perceive staff development since the implementation of the Developmental Training Model?

2. Has on-going training on the Developmental Training Model been sufficient to sustain perceived benefits of implementation?

3. What are some of the challenges, advantages and disadvantages programs have faced since implementation of the Developmental Training Model?

4. What portions of the Developmental Training Model are unclear or require additional support in order to maintain effectiveness?

Operational Definitions and Key Concepts

1. *Assistant Director* is the person who provides support to the director and/or in the absence of the director. The term is used interchangeably with director because their duties with regard to DTM are similar.
2. *Caregiver* is a person or persons employed by the military child care system. Staff typically works in a classroom with children. The term is used interchangeably with terms such as employee and staff.
3. *Child development center/program* encompasses the facility used to offer childcare and the staff that provide the actual care.
4. *Developmental level* refers to the readiness of an employee in terms of ability and willingness to complete a task.

5. *Director* is a person in the leadership capacity of monitoring day-to-day operations of the child development program to include managing resources, supervising staff and conducting training.
6. *DTM Implementation Lead* is a person who was responsible for providing training and developing staff assistance tools for the Developmental Training Model during the initial implementation period.
7. *Family Child Care* is a supplemental child care program that provides services in a home based child care setting.
8. *Flight chief* is the person responsible for the flight to include supervision of positions such as the center director and training and curriculum specialist.
9. *Flight* is the overall base unit/organization, which includes the Child Development Center, Family Child Care, School Age Program and Youth/Teen Program.
10. *Major command specialist* provides technical guidance and support to their assigned bases to include identifying the need for and conducting training.
11. *Staff turnover* occurs when a staff member leaves a position and must be replaced and is measured by the number of times a particular position is replaced within a given time period usually a year. Staff turnover is considered to be voluntary.
12. *Supervisor* is the person responsible for the program at any given time in the day and can include the director, assistant director, trainer, supervisor, manager and program management.
13. *Training and curriculum specialist* is the person who provides leadership, support, and comprehensive training to ensure the staff is prepared to work with children. Additionally, they serve as an early childhood subject matter expert providing

guidance and support to parents and the child care organization. This title is also used interchangeably with “T&C” and “trainer.”

Chapter Summary

This dissertation is presented within five chapters. Chapter one has provided the history and relevant information regarding this study accompanied by the purpose for conducting this study. Additionally, the research questions were presented and a list of operational definitions and key concepts used in this study were also included. Chapter two contains the literature review as it pertains to the research. It highlights previous studies on reflective practice as a basis for staff development and information regarding professional development within the early care and education profession. Chapter three explains the research methods used in the multi-case study and describes content analysis, which is the methodology. Chapter four focuses on the specific results and findings gathered from the data collection in each case. Finally, chapter five closes the current study with an outline of the findings as they relate to the research questions. Also included in the final chapter are the limitations of the study along with recommendations for the sustainment of the Developmental Training Model along with a summary of implications for potential further research.

CHAPTER TWO: Review of the Literature

This literature review provides insight on how situational leadership applies in the context of military childcare centers with regard to the varying levels of ability among staff and the corresponding need for administrators to adapt their leadership style to best suit the task and particular individual at hand. Furthermore, the literature review examines the various components of professional development to include observation based feedback and the need for reflective practice as well as considerations that must be taken into account when examining its effectiveness as well as current practices in the early care and education profession. In addition, an introduction to the Developmental Training Model and supporting leadership theory and research for its framework is addressed.

Theoretical Foundations of Staff Development

Staff development in the educational arena is commonly viewed to include teachers as active participants in their own professional growth through exploration, mentoring, reflective practice and learning both on-the-job and in formal educational settings (Fleming & Love, 2003; Truscott & Truscott, 2004). Likewise, the concept of "professional development" is thought by many to be a continuum of development that revolves around an on-going building of skills in a progressive manner (Gravani & John, 2005). The various pieces of a professional development system are critical as they directly influence children's learning and development within early childhood programs (Campbell, Ramey, Pungello, Sparling, & Miller-Johnson, 2002; Van Huizen, Van Oerls & Wubbels, 2005; Joyce & Showers, 1988; Zaslow & Beck, 2006).

The type of information being imparted to staff must also be examined when

developing a professional development system and consequently choosing which delivery methods will be most effective (Banilower, Heck & Weiss, 2007; Garcia, Sanchez & Escudero 2006; Riley & Roach 2006; Truscott & Truscott 2004). Some information may be better received and digested in a one-on-one setting as opposed to a presentation delivered to a larger sized audience (Wood & Thompson, 1993). In addition to examining the type of delivery method, decision makers must also take a close look at the timing of delivery to ensure staff are ready and able to accept the information and or skill being targeted (Park-Jadotte, Golin, & Gault., 2002; Peredo, 2000). Also of importance is the organizational atmosphere in the child care setting, to include the effects of change as it relates to changes in staff, management and program objectives (Clair, 2000; Fleming & Love, 2003; Sumsion, 2003).

Theoretical Foundations Supporting the Developmental Training Model

The Developmental Training Model (DTM) currently used in Air Force Child Development Programs is grounded in sound leadership theory, principally Hersey and Blanchard's (1977) "situational leadership" model which gives rise to the notion that there is no one leadership style that works best in all situations. Rather, effective leaders in the early care and education field are those who are able to "flex" their leadership style dependent on the situation and individual involved (Goleman, Boyatzis & McKee, 2002; Klinger, 2004; Sheerer, 1997). In the majority of child care settings, the workforce is made up of individuals possessing varying levels of skills, abilities and knowledge sets. Consequently, to be able to adequately address the array of needs through effective staff development will require a situational leadership model.

Hersey, Blanchard and Johnson (2001) discuss the situational leadership model

and its four basic styles of leadership behavior as they depend on the situation and the readiness of the follower. In the "telling" or authoritative style, the leader may make the decision and provide specific instructions to the employee. In this instance, the leader is high on task behavior and low on relationship behavior. In the "selling" or consultative style, the leader may make and explain the decision while providing an opportunity for dialogue and clarification for employees. In this style, the leader is said to be high on relationship behavior and high on task behavior. In the "participating" or facilitative style, the leader may share the problem and mutually make a decision along with the employees. This style is reflective of someone high in relationship and low in task. In the "delegating" or monitoring style, the leader is low in task and low in relationship as they turn responsibility for the decision over to the employees (Hersey, Blanchard & Johnson, 2001, p. 196).

The continuum of employee development runs alongside the varying styles of leadership with employees who are low in skill and readiness being on the lower end requiring more authoritative styles of leadership. On the other hand, employees who are high in skill and decision making readiness are on the other end of the continuum and are more appropriately matched with a delegation style of management where they can be given a task to master on their own. As indicated, there exists a myriad of child care settings as well as differences in staff that comprise the child care workforce in regard to their educational background and respective demographics (Klinger, 2004; Whitebook & Sakai, 2004).

With the constant influx and turnover of military personnel an overwhelming majority of staff in Air Force Child Development Programs seem to reside in

intermediate levels of their professional growth. Norris and Vecchio (1992) describe intermediate-maturity followers as employees who require a style of supervision that is intermediate on the task dimension but comparatively high on the relationship dimension. Air Force Child Development Program leaders, a portion of whom are the training and curriculum specialists (T&Cs) for the purpose of the current study, must be flexible in their styles and ready to adapt, modify or abandon a particular style of leadership at a moment's notice. Training and curriculum specialists who can employ a more situational leadership style are capable of inspiring positive outcomes from the caregivers to whom they offer staff development because they remain vividly attuned to cues given off by staff in terms of what degree of leadership they need at that moment.

Better still, astute T&Cs are prepared to start over when they realize they have misinterpreted a situation or person. This type of flexibility in insight and direction as to what leadership style to employ is what can attribute to an increase in employee satisfaction with staff development efforts within the Air Force childcare system. Situational leadership in a military child care setting is extremely useful in terms of an adequate and appropriate response to individual staff members' needs during a time of increased deployments and increased numbers of single parent homes. According to Wilson (2003), the Developmental Training Model is an approach that "recognizes that adult learning is a developmental process, which requires acknowledging and responding to the skills, knowledge and needs of individual staff" (p. 1). Situational leadership not only helps to address the needs of staff members working in the program but also indirectly addresses the needs of the children in the child care program and the parents utilizing the services of the program. Using the Developmental Training Model

transforms traditional training methods from “large group” settings to more individualized, situational specific settings.

Dearborn (2002) proposed that in times where leaders must do more with less, it is necessary not only to possess information but also to utilize social networks within the organization that personify the ability to develop others, listen, be intuitive about others' needs and create positive outcomes (p. 524). The Developmental Training Model is an ideal construct for the military child care setting in that it provides a method to address not only professional needs but personal needs as well. Wilson (2003) addresses this issue in stating that the DTM affords T&Cs the opportunity to customize training material based on observation thus allowing staff to actively participate in their own professional development.

Increased military operations tempo manifests itself in program challenges that require leaders to learn a myriad of new skills such as conflict mediation and family support counseling for spouses who are working in the child development center. In some cases, this need for support also extends to parents with children in the centers. Due to the increased stress and demands placed on the spouse that is left behind during multiple deployments, workplace disagreements and marital strife occur more frequently. As a result, the leader may need to increase their relationship behaviors as they are often left to play the role of confidant and advisor to the spouses. Moreover, many spouses have no indication how to proceed with family finances in the absence of the military member and therefore look to the leader for financial advisement and budgeting assistance while the military member is deployed. In order to maintain workplace productivity, the leader must learn the skills of handling a variety of different tasks and

prioritizing them in the most efficient manner to benefit staff, children and parents. Most critical is the need for the leader to develop these skills and know when to apply them and which employees need more versus less direct support.

The timing of when these skills are learned as well as building a structure to ensure training and educational opportunities are progressively implemented is also especially critical when determining how best to approach staff development (Fullan, 1998; Wood & Thompson, 1980). On many occasions, the staff member spouse exhibits behaviors that are both confrontational and disruptive to work place harmony. Staff is unable to learn developmentally appropriate practices if they are not in the frame of mind to accept the training or if it is administered in a large group setting. Truscott and Truscott (2004) emphasized this more traditional method of trainings as being ineffective as learning is more of a direct dissemination as opposed to an exchange of ideas and information.

Utilizing the DTM facilitates the situational leadership aspect and allows that leader to address individual staff development needs in a more appropriate setting. Wilson (2004) reiterates, "Learning occurs best in a safe, valued and psychologically secure context" (p. 4). Wilson further indicated that the goal of the Developmental Training Model was to offer a training environment where staff were supported, respected and felt secure enough to take the necessary risks for change. Among the child care staff, this more nurturing and responsive type of supervision that comes as a result situational leadership works much better in establishing the foundation for sustained learning. By studying the implementation of the Developmental Training Model, the researcher will be able to ascertain how the adoption of a situational leadership style has

impacted staff development in Air Force Child Development Programs.

In a report from the National Research Council entitled "*Neurons to Neighborhoods*" (Shonkoff, 2000), the Council identified several factors, aside from provider's education, that were deemed critical to maintain high quality programs to include

> specialized training, and attitudes about their work and the children in their care, and the features of child care that enable them to excel in their work and remain in their jobs, notably small ratios, small groups, and adequate compensation . . .. (p. 318)

Likewise, Landry (2005) agrees that motivated and trained professionals directly contribute to increased program quality.

When considering factors such as those cited by the National Research Council, a worthy place to start is to begin with the practices of leaders in the early care and education field. Leadership, in general, means to motivate people towards a goal. It is the cumulative deeds and communication used by a person to influence another person or group of people. Leadership is more than just managing in the sense that it involves people and their paradigms as well as their collective energy directed at achieving a common interest or position. According to Langford, Welch and Welch (1998), leadership is comparable to power in that it describes " . . . the ability of a person to influence another toward a goal, to influence decision-making, to get things done the way a person wants them to be done" (p. 2). Adept leaders are able to take it a few steps further in that they not only motivate people to do what they want done but they are able

to identify which leadership style would be more effective in obtaining specific outcomes for their organization.

Leadership is ever changing and evolving depending on the players involved or the situation at hand. There is no quick fix or one stop shopping when it comes to the many skills a leader needs to employ in order to be effective in their endeavors to reach and influence people to the point of motivating them into action. Yukl (1989) asserts that a manager has to be concerned about more than just relationships and tasks but instead must choose behavior that is guided by a vision of what the manager hopes to accomplish and by the specific objectives necessary to achieve the vision. Effective managers must be consistently cognizant of what style the situation requires and prepared to deliver that style at a moment's notice.

Loke (2001) stated, "Studies have been carried out to determine how leadership behaviours can be used to influence employees for better organizational outcome. Many studies concluded that effective leadership is associated with better and more ethical performance" (p. 192). Flexibility in attitude is essential but does not equate to flexibility of conviction. Leaders must be aware of staff developmental needs in order to attain goals. Leadership is the single most quality that builds, maintains and propels not only businesses but virtually every single thread of our society to include schools, families, religious institutions and other units of people with shared interests. Situational leadership will directly contribute to a place where childcare staff feels valued and leaders move beyond management towards true leadership. Increased job satisfaction stems from employees being involved in a quality relationship with their supervisors (Wech, 2002).

Research on Staff Development

There are varying definitions of staff development and what it is, how it best works and what makes it effective or ineffective. Several studies (Taylor & Walls, 2005; Truscott & Truscott, 2004; Van Huizen, Van Oers & Wubbles, 2005) emphasized the importance of avoiding stand-alone workshops where the transfer of information takes place in a deliver and receive type forum. Instead, they advocate for effective staff development programs that are both dynamic and integrated while addressing the context, the content and the process (Klinger, 2004).

Taylor and Walls (2005) used a nine-step process that involved participants completing a prerequisite that required using a particular methodology in the classroom prior to attending a five-day workshop working in interdisciplinary teams that resulted in integrated instructional units. Participants then became in-school mentors for their peers. Utilizing technology to connect teachers and facilitate a train-the-trainer approach, the model was able to help teachers become part of a larger professional development context. The authors attest, "Teachers gain new teaching strategies, curriculum development experiences that showcase their expertise, and co-ownership of a rich repository of integrated units" (p. 38).

In the study by Truscott and Truscott (2004), the authors focused on participants learning in authentic situations so as to provide more connected and contextual meaning to the concepts being discussed in quality professional development sessions. The study centered around 12 teachers receiving direct instruction in the form of in-service workshops and observation-based coaching from either a peer or a consultant. Subsequent training sessions were identified through discussions with the team. Based

on observational feedback, teachers worked collaboratively to assess future strategies and approaches that would benefit student learning. As put forth by the authors, a variety of approaches were then offered to the teachers to provide additional training support such as " . . . direct in-services (all teams or individually), classroom coaching (peer or trainer), demonstration lessons in the classrooms (peer or trainer) and ad hoc inquiry groups (peer-led and/or trainer facilitated)" (p. 56). Participants concluded that this form of professional development was effective as it allowed them to learn cooperatively with other teachers and relied on a model that focused on individual needs and abilities. The results of the study reaffirmed the necessity to provide professional development in such a manner as to reinforce pedagogical practice using self-directed input from teachers regarding their own professional development.

Of particular interest in the aforementioned study is the reference to observation-based "coaching." Unlike the type of leadership received from a supervisory or evaluative perspective, coaching provides feedback in a more collaborative and constructive environment. Coaches provide more in-depth, individualized and on-going support based on techniques such as observation and reflection. Likewise, coaching is also very different from mentoring due to its intentional and individualized level of support and has been shown to have different effects on staff development in terms of children's outcomes (Griffith, Kimmel, Fronheiser, Briscoe & Trautman 2008). In their assessment of teacher professional development and its impact on closing the achievement gap for at-risk preschoolers, these researchers found that coaches working side-by-side with teachers were able to increase implementation of best practices through focused discussions resulting in improved literacy instruction for teachers and increased

scores on standardized assessments for children.

Taking this concept one step further, Zaslow and Martinez-Beck (2006) partition the definition of staff development into three basic areas: education, training and credential. First, the authors describe the term "education" as "the professional development activities that occur *within* a formal education system." Second, "training" is described as "the professional development activities that occur *outside* a formal education system." Third, the authors clarify that the "credential" is not exactly training or education and is typically granted by an organization other than that which provides the knowledge itself (p. 13).

It is possible to provide a training experience that is viewed as successful if the attendees are involved and the content is based on useful information (Corcoran, 1995; Joyce & Showers, 1988; Peredo, 2000). Continuing the advocacy for authentic experiences, Engstrom and Danielson (2006) examined teachers' perceptions of support for and sustainment of a "staff development committee" (SDC). The SDC was a professional development program focusing primarily on multiple intelligences theory. One portion of the program was a one credit-hour seminar on multiple intelligences, for which nearly 40% of the teachers enrolled over the three semesters during the time it was offered. Other portions included a summer study opportunity to create units of instruction, participation in area workshops and conducting independent reading on multiple intelligences. The population studied consisted of 30 public school teachers who had participated in at least one of the aforementioned professional development opportunities focusing on multiple intelligences. Eleven of the teachers representing a random sample completed a focused writing survey and agreed to be interviewed.

Lesson plans, learning centers and student projects were discussed during the interviews. Among other positive outcomes, participants responded favorably to the peer coaching nature of the seminar as well as the resulting collaboration. The study's findings were in favor of professional development models that incorporate shared leadership as well as "a collaboration process that is authentic and embedded into the teachers' work day" (p. 70). Additional studies support constructivist staff development as an opportunity for teachers to "make sense of the teaching/learning process in their own contexts" while collaborating with peers (Riley & Roach, 2006; Sparks, 1994). Riley and Roach (2006) gathered data from their role as technical assistance providers in increasing the quality of care for low-income children. Their study examined the role of reflective practice as a basis for an emergent curriculum model designed to help teachers grow in their professionalism and effective classroom practices. Sparks (1994) identifies this type of staff development as including "activities such as action research, conversations with peers about the beliefs and assumptions that guide their instruction, and reflective practices" (p. 27).

In examining what works best for adult learners and specifically those in child care settings, the literature reflects a strong advocacy for reflective practice (Heflich & Rice, 1999; McLaughlin & Hanifin, 1994; Minott, 2007). Focusing on methods to provide adult learners with opportunities to associate their life experiences with theory positively impacts staff development (Hyrkas & Tarkka, 2001; VanderVen, 2000). However, what sometimes occurs is that teachers rely on academic knowledge and theory and lack the encouragement and routine of learning from classroom experiences. Schön (1992) described this dilemma, "Teachers are cut off, then, both from the possibility of

reflecting and building on their own know-how and from the confusions that could serve them as springboards to new ways of seeing things" (p. 121).

Previous works (Bellm, Whitebook & Hnatiuk, 1997; Helterbran & Fennimore, 2004) advocated a need for teachers to have the ability to adjust their classroom practices to best fit the needs of the children in care at the time using reflective practice as a vehicle to attain this ability so as to show respect for children's developmental needs and interests. Bellm, Whitebook and Hnatiuk (1997) developed *The Early Childhood Mentoring Curriculum* to serve as a resource for developing and maintaining an effective mentoring plan for both center and home based child care settings. The curriculum training units include topics such as reflective practice, the process of change, needs of beginning teachers, establishing expectations and goals, modeling, giving feedback, child care advocacy and the adult learning environment. The authors provide guidance on implementing an effective mentoring program that not only highlights the importance of reflective practice, but also provides tips on increasing the ability to implement it in such a way as to shape daily classroom practices thereby increasing the quality of care for children. Likewise, Helterbran and Fennimore (2004) identified a minimum of three stages they felt were necessary to have an effective professional development program. Those stages were: action research by teachers in the classroom, collaborative problem solving and agreement on outcomes and measurements of those outcomes. With regard to action research, these authors emphasized the need for teachers to be able to "take an active, self-directed, daily hand in their own learning" (p. 270). This type of reflective practice affords child care staff an opportunity to think over their past actions in the classroom and consequently shape their future actions with intentionality and purpose.

When designing child care staff development, training should be directed at the needs of the adult caregivers and focus on developing their professional skills as child care workers (Edens, 1998; Pianta, 2007). This includes providing teachers with information on child development and specific feedback about their classroom interactions.

In 2007, the National Association of Child Care Resource and Referral Agencies (NACCRRA) described child care staff training as most effective if cumulative in nature and offered within the context of the work setting. According to Schweinhart (2003), One of the aspects of providing a high-quality child care program is to provide teachers with "systematic in-service curriculum training and supportive curriculum supervision" (p. 7). Helterbraun and Fennimore (2004) defined successful professional development opportunities as only being so if staff perceived the training as a venue to be crafted *for* and *with* teachers, rather than something to be done *to* them. Riley and Roach (2006) stated it this way, "The most important service we can provide for teachers may be to engage in co-exploration: Repeated, thoughtful, heartfelt discussions of what we are doing, and why, and what else we might try" (p. 368).

Training and education are integral to the effectiveness of the military child care system. When child care staff is provided with the tools, training and educational resources to conduct their jobs in a professional manner, stronger commitment to the child care field is evident. (DeVita & Montilla, 2003; Moon & Burbank, 2004). With the implementation of the Developmental Training Model, the Air Force has taken yet another step towards increasing quality in its programs.

Current Staff Development Practices in Early Care and Education

Concerns related to ineffective staff development have been echoed over at least the last 25 years with many viewed as ineffective (Wood & Thompson, 1980). Disjointed workshops and courses that primarily disseminate information rather than focusing on appropriate practice fail to adequately address the needs of the early childhood field. Several authors point to the lack of attention on quality of professional development (Corcoran, 1995) as having nationwide implications.

Joyce and Showers (1988) cited five conditions that make reflective practice a difficult process for teachers: working in isolation, concerted organizational action is not regularly occurring, limited preparation time, limited collective decision making opportunities, and limited time for studying academic substance and educational process. Hargreaves (2004) cited another issue in educational institutions that can be related to resistance to staff development efforts revolving around staff reaction to management turnover and organizational change.

Another issue that affects staff development is the lack of equitable compensation for early childhood education providers (Hanushek & Rivkin, 2007; Jalongo et al., 2004; Moon & Burbank, 2004; Whitebook, Howes & Phillips, 1990). This compensation issue affects far more than teacher morale, motivation or intentionality of classroom practices. It has far reaching implications to include effects on children's own learning.

Herzenberg, Price and Bradley (2005) described the sentiment as "Parents can't afford to pay, teachers can't afford to stay, there's got to be a better way" (p.1). Their 2005 study "Losing Ground in Early Childhood Education" examined trends at the national level. It centered on data from the early childhood education workforce taken

from the 1979-2004 Current Population Survey (CPS) and discussed losses in the advancement of the early childhood education field described the far reaching implications of lack of adequate compensation. The CPS is a monthly survey of 60,000 households and collects data on an annual basis. The "Losing Ground" study focused primarily on center-based early childhood education programs to include private and public, for-profit and not-for-profit child-care centers, Head Start programs, and stand-alone preschools and nursery schools. One of the key findings in the study was that one in four of center-based teachers and administrators had incomes below 200% of the poverty line as opposed to one in five for all workers and one in 14 for female college graduates. It is important to note that although wage data was only available from a third of the basic CPS sample in this study, the authors increased sample size by pooling data for three years to provide a more clear analysis of wage trends.

Although studied over a decade prior, Powell and Cosgrove (1992) echoed similar sentiments in concluding that increasing staff experience would have a two-fold effect of reducing overall operating costs as well as raising the quality of care. The benefits of formal education or specialized training have been found to lead to teachers who exhibit more attentive and nurturing behaviors in the classroom (Frede, 1995).

In a 2007 report by the National Association of Child Care Resource and Referral Agencies (NACCRRA), the authors researched child care center regulations for all 50 states, the District of Columbia (DC) and the Department of Defense (DoD). From the research, rankings were developed on various aspects of minimum standards such as teacher qualifications, annual training requirements for teachers and pre-service training requirements for teachers. States were able to receive 10 points if fully meeting a

benchmark and partial credit if only "making progress" toward meeting them. In the study, the benchmark for teacher qualifications was that teachers held a "Child Development Associate" (CDA) credential or associate's degree in early childhood education or related field; for annual teacher training requirements all teachers must have at least 24 hours annually; and for pre-service teacher training requirements, orientation must include first aid, Cardiopulmonary Resuscitation (CPR), fire safety and specified health and safety training. In reviewing written governing regulations from the 50 states, DC and DoD, the authors found that the DoD ranked first on the top 10 list of states with the best child care center standards and first on the top ten lists of states conducting effective oversight. Other than DoD, Illinois and New York are the top ranking states with 90 points. The average score for the remaining states was 70.2 indicating a need to place continued and increased focus on the standards set for quality child care.

A 2009 updated report issued by NACCRRA indicated there is still work to be done in the areas of staff development and general oversight. According to the report, "The average score for states was 83 out of 150 points--the equivalent of an F. No state earned an A. Only the DoD earned a B, and one state (District of Columbia) earned a C" (p. 1). A total of 33 states received grades equivalent to failing and the military child care system held onto its previous first place ranking on both regulations and oversight." The study looked at factors such as the requirement for pre-service training as well as ongoing training. The absence of such requirements regarding staff development is just one of many factors that contribute to the lack of job satisfaction and subsequent turnover for staff.

Another factor that hinders effective staff development concerns assignments of new staff. Participants in a study on professional learning for early career teachers cited an additional aspect that hinders staff development revolving around the tendency to place beginning teachers in difficult classes or ones others do not want to teach (McCormack, Gore & Thomas, 2006).

Research on Effective Staff Development

Guskey and Huberman (1995) propose the idea that the interaction among and integration between dimensions such as technical competence, moral purpose and emotional type engagements among other factors are what matters most concerning effective teacher development.

Banilower, Heck and Weiss (2007) highlight similar features to attain when seeking effective professional development: "involving teachers as active learners, treating teachers as professionals, and situating teacher education in classroom practice" (p. 377). Their study scrutinized longitudinal data from the National Science Foundation's Local Systemic Change through Teacher Enhancement Initiative (LSC) to examine the impact of professional development that is "content based, situated in classroom practice, and sustained over time on teacher attitudes, perceptions of preparedness, and classroom practices." Seeking to add to the field's definition of effective professional development, the data examined were collected from 42 projects conducted in the course of a seven-year period. The chosen data set included 25,016 surveys completed by 18,657 teachers participating within the 42 projects. Throughout the years, participating teachers attended an average of 32 hours of LSC professional development. In addition, teachers were asked to respond to a survey questionnaire

which measured aspects such as teachers' beliefs about teaching, teaching practices, perceptions of principal support, and perceptions of their content and pedagogical preparedness. The survey average response rate was 83%, which provided a high degree of confidence in the results. Contextual variables such as teacher experience, school size and demographic composition were included in the models as controls. The authors indicated that evidence exists that teachers are able to describe their classroom practices with "reasonable validity and reliability" (p. 391). In addition, teachers were found to be more likely to use specified instructional materials based on perceived support from the school principal. These two findings are noteworthy in relation to the Developmental Training Model in that they indicate classroom staff is able to engage in accurate reflective practice and that supportive relationships from administrators can have a positive effect on classroom practices.

To understand what motivates a staff member, leaders must continually refer back to the most basic of internal drives and that is to satisfy the psychological needs through revamping traditional training methods (Ryan & Deci, 2000; Stovel & Bontis, 2002). Guskey (2003) suggests that attempting to nail down a complete list of all the essential characteristics needed for effective professional development might be an unreasonable effort. Rather, he offers "by agreeing on the criteria for 'effectiveness and providing clear descriptions of important contextual elements, we can guarantee sure and steady progress in our efforts to improve the quality of professional development endeavors" (p. 750).

Reflective Practice

As it relates to teachers, the concept of "reflective practice" is commonly used to refer an individual's awareness about their teaching styles and methods. This awareness incorporates theory, application and in terms of professional development, it provides an opportunity to shape future practice. Reflective practice is built on the idea of taking an in-depth look into one's own areas of strength as well as those, which require improvement and utilizing this information to increase one's competence. A theoretical definition would include the following components: 1) performing an action, 2) reflecting, after the experience, 3) engaging in discourse regarding the experience, 4) constructing new information based on the experience as well as the discourse and 5) utilizing the new information to improve similar future actions. In examining physician practice and learning, Cervero (2003) wrote, "Trying to produce clinical change by focusing only on the individual physician (e.g., formal continuing education) would be like crossing a crowded intersection with your eyes closed" (p. 14). His point was that the context in which professionals learn plays an important role in addition to "how" individuals learn.

The value of reflection in the practice of caregiving skills should not be overlooked or undervalued. Riley and Roach (2006) studied reflective practices using "training specialists" who observed 25-30 classrooms every one or two weeks for a 15-45 minute time period. These observations were followed by a 15-30 minute discussion with the lead teacher to provide immediate feedback on what had just transpired in the classroom. The authors referred to this model as "emergent curriculum" in that it included relational and self-exploratory processes with the goal of having teachers view

themselves, clearly and learn to have open, effective discussions of their work inside the classroom. Much like the Developmental Training Model, the "emergent curriculum model" in the current study was dependent on a trust-based relationship between the training specialist and the staff member. At the end of a one year period, the eight training specialists felt as though they were able to "build trust" with three-fourths of the teachers in approximately 150 classrooms. Using feedback from an anonymous questionnaire survey, the authors were able to confirm that the training specialists were viewed to have performed in an "objective" and "positive" way.

Reflective practice plays a vital role in allowing caregivers a mechanism to evaluate their own practice and thus make necessary changes in future classroom behaviors based on perceptions of past practices (Garcia, Sanchez & Escudero, 2006; Girolametto, Weitzman & Lefebvre, 2007; McLaughlin & Hanifin, 1994). Furthermore, Peredo (2000) suggested accounting for "self-directed, experience-based learning needs," assisting teachers in developing reflective practice approaches to their work and supporting collaborative "communities of practices" were three principles needed to build an effective staff development program.

Washington State University conducted a three-year study of a pilot program entitled "The Washington State Early Childhood Education Career and Wage Ladder" (Moon & Burbank, 2004). The study compared 126 centers participating in the pilot program against an equal sample size of programs that had applied but not participated in the pilot. The study included telephone interviews, mail surveys and observations conducted in the centers. According to the authors, several statistically significant

improvements for the participating centers were noted, to include retention, job satisfaction and quality of care.

Collaboration

In order for professional development to be effective, educators and policy makers must build professional teaching communities that take place in the context of "real world" settings and embedded in the spirit of collaboration (Campbell & Brummett, 2007; Guskey, 2003; Hargreaves, 2000). Collaboration opens the door for learning to occur at various levels to the overall good of the organization. It facilitates a fundamental framework for staff to work together in identifying and resolving issues as well as sharing responsibility for their own professional development as well as that of others, which includes less experienced staff.

In a study conducted by Goodnough (2005), the author examined varying professional development efforts that moved away from the traditional "one size fits all" method of delivery. The author advocates for more team-based staff development initiatives such as collaborative inquiry and study groups to address the unique learning styles of adults. Goodnough examined a Collaborative Inquiry (CI) project. Two of the research questions asked were "How will the teacher's professional knowledge (beliefs, values, and classroom practice) change as a result of this experience?" and "How will CI foster teacher learning?" A small group of three teachers coordinated efforts over a two-year period to examine the effects of collaborative inquiry while also evaluating students' perceptions of a problem-based learning model. Data collection methods included participant observation, surveys and examining a variety of documents such as teacher lesson plans and student work assignments. Following the two-year collaborative

project, the participants concluded collaborative inquiry served a two-fold purpose of fostering adult learning as well as providing an opportunity for educational research among peers.

Another component of collaboration that may prove effective in staff development is peer-based observation. Sparks (1986) conducted a study comparing three types of in-service training and found that "the provision of objective, nonthreatening peer-observation activities boosts the effectiveness of normal, workshop based in-service training" (p. 224).

Mentoring

Along these lines, mentoring is an essential piece of an effective staff development program as well. Kreader, Ferguson and Lawrence (2005) examined providers in center-based and family home care settings to ascertain what type of professional development approaches will support an increase in the quality of care provided to children. In their study, the authors describe research findings of a Pennsylvania child care centers mentoring program for infant caregivers. As part of the program, caregivers were randomly assigned to a mentoring group that received four months of intensive one-on-one training from an experienced professional or to a control group that received only workshop-type training. The findings indicated the mentoring group demonstrated increased quality in areas such as learning activities and appropriate discipline. One of the other key findings from their study indicated "the mentoring group saw significantly improved quality in the areas of routines, learning activities, sensitivity, and appropriate discipline" (p.4).

Regardless of the chosen delivery method, the approach to professional development has to be one with a long-term goal of sustainability and continual improvement at the crux. Stager and Fullan (1992) assert:

> It has long been known that skill and know-how are central to successful change, so it is surprising how little attention has been paid to it beyond one-shot workshops and disconnected training. Mastery involves strong initial teacher education, and continuous staff development throughout the career, but it is more than this when we place it in the perspective of comprehensive change agentry. It is a learning habit that permeates everything that is done. It is not enough to be exposed to new ideas, or to like these ideas. It is necessary to know where they fit, and to become skilled in them. (p. 6)

Campbell and Brummett (2007) discuss mentoring pre-service teachers in a university setting and recommend that mentors focus on more than imparting knowledge to the mentee; rather they should seek to share resources and analyze teaching practices to aid in building collaborative environment.

Results from these studies have shown that staff development does not take place in a vacuum nor manifest itself as an isolated event. Rather, effective staff development is an on-going integration of collaboration, reflective practice and mentoring. Morgan et al. (1993) found that most child care training was targeted towards entry level staff, tended to be repetitious in nature and did not sufficiently address the types of competencies most commonly associated with quality caregiving. In reviewing the

literature, there appears to be limited models of effective staff development that are tested specifically in the early childhood setting. The need for this research is critical when one considers the numbers of children in early care and education programs each day combined with the high levels of staff turnover and low compensation. In an attempt to identify contributing components of an effective staff development model, a qualitative methodology has been selected for the current research.

For the purpose of this study, assessing whether on-going training on the Developmental Training Model has been sufficient to sustain perceived benefits of implementation will help shed light on future training support mechanisms needed for Air Force Child Development programs if the usage of the DTM is to continue.

DTM in the Context of Organizational Leadership and Staff Development

According to Allen (1996), communication between supervisors and subordinates or satisfaction with superiors is directly linked to turnover resulting in supervisory intentions being recommended as a method to reduce turnover within organizations. Staff turnover has the potential to have a detrimental effect on the quality offered in early care and education type programs. In the Powell and Cosgrave (1992) study that focused on quality and cost in early childhood programs, the authors concluded that turnover "appears to impose significant costs on centers as well as reduce the quality of care. These potential cost savings should be deducted from any estimates of the cost of reducing turnover as a means of improving quality" (p. 483).

Wilson (2003) promulgates,

> The intersection between the needs of the program and the training experience is critical. The individualized, collaborative tone of the Developmental Training

> Model invites caregivers to reflect on their practice and actively problem-solve. They are able to build on their existing skills and knowledge with the ultimate goal of improving programming. (p. 6)

This developmental approach to training is particularly useful in military childcare settings. This is evidenced in situations where employees are essentially capable of executing the mechanics of childcare but are unable to translate this capability into more meaningful classroom interactions and developmental programming because they are distracted by personality and conflict issues that arise as a result of increased stress factors associated with their spouses' deployment. As a result of this distraction, the level of customer service provided to the children may suffer and the desire to leave the organization may increase.

According to Bennis and Nanus (1985), " . . . leadership is also a transaction, between leaders and followers. Neither could exist without the other. There has to be resonance, a connection between them " (p. 30). For leaders, the skills of mediation and problem solving help the leaders to ensure the children are still being cared for in a quality environment while the adult staff members' needs are also met. This appropriate balance of attention to task and relationship is often simultaneously perceived by staff members as just what the organization needs to survive difficult times. Campbell, Bommer and Yeo (1993) argue that leadership styles that lead to task accomplishment at the same time they preserve satisfactory work-group relationships may work well because those followers may view it as just the right "tool for the job." Consequently, employees are more satisfied with their jobs because they perceive the leader as acting appropriately in the given situation. As stated by Bloom (2000), "In early childhood

centers, as in all organizations, things tend to get done because of relationships, not because of job descriptions or formal roles. . . . trust begins with one-on-one connections--getting to know staff individually" (p. 38). Leadership in military childcare systems is experiencing the need to adapt a more flexible and nurturing method of working with employees in order to effectively address their self-identified staff development needs.

According to Loke (2001), "Organizational research has indicated that employees who experienced what they considered to be job satisfaction were more inclined to be productive and remain employed with the organization." Dissimilarity in leadership style when matched with employee development has a huge impact on staff development and thus can severely limit the effectiveness of staff training. When employees experience dissatisfaction in communicating and working with leadership in an organization, the end result is often failure to recognize or benefit from staff development efforts. Fullan (1998) discussed the importance of early induction training for school teachers given "the high probability that solid induction programs represent one of the most cost-efficient preventative strategies around" (p. 4).

Both new and experienced staff suffers when leadership fails to recognize the introductory and developmental needs of caregiving staff. As a result of mismatch of supervisor leadership style with subordinate developmental level, remaining childcare employees are often over-tasked with assignments due to staff shortages and therefore may experience increased stress and health related problems thereby resulting in possible increases of sick leave use or abuse. Costs associated with sick leave usage of remaining employees are often overlooked when figuring the cost of employee turnover in a childcare organization. Jalongo et al. (2004) asserted:

> When salaries are low, payment is unpredictable, and opportunities for advancement are limited, many highly-qualified teachers will leave. . . . When teachers are pushed out of the profession due to poor compensation and/or lack of respect for their work, young children who need vast amounts of stability, care, and education find themselves subjected to a multitude of inexperienced caregivers. (p. 146)

Another matter for consideration is that remaining employees are often limited in their access to on-going staff development which in turn contributes to increased job dissatisfaction. Kim (2002) states "Given the significant cost of employee absenteeism and turnover for organizational performance, scholars must clearly identify factors affecting employees' job satisfaction in the context of organizational environment changes" (p. 277).

Developing a situational leadership style helps childcare leadership to keep their fingers on the pulse of the program and more adeptly identify the staff development needs of their employees. Balancing the needs of the childcare program with the needs of individual staff members is often a difficult task that presents some unique challenges. In order to increase satisfaction with staff development efforts, leaders must convey to staff that they are genuinely concerned about their well-being and interested in their continued employment and success with the early childhood career field. Allen (1996) asserted those employees most likely to consider turnover were those who felt the organization did not value or care about them. When decisions must be made, leaders must rely on staff for input regarding the advantages and disadvantages of all possible decisions. In some instances, leaders must act in an autocratic manner and make the determining

decision with little or no input from staff depending on the time frame and nature of the proposed decision. On the other extreme, in the case of delegation, the manager may completely defer the authority to make the decision upon a select individual or group of individuals usually maintaining specified decision parameters while reserving the right to exercise final approval before implementation (Yukl, 1989).

Implementation of the Developmental Training Model supports a situational leadership style believed to have benefited Air Force Child Development Programs. Referring to the definition of situational leadership as set by Hersey, Blanchard and Johnson (2001) as the interplay among the amount of task behavior given by a leader, the amount of relationship behavior provided by a leader and the readiness level of the follower exhibited when performing a specific task or objective (p.172), it is clear to see how the design of the Developmental Training Model could so easily fit the needs of the Air Force childcare workforce.

As a result of the DTM implementation, childcare providers may be more inclined to commit to the program and to uphold the standards they have set for themselves as a program staff. It is expected that situational leadership displayed through small group debriefs has contributed to employees being more satisfied with the mechanism for meeting their current training needs and has increased communication between staff and the training and curriculum specialist. By using a situational leadership style to ensure an appropriate match with each employee's staff development needs, the Air Force aims to make a step in the right direction to maintain the national respect garnered when the military childcare system was first propelled as a model for the nation by former President Bill Clinton (Kozaryn, 1997).

Prior to this noteworthy transition, the military child care system was in shambles. According to Campbell (2000) in a National Women's Law Center report, "caregivers lacked training and were so poorly compensated—earning less than commissary shelf-stockers—that they did not stay long in the field; annual staff turnover rates at some child care centers were as high as 300 percent" (p. 1). Through implementation of the Military Child Care Act, the Department of Defense was able to address many of the issues plaguing the organization and significantly impact the level of quality offered in its program.

In 2002, the Developmental Training Model (DTM) was introduced at Child Development Programs located on eight bases under the jurisdiction of the Pacific Air Forces command. For years, the Air Force Child Development programs have embraced the Developmentally Appropriate Practices (DAP) set forth by the National Association for the Education of Young Children (NAEYC) as an accepted and positive mode of providing quality childcare. In 1986, NAEYC published the booklet "Developmentally Appropriate Practice" by Sue Bredekamp to help early childhood educators identify methods for supporting children's growth and development. Marion (1995) states, "A part of developmentally appropriate guidance is the area of limit setting based on a child's developmental level, that is, setting limits that are suitable for a particular child at a specific age" (p. 68). The Developmental Training Model was developed under the same premise of supporting staff's growth with consideration to their level of professional development. Wilson (2004) proposes,

> Committed to continued progress, the Air Force Child Development Program is now addressing, the ongoing challenge familiar to many child development

centers: how to better respond to the individual developmental levels of teachers . . . in order to promote sustained curriculum improvement. (p. 2)

For Air Force decision-makers, it made perfect sense to work with the staff in much the same way we expect them to employ learning strategies in the classroom. The DAP worked well for helping children learn best in a supportive and individualized manner and therefore may be more receptive to learning in a similar fashion. Applying the principles of DAP to adult learning made for a smooth transition in helping caregivers to develop the skills and knowledge needed to improve their practice.

The goal of the DTM was to identify and employ those conditions that best supported effective training for caregivers. Wilson, Storc & Gries (2004) identified several common elements between DAP and DTM:

- Individualized, respectful interactions
- Challenging, supportive experiences targeted at range of developmental levels
- Curriculum (training topics) emerge as a result of observation and individualized interactions
- Time and opportunity to learn and practice new skills in a logical sequence
- A safe, supportive learning environment

The Developmental Training Model consists of several parts: classroom observations conducted by directors and training and curriculum specialists, classroom-specific feedback in the form of observation debriefs, gathering of staff input, small group training based on observations and de-briefs, collaboration and recording of goals

on the Individualized Training Plan (ITP), provision of modeling and coaching and resources as required, semi-annual evaluations and providing follow-up support to individuals and classroom teams. Continued cycles of DTM are conducted, usually on a monthly basis, throughout the employees' employment and as individual classroom needs change.

The first step in the DTM is for either the director or the training and curriculum specialist to conduct a one-hour classroom observation. Ideally, the training and curriculum specialist would be the person to conduct the observation and subsequent "de-brief" with the staff. However, the DTM provides opportunities for directors to also conduct observations on classrooms periodically throughout the year. When in the classroom, the observer remains as unobtrusive as possible and records any related information pertaining to classroom environment, interactions between adults and children, conversations and nonverbal communication. A sample classroom observation is included in Appendix A.

The second step in the DTM involves the observer completing an Observation De-brief Form (see Appendix B) based on what is recorded on the classroom summary sheet. The observer summarizes the classroom observation and identifies any potential training topics to be discussed during de-brief with the classroom staff.

In the third step, the Observation De-brief form is then utilized to facilitate discussion during the de-brief session. The training and curriculum specialist facilitates an interactive session with the classroom team of caregivers. This session is recommended to be scheduled during working hours and outside of the classroom. The goal of the de-brief is to build relationships with the caregivers, discuss the observation,

identify on-target areas (strengths) and focus areas (in need of improvements), solicit input from the caregivers, provide training on specific topics that emerge and promote problem solving which leads to the fourth step. In the fourth step, the trainer and the classroom team members collaborate to set goals and timelines of implementation toward program development. These goals and timelines are recorded on the Individual Training Plan (ITP) found in Appendix C.

The final step in the DTM process is to provide follow-up support to caregivers within classroom teams. Follow-up support may involve assistance in setting priorities, locating additional resources, providing feedback to leadership and/or touching base with caregivers usually on a monthly basis or as needed to support each classroom team of caregivers. In addition, the director conducts an evaluation meeting with individual caregivers at least twice per year. This meeting is recorded on the Semi-Annual Evaluation Form located in Appendix D.

Incorporating classroom observations and ongoing debriefs as part of the overall training program helps childcare leadership to keep their fingers on the pulse of the program. In addition, the DTM meets one of the suggested policy changes suggested by the *National Center for Early Development and Learning* (1997), "Staff training and support are essential to quality caregiving. The profession must find ways of providing this training that are not expensive and allow caregivers to continue their work" (p.3).

When examining the implementation of the Developmental Training Model within Air Force Child Development Programs, the aforementioned five issues (see bulleted list above) provide a good start to assessing how successful the implementation has been thus far. Even so, it is critically important to keep in mind that balancing the

needs of the childcare program with the needs of individual staff members is often a difficult task that presents some unique challenges. In order to increase training effectiveness, leaders must convey to staff that they are genuinely concerned about their wellbeing and interested in their continued professional development while employed with the program. When decisions must be made, leaders must rely on staff for input regarding the advantages and disadvantages of all possible decisions. In some instances, leaders must act in an autocratic manner and make the determining decision with little or no input from staff depending on the time frame and nature of the proposed decision. On the other extreme, in the case of delegation, the manager may completely defer the authority to make the decision upon a select individual or group of individuals usually maintaining specified decision parameters while reserving the right to exercise final approval before implementation (Yukl, 1989).

Since implementation of the DTM, training practices have changed from primarily large group to mostly small group sessions. As a result, childcare providers may be more inclined to commit to the program and to uphold the standards they have set for themselves as a program staff. It is expected that conversations developed through training de-briefs will lead to employees being more in tune with children and classroom needs, providing developmentally appropriate activities based on children's individual needs and interests and consequently an increased satisfaction with the overall training program.

Researching the impact on staff development in Air Force Child Development Programs since implementation of the Developmental Training Model is important for a number of reasons. Johnson, Pai and Bridges (2004) affirmed, "Well-trained staff

members tend to provide nurturing, responsive care to the children they serve, facilitating children's positive cognitive, social, and emotional development, and making for a higher quality ECE environment" (p. 1). Air Force senior leaders need to know if the DTM is meeting the objectives of serving as an effective method of offering professional development in child care programs. Being able to identify the portions of the model that are working well will help in shaping the model to increase feasibility of use across the Air Force programs. The recurring theme in the current literature is that staff development is most effective when it is observation-based, allows for reflective practice, supports goal setting and is tailored to support the needs of the individual caregiver. As noted by Hyrkas and Tarkka (2001):

> Reflection is considered as an efficient learning method and therefore increasing attention has been directed at its promotion. . . . It is target orientated and involves more than just recollection of experiences: it incorporates active commitment, involvement of the 'self' and a change in one's behaviour or viewpoints. (p. 504)

Additional support for reflective practice, is posed by Baginsky and Macpherson (2005), who found that students (teachers) gain benefit from spending time reflecting on their experiences. They suggest that when situations arise teachers need the ability to act quickly when response time is limited stating, "their responses must be based on understanding and confidence, not checklists" (p. 328). This statement has profound implications for staff in Air Force Child Development Programs.

One of the guiding questions of this dissertation is how employees perceive staff development since the implementation of the Developmental Training Model. Assessing whether the implementation has increased satisfaction with professional

development may provide insight into whether employees are more likely to translate what has been learned into increased quality of classroom experiences. Moreover, the principal research will seek to identify some of the challenges, advantages and disadvantages programs have faced since implementation of the Developmental Training Model. "Professional development activities, by themselves or in combination with other strategies, offer a cost-effective means for effecting change in the quality of childcare" (Campbell & Milbourne, 2005, p. 12).

As many Air Force Child Development programs face increased scrutiny and limitations on resources, finding methods to motivate staff while minimizing costs are even more crucial. Of particular importance will be the need to know whether the implementation method was sufficient to sustain effective outcomes. For instance, how well do those who are responsible for implementing understand the model? Have training efforts been sufficient to sustain the implementation of the DTM? Schwarz, MacDermid, Swan, Robbins & Mathers. (2003) supported " . . . practices that increase the extent to which the job provides intrinsic enjoyment and fulfills a caregiver's needs for recognition, creativity and skill building can be powerful retention incentives in lieu of direct increases to compensation."

Examining whether the DTM has provided a mechanism for directors and training and curriculum specialists to communicate more effectively with staff may be impetus for determining whether the model could be used in other child care settings across the military child care system. With more parents entering the workforce and increasing numbers of children in care outside of the home, having quality child care programs is even more critical today. Whitebook & Sakai (2004) highlighted the fact that the

capacity for early learning was slowly being connected to the realization that most preschoolers are in non-parental care despite parents being or not being a part of the workforce.

To date, only one survey has been conducted to ascertain progress since the implementation. In March 2005, the Family Member Programs policy office conducted an Air Force-wide survey and although it did not address each of the objectives of the Developmental Training Model, it did reveal several indicators as to the successes and challenges of the program since implementation. A total of 349 management participants responded to the March 2005 survey answering a wide array of questions asking to rate themselves on such tasks as "how often you use the five steps of DTM," "your success on the steps of conducting observations," "success in completing the observation de-brief form," "building relationships," "success in strategies for getting started," "success in connecting to individual team members," "keeping debrief sessions moving," "promoting problem solving," "success in identifying individual training plan goals," "success in providing follow-up support," and a question on future training format preference.

Although the above survey provided some insight into the implementation of the model, more in-depth analysis is needed to determine if implementation efforts have provided full use of the model. In addition, the current research aims to determine if the field has the resources to ensure implementation comes to full fruition and if the model has been applied consistently throughout the Air Force. Determining what questions exist and what additional staff and leaders have regarding the model is also critically important. For example, what portions of the Developmental Training Model are unclear or require additional support in order to maintain effectiveness? The current study will

examine all of these factors and provide an outline of the challenges and successes experienced by staff, directors and training and curriculum specialists since implementation. This information will be helpful in shaping future direction for the DTM in Air Force Child Development Programs.

Chapter Summary

To provide additional information effective professional development, this study will add to the current available body of literature through focusing on the impact of the Developmental Training Model (DTM) on staff development in the Air Force Child Development Programs. Current theory gives credence to the notion that a combination of methods are needed depending on the experience level of the staff member as well as the context in which professional development is provided. The size of the group in which information is delivered also plays a critical role in determining effectiveness. Likewise, the opportunity to interact with other professionals and offer discourse on a particular problem has shown promise for shaping effective classroom practices by teachers. The ability to build upon actual classroom practices has also been found to have positive effects in helping teachers identify potential issues with their own style. The previous professional development practices studied have demonstrated that situational leadership style, observation based performance feedback, mentoring and reflective practice are all necessary components to establishing an effective professional development model. In examining the impact of the DTM, the presence or absence of these components will be examined to ascertain the effectiveness of the professional development for staff in Air Force Child Development Programs.

CHAPTER THREE: Design and Methodology

The design of this research is a multi-case study that examines the impact of the implementation of the Developmental Training Model on staff development in Air Force Child Development Programs. The study involved data collected via interviews with staff working in the programs at four bases across the Air Force as well as interviews with individuals who were involved during the various stages of implementation. Krathwohl (1998) describes case study as a project that is "bounded by a particular individual, situation, program, institution, time period, or set of events. Within those boundaries, whatever is the focus of attention is described within the perspective of the context surrounding it" (p. 332).

The goal of the author was to assess the impact on staff development in determining both successes and challenges as a result of the implementation of the new training model. As evidenced in the literature review, effective staff development includes at a minimum collaboration, reflective practice and mentoring. These components help provide a stable foundation for staff to utilize constructivist theory and build knowledge based on their own experiences and discussions with peers and leaders in the early care and education field.

Effective staff development manifests itself in the form of better quality practices in the classroom when provided on a recurring and intentional basis throughout the length of employment. This study will specifically examine the impact on staff development of the implementation of the Developmental Training Model in Air Force child development programs.

Purpose of Study and Research Questions

The purpose of the current study was to identify the successes and challenges since implementation of the Developmental Training Model. The research questions were as follows:

1. How do employees perceive staff development since the implementation of the Developmental Training Model?

2. Has on-going training on the Developmental Training Model been sufficient to sustain perceived benefits of implementation?

3. What are some of the challenges, advantages and disadvantages programs have faced since implementation of the Developmental Training Model?

4. What portions of the Developmental Training Model are unclear or require additional support in order to maintain effectiveness?

With the Developmental Training Model being a newly created training method, the author felt it was important to gather a wide array of information on perceptions about the program, which is why a qualitative research approach was chosen for the current study. Ponterotto and Greiger (2007) describe a stage in which researchers become dissatisfied with the limitations presented by quantitative research as "disillusionment." This inability to fully account for and describe the experiences of participants is what leads researchers to seek out a qualitative approach to provide a detailed picture and description of the phenomena being studied. Using a qualitative study helps define aspects that are sometimes overlooked or incorrectly categorized when attempting to assign a quantitative value to the different variables being examined. When seeking to determine what is happening behind the factors being studied, qualitative research tends

to be more appropriately suited (Chen & Hirschheim, 2004; Siraj-Blatchford, Sammons, Sylva, Melhuish & Taggart, 2006).

With regard to qualitative research, a number of studies have identified interviews as good sources of expanding information gained from participants (Ambrose, Huston & Norman, 2005; Chaloner, 2006; Haverkamp, 2005; Tillema & Orland-Barak, 2006). In a study conducted by Little (1989), the author used interviews as a method to complete the larger picture of how staff development resources were utilized and to gain insight into teachers' "views of the content, format, and value of staff development opportunities in which they had participated during the preceding calendar year " (p.167). Qualitative research works well in the pursuit of information on the impact of the Developmental Training Model because this is a case where the researcher does not believe that an absolute truth or set of truths exists. Rather, the researcher is particularly interested in a variety of information regarding the more subjective aspects of its impact such as perceptions of what has worked well and what areas are in need of improvement.

A study conducted by Bishop and Lunn (2005) examined perceptions of a training conducted for early care practitioners. The authors were particularly interested in the attitudes and perceptions of the participants and wanted to take a close look at the "opportunities and constraints" the participants experienced in accessing and participating in higher education efforts (p. 1). The researchers used a questionnaire that queried both open-ended and closed type responses so as to illicit both "exploratory and reflective comments from the participants (p. 2). According to Hayhow and Stewart 2006, identifying how individuals feel about and experience a particular subject or issue is just one of the virtues of qualitative research. Subsequently, quantitative research

might be used afterwards to determine the applicability of these feelings and experiences to larger populations. In the case of this study on the Developmental Training Model, the results from the qualitative interviews will be used to build a framework for future research the Air Force can use to assess trends in perceptions of challenges and successes of the new training model.

Participants

The field study was conducted in Air Force child care environments both stateside and overseas. The rationale for doing such was to ensure both traditional and non-traditional programs were included in the study. Specifically, overseas bases often are faced with significantly high turnover rates when compared with stateside bases. In an online article taken from the March 2005 *Stars & Stripes* online edition, reporter Svan cites, "Many DOD overseas centers struggle with staff turnover, base child-care officials report. Unable to tap deeply into the host country's workforce facilities will employ military spouses who often move every three years" (p. 1). Consequently, the level of staff development and its respective approach tends to be different when considering stateside compared to overseas child development programs.

Setting

The actual research setting took place at four Air Force installations: Andersen Air Force Base, Guam; Elmendorf Air Force Base, Alaska; Hickam Air Force Base, Hawaii; and Luke Air Force Base, Arizona. Interviews with the 16 participants were conducted in private offices located within the base child development centers on the installations.

These four installations are bounded by a shared context of being nationally accredited programs serving predominantly children of military members. Additionally, the programs share the military culture of extensive resources, dedicated training and on-going staff development as well as a high level of regulatory oversight. This shared context provides programs that are more similar in nature than they are different. Although some of their challenges are unique, many of them are similar. Additionally, all of the selected installations share a common mandatory training program, competitive staff wages and standardized operational policies and procedures. This likeness eliminates some of the variances that may have skewed responses to the impact of the DTM.

Data Collection

At each of the four installations, a total of four interviews were conducted with staff and management working in the child development center. The four interviewees were comprised of two classroom caregiving staff, one training and curriculum specialist and one representative from management (either the child care center director or assistant director). None of the participants were randomly selected due to the researcher's desire to have two caregiving staff that was employed in the program at the time of the implementation of the Developmental Training Model. The training and curriculum specialists at each installation were serving as the only such position assigned to the facility from which the caregiving staff was selected. Likewise, the management staff representatives were intentionally selected from the same facility under the researcher's assumption that their experiences with the Developmental Training Model would be more closely aligned with one another than individuals from outside the particular center.

The researcher believed individuals working as part of the same child development center "team" constituted a naturally occurring group that shared a somewhat more common set of experiences than those outside of the team.

Secondary source interviews were conducted with personnel at varying positions within and outside of the Air Force Child Development Program to include the lead training and curriculum specialist, two major command specialists and an outside consultant who conducted most of the training of Air Force personnel during the initial implementation of the Developmental Training Model. These particular individuals were selected based on their oversight and interaction with a number of bases and numerous staff across the Air Force both during implementation and afterwards.

Additionally, the researcher utilized documentary data to provide increased insight into the culture and atmosphere surrounding the DTM implementation. Documents were collected from archived newsletters, agency training files and personal collections from DTM implementation leads. Additionally, documents were collected from individuals who were attendees, hosts or organizers at one or more of the various implementation trainings. These archival documents provided a loose context for beginning to analyze particular responses and attitudes of participants.

Data Collection Procedures

A total of 24 questions were asked of each participant. All participants responded to a set of identical interview questions (Appendix E). Some of the questions posed to the participants asked about training received "to date" on the Developmental Training Model and current level of understanding of the DTM. In addition, questions were asked to determine what parts of the DTM were hardest to implement as well as what resources

are needed to ensure if further implementation is to be successful. Participants were also provided opportunities to add any remaining information or input at the conclusion of each interview.

Each participant was interviewed individually in a private location away from other staff and out of sight and hearing of program management. Participants were informed about the purpose of the study and asked to sign a consent form. Each interview was recorded on audiotape with the researcher taking additional notes as the discussion progressed. For additional information, ten key stakeholders holding various positions related to the implementation of DTM were also interviewed using the set of questions found in Appendix F. These secondary source interviews were conducted both face-to-face as well as by phone. Face-to-face interviews were conducted in a variety of office as well as informal settings at the convenience of the interviewees.

Table 1 below provides a schema of the research questions related to the data sources. The table is laid out as a matrix to show how the research questions can be mapped to the interview questions and provide a framework of cursory analysis. By visually mapping the questions, the researcher was able to identify in gaps in data sources and ensure all of the research questions were addressed by a minimum of one data source.

Table 1.

Data Sources

Question	**Data Source**
1. How do employees perceive job training satisfaction since the implementation of the Developmental Training Model?	Interview Questions: 1. What did you think of the process when you first used DTM? 2. What portion of DTM did you find easy to implement? 3. What portion of DTM was difficult to implement? 4. How do you feel DTM compares to previous training methods? Other data sources: Interviews with key stakeholders (AF lead training and curriculum specialists, DTM implementation leads, major command specialists and flight chiefs)
2. Has on-going training on the Developmental Training Model been sufficient to sustain perceived benefits of implementation?	Interview Questions: 1. When were you first introduced to DTM? 2. When was your initial training on the Developmental Training Model (DTM)? 3. Describe the initial training you received on DTM? 4. What additional training (if any) have you received on DTM? Other data sources: 1. Interviews with key stakeholders (AF lead training and curriculum specialists, DTM implementation leads, major command specialists and flight chiefs) 2. Historical Documents (training materials, memorandums, frequently asked questions)
3. What are some of the challenges, successes,	Interview Questions: 1. What challenges do you experience in relation to

advantages and disadvantages programs have faced since implementation of the Developmental Training Model?	DTM? 2. What successes have you experienced in relation to DTM? 3. What are the advantages of DTM? 4. What are the disadvantages of DTM? Other data sources**:** 1. Interviews with key stakeholders (AF lead training and curriculum specialists, DTM implementation leads, major command specialists and flight chiefs) 2. Historical Documents (training materials, memorandums, handouts)
4. What portions of the Developmental Training Model are unclear or require additional support in order to maintain effectiveness?	Interview Questions: 1. What resources are needed to ensure more successful implementation of DTM? 2. What changes would you suggest for more successful usage of DTM? 3. How do you rate your current understanding of DTM? 4. Where do you go for additional information and answers on questions about DTM? 5. What questions do you have about DTM? Other data sources: 1. Interviews with key stakeholders (AF lead training and curriculum specialists, DTM implementation leads, major command specialists and flight chiefs) 2. Historical Documents (training materials, memorandums, frequently asked questions)

Data Analysis

Merriam (1998) suggests that case studies provide an in-depth knowledge and understanding of a particular occurrence, which can then be utilized to "directly influence policy, practice and future research" (p. 19). The goal of this qualitative multi-case study was to examine the impact of the Developmental Training Model on the professional development of child care staff working at four Air Force installations in hopes of providing a road map of what is needed for future and further implementation of the training model. According to Miles and Huberman (1994), "With qualitative data one can preserve chronological flow, see precisely which events led to which consequences, and derive fruitful explanations" (p. 1). A total of four research questions provided direction for this study and guided the focus of the collection and analysis of data.

Creswell (2005) emphasizes the value in closely looking at the details of qualitative data and using this examination to develop themes and answer major research themes. Merriam and Simpson identify three primary methods of traditional qualitative research in terms of data collection: interviews, observations, and examinations of archival documents. The three key qualitative techniques used to gather data for this study were interviews of program staff and management, conversations with key Air Force implementation team leads and stakeholders during the implementation and examination of archival documents. Informed consent was given by each participant for the interviews to be tape recorded and transcribed. Audio tapes were initially transcribed within three days of the time the interview was conducted. A second transcription occurred later to provide a comparison to the first set of notes and to annotate any comments that may have been inadvertently not recorded previously. The researcher

carefully reviewed and analyzed the interview transcripts looking to detect recurring themes and patterns within the comments.

After printing out the hard copies of the transcripts, the researcher used different color pens and highlighters to provide initial coding by identifying similar expressions. The pens were red, blue, and black with red representing potential negative themes, blue representing neutral themes and black representing those that were positive. The highlighters were used for second-level coding to further breakdown the patterns into more specific themes such as: "perceived as providing valuable training," "perceived as challenging," "lack of clarity," "frustrated," "non-familiar," "ownership of the process" and "identified improvement." These are noted in Table 2 below.

Table 2.

Recurring Patterns and Themes

Positive	**Neutral**	**Negative**
Perceived as providing valuable training	Lacks clarity	Perceived as challenging
Ownership of the process	Non-familiar	Frustrated
Identified improvement in self/others		Insufficient Resources

The data responses were then analyzed to the respondents' position. The numbers of comments were then counted according to where they fell among the recurring themes and annotated accordingly. All of which will be discussed in further detail in the subsequent chapter. Miles and Huberman (1994) suggest a myriad of approaches to

cross-case analysis. One such method is to identify themes through coding and exploration of patterns. The researcher began by considering each installation as its own separate identify and exploring themes within responses from the designated installation. Repeatedly examining multiple data sources is aligned with constructivist epistemology and also provides reinforcement for the dependability of the data. Then a comparative analysis was conducted across installations to compare themes as well as detect differences and variations between installations. When the researcher noted responses that could be characterized in multiple places, they were utilized as directional markers for even broader recurring themes across cases. Coding and interpretation of themes within the various responses allowed the researcher to infer the impact that the DTM had on professional development and job training satisfaction.

Miles and Huberman (1994) describe some strengths of using this type of qualitative research, " . . . is their richness and holism, with strong potential for revealing complexity; such data provide "thick descriptions" that are vivid, nested in a real context, and have a ring of truth that has strong impact on the reader" (p. 10). With this in mind, secondary data sources and documentary data were carefully scrutinized reflecting upon each of the emerging themes and using those to inspire a new way of looking at the additional data. Throughout the review of each data source, emerging themes were noted. Detailed findings from each level of analysis are presented in chapter four.

Accompanying the interviews were the additional data sources, which consisted of conversations as well as analysis of archival documents. These additional data sources included PowerPoint presentations, training handouts and training calendars. Reviewing these additional data sources provided the researcher with a better understanding of the

DTM implementation culture and subsequent support. Additionally, it gave an idea of the time frame between trainings on DTM from the initial implementation.

Chapter Summary

The method in the current study was designed to examine successes and challenges in staff development that have been experienced as a result of the implementation of the Developmental Training Model. Gauging whether the model has been effective in encouraging management and staff to engage in reflective practice, mentoring and collaborative exploration of classroom performance is an important assessment for determining future delivery methods used in Air Force programs. Moreover, the method of surveying both currently employed staff as well as those involved throughout the DTM implementation process is an approach that may be deemed appropriate in examining other Air Force initiatives. This qualitative multi-case study took place in four Air Force Child Development Centers. Through the study, the researcher investigated the impact of the Development Training Model on professional development by focusing on staff, management and key stakeholder's perceptions of the implementation. The data from this study was triangulated through participant interviews, historical document analysis and interviews with key stakeholders.

CHAPTER FOUR: Results and Discussion

The purpose of this qualitative multiple case study was to look at the impact of the implementation of the Developmental Training Model in Air Force Child Development Programs. Although the author believed the Developmental Training Model had a positive impact on staff development, it was hypothesized that sufficient training and resources were not in place to ensure the intent of the model could be sustained over time. This section examines multiple data sources such as participant and secondary source interviews, archival records and documents to shed light on the actual impact of the DTM implementation. This study is divided into case studies of four individual Air Force bases. Each case contains background information, statements of general beliefs about perceived job training satisfaction, sustainability of the model, successes and challenges as well as advantages and disadvantages, areas of needed support for continued effectiveness and cognitive patterns that are salient in participants' verbal responses. The cases are presented in alphabetical order. All participants are females who have given permission for their names to be used. The participant interviews provide insight from the perspective of those working in Air Force Child Development Centers on a daily basis. The secondary source interviews include feedback from a variety of stakeholders in various support and training roles during the implementation. The archival records and documents provide factual information on communication efforts surrounding the initial implementation and help to build a descriptive map of various events that took place shortly before, during and after the initial "rollout" of the Developmental Training Model.

In this chapter, an analysis of the data collected during the researcher's investigative process is presented to address the four research questions posed at the outset of this study. The research questions for the study were as follows:

1. How do employees perceive staff development since the implementation of the Developmental Training Model?
2. Has on-going training on the Developmental Training Model been sufficient to sustain perceived benefits of implementation?
3. What are some of the challenges, advantages and disadvantages programs have faced since implementation of the Developmental Training Model?
4. What portions of the Developmental Training Model are unclear or require additional support in order to maintain effectiveness?

This chapter has been divided into the following segments: a review of the data analysis strategies and procedures, a descriptive framework of the four case studies, an explanation of the findings for the respective research questions and a summary section presenting the culmination of the overall research findings.

Context

A description of the case study locations and respondents is below. Included in each is a description of the respondents and the roles each plays in relation to the daily operation of the Child Development Center. Pseudonyms were used throughout the chapter for each of the respondents. A complete description of each of the three primary roles is included in chapter one. For the purpose of setting the context of the case study, a brief overview of the roles is included here as well.

The first role is that of the caregiver. This individual is responsible for the direct

care of children assigned to their classroom. As it relates to DTM, the caregiver role is to participate in the debrief following the classroom observation by identifying classroom strengths, offer input on areas of needed improvement and set professional development goals for themselves. These expectations are set to help staff become responsible and engaged in their own learning and development. The second role is that of the training and curriculum specialist. This individual is responsible for providing leadership, support, and comprehensive training to ensure direct care staff is prepared to work with children. Their delivery of training includes developing and managing appropriate curriculum within the center, educating and collaborating with parents on child development and special needs issues and assisting staff in developing and meeting goals and objectives that promote children's cognitive, social, emotional and physical growth. In terms of DTM, their role is to conduct the observation, facilitate the debrief and provide on-going training and support to the caregivers regarding topics identified in the debrief. The third type of respondent included in this study is employed in the role of the director (or assistant director at some locations). This individual is responsible for the daily administration and supervision of the center which includes a variety of tasks such as: implementation of developmentally appropriate programs, budgeting and financial management, food service, purchasing of equipment and supplies, personnel management, child abuse prevention and reporting, parent involvement programs and other related operational requirements. As it pertains to DTM, the director (or assistant director) role is to assist the training in providing oversight of the staff training, conduct classroom staff observations and assist where needed in providing input on areas of strength as well as those that need improvement.

The Case of Andersen Air Force Base. A total of four participants were interviewed at Andersen Air Force Base to include two direct care staff members (caregivers), one training and curriculum specialist and one assistant director. Andersen Air Force Base is located in Yigo, Guam and the Child Development Center typically operates 17 classrooms serving approximately 150-200 children ranging in ages from six weeks to age five. Andersen Air Base is located about 15 miles from the capital of Guam and offers a host of recreational activities for those stationed there. Tour lengths are usually for two-year periods for individuals who come with their family and approximately 15 months for those who go alone. In comparison to typical tours at other locations, this could be considered a "short" tour of duty. The program consists of one facility co-located with the base School Age Program and Family Child Care office. Personnel include a director, assistant director, one training and curriculum specialist and approximately 40 caregiving staff members.

The first direct care staff member is April who had been employed at the center for one and a half years at the time of the interview. She is considered a "local hire" from the surrounding community and is not a military spouse. She held entry and intermediate level positions at the base prior to her current position as a target level caregiver. Target level caregivers are those who have completed all fifteen of the mandatory early childhood based competency training modules plus a minimum of one year experience as a caregiver. April held no other positions at the base prior to her current position and had volunteered in public schools and local child care programs for three years prior to her current position. Her first introduction to DTM was in the summer of 2003. The second direct care staff member is Penelope who had been employed at the center for 10 years at

the time of the interview. She is also a local hire from the area and her presence has provided stability to a partially transient workforce. The director estimates just less than half the staff is military spouses, which helps provide a considerable amount of continuity for the program. Likewise, nearly 75% of the staff has reached the "target level" meaning they have completed the module training program. Penelope has held entry, intermediate and target level child care positions at the base prior to her current position as a lead program technician. In recent years, she had worked temporarily as the desk clerk for two months and filled in as the assistant director for a month. Her first introduction to DTM was in the summer of 2003. The training and curriculum specialist is Arysta who had been employed at the center for six months prior at the time of the interview. She is a Department of Defense (DoD) civilian "stationed" at Andersen on official travel orders. She expects to remain at Andersen approximately two years before traveling to her next assignment. She held no other positions at the base prior to her current position and had been employed with the Air Force for four and a half years in Japan prior to her employment at Andersen Air Force Base and at various other locations in the 10 years prior. Her first introduction to DTM was in the spring of 2003. The assistant director is Victoria who had been employed at the center as the assistant director for three and a half years at the time of the interview. She held no other positions at the base prior to her current position and had been employed with the Air Force as a School Age Program coordinator in England for two years prior to her employment at Andersen Air Force Base. She is a military spouse and expects to rotate to another military installation in the near future. Her first introduction to DTM was in the spring of 2003.

The Case of Elmendorf Air Force Base. A total of four participants were interviewed at Elmendorf Air Force Base to include two direct care staff members, one Training and curriculum specialist and one director. Elmendorf Air Force Base is located in Anchorage, Alaska and the Child Development Center is a part of three geographically separated centers on the base. Elmendorf is located in the capital and although winters can be harsh, it is considered an ideal training location and aircraft hub for many military occupations due to its proximity to both the Orient and Europe. Tour lengths are usually for four-year periods for individuals who come with their family and three years for those who go unaccompanied. This is a more traditional tour of duty in terms of length. The three facilities typically operate 37 classrooms serving approximately 450-500 children ranging in ages from six weeks to age five. Personnel at the particular center utilized in this study include a director, assistant director, one training and curriculum specialist and approximately 50 caregiving staff members. The director estimates approximately half the staff are military spouses who provide just as much turnover as it does stability for the program. In an interesting twist, approximately 75% of the staff is either at the entry level or at the target level with very few falling in the intermediate level. The trainer indicates this puts a serious challenge on the training program to meet the survival needs of the "newbies" while continuing to motivate the "seasoned" staff.

The first direct care staff member is Amy who had been employed at the center for four years at the time of the interview. She is a military spouse and has arrived in Alaska as a family member. She held no other positions at the base prior to her current position and had been employed first as an entry level and then as an intermediate level direct care staff member at another Air Force Base in Texas during the seven years prior

to her employment at Elmendorf. Her first introduction to DTM was in the summer of 2003. The second direct care staff member is Mya who had been employed at the center for four and a half years at the time of the interview. She is also a military spouse who expects to rotate to another military installation in the near future. Mya has held entry, intermediate and target level child care positions at an Air Force Base in Hawaii for four years prior to her employment as a lead program technician at Elmendorf. Her first introduction to DTM was in the summer of 2003. The Training and curriculum specialist is June who had been employed at the center for one week at the time of the interview. She is a DoD civilian "stationed" at Elmendorf on official travel orders. As a civilian, she has the option of staying at Elmendorf for an indefinite amount, applying for a new assignment after one year or returning to her previous position after her tour of three years. She is not certain of how long she will remain at Elmendorf but remains open to the possibilities of continued travel as part of her career with the Air Force. She was the Training and curriculum specialist in the School Age Program on the base for one and a half years prior to moving over to this new position. Prior to her employment at Elmendorf, she had been employed as a Training and curriculum specialist with the Air Force for two years in Texas, as a School Age Program Coordinator for one and a half years in Germany and as a Child Development Program direct care staff member for six months in Germany. Her first introduction to DTM was in the fall of 2004. The assistant director is Kristal who had been employed at the center as the director for eight months at the time of the interview. Kristal is a military spouse who is relatively new to the Elmendorf community and expects to rotate once her husband receives orders to their next assignment. She anticipates being at Elmendorf at least another two years. Prior to

her employment at Elmendorf Air Force Base, she had been employed as a School Age Program coordinator for one year and training and curriculum specialist for five years at an Air Force base in North Dakota and worked in various positions at an Air Force Base Child Development Program in England. Her first introduction to DTM was in the fall of 2004.

The Case of Hickam Air Force Base. A total of four participants were interviewed at Hickam Air Force Base to include two direct care staff members, one training and curriculum specialist and one director. Hickam Air Force Base is located in Honolulu, Hawaii and the Child Development Center is a part of three geographically separated centers on the base. Hickam is definitely considered a tropical location and one of their better assignments in the Air Force. It is a fairly large base and shares a fence line with neighboring Pearl Harbor. The three facilities typically operate 20 classrooms serving approximately 250-300 children ranging in ages from two to five. Personnel at the particular center utilized in this study include a director, assistant director, one Training and curriculum specialist and approximately 25 caregiving staff members. An estimated three-fourths of the staff is military spouses who contribute to a high level of turnover and a constant need for basic training according to the training and curriculum Specialist. Additionally, just over half of the staff has attained the "target level" in their career development with the remaining employees being split evenly between entry level and intermediate level.

The first direct care staff member is Sheri who had been employed at the center for two and a half years at the time of the interview. She is a military spouse who has traveled to Hawaii as part of her husband's military assignment. She is not sure of when

their next rotation will occur but is fairly certain this will not be their last duty location. She held entry and intermediate level positions at the base prior to her current position as a target level caregiver. Her first introduction to DTM was in the fall of 2003. The second direct care staff member is Fredericka who had been employed at the center for two years at the time of the interview. She is also a military spouse and is not certain of when her next rotation will occur. Fredericka has held entry, intermediate and target level child care positions at the base prior to her current position as a lead program technician. She also worked in an Army Child Development Center for five years prior to her employment at Hickam. Her first introduction to DTM was in December of 2003. The training and curriculum specialist is Noelle who had been employed at the base in her current position for four years and as a Child Development Program director for the three years prior to that at the time of the interview. Although she is not a military spouse, prior to her employment at Hickam, she had been employed as a director in numerous military child care programs for approximately 18 years. Her first introduction to DTM was as part of the initial PACAF pilot in 2002. The director is Marty who had been employed as the director for four years at the time of the interview. She is also not a military spouse but has worked at other military installations. Prior to her current position, she had been employed as the Family Child Care coordinator for nine years and director for three years at one of the other Child Development Programs at Hickam. Her first introduction to DTM was in the fall of 2003.

The Case of Luke Air Force Base. A total of four participants were interviewed at Luke Air Force Base to include two direct care staff members, one Training and curriculum specialist and one Assistant director. Luke Air Force Base is located 30 miles

northwest of Phoenix, Arizona and the Child Development Center typically operates 19 classrooms serving approximately 225 children ranging in ages from six weeks to age five. It is a premier retirement location for many as it is within driving distance of many recreational pursuits such as the Grand Canyon and the beaches of California. Personnel at the particular center utilized in this study include a director, assistant director, two training and curriculum specialists and approximately 70 caregiving staff members. Nearly half of the staff is military spouses which means staff turnover is a constant. Furthermore, approximately three of every four caregivers have reached the target level in their training. The majority of these have been with the program for quite some time and this provides a constant challenge to the training and curriculum specialist in providing new, fresh and interesting training to those most familiar with her style.

The first direct care staff member is Donnica who had been employed at the center for nine years at the time of the interview. She held entry, intermediate and target level child care positions at the base prior to her current position as a child care technician. Prior to her employment at Luke, she had not worked in the child care field. Her first introduction to DTM was in the spring of 2004. The second direct care staff member is Ashley who had been employed at the center for 17 years at the time of the interview. She held entry, intermediate and target level child care positions at the base prior to her current position as a lead program technician. Her first introduction to DTM was in the fall of 2003. The Training and curriculum specialist is Clarissa who had been employed at the base in her current position for 12 years at the time of the interview. She had worked previously as a Training and curriculum specialist in Guam in the two years prior to her employment at Luke. In the years prior to that assignment she had worked in

a lead program technician position for a number of years. Her first introduction to DTM was in the fall of 2003. The assistant director is Tammy who had been employed in her current position for 20 years at the time of the interview. Prior to her current position, she had been employed as a direct care staff member for nine and a half years at Luke. Her first introduction to DTM was in the fall of 2003. True to form with Luke having such a high retiree population, all four of the participants are spouses of former active duty military members.

Results

Research Question One: Perceptions of Staff Development Since Implementation of the Developmental Training Model.

The first research question in this study examined employees' perception of satisfaction with job training and staff development since the implementation of the Developmental Training Model. The sources of data to answer this question are participant interviews from those working day-to-day in the four case study locations as well as secondary source interviews from various key stakeholders such as the Air Force Lead Training and curriculum specialists (both past and present), DTM Implementation Team Leads and major command specialists responsible for various bases throughout the Air Force. An analysis of the responses from the participants is presented first and divided according to their respective positions. Throughout this section of analysis are responses from the key stakeholders.

Table 3.

Initial Thoughts about DTM

Source	**Frequency of Responses**		
	Positive	*Negative*	*Neutral*
Caregivers (Total: 8)	7	0	1
T&Cs (Total: 4)	3	0	1
Directors (Total: 4)	3	1	0

During the case study interviews, participants were asked what their initial training was and to describe their first thoughts about DTM.

Positive Thoughts. The majority of caregivers (seven of eight), T&Cs (three of four) and directors three of four) indicated their initial impression to be a positive one. Caregiver responses included: "It was good because I was new and the training was small so I was relaxed and felt welcomed to ask questions" (Fredericka) and

> I thought it was a great idea. I don't think we were getting as much training that was specific to our age group as they were doing things overall to everyone. Those trainings were better for discussing center wide issues but that could have been done during a lead meeting. To me it didn't meet the purpose of actually being trained on something. This way makes a lot more sense. (Amy)

In general, the tone of the responses from caregivers pointed in a positive direction and all seemed to center around two primary aspects with one being the debrief was viewed as a new source of information. The purpose of the debrief is to provide a time (ideally

one hour) for the trainer to facilitate an interactive feedback session with the classroom staff based on the observation that was conducted. The other primary aspect identified by the caregivers was that classroom observations were providing an additional set of eyes in the classroom. The three directors used words like "good," "beneficial" and "great" to describe their first impressions. When discussing further, each of the three pointed out that it was a welcomed process as it provided a way for the trainer to focus on the classroom as an individual unit and customize the training that unit would need. One T&C described her first thoughts as:

> I thought it was great because I thought it was a big step for Air Force to let caregivers out of the room for an hour. I think it was a big sign of respect for them in that we were validating them as professionals also validating us as trainers. I thought that was the beginning key to individualize our programs. (Clarissa)

Other responses showed commonalities around the words "exciting," "wonderful" and "great." Unlike the other roles, the T&C group's responses focused more on this not being a "new" way as much as it was a formalized way of doing what they were doing already. One of the assistant directors received her first training "second-hand" and did not attend the official implementation. Her response was:

> Thought it was great. My first exposure was here at Andersen. The first trainer I saw using it was [name omitted] and she really grasped the style. She knew the questions to ask. She was patient to get that information out of them. Some trainers are not patient and are used to the old style of

> spoon feeding and will throw the answers out at them. Watching her was amazing when you saw the light bulbs go off. (Victoria)

Jordan, one of the DTM Implementation Leads, reflected on the early days of Air Force-wide Implementation and stated that both trainers and flight chiefs would come up to the presenters after a regional training and would say "I finally get it" in terms of their job being more than sitting in an office trying to affect meaningful change from a distance or through procedural compliance. This comment was reflected in one of the evaluations from the 2004 regional trainings in which a participant stated "I really feel like I will finally be able to do what I'm supposed to do--feels like I'm starting a new job!" (K. Storc, personal communication, May 17, 2008).

Neutral Responses. There were some responses not rated as positive. One Caregiver expressed a neutral response of concern in stating:

> To begin with it was really confusing. We didn't understand what it was. They [director, assistant director and T&Cs] were also confused to begin with. They were telling us about the process and they said it would be hard to get into but they were excited about doing it. (Donnica)

One T&C specialist also expressed neutrality with her response of:

> Most of the people had already been through the initial DTM training so it was like a refresher for them. There were only about two or three of us that it was our first time. There was a lot that the three of us didn't understand. I know that one person had a lot of questions and concerns at my table that were interesting to hear. . . . I also think that it was good that

> there was someone from headquarters that wasn't 100% sure how DTM worked and also had questions. (June)

This T&C appeared to find comfort in the fact that she was not alone in her confusion and particular assurance that her major command specialist also had questions. In addition there was one director, Marty, who expressed some negative feelings regarding her first impressions of the DTM expectations. She stated, " . . . My first thought is that it was confusing. As a director I had no idea what the observation was to contain."

Hopeful Aspirations. When interviewing the various stakeholders, it was important to talk with those who were on the ground in the very beginning as DTM came into fruition. Ingrid, one of the Implementation Leads, recalls:

> I was thinking about how to make the staff training more effective and working on a 'train the trainer' model so that T&Cs would have new and more effective skills. This was in response to having seen them doing 'pull-out' training that wasn't integrated, customized or individualized for their centers or teachers. We were looking at a system that would personalize and make relevant the types of training experiences that T&Cs were making available to their staff. The way to do that was to base it on the observations of the classrooms and to partner with the staff so they could be a part of their own staff development process.

When asked to define this "pull out" training, Ingrid describes it as:

> There would be an expert in town who the AF had contracted to teach staff members about music education for preschoolers. Life sort of stopped at the center, staff came out and got this training and then went back in their

> rooms. They may not be able to implement what they learned because they were dealing with behavior/classroom management so there was no connection between what they had received and what they were able to implement. It needed to be more meaningful so that what they were getting was what they needed in their room at that time. While the pullout training may have been very skilled it was not very relevant.

An emerging theme developed regarding the hope that DTM would be just what was needed to augment training methods that were in place at the time of implementation. One of the other DTM Implementation Leads, Jordan, reflected:

> DTM allowed us to make processes similar and yet individualize information. What we lacked was in-depth training with staff. We had such a HUGE variety of skill levels. Our pool of applicants was so slim. Most were young mothers who knew nothing about working with children. To more experienced staff who had worked at a number of bases but had developed horrible skills in their time. We wanted to improve on those weak areas by taking away the issue of forms, management and procedures. Removing that concern and standardizing, we didn't have to spend so much time on that piece. So we could focus on quality interactions, planning and things of that nature.

This idea that DTM could standardize the way in which training was delivered across the Air Force was a huge undertaking but one that many of the respondents and key stakeholders recall was always needed but no one had taken the time to develop.

When asked how DTM was perceived after the initial implementation, Jordan elaborated with a chuckle:

> I think the reaction from T&Cs was an immediate success when the light bulb finally went off and they were able to improve their training. I will always remember the first program we got accredited using DTM solely as the training style. The input from the validators [accreditation agency representatives] on what we were doing was positive. Management felt better because the amount of time spent training had decreased because they weren't doing these large group trainings after hours anymore which they couldn't afford. Instead, they could use nap time and other downtime and reduce the training hour/costs for night differential because of the switch to DTM. Staff were more confident because the information they needed, they were able to get without being embarrassed in front of a whole group. It was a much kinder approach. By no means disciplinary. All very supportive. It was much more professional way of working with staff. Treating them with respect. Looking at them as if they were professionals. Respecting them and what they brought to the table.

Several of the respondents made reference to knowing there was a training issue before DTM was implemented and recognizing a need to change how business had previously been conducted in terms of staff development. Likewise, the fact that trainers were "out of the classroom" was brought up in several responses as well. Seeing DTM as a method to facilitate the trainers' re-entry as a regular part of the classroom seemed to be a recurring theme with the stakeholders. Stakeholders recognized that the T&C plays a

large role in shaping children's experiences through the guidance they provide to staff and that DTM offered an improved, more intentional method of increasing the lines of communication between the T&C and the staff. One of the DTM Implementation Leads described some of the thought behind the conception of DTM:

> I think it's the most meaningful approach. We didn't create the idea of reflective practice. It's been around for years in other staff development models. What DTM did was frame it up and package it for implementation in AF programs. I think ultimately if we know and believe that adults want to be involved in practices that involve them, it is the only way to provide sustained meaningful training. Yes there is still a place for large group training but I think DTM is superior to other techniques I have used. It's not always possible or for every forum due to access but I think it is the optimum way to do so. (Ariel)

This comment echoed the responses from the T&Cs earlier in that DTM put a name on what seemed intuitively common sense to many T&Cs. DTM provided a framework and standardized the "how" for most T&Cs who already understood the benefits of "why." The researcher was perplexed by these responses and wondered if so many understood the rationale and found it to be second nature, then why were the T&Cs not "in the classrooms" prior to DTM? If DTM simply added the "rules," then why was the practice not in place already? Some of the responses to the additional research questions included in this study will shed light on possible reasons this occurred. For now, it will suffice to say that DTM appeared to be a welcomed change that was recognized and initially valued as a needed process by most of the participants in this study.

Reflections on the Five Formal Steps of DTM. There are five formal steps of DTM as identified in Table 4 below.

Table 4.

Formal Steps of DTM

Formal Steps of DTM
1. Conduct One Hour Classroom Observation**:** Trainers conduct classroom observations.
2. Complete Observation De-brief Form**:** Trainers summarize classroom observations and identify potential training topics in order to focus and guide the training session.
3. Facilitate De-brief Session**:** Trainers facilitate interactive de-brief sessions with classroom teams (during scheduled working hours outside of the classroom); formal training topics emerge during these sessions. Topics discussed are documented on the AF Form 1098 (Special Task Certification and Recurring Training Form) after each De-brief Session.
4. Identify Individual Training Plan (ITP) Goals: Trainers and classroom team members collaborate on goals and time-lines for program development.
5. Provide Follow-up Support**:** Trainers provide modeling, coaching, and materials as needed to assist staff in meeting their goals.
The observation-training cycle is repeated as needed to support each classroom – preferably once monthly.

Essentially, the DTM process begins when the trainer conducts a one-hour classroom observation of the caregivers and children in their normal routine. Following the observation, the trainer completes a certain set of documents identifying what was observed during the hour. The trainer reflects on the observation and identifies strengths as well as areas for improvement. Using this information, the trainer prioritizes which "training" areas to focus on in the upcoming debrief session for the staff that works in the classroom that was observed. The trainer gathers any necessary resources surrounding the training topic to prepare for the debrief and to have available during the debrief. The trainer relies on the director to ensure classrooms have appropriate staff coverage during the debrief session. The trainer then meets with the staff to conduct the debrief. The DTM process calls for the debrief to be interactive rather than directive. The trainer asks the staff what they thought happened during the observation and seeks input from them regarding what went well and what areas of improvement they believe are needed. The trainer acts as a facilitator to guide staff to reflect on their own classroom practices. The debrief serves as a place and opportunity to share information, resources and suggestions on ways to address any concerns identified by staff. At the end of the debrief, the trainer helps the staff document goals they would like to work on as individuals and as a classroom team. The goals are recorded and the training is documented on the respective forms. The trainer then works with the staff to track progress of their goals and to provide on-going support around the staff's self-identified areas of improvement. The trainer typically observes each classroom on a monthly basis at which time the cycle would repeat and any updates to goals are made in subsequent debrief sessions.

Easiest/Most Difficult to Implement. When asked about portions of DTM that

were easiest and most difficult to implement, all of the responses for both ends of the spectrum could be classified into one of three areas: debriefs, goal setting/writing and observations (see Table 5).

Table 5.

Easiest/Difficult to Implement

Task	**Rated**	**Frequency**
Observations *(Conducting, Participating, Scheduling)*	Easiest	1 Director 2 T&Cs
Debriefs *(Conducting, Participating, Scheduling)*	Easiest	2 Caregivers 1 Director
Goal Setting/Writing	Easiest	3 Caregivers
Observations *(Conducting, Participating, Scheduling)*	Difficult	2 Caregivers 1 Director 1 T&C
Debriefs *(Conducting, Participating, Scheduling)*	Difficult	1 Caregiver 2 Directors 3 T&Cs
Goal Setting/Writing	Difficult	2 Caregivers 1 T&C

The three areas identified as easiest to implement correspond with Steps One, Three and Four from Figure 1 above. As it happens, these same three areas cited as the easiest to

implement by certain individuals were also cited as the most difficult to implement by others.

Regarding Step One (Observations), one director and two T&Cs cited it as being the easiest to implement. Noteworthy was that two of the respondents were from the same case study location. At this particular base, the director noted observations were the easiest to implement " . . . because most of the times we were in those rooms anyway observing things and seeing things" (Tammy). In a separate interview, the T&C unknowingly confirmed observations as an already institutionalized practice when she stated the easiest to implement was "Doing the observations because we were already doing those" (Clarissa). Spending a specified amount of time in the classroom conducting an observation requires a certain amount of skill and ability to understand what is happening between the Caregiver and the children. The researcher believes that skilled trainers would identify Step One as the easiest as it is the most familiar to them.

On the other hand, conducting a one hour observation can be a very daunting task for a trainer who has not perfected the art of making themselves "invisible" so that the classroom experiences can remain as close to authentic as possible. Along these lines, there were two caregivers, one director and one T&C who identified the observation step as the most difficult for them. From one caregiver's perspective:

> Getting observed on a monthly basis was hard. For a while we weren't used to people coming in our room every month. Just getting used to knowing when you would get observed. (Penelope)

Another caregiver stated:

> The observations make you nervous. Knowing that someone is watching you was hard at first but now I am used to it. I wish they could watch us from outside without coming in the room. Maybe a video. Then they could watch us at any time and see how we really did our job. (Fredericka)

In reviewing the caregivers' responses, it seems a feeling of uneasiness exists among this particular group when it comes to being observed in their work environment. Their comments center on the trainer's presence in the classroom more than any other task associated with the observation itself. Using words like "nervous" and "anxious" reinforce this idea of discomfort. Marty, a director at a different location, commented, "Doing the observation, I have detailed a lot of it to my assistant. Because we have so much other stuff to focus on, you have to push it on to someone else." This notion of the observation being less urgent and easily delegated to a subordinate was an interesting perspective that did not surface among the other directors. Unlike the T&C responses, this particular director's response indicated a feeling of being "removed" from the process that we will discuss in subsequent sections of this chapter.

With respect to Step Three, there were two caregivers and one director who identified the debriefs as being easiest. One caregiver stated:

> She was very, very nice to everyone. She would not really judge us. It would be just a discussion of what she had seen. It was never negative. She always told us to be ourselves and not put on a show because she could tell and the kids could tell. (Sheri)

An assistant director offered this perspective:

> When they ask you a question. You just ask that question right back to them. That way they have to answer their own question. The whole point was that the staff knows the answers nine out of ten times. It's making them thinking about it and have them come up with that solution on their own. Empowering them and making them realize they know what's going on in their room and what's going on with those kids. . . . So instead of always having to look to management and trainers they know they can come up with their solutions on their own. In the long run, that's going to make them a better caregiver and a better program. The trickledown effect is overall a better program. (Victoria)

These respondents seemed to agree on the debrief as being more of a "discussion" and a "chance to talk about issues" in a safe, supportive environment. It was described as "comfortable" and "not negative" while the trainer herself was stated to be "nice to everyone."

On the other hand, one caregiver, two directors and three T&Cs found this to be the most difficult part of the process for them. This was the largest number of respondents identifying any one particular category as most difficult. The words "judge," "dictate," "criticize" and "weakness" appeared repeatedly throughout comments from various respondents. While the actual debrief seemed to be welcomed from both the trainer and the staff perspective, the discussion and comments associated with the debrief seemed to have a negative connotation judging from the punitive type words used when referring to why they found the debrief to be difficult. With regard to what was hard

about the debriefs, most of the discussion for T&Cs and directors centered on being able to conduct a debrief with concerns about what to say to the staff with a particularly high emphasis on the difficulty of scheduling the debrief. The one caregiver who cited debriefs as hard referred to the scheduling issue "…there are a lot of issues with the ratio and staffing so there are not enough people to call in to cover" (Amy).

Marty, a director, reflected,

> It was hard not to find negatives and say them to the staff. Our focus before that when you did observations was to tell them what to correct. It was hard to think during the debrief of a different way to say things without focusing on what was wrong.

Echoing this same sentiment, a T&C responded:

> I heard laughs and giggles from the participants at the debrief forms we had to turn in as samples for the recent training. I know when I looked at them I was thinking . . . WOW did I really write that? But trust me when you do an observation and you are trying to pull out the most important part, sometimes there isn't anything there. It's easier to pinpoint positive things. But as far as pulling out topics you want to do for training, sometimes they are very trite. Like environments for the 30th time or positive guidance for the 50th time. We're going to talk about it again. It could be that because we are doing snapshots, it's not accurate of what always happens in that classroom. So here we are doing 'positive guidance' because of what we say today while she was trying to redirect a child and we end up doing the same topic again. It's kinda hairy. (Noelle)

This concern about the debrief seemed to focus more on "what" rather than "how" to say what was needed when discussed by the trainers. Several responses identified the need for additional support in terms of the most effective and appropriate language to use when facilitating discussions around areas of improvement. One of the DTM implementation leads summarized it this way:

> . . . many struggle with the implementation. I don't think they reject the idea behind it, they struggle in how to implement it. The ones for whom it works, quality facilitators, feel it is very valuable. I think the others think it is valuable but not as much so because they don't see the training topics and goal setting emerge as easily. Those who are good at it support it more than those who are not. I think they struggle because it requires two skill sets. One is early childhood background which most universities don't provide you with. You have to know what you need to know. The second skill set has to do with communication and psychology because you are dealing in the moment with peoples' feelings, beliefs and misunderstandings. It's nothing you have prepared. The fear of public speaking is the number one concern. Although not quite public speaking, you are in a public setting having to think on your feet. Many people are not good at that and don't understand it can be practiced and developed. (Ariel)

Aside from the conducting of the debrief, another critical area identified as hard when it pertains to debriefs has to do with scheduling and timing. This was a

recurring point of concern for several of the respondents. For instance, one T&C offered the following response:

> The only problems I had was finding the time to do it . . .. My whole thing with DTM is that it's very hard for me to schedule debriefs. I think I have told this to everybody including you now . . .. If you have never done DTM in your life and you are my boss or you are the guru on child care, you don't understand that I can do an observation for one hour in this room and then go and do an hour in a different room. Then you say you need to schedule them for a debrief the next day or so. And then they [management] go like 'we are short of staff, we can't do this.' Or the teacher says our babies don't sleep so you can't do it at nap time. I'm thinking to myself, I have 67 women that are in 13 or 14 teams that I need to meet with and the reaction is like 'Oh well so I was very shocked when they said at our last training that if you don't get them debriefed within two days then it's too bad, you gotta go back and do it again. I was thinking 'oh no . . . don't tell me that.' It's difficult because I don't schedule. I don't have the power to schedule. It's up to the director and her staff. I tell her who I need and then she comes back to me and says too bad, I just can't do it today. Other than cry, there's not much you can do. Sometimes I get firm and say I really need to get these people. I try to be very creative. I will go in on their break time and ask if they have a minute I can talk to them. If it's something I feel is really important or a possible danger, then I will try to get to them during break time or before

> they go home. I say it nice to see if they will let me catch them before they go home. But I can tell you I don't do an hour. I do whatever I can with them. Maybe 15 or 20 minutes or whatever. It's like I don't want to hold the information for over a week. Some weeks are bad because you have it planned and the staffs don't show up. But then the next day you are short of staff or a holiday occurs. You are past the two days. So can you still use the observation? It's hard. (Noelle)

Of particular importance, Noelle's comments and concerns are reflected in the responses of 13 of the other 15 participants who were interviewed. Although not all of those participants identified this as the hardest portion to implement, there was clear agreement that scheduling the staff and the timing of the debrief had presented its fair share of challenge from both caregiver and management perspectives. The associated "challenge" of scheduling will be discussed more in detail later in this chapter.

Step four focuses on setting goals and writing them on the Individualized Training Plan. The primary role group to identify goal setting/writing as easiest to implement were the caregivers with three of them citing such. Sheri stated, "The debriefs were simple and we always had a lot of freedom when we choose our goals. She never told us we have to do this because of this or that." Mya commented in a similar fashion, "I like the fact that we are setting goals and getting ourselves to think. It helps me personally. I like to have a certain date." Goal setting seemed to garner a positive response across all roles in terms of allowing caregivers to identify what needed to happen in their room and as far as having been missing from the previous training format. Interestingly enough,

the only role group to cite goal setting/writing as most difficult to implement was also the caregivers. One of whom answered:

> Writing the goals because it is the same stuff over and over again. It's like self-explanatory when you tell them verbally and then turning around and having to write it also. They [new employees] document their part of it after I have told them but then I have to write it out too. (Ashley)

Another caregiver concurred:

> Coming up with goals. Every time I am observed the goals I come up with are always the same. I want them to be different. I try to ask if there is anything else that I need training on instead of doing the same thing all the time. I want to make sure I am doing it right and if changes are needed they are made now. (April)

Additionally, one T&C identified goal setting as most difficult and explained her reasoning as:

> Goal writing is my weak point…also time has run out by the time we get to the goals . . .. Not that I don't know or lack effort but what do you cut back on. Writing wasn't as important as knowing what we need to do and why. (Arysta)

The researcher found it noteworthy that only one T&C cited goal writing as being most difficult. Was this indicative of a comment made by several stakeholders? One in particular is a headquarters major command specialist whose position involves providing support to multiple bases and therefore hundreds of child care personnel. During her interview, she commented:

> There is no quality to the goals, if they are even set, which indicates to me the T&Cs don't have a clue or a goal in mind. The methods are poor. They are not building on anything. We have been doing this since 2004. I should see very good individualized training plans. The goals are more like methods. They are poor plans. (Analise)

Another key stakeholder, Ariel, reflected a similar thought in how DTM as a whole (to include goal setting) presented a challenge to advance the quality in rooms that are already performing at a pretty high quality level because it requires the trainer to be even more knowledgeable to take those teams to a higher level.

DTM Compared to Previous Models. When asked how they felt DTM compared to previous training models, 14 of 16 base-level participants and nine of 10 key stakeholders responded favorably. In reflecting upon the earlier question of initial impressions, it appears that DTM is still seen as a positive change years after the initial "halo effect" would have been expected to have worn thin. In comparing DTM to other models used inside and outside of the program, the thoughts expressed centered squarely on the positive end of the spectrum. Comments from base-level respondents included phrases such as: "The Air Force idea is good because it happens every month that you get training. This job has more opportunities to learn on a higher level. It's better this way" (Fredericka); and, "I think that right now we probably the shining examples throughout the military as far as how we talk to our staff and get their buy-in. It's not like we are dictating to them anymore" (Noelle).

Others added:

I like it a lot better because you have that one-on-one and you know what everybody needs. “If you know the different ways that people learn, you can individualize it for that one person. With a whole group, you are limited to one type or the other such as visual learners. (Kristal)

For those that are more on the quiet side, they are able to speak out, ask questions and be more open instead of raising their hand and saying “my neighbor wants to know about . . .. (June)

One caregiver responded quite favorably and provided a level of insight from her experience on the receiving end of training:

I thought it was a great idea. I don’t think we were getting as much training that was specific to our age group as they were doing things overall to everyone. Those trainings were better for discussing center wide issues but that could have been done during a lead meeting. To me it didn’t meet the purpose of actually being trained on something. This way makes a lot more sense. I benefit a lot more personally and I like it so much better because I feel I can talk one on one with the director and also the trainer once they do an observation . . .. My personal opinion is that they looked at our past and found this was a better way to do it because it benefits us more individually. If you think about going back to the issue with the room, when you do your lesson plan you try to individualize for the children. I think that is the key point. To be honest with you before it was a lot of wasted time because when you put a lot of people together for a group training, you tend to get distracted talking and spend time on

> things other than what applies to the meeting was supposed to be about. (Amy)

There were several additional comments phrased slightly differently but each indicating that DTM offered an improvement over previous training methods. These responses indicated that staff and management were able to reflect upon the past and viewed the new process as one that offered greater benefits in terms of professional development. One T&C specialist offered a deeper description:

> DTM helps me to be able to meet more individual needs in an intentional and relevant way. I am able to focus on their specific needs and strengths and can adjust to staff interest, which means I start talking about something totally different but that is important to them, something they may not otherwise say in a large group. (Arysta)

Another trainer reflected with a similar thought:

> I think we are addressing more 'here and now,' immediate needs of the caregivers and the children . . . before it was more group centered and this is about a more smaller, enclosed atmosphere. We can focus on rooms individually as opposed to training on the larger program as a whole. (Clarissa)

Likewise one assistant director elaborated even further:

> Small groups are based on the needs of the classroom, which allows them to stay focused and engaged more. They think more. When you aren't engaged like in a large group, your mind wanders. When you are actively

engaged in a conversation, it turns your brain on and makes you think. (Victoria)

One of the Major command specialists expressed the same train of thought as the base level personnel reflecting:

> Personally I think it is a better model. It allows you to be more in tuned to what is actually going on in the classroom and to work with those teachers individually as opposed to doing it presentation style where you may 'hit' a few of them but the rest tune you out. DTM allows the teachers to bring in their knowledge and expertise. (Anastasia)

Thinking back on their own professional development over the years, one of the DTM Implementation Leads reflected:

> To me there is a night and day difference of when you can train based on specific needs of a specific staff member. Other than force feeding information. I wish in college when I was bored out of my mind because I already knew certain information, I wish the teacher had focused only on those areas I needed to know not what the entire class was getting. Think how much more I could have learned and how much more valuable that time would have been if it had been about me, and what I needed. (Jordan)

Jordan's thought is supported by that of another DTM Implementation Lead, Ariel, who suggested DTM provides an opportunity for personalization and connection between trainer and staff that would never happen in large group and gives opportunity to dig to the true root of behavior (non-compliance or

compliance). She states, “You can’t get at that in a large group training but you can delve into those kinds of issues and beliefs in a debrief” (Ariel).

Having such a high number of respondents indicating that DTM was an improved model over previous training format takes on even more significance when one considers that all of the participants had worked in military child care for years with the “newest” being someone who had been on board for at least two years at the time of the interview. This strong foundation in military child care gave the respondents a wealth of comparisons to draw from in evaluating DTM against previous training methods. That said, the fact that so many responded favorably was significant to the researcher.

One of the three respondents who did not describe DTM as a “better” model was a caregiver. This particular caregiver had been employed just over 8 years, had worked on at least one other Air Force base prior to her current assignment and had over two and a half years experience using the DTM at the time of the interview. Her rationale covered a wide spectrum of reasons:

> I never really got much out of the process . . .. I also don’t feel that with losing the large group training that people are getting proper guidance training. I don’t feel people are getting developmentally appropriate processes and activities . . .. I don’t think they [management] see the real picture when they conduct observations. I have seen it several times that when someone is in the room observing, they change their behavior, change the tone in their voice, change how they typically deal with situations . . .. Things done on a daily basis, the trainer is not going to see

> that. The director is not going to see those behaviors . . .. I think people are missing out on training. Even though the debriefs are supposed to be specific toward them. A lot of times there may be a flex in the room when the observation was done but the whole room gets briefed on guidance training. By that time, the flex who was having the inappropriate guidance has moved to another room and missed out on that particular debrief. I think the logistics of the whole process haven't been fleshed out yet. (Mya)

One of the key stakeholders, Anastasia, reflected on her role as a major command specialist in providing staff assistance to various bases within her region. In doing so, she echoed the point Mya makes above in that some staff feel they are not getting real training:

> A few have said they felt like they are not getting training. I think that relates to the quality of the T&C. I sat in on a debrief at one program and after the debrief, staff asked me *when* [italics added] are we going to get some good training? When are we going to get someone in here who knows what they are doing? I could agree with them but of course I couldn't say that. I made some general comments about how the process worked in that they were a part of the training in collaboration with the T&C and had to bring 'information' out. My impression was that the debrief was not good. The first thing the trainer did was to say 'This is DTM. This is DTM.' That was some sort of announcement to indicate the training was getting ready to start, I guess. She missed the points that

> the staffs were bringing up. At least one of the staff members was on target and bringing up valid points but the T&C was unable to address those. She was beating around the bush. Not directly being able to discuss the concerns or bring about further discussion. She couldn't help them delve deeper into the topic.

Anastasia went on to say that she had seen this type of "empty" debrief on several occasions and that she felt a good number of trainers struggled with developing appropriate content to facilitate the staff's development. This echoed Mya's comment above regarding never getting "much out of" the debrief. Likewise there was one flight chief, who describes an experience that both caregivers and other stakeholders brought up in their discussions about the trainer's ability to facilitate a debrief:

> I have one T&C who is stellar and outstanding. I have another who meets the basic requirements. She does observations, sets goals and goes through the motions. The ability to draw out from staff what they want/need to do and give them ownership is hard. I think they just come up with a goal to meet the requirement. She can't help people come to conclusions so she tells them. Consistency is an issue if you have two that don't cross. They have their assignments and they don't touch one another's room. (Sharise)

In addition to Mya, there was one other respondent who did not necessarily indicate DTM was more favorable than previous training methods. However, this respondent's rationale indicated she may not understand that DTM is a process and a type of training method: "I did not like [curriculum brand name #1], I like [curriculum brand

name #2]" (June). This was a particularly interesting response considering the individual was a Training and curriculum specialist. It gave the impression that the person responsible for oversight of the staff's professional development may not understand the concept of DTM which invariably leads to the question, how well can one implement and lead a process not completely understood? It is important to note that this T&C had not been to the original implementation training but had attended the refresher training, which she described as follows:

> Most of the people at the training had already been through the initial DTM training so it truly was a refresher for them. There were only about 2 or 3 of us that it was our first time. There was a lot that the three of us didn't understand. I know that we had a lot of questions and concerns . . .. I think other people were afraid to ask or didn't know the correct way to ask. I also think it was good to have someone there from our Headquarters who also wasn't 100% sure how DTM worked and also had lots of questions. (June)

This response indicated not only uncertainty, but some measure of reassurance in the fact that she was not alone in not understanding. It also indicated that there may be an equal amount of "unknowns" circulating at the headquarters levels which echoes the sentiment of the question asked above "how well can one implement and lead a process not completely understood?" This resonated with the researcher since the headquarters personnel are typically expected to provide the mid-level support and staff assistance to the bases. This concern of the unknown and ability to conduct

training without a strong foundation in DTM surfaced in somewhat of a different manner as described by one stakeholder who had worked in a variety of capacities within the Air Force as trainer, director, flight chief, command specialist and inspector:

> Before we were all over the place. Some of them may not have been doing any training. DTM gave us consistency, standardization and just having a structure has been very positive for AF regardless if they understand the system or not. (Deborah)

Collectively speaking, in reviewing the responses to this portion of the questioning, it appears that most respondents and stakeholders were in certain agreement that DTM offered an improvement over past training methods. Commonalities in descriptors included learning from their own mistakes, spending time one-on-one with the trainer, individualized feedback, comfortable small group setting and routine frequency of observations. These factors appeared to be the most highly identified positive features of the new format that DTM offered to both staff and management.

However, while most of the base level and stakeholder participants agreed that the DTM was an improved model over the previously used "large group" format, the majority of them also acknowledged that large group training had a place in the overall training plan and should not be excluded. One caregiver commented:

> I like to think that an explanation of some of the rules and regulations in a large group setting so that they can be discussed. It helps because it might trigger a memory that someone else may want to say that might not come up with just three or four people sitting in a group. (Mya)

Similarly, one Training and curriculum specialist offered the following thought:

> I still feel that there is a need for some of the large group trainings. I still think there is value to those. We are missing that. There isn't time to do those . . .. I feel that large group setting where caregivers can get out and meet other people that are not in their every day setting is a very valuable thing for caregivers. I think they need that and they need to be able to meet other people in the field and they don't always have an opportunity to do that or that they don't do that on their own. That is something we need to provide for them. It strengthens them and it encourages them to advance in this career. It gives them an opportunity to collaborate with other people that are working in the same field they are in. I think that is a valuable thing for people that our working with children. (Clarissa)

In a similar fashion, the third respondent who did not describe DTM as necessarily being better than previous training methods pondered over the existence of a previous training method:

> I don't think we had an old training method. We had staff meetings but those aren't addressing your individual needs. If there was a problem in your room, you had to try to work it out in your room . . .. There was no mentoring. To me, it was overwhelming; we were putting a lot on the new people and scaring them. (Ashley)

One of the DTM implementation leads identified with the need for an appropriate balance between large group and small group training stating:

> There is certainly a time and place for video watching, large groups, power points, read this/sign that, etc. We still utilize those methods but I think they are all secondary in terms of results compared to the time we spend on the debrief . . .. I think people still make mistakes but the individualized follow up in addition to just reading and signing a policy is what helps cement the knowledge we want to impart to the staff. It doesn't negate the need for other types of training but I feel it is the most effective of the types we use. (Mya)

Additional comments about large group training present an interesting perspective as it appears some staff and management in the field has interpreted DTM to mean that large group training has no place in conjunction with the small group debriefs. One stakeholder who was very passionate about the declining quality in training put it like this:

> Although it was never said, some people took the rollout to mean that the only training we would provide would be through the debriefs. For a while we were not providing any other type of training. There is still a place for other training. DTM is individualized but just a piece of the overall training. Many bases struggle with this concept. We took it to the extreme and did not offer any others like annual training. We were better off before when we were doing large group training because we were providing some type of information. Right now, if you look at the 'training they say they have provided it makes me want to cry. It is not training. At best it is information. (Analise)

In reviewing the historical documentation and in discussions with stakeholders, it is not apparent where this misconception was portrayed. Throughout the initial and refresher trainings, there was heavy emphasis on the need for individualizing and focusing on the individual classroom's observation. Perhaps the lack of clear guidance on how to supplement the DTM debriefs with large group training opportunities was not as clearly articulated. In such a military environment where most procedures are heavily regulated, it could be said that the absence of direct guidance advocating for inclusion of large group training attributed to the interpretation that large group trainings were a thing of the past once DTM began.

In summary, when answering the first research question of how employees perceive job training satisfaction since the implementation of the Developmental Training Model, the researcher found that the majority of base level respondents indicated a higher level of satisfaction over previous methods. This heightened level of satisfaction is perhaps evidenced best by a comment from a caregiver.

> Before it used to be just me as the lead now its both teachers who are in the classroom. It's better. I have to admit it's better now. Only because me being observed as one person when there is another person in the classroom is very uncomfortable. I wanted to hear more input from the other teacher and what she thinks of how I am doing in the classroom. Now that's why I say it's better. It's more like a team. We plan lessons together. We bring our ideas. Everything is out there. Which is good. It's not just me. She's not just talking about just having observed me alone. It's something she observed that we can work on as a team. I hear

more of the other teacher's input and she tells me every time her ideas. I take criticism well. It's better to have both of us in the debrief. We get more input, ideas and teamwork, which helps a lot. (April)

While responses such as the aforementioned one indicate a high level of satisfaction, the additional feedback in this section included above were clearly indicators that there is room for growth and improvement of the DTM as it was currently being utilized. Interviews with various other stakeholders such as the AF lead training and curriculum specialist, DTM implantation leads and major command specialists also seemed to point towards DTM offering increased job training satisfaction with caveats regarding areas that were needed to sustain its effectiveness as a training model. Many of the areas and thoughts surrounding how the process could be improved will be included in subsequent research questions.

Research Question Two: Sufficiency of On-going Training to Sustain Perceived Benefits. The second research question in this study looked at whether on-going training had been sufficient to sustain perceived benefits since the implementation of the Developmental Training Model. The sources of data to answer this question were participant interviews, input from various key stakeholders and a review of various archival documents.

Of the 16 base level respondents, eight were first introduced to the Developmental Training Model as a part of the Pacific Air Forces (PACAF) major command-wide pilot that took place in the year before Air Force adopted the model for use at all of its installations. Another five participants were part of the initial Air Force implementation and the remaining three were introduced in subsequent years after the model had been

implemented. Table 6 below outline the introduction to DTM as defined by the role the base-level respondents held.

Table 6.

First Introduction to DTM

	Caregivers	**T&Cs**	**Directors**
Before AF-wide implementation	6	1	1
During AF-wide implementation	2	1	2
After AF-wide implementation	0	2	1

It shows that the majority of caregivers were exposed to DTM prior to the Air Force-wide implementation. The most likely explanation for this is that three of the four bases used in the study were located in the Pacific Air Forces region, which was served as the "pilot" sites before AF-wide implementation. On the other hand, two of the Training and curriculum specialists and only one director were exposed some time after AF-wide implementation. This makes sense to the researcher given the fact that tenure in these positions is typically limited to a three- or four-year tour at bases in the overseas environment. It appears there has been some turnover in these positions since the pilot phase of DTM and thus the lower number of individuals at these locations who were introduced before AF-wide implementation.

The term “pilot” is used loosely in this sense, as there were no official intentions to implement this model AF-wide at the time DTM was being developed and used in the PACAF command. In discussions with one of the DTM implementation leads, it was stated that the idea of possibly using DTM across the AF was not widely accepted when first suggested to key decision makers and that additional time was needed to demonstrate the value such an approach could have in other locations outside of the PACAF region. Therefore, initial implementation was approved for usage in PACAF only with an underlying thought of DTM being a “pilot” approach that may have future implications across the Air Force.

Initial Communication and Training Plan for DTM Implementation. One of the archival documents reviewed was a “statement of work” that outlined the description of services the contractor would have to perform in conducting the DTM implementation trainings. The proposed training at that time included inaugural headquarters training, the introductory training for flight chiefs and trainers and the additional regional trainings for base level personnel. The training topics included areas such as child development, accreditation, team building, communication, management skills, leadership and other child care specific topics.

Inaugural Training for Headquarters Personnel. As evidenced by the archival documents, it appears the first official communication of the DTM implementation took place as part of an introductory two-day training Air Force Services “Agency” staff and major command specialists. It makes sense to the researcher that this particular audience was targeted as the first to receive training because the Agency personnel are the ones who are responsible for visiting bases and conducting compliance inspections as well as

providing AF-wide training when necessary and the major command specialists provide oversight to include training support and staff assistance for the bases in their command. In reviewing the archival documents, the stated objective on the agenda for this first round of training was "To familiarize major command specialists and Agency staff with DTM: the specific training process, the impact on T&Cs, and the impact on the existing culture at the Command level and at the Agency" (K. Storc, personal communication, October 8, 2003). The agenda included opportunities for attendees to conduct live classroom observations at a nearby Air Force Child Development Center, familiarize themselves with what happens during the debrief and get hands-on experience with the associated forms that were to be completed as part of the DTM process. Topics covered during the training also included: adapting a developmental perspective, getting buy-in and diffusing rumors. Topics such as these were aimed at helping prepare individuals to go into bases in a helping mode, provide feedback and gain support for a smooth transition through the implementation of the model.

***Introductory Training for Flight Chiefs and Trainers*.** One archival document included in this study was a 2004 news release that announced the Developmental Training Model was introduced to over 200 Family Member Programs flight chiefs and training and curriculum specialists in November 2003. This three-day training took place following the headquarters personnel training and was presented to flight chiefs and T&Cs who would presumably be those responsible for oversight and implementation. The news release announced the goal of DTM as being "to enhance our high quality programs by improving the delivery of critical training" (Toni Koppen, personal communication, February 12, 2005). The agenda included an overview of DTM and its

foundation, a debrief demonstration, a session on facilitating staff development and an opportunity for major command specialists to develop implementation timelines with their respective bases. Following the training, participants were asked what items they still had questions about and foreseen challenges. In reviewing their comments, the researcher identified "time management (how to get everything accomplished)," "staff buy-in," "funding issues (additional staff)," and "T&Cs who are ineffective communicators." These items were of interest as they manifest themselves in research question three later in this chapter.

First Round of Regional Trainings. The 2004 news release also mentioned there were six regional conferences to be conducted as the final round of initial training. These four-day regional trainings were targeted toward child development center directors, caregivers and T&Cs. The training covered the basic information on what DTM was, how it worked and what the expectations for Child Development Programs would be in relation to DTM.

Two other documents reviewed were the Regional Conference Agendas for trainers and managers. The agenda for trainers included the following topics: individualized staff development, classroom observations, mock debriefs, facilitation strategies, curriculum as a framework, mentoring, individualized planning and emergent curriculum. For Managers, the agenda included topics such as: what DTM means for children and caregivers, mock debriefs and challenges and solutions. On the last day, both managers and trainers received training on new employee orientation, shifting the culture, scheduling and team communication. The topics chosen for this joint training day are those that appeared to be most relevant to the success of DTM as it pertained to

overlapping areas of responsibility between the trainer and the manager. Topics such as scheduling and communication are ones that will be discussed later in this chapter and their relevance to the sufficiency of training will be further explored.

Of particular interest was a comment found in one of the archival documents that included evaluations from the regional trainings. When asked what attendees would like more information about following the training, one individual asked what training is "on the horizon to sustain this process as new managers and T&Cs come on board?" (K. Storc, personal communication, May 17, 2008). One may chalk that question up to instinct or perhaps past experience. Either way, the question seemed as poignant at the time of this research study as when initially posed in 2004.

Reflections on Initial Exposure. To shed light on what their initial training and exposure was like, participants were asked to describe how they were first trained on DTM. The comments varied greatly among roles as well as locations. One Caregiver remembers her first exposure as one of fear and uncertainty that grew to become more comfortable over time,

> I was scared at first because I had no experience . . .. I was wondering what it was like to have someone in the room watching us. I was really, really nervous. I was shaking because she came with a notebook so I knew she was coming to observe me. Then when she learned I was nervous every time I saw her, she started not to bring the notebook. She would make the effort to memorize whatever was going on and then go back to her office and write down the notes. Once I got to know her I became more relaxed. (Sheri)

Most of the caregivers reported similar feelings which gave the researcher the impression that not only were observations not taking place on a regular basis prior to DTM, that some of the staff were seeing their T&Cs in a different light and that the nature of their relationship may have changed as a result.

Another caregiver remarked that the usage of DTM (as part of the PACAF pilot) had started in her program before her employment began. She stated,

> I was told once a month we would have de-briefings and this is when training would happen. I was already working in the room before my training started. The orientation the director did. I didn't get any details on how the training was going to be done. She went over the job description and the orientation. She told me I was going to be the lead so there would be certain things I had to do. (Fredericka)

The caregiver recalls she was unsure of what to do in the beginning but once the DTM debriefs took place she gained more confidence in her role as a lead caregiver,

> It was good because I was new and didn't know what to do. In the debriefs she explained everything and could remind me of things I forgot to do. It was good because I was new and the training was small so I was relaxed and felt welcomed to ask questions. My [other military] center and Air Force were different so it really helped me to feel like I was included in the way we did the debriefs. (Fredericka)

Another caregiver indicated similar confusion over how and when the initial training happened,

> We were told that the late night two hour staff meeting trainings were going away and that they had decided to be more specific and that it would be more beneficial to us if we held individual trainings and did it this way. There wasn't really a training. More of an announcement of when it would take place. Later we had a training on the process and were told how they could make it more specific to our age group. We mostly learned about it once it began during one of the DTM debriefs. (Amy)

Similarly, another caregiver from a different location reflected on having attended the AF-sponsored training,

> We all went to dinner during the New Mexico training. Their session was a little more in depth. Our portion was not about DTM per se. It was more about mentoring and learning new techniques for working in the classroom. More like workshops. (Donnica)

In reviewing the responses from the caregivers, the recurring theme seems to be that most do not recall their initial training on DTM and describe it rather as an "announcement" that a change was coming. One T&C, who had been with the Air Force for a significant number of years, recalls her introductory training in a positive light,

> We were given an overview of what this would be and how it would help us. I think a lot of us had been waiting for this a long time. The standardization of things was great because our bases get people moving in and out. It really helps when you know a caregiver has had the same basic introduction to early childhood no matter what base they came from.

> To us it was really exciting and we came away feeling really good about it because it was a different type of process. (Noelle)

One director, Tammy, recalls the mechanics of the training as having included "hands-on, Q&A and slides presentations . . .. We discussed what it was, what it entailed, what we were expected to do here at our centers." An assistant director remembered similar details:

> We met as a group at one of the CDCs. As a group we observed in classrooms. Hands-on did a debrief with the staff that we observed. Dr. Wilson did most of the talking. We took notes on how she pulled the info for them. I felt bad for the staff because the group was full of directors and trainers. They were intimidated and spoke very quietly. Dr. Wilson was good about making them feel more comfortable. After she did a few she encouraged other people to do more of the talking to get the hang of the verbiage and what questions to ask and asking open-ended questions and how to pull the info out of the staff to get them drawn into the conversation to come up with their own solutions. (Victoria)

On the opposite end of the spectrum one director, Marty seemed concerned about the nature of the DTM training having not been in alignment with the shortcomings of large group training, which DTM had been purported to address, "It wasn't individual training, it was mass training. PACAF came down and told us we would be a test site. We were given skeleton remarks and told that we had to do a certain number of observations" (Marty). Extending this thought one

T&C, Clarissa, recalls more specific details of what was covered in her initial training,

> Just a basic introduction of the system, talked about getting the caregivers out of the room and that we were to go in and observe for an hour, use our observations to bring the caregivers out for an hour and use those observations to work with them to improve the program by making training more individualized.

Looking back at Marty's response raises the question of why the DTM implementation training would be in "large group" format if "small group" training was the very aspect Air Force wanted to convey in this new shift? This questioning of how the new training format was disseminated primarily surfaced in comments from those in management roles.

In reviewing caregiver responses, the researcher noted there were not many distinctions in the responses of those caregivers who had attended the actual Air Force training as part of implementation and those who had not. The latter group having received their training/exposure after the T&C returned from the Air Force training reflected a similar lack of understanding regarding the process and its expectations for impact on staff development. For trainers and directors, it was important to note that although most reflected upon their initial training as having been "large group" in nature but providing enough structure for them to feel comfortable in their ability to begin utilizing DTM in their programs following the training. The one trainer, Arysta, who indicated she began using DTM at a time much later than the official implementation describes her training as having been

> from word of mouth from other T&Cs . . . I did a lot of reading of old slides and handouts. I would say it was mostly self-directed. Fortunately, it was what I had been doing except I didn't know it was the same thing as DTM.

Additional Training in the Outyears. Moving on to address the question of additional training since the implementation, the answers from all role groups indicated training had been either completely non-existent or sporadic with considerable time gaps between retraining and initial training. For the purpose of this section, training refers to information dissemination to include updates on the DTM process. One of the key stakeholders, Alicia, reflected on the need for additional training:

> We are in a very transient world. Some of our T&Cs are getting their info based off what other T&Cs think they know or what they read in the manual. We haven't done a lot of addressing it. Lots of urban legends. So sometimes trainers don't even have a vision, they just let staff talk among themselves. Lots of misconception about what DTM really is.

When asked about additional training on DTM since their initial training, base level responses indicated none of the eight caregivers and none of the four directors had attended the Phase Two refresher training (see Table 7 below). Three of the four T&Cs had attended with just one noting she had received no additional training on DTM. In particular, one T&C attended the initial implementation for Air Force School Age Programs (SAP) commented:

> They didn't touch much on it. Even though it was a School Age training, they focused on CDC. A lot of the questions had to do with CDC. It seemed like there wasn't a whole lot of difference in what I heard at the

first one versus what I heard at the second one. The role play was almost identical. Working with SAP, it is very different than CDC. Like you don't do DTM during the summer time. Since this was the first time it was introduced to School Age, there were questions that came up and really it didn't seem like the people that were there could answer them. Like they said 'we'll get back with you on that.' But we did get a whole list of questions answered after that because a lot of people had questions and the whole question board was covered with questions. It was good that they did come back and we were able to get answers to things. In other words they needed to have their time to come up with answers just like we have to research. (June)

Table 7

Additional Training Format

Additional Training	**Frequency of Responses**		
	Caregivers	T&Cs	Directors
None	8	1	4
CDC Phase Two Refresher	0	3	0
SAP Implementation*	N/A	1	N/A

*CDC caregivers and directors would not be expected to attend.

Not listed in the table is one source of additional training known as the DTM video teleconference (VTC) discovered during the review of archival documents. It was

not mentioned by any of the 16 base level participants but was recalled by one of the major command specialists as an additional training opportunity. The VTC took place in 2004 approximately one year after the AF-wide implementation and was offered at four different times to provide maximum attendance opportunities for individuals in a variety of time zones. The stated purpose of the VTC was to provide updates on the DTM process, to highlight success stories and information from the field, to answer questions from the Q&A website and recent regional trainings and to introduce and discuss plans for the second year of DTM. In reviewing the list of questions covered during the VTC, there were questions on whether large group trainings were still appropriate, how much time to invest in mentoring and role clarification as it pertains to DTM for directors and T&Cs. Headquarters personnel answered each question, with an explanation for the rationale. In reviewing the timing of the VTC, it seemed to provide relevant and current information at a time when the bases were thirsty for it.

Another training opportunity took place in 2005 when the Air Force implemented DTM in all of its School Age Programs (those which serve older age children). It is important to note since the School Age Program is a separate entity, it would not be expected that a CDC caregiver or CDC director attend the School Age Program DTM implementation training. However, some T&Cs work with both age groups and in those cases, the T&C would have the opportunity to attend the additional DTM training. In June's case, she did not work with both groups but had transferred assignments and thus was able to attend the SAP training. June proceeded to describe her impressions of an additional DTM training opportunity as:

> I also went to Phase Two training for CDCs. Between the initial training and this most recent one, I think PACAF came down and did a staff assistance visit with one of our other trainers. I believe Dr. Wilson came here too and met with the other trainers. Unfortunately they didn't share anything. I didn't ask either. I thought if there was anything new they would have told me but they didn't so I just assumed it wasn't . . .. I don't think I had any other training." A similar comment from a T&C was "I didn't go to the latest training on it and I haven't spoken with anybody who has attended. I hear there's been a few changes. It sounds like there are some good changes coming along with it that will make it clear and more concrete. So as trainers we can pass it on to the staff. I am really looking forward to being briefed on that. I believe it's next or possibly the week after.

The fact that June stated the other trainers "didn't share anything" following their staff assistance visit and she "didn't ask either" stood out to the researcher as problematic in that communication of information regarding updates was not taking place. This raised the question for the researcher of whether DTM is viewed as a vital, critical tool needed to accomplish the day-to-day responsibilities for this particular T&C? Or perhaps was the thought simply that what she was doing must be good enough to suffice? One flight chief, Sharise, stated that although she really liked the concept of DTM and believed it provided staff with much needed individual attention and a personal touch, what she did not like was that "we are relying on the skills of the T&C and I don't think they have

been offered enough training. Other than the rollout, I don't think they have had any refresher/update training." However, according to the archival documentation, the VTC trainings in 2004 and the second phase of training conducted in 2005 had both been provided. It is possible that Sharise did not recall because flight chiefs were not part of the targeted audience for those trainings. As a flight chief responsible for overseeing the T&C and DTM implementation on the base, it did beg the question if the lack of availability of ongoing training had contributed to a situation where the need to stay current was not valued by those held responsible for implementation at the base level?

In reviewing the training announcement for the Phase Two training, it was stated that the training would include an "opportunity for T&Cs to have their specific questions answered about the philosophy or implementation of the DTM" (Headquarters Services Agency Memorandum, October 14, 2005). Furthermore, the agenda included opportunities to discuss staff development since DTM implementation, review how to identify training topics, observation and debrief techniques and an exercise in goal writing. These were all key areas listed in terms of areas requiring additional information following the first round of regional trainings.

However, after receiving Phase Two refresher training there were some comments that indicated some confusion still existed. One T&C remarked:

> I will say this last one was the best. Only reason I say that is because we had an idea of what we were doing and were able to expand it. Doesn't mean we know what we are doing right now. We are still floundering

> with this new version of doing the training topics, goals to make them fit the new accreditation criteria and AF checklist. (Noelle)

Noelle's comment alludes to the fact that she and her team felt they were able to gain clarity through attendance at the refresher training because the time between initial and refresher training allowed them to build on their familiarity and experience with DTM.

Reviewing the archival documentation and comments from various stakeholders revealed there had been various forms of training updates provided to include consultant support, a DTM manual, webinars, a Q&A website in addition to the phase two regional in-person training. In reviewing, the DTM manual appeared to be very robust in terms of answering the "How to" and providing guidance with common questions. For instance, the manual's table of contents showed five primary sections that included guidelines for: "Classroom Observations," "Identifying On-Target and Focus Items," "Facilitating Debrief Sessions," "Identifying ITP Goals," and "Follow-Up Support." The manual provided an introduction explaining the purpose of DTM, an overview of the formal steps and section-specific "tips" and common " pitfalls to avoid." However, it is interesting that respondents most commonly referred to the Q&A website and Phase Two training as their only source of additional training. What seemed to be missing was a "road map" that tied the various forms of additional training together. Even within bases where staff and management teams worked alongside of one another, it was not apparent in their comments that any particular four person team (two caregivers, one trainer and one director) all shared the same knowledge of what additional training support had been made available to them. Training support seemed to be disconnected, with significant time lapses in between and not fully articulated to all of the various role players.

A key stakeholder response from one of the major command specialists, Anastasia, indicated the Air Force had reached a point where an extremely small minority of trainers were proficient in their use of DTM as an approach to increase quality. On the contrary, she felt the overwhelming majority of Air Force trainers fell into one of these categories: 1) those who were formally trained on DTM but no longer working as trainers, 2) those who were formally trained on DTM but received insufficient or no follow-up or 3) those who had never received formal DTM training and were either being trained by someone else who had not received it or someone who had received it but were not strong in its application themselves. Anastasia went on to describe the lack of an on-going source for formal DTM training as a "downward spiral." Along these lines, one of the flight chief's responded:

> I think one of the biggest challenges is the lack of ongoing training for the T&Cs. Other than the initial training they received, they have not received any. With something as important as the *DTM* [italics added], you would think there would have been something additional. When it's the main focus of their job it's important to give them refresher trainer. I worry about the brand new trainers who are receiving it as a pass on/word of mouth. They are then recreating bad practices that someone else may be doing. (Sharise)

From all of the aforementioned comments, it is apparent that the lack of follow-on training is a significant concern at various levels from caregiver, to flight chief and also to major command specialist.

Research Question Three: Challenges, Successes, Advantages and

Disadvantages. The third research question in this study focused on the challenges, successes, advantages and disadvantages programs have faced since implementation of the Developmental Training Model. The sources of data to answer this question were participant interviews, input from various key stakeholders and a review of archival data such as training agendas and information disseminated during the initial implementation trainings.

***Challenges Associated with Implementation*.** With regard to the question on challenges faced since implementation, the various role players provided a myriad of responses but most responses boiled down to one of three areas: time management, documentation/filing and scheduling of the observations and debriefs.

Table 8.

Challenges

Challenges	**Frequency of Responses (Total: 16)**		
	Caregivers	*T&Cs*	*Directors*
Time Management	0	3	1
Documentation/Filing	0	2	0
Scheduling	2	1	2

It is important to note that the second research question covered earlier in this chapter describes tasks easiest and most difficult when implementing DTM initially. Table 8 provides an outline of the most frequently cited challenges that are "on-going" when using the DTM format for staff development. Three out of the four T&Cs who were interviewed responded with regard to the overall issue of time management;

however their reasons for citing time management varied greatly between them. For instance, Noelle, indicated her biggest issue with time management is becoming "too involved" in what is happening in the program. Stopping to answer questions and talking with staff who are on their breaks consumes a great amount of her time as it is unscheduled and often occurs when she is supposed to be somewhere else in the program. Noelle reflects:

> In all honesty, I know I am not a whiz at time management because I just get too involved with what goes on. If a staff person needs to talk to me, I will make my time available for them. Sometimes it just doesn't work out as well. I am reading time management books though. I am trying hard to stick to more of a schedule but there are so many things that pop up from staff, children and parents. They really need answers right away.

Another trainer stated her reason for time management issues had to do with juggling so many competing demands outside of DTM such as lesson plan reviews, parent meetings, reading and administering modules as well as being pulled to assist in other areas of the flight [overall base organization which includes Child Development Center, Family Child Care, School Age Program and Youth/Teen Program]. The theme among trainer responses was that there just were not enough hours in the day to balance the daily tasks and unscheduled interruptions along with the required pieces of DTM such as conducting the observation, scheduling the debrief and providing follow-up support. Digging deeper into their responses indicated they were seeking smarter ways to "learn to balance" but it seemed to be beyond mastering time management techniques in that the amount of work was simply too much from their perspective.

In regard to the filing/documentation, Training and curriculum specialists were the sole source of respondents, which makes sense considering most of the paperwork and procedures associated with implementation of DTM falls in their area of responsibility. For instance, Noelle provided the following thought:

> I think filing and documenting is just getting monumental. I mean I try to stay on top of it but there are so many pieces of documentation to make. Trying to go back to the staff and track the goals and how they are coming with it. It's really hard to get it all done.

Reflecting on Noelle's comment, the researcher was surprised to find an archival document that appeared to be a tool designed to assist T&Cs in gathering the needed DTM forms entitled "Processing DTM Forms" and included a step-by-step explanation of the forms necessary to have at the debrief as well as what steps the T&C needed to take following the debrief. It could be used as a "cheat sheet" to remember all the documentation and also provided helpful tips such as

> For accessibility, it is recommended that both current ITP goal setting forms and current 1098s be maintained in their own portable filing system. Additionally, it is encouraged that ITPs and 1098s either be organized in tab sections by room number . . . or alphabetically by last name. (Noelle)

Additional studies should pursue whether such documents were indeed utilized and found to be helpful.

Noelle also indicated that scheduling time to follow up on goals is also tricky to coordinate. Since most caregivers choose various time frames to complete their goals, she says it is a delicate balance knowing "what" to check and "when" to check it. She

finds that referring back to their Individual Training Plans to see what their timeline for completion of particular goals often consumes a great deal of her time and says it would be nice if there were an easier way to see all the goals in one place and be "flagged" or reminded of upcoming completion dates. Clarissa, another T&C, cited challenges with filing and documentation narrowed down the source of her frustration to the lack of supportive technology:

> There's just a lot to do in the aspect of a trainer. There's lesson plans to check, other trainings to give since we are a big center with lots of rooms, the paperwork, managing time is a challenge. The paperwork having to document every file when we have almost 80 employees, which we split between the two of us trainers. Keeping each individual file plus we keep a computerized training file for every training, they have had. I wish there was a better system that would computerize a file so it would be easier. If you did it on the computer and could print it out versus having to write everything . . .. Less paperwork would be my wish.

This struggle with the process piece ties in with several of the additional challenges to be mentioned in subsequent sections. It is important to note that the frustration reflected in their comments tends to center around the process of DTM rather than the product of DTM as evidenced by the various comments. In response to the question on challenges, one of the DTM Implementation Leads described watching the internal struggle of T&Cs as they struggled to find a balance during implementation:

> Not enough time to observe, too many responsibilities. Some cases there were feeling like the demands of being a trainer and completing other

> paperwork took priority to this more long-term process of DTM. It didn't seem to have the priority. It takes time to observe in classrooms and to do it thoroughly. Unless you are committed to that as a necessary condition to changing teachers' behavior and training them, it is very hard to do it. (Ingrid)

While the value of DTM may be appreciated and welcomed, its current format and documentation requirements have continued to contribute to some frustration on the part of the trainers who incidentally are those most heavily responsible for implementation. As discussed by several base level respondents and key stakeholders, it is important to keep in mind that the lack of clarity on the actual requirements may be a key factor in the perception that the documentation is overwhelming.

The third most commonly cited challenge associated with the DTM implementation centers around the concept of scheduling. It is important to note here that this challenge was the only one of the most frequently cited challenges to be cited by someone in all three roles (caregiver, director and trainer). This indicated to the researcher that scheduling is one of the more pressing challenges faced regardless of roles and perhaps an important area of focus for any future DTM adaptations or changes to the process. In looking at scheduling as a challenge, the caregivers seemed to focus on the outcome of the scheduling and particularly how it affected their classrooms in terms of it being a disruption to the day's flow of activities. One caregiver wrapped it up as follows:

> We have a major staff shortage right now and it's difficult. I'm having a problem with the caregivers who come in to replace me. Sometimes they don't know the children that well. So when I go back in the room I have

> seven or eight crying babies and it takes me quite a while to calm them down. And it's around the time that parents start to arrive. So that's just added pressure to where I almost dread going to the debrief because I know I could do more in the classroom. That's my issue . . . I have so much to do getting the room organized, help the kids be happy, feeding bottles, doing final diaper changes and I have parents coming in at the same time. It is only one day a month but it's just kinda chaotic and I feel bad for these parents walking in. (Donnica)

Alternately, one caregiver addressed it from the perspective of the observation being scheduled when "flexible" staff is in the room and how the observation may not reflect the true classroom environment because the regular caregiving staff is not in the room at the time of the observation. The term "flexible" or "flex" is used to describe staff that are not assigned to any particular room but are used to fill in for staff absences and to give breaks throughout the day. The caregiver summarizes:

> A lot of times there may be a flex in the room when they did the observation so maybe that room didn't need guidance training. But if that flex went to another room, they wouldn't know how to deal with it because they wouldn't have sat in on that particular DTM. I think the logistics of the whole process haven't been fleshed out yet. (Mya)

Her point is essentially that the training topic of child guidance was based on an observation that the regularly assigned classroom staff may not have needed. Furthermore, the "flexible" caregiver who needed the child guidance training based on the observation did not receive it because she was not scheduled to be a part of the

accompanying debrief. This response is echoed by Alicia, the Lead Training and curriculum specialist who summarized flex employees get missed inadvertently during a debrief if they are not working during that time or in a different room. She goes on to state that this has another negative effect in that it creates a time issue for the T&C who then still has the onus of addressing the issue with the "flex" at some point in the future.

The challenge of scheduling was described pretty much in the same sense for directors and trainers. With both roles reflecting on the coordination and timing of both the observations and debriefs. Of particular note was that debriefs seemed to be the harder of the two components to schedule. One trainer remarked with a deep sigh of exasperation:

> Definitely getting people scheduled out of the room has been a major problem. There are many times when you do get the people out, you can't spend the entire hour with them. You're supposed to have an hour but there is no way you can do it. Sometimes you only get 20 minutes. I know they don't want you to go into the rooms when the children are sleeping but sometimes that is the only choice when you can get all of the people together. It's that or miss the DTM altogether. (June)

Other comments took on the similar thread of timing being the key issue and identified the same question of "how" to make it work for the full hour on a consistent basis. One base team of trainer and director described how scheduling had been an issue for them at the start of the process but communicating regularly and working closely together had helped reduce the stress of scheduling. Even so, both individuals echoed the sentiment of the three other bases in that, competing

factors of unexpected staff absences, staff vacations and other on-going program activities contributed to the difficulty of scheduling.

Additionally, several of the key stakeholder interviews revolved around scheduling as a challenge. One flight chief, whose role it is to oversee the entire child care system on base, stated:

> I think the biggest issue is staffing it and scheduling it . . . every day gets derailed by the eight people that call in. You are putting everyone you have in ratio so there is no way you have extras to relieve a team of three people to get their debriefs. I think it's more specific to overseas but I think it happens probably everywhere. Staffing in a CDC is complicated and challenging anyway and trying to set it up to get all three core people out at a time is hard even without the callouts. (Myra)

Another flight chief, who has also been both a director and a trainer, agreed that scheduling was a significant issue.

> It has been difficult for scheduling. DTM has become hit and miss. We tried doing evenings for a period of six months when we couldn't get them done during the day. We had a lot of negative feedback from the staff/T&Cs regarding giving up their evenings. If someone calls in sick, debriefs go on the back burner getting them done is a struggle. (Sharise)

Other key stakeholders mentioned the impact that staff turnover on the schedule. Balancing the increased hours required for new employee orientation as well as the review of staff training modules consumes a disproportionate amount of time as compared to a program where staffing is more stable and turnover is minimal. In

addition, stakeholders identified the ability (or lack thereof) to master the concept of scheduling itself, which requires a specific set of competencies to get the balance just right so as to continue to operate the required daily aspects of the program as well as implement DTM successfully. Coupling these aspects together, it is easy to see how the scheduling of the DTM observations and debriefs was the most frequently cited challenge.

One source of archival documents included the evaluations following the regional trainings. One of the questions on the evaluations was to list suggestions that might help strengthen future trainings. Responses included: "include a 'Train the trainer' portion," "more smaller group presentations," "discuss nature of group dynamics," and "provide more emphasis to the personal skills that collaborative group participation necessitates." These comments highlight the areas that participants wanted more information on and are very closely matched to some of the challenges of DTM implementation that were identified.

Successes Since Implementation. The next question posed to the participants centered on identified successes since the implementation of DTM. Table 9 describes some of the successes cited by the participants.

Table 9.

Successes

Success	**Frequency of Responses (Total: 16)**		
	Caregivers	*T&Cs*	*Directors*
Improved Communication	4	3	2
Increased quality	3	0	1
Scheduling	0	1	0
None Identified	1	1	0

In terms of improved communication, the responses were varied among the participants. One caregiver reflected:

> When you go back in the office, they ask you what do you think happened and what do you feel about it. You get to judge yourself. You can say what you did wrong. You can do it yourself and think about it on your own. It's a relaxed atmosphere because they aren't telling you what the mistakes are, you are thinking of them yourself. You do learn because you learn from your own mistakes and their suggestions of what they liked that they seen. If you can't come up with a goal, they will suggest something. But it's an open discussion. (Sheri)

Another caregiver phrased her thoughts in a similar fashion:

> The trainer made me feel good about what I was doing. She encouraged me to continue what I was doing and supported my ideas. I think that was successful. Having her input and being able to share my ideas with her. I was never criticized. I have seen successes in the other rooms after DTMs. (Mya)

A third caregiver stated:

> I think that before DTM, working with a group of women sometimes was difficult because you would see something that needed to be done and you didn't have a way of solving the problem unless you were pointing fingers. Now with DTM it's a less judgmental type of thing, it's not about you did something wrong or you need to fix this. It's about all of us working together to fix the problem. I think our communication is a lot better and people aren't as upset at each other because we are all at just a group meeting talking about it. (Donnica)

These statements are very poignant considering the content of one of the archival documents which was a paper written by Dr. Lynn Wilson (2004), one of the individuals credited with helping to develop the Developmental Training Model. In the paper, Dr. Wilson refers to DTM as the instrument that was responsible for the significant shift in training styles from "large group training sessions on topics planned months in advance" to "individualized training sessions . . . precisely focused on their own classrooms" (Wilson, 2004, p. 2). Additionally, one of the presentation slides used in the initial round of DTM training discusses the principles of adult learning as it relates to developmentally

appropriate practices for young children. One of the common elements identified in the presentation is that both provide a "safe, supportive learning environment." This is also further reiterated in another archival document, the Air Force Child Development Program Philosophy (2004). This document included statements such as "We respect each child's unique interests, experiences, abilities and needs, thus allowing us to be responsive to and appropriate for each child. Children are valued as individuals, as well as part of a group" (p. 1). While the philosophy refers to how children are treated, the premise of DTM follows this same rationale in terms of staff development. This notion of commonality with developmentally appropriate practice is also reinforced by Nora, a director, who commented that the staff seemed to like the "one-on-one" discussions that occurred during the debrief. A trainer stated it like this:

> I think the staffs are really focused now and they talk about things. They put suggestions to work. You can see that they are accomplishing something. Not just because I told them to do something. DTM gives us a way to discuss issues without hurting anyone's feelings. It allows us to support them without criticizing their work. (Noelle)

Tammy, an assistant director, indicated agreement in stating that communication between the staff in the classroom was the area where she saw success. Whereas staff had previously elevated their issues to management, now through the DTM process they were able to talk with one another outside of the classroom and resolve most of their own issues. One assistant director recalls an

exact moment during a debrief when she "saw the light bulb go off" for a new staff member:

> They were having a conversation on discipline. Getting him to realize there were other ways to guide children. It was very interesting to see how the conversation evolved. A lot of the information he was getting came from his other two coworkers that were in the room with him. They did a lot of the talking to help him understand so that was good. (Victoria)

The fact that the director remembers this moment in time and that she identifies the staff member's receipt of knowledge from his peers is her identified success in terms of increased communication among staff and the trainers. One trainer identified various aspects of success in terms of her communication with the staff to include being able to meet "more individual needs by being intentional and relevant" along with the ability to "focus on their specific needs and strengths" and to "start talking about something totally different but that is important to them that they may not otherwise say in a large group." June, another trainer, agreed "I have had real success with people telling me they have seen a lot of differences coming from the classroom. They have come together as a group and asked for information." Other comments regarding improved communication included similar expressions of the ability to discuss issues openly in a safer, smaller environment. Participant statements regarding perceived successes indicated they seemed to appreciate the more immediate and individualized feedback they were receiving as a result of the DTM debrief format.

Increased quality in the form of stronger classroom environments and peer mentoring was also mentioned as a success. One Caregiver reflected:

> I think that DTM keeps us on task as far as environments. Sometimes we get tired of them and having that other person come in our room gives us some suggestions. Even though there are four of us in there to look and plan, sometimes you get stuck in a rut. An outsider coming in might come up with different things or something to try differently. (Ashley)

Another caregiver, Fredericka, specifically identified quality as a success in stating "It's good for my room because my quality is going up and eventually that goes to the children and they get high quality child care." Yet another identified success as:

> . . . being offered to open up my own classroom which is something I didn't think would happen. I was so used to be an assistant. Hearing from the trainer that I have the potential, knowledge and training to lead my own room. I have made an achievement. It's a big step. I've learned portfolios, assessments, planning and conferences from working closely with the lead teacher. Taking on small roles along the way has prepared me. (April)

A third caregiver, Penelope, described success as "Seeing new staff succeed . . .. I like the DTM. One of my goals is that I continue to mentor staff and build morale." Although it was not a formal component of DTM, peer-to-peer mentoring was one of the focus areas of the training provided to caregivers who attended the initial implementation regional trainings according to the caregiver training agenda. In reviewing that agenda, it appears caregivers were provided with information on the benefits of being mentored as

well as serving as a mentor. In looking at another archival document, a 2004 news release indicated caregivers had the opportunity to choose from 20 workshops designed to "enhance programming as well as provide professional development for all participants." The goal was to help more experienced caregivers identify and establish themselves as key players in their classroom quality and the staff development of newer employees. In reviewing the management and trainer agenda for that same round of regional training, caregiver mentoring was covered in two separate sessions targeted for this audience: "The Mentor Role in the New Employee Orientation Process" and "Overview of Mentor's Role." This indicated there was a fair amount of emphasis on the importance of mentoring as a key supplement to the DTM process.

One trainer recognized how most other bases were struggling with the scheduling aspect and her comments reflected pride in the fact that their base had found a system that worked for them. When asked to identify any successes as a result of the implementation of DTM, she quickly responded:

> Scheduling. We work very closely with the director and we have pretty much solved the problem. We have set aside breakers [flexible, rotating staff that are not assigned to a particular classroom] that do breaks in the morning and they cover in the afternoon for the classes scheduled for DTM debriefs. We have a schedule of DTMs. We don't do Mondays or Fridays. We do Tuesdays and Thursdays and we have a 3-month schedule for those. We do them in the afternoons. We don't do lunchtime or the mornings. We tried those times and those just didn't seem to work where it could be on a regular basis because we couldn't get coverage. They

> would get cancelled for some reason. We went to an afternoon schedule from 1:30 to 3:45 when we have two rooms on Tuesday and two on Thursday. We have 18 rooms and we get them all done during the month and we don't miss a one. We have two breakers that are assigned to that. We did that for consistency for the rooms so the children see the same people. (Clarissa)

She rattled the entire process off without referring to any notes, which indicated to the researcher that the system had become a familiar routine for her. The specifics of knowing what scheduling aspects had to be covered and the identified method of providing consistency seemed to work for this particular base as one of the caregivers and the director at this location also reflected similar expressions of satisfaction with the scheduling in their interviews. Although the other caregiver at this location did not reflect this same sentiment, she did clarify that the issue with scheduling had to do with a current staffing shortage and that prior to that it had not been a significant issue. That said having one base identify the scheduling as a "success" provided an indication that additional resources that provide consistent staff coverage might be a key to helping other bases with the scheduling dilemma.

One key stakeholder, Ariel, defined DTM success from the point of having formerly been employed as a trainer. She defines the success of having first hand knowledge of program practice and quality in that the trainers know what is happening in the classrooms which she felt must be very empowering. She looked at it from the perspective of a program subjected to so many

inspections and outside reviews. If outsiders came in and there were no surprises, then a trainer could validate their awareness of program strengths and areas for improvement.

Interestingly enough, some participants were unable to identify any successes. Phrases like "I can't think of any" and "I'm sure there were some" do not indicate that there have not been any successes but rather they are unable to easily recall them. Perhaps this is an area for increased focus in that the successes may need to be better communicated in order to help identify the value of DTM and possibly contribute to greater participation by all. Knowledge of what DTM has done to help others or increase quality could impact the number of staff call-ins and the willingness of the director and T&C to work with more diligence and collaboration on the schedule if they are able to identify positive outcomes associated with the implementation of DTM. Many of the advantages and disadvantages of using the DTM format were found by the researcher to be reiterations of the successes and challenges. Therefore only those that were different have been separated out for this discussion.

***Advantages of Implementation*.** There were several excited responses when asked the question of advantages posed by use of the DTM approach. The Air Force Lead Training and curriculum specialist, Alicia, defined the advantages for the overall child care program:

> I think you become much more in tune with your staff and inadvertently with the children in your program, you can really specifically talk about issues that pertain to them. To me it always goes back to a best practice thing . . . you respect their knowledge, treat them as individuals, you

> change your training methods to meet their needs (some like reading, conversation or a video) . . . you have the opportunity to do that. And it helps to form teams within the classroom. Because now it's not your or my issue. Even if I am not there part of the day, it affects what happens to children/parents and it becomes our classroom issue not a morning shift issue or an afternoon issue.

Alicia's response points out value for the staff and the children. Additionally, she identifies one of the reasons caregivers reflected in an earlier question of the positive nature associated with individualized training. This resonates with one of the archival documents was a paper drafted by Dr. Lynn Wilson in June 2003 prior to the Air Force implementation of DTM. Dr. Wilson states that the paper could be used as a guide to explain the new approach to staff training. In the paper she identifies one benefit of the DTM approach versus large group training is that training is "in the context of their own classroom" and addresses "caregivers' own concerns, frustrations and developmental needs" (Wilson, 2003, p. 6). Likewise, one caregiver felt the process had contributed to her willingness to remain employed in the program and her overall job satisfaction. She identified DTM as an advantage:

> . . . because you have the chance to have someone to help you and assist you every day if you want to or if you have an issue and want to know more about something . . .. I like having all the three people in the room to debrief with . . .. It's nice this way because you can express your opinions and because the trainer is there as a mediator and you can say things better than if you were saying it just in the room with your

colleagues. I have a good team and have not had a bad experience yet. They point out what you are doing good and encourage you to stretch yourself . . .. I could have gone back to the school system but I choose to stay here because I love this job and the children. (Sheri)

Similar comments from other caregivers included, "I like the way we do training now. I can challenge myself every time we meet. There is no time to get lazy because you are constantly being observed" (Fredericka). While another stated,

> We have learned a lot in training to help our parents come and interact in the room on field trips and special projects. Now we invite them and we get a good turnout. I credit a lot of this to the trainers for helping us learn how to talk to the parents and plan activities they can participate in. (Fredericka)

One director indicated the advantage as "I see a lot of progress" (Marty). From the trainer perspective, one offered:

> As far as training goes, I think staff is a lot happier. Even though it's more work for us. We benefit because when you go home at the end of the day you don't dread talking to them. I personally enjoy doing it . . .. The best thing about DTM is that we get people from other bases that come in and can hit the ground running. (Noelle)

Another trainer, June, saw the advantage in "Getting to know the caregivers one-on-one. Building the relationship with them so they know they can come to you." Individualization as an advantage was also valued by Kristal, a director who reasoned

Individualization, because staff are at so many different levels. You know from the observations which staffs are ready to take on more. It gives staff a chance to come back and ask questions where you can't necessarily do that in a large group. April, a caregiver, agreed "Hearing what she is observing and how we are fulfilling our role. We get new ideas and it's specific to the children in our classroom."

Another caregiver responded in kind:

We do a lot of one-on-one that I like and look forward to . . .. Through the years I have gotten good quality information. I have never gotten anything misleading. It's always been real helpful. I think the Trainer gets to know us better our weaknesses and our needs. It helps the people in the room grow more as a team and really come as one. (Penelope)

Of particular interest was a comment from one assistant director on the potential long-term advantages of DTM:

Long term the Air Force is going to see stronger programs and staff because staff won't need to be spoon fed. They will be able to see a problem and fix it on their own. Maybe even before it becomes a problem. They know the 'whys' behind the reasons we are required to do things. Hopefully it empowers them and they want to become a professional educator of young children and not just a daycare provider. They will tell parents 'this is what I am teaching your child. This is what your child is getting in an AF accredited program.' Hopefully it will turn their whole thought process around. It will take time for everyone to

> embrace this. It's really a matter of how patient everyone is willing to be while this new process takes place. I don't think we are going to see the real impact of this in a year or two. I think it's going to take a long time. Here we are fortunate to have some staff that has been here for a really long time and they are excellent caregivers. We have key people that are mentors and we send everyone through them because they are the strong staff. They get it. They understand it. They truly want to be here. They are here for the kids. Because some people can be intimidating, I think DTM stops the 'I gotcha' and helps us work better together as a team in terms of how we can make this a better program. Adults don't like being scolded. Hopefully this process stops that. As managers we will always have to talk to people but I don't think it's to the degree it used to be back in the day. I don't know it firsthand, it is what I hear people say. (Victoria)

Myra, one of the DTM Implementation Leads, described DTM as "extra effective" with new staff because their stress level is so high and their skill level is so low that they really need the specific feedback that comes from the observations the T&Cs are seeing in their actual classrooms. This advantage of one-on-one, specific feedback seemed to be repeated throughout several of the responses by both base level personnel and key stakeholders.

Disadvantages of Implementation. When it came to describing potential disadvantages, responses were limited as most participants indicated they were unable to see any actual disadvantages. In fact, Noelle, a trainer emphatically responded to the

question with “None that I can see whatsoever!” Similarly, Penelope who is a caregiver responded, “Honestly I can’t think of any. I haven’t heard any from others either.” Of those that offered comments to this question, the responses centered on the theme of consumption of time and the need for strong time management skills. Fredericka, a Caregiver indicated, “Sometimes the time is not enough to discuss. We need more time but the kids are getting up from nap and someone needs their break. So we have to stop the debrief early.” Another Caregiver echoed a theme that was reflected in the challenges portion above when describing what she viewed as the disadvantage. She stated:

> The only thing is that it’s time consuming. One day a month, you are trying to get people out of the room and it throws the routine and consistency off for that hour. Sometimes it’s not a good time to be out of the room especially when you put someone new or someone who doesn’t deal with that age group. You come in and your room is out of control. Makes you not want to go. They are doing the best they can to get us out though so they put the people in that they can. (Ashley)

A similar thought came from Marty, a director, regarding the disadvantage of using DTM being that it was “time consuming and not always consistent between trainers and over time. New trainers don’t know how to apply it so it may not be viewed as positive or a good process” (Marty). Additionally, one trainer stated:

> The workload is astronomical and there are unrealistic expectations that I can support this many staff. Training for all these areas. How do you do it all? I am torn between doing paperwork in an office and spending time

> in the room even though I know I should be in the room. Support comes from being there. (Arysta)

At the crux of all of these comments are the recurring themes of issues surrounding scheduling, time management and consistency. From all three roles, the need to provide a resource that can address these issues is apparent. Until that is done, the disadvantage of time associated with DTM will most likely not change. One of the DTM Implementation Leads, Myra, felt strongly that using the DTM was worthwhile because it was "results oriented and facilitated actual change and improvement in practice." She stated one of its strongest points was that it provided staff with dedicated face time with a T&C and sometimes even a manager, especially in large programs. Myra sheds a different light on the time challenge:

> I think these megacenters that Air Force is building are difficult to operate and managers and trainers are spread so thin they are so busy keeping the moving parts moving that time to sit down and look people in the eye and talk to them about their challenges and goals just does not happen. I think it's more so in the larger centers. The bigger it is, the harder it is to keep it operating smoothly and a lot of time is devoted to keeping parents happy and basic health/safety requirements in place and feeding in large quantities. I think the complexity of running the larger center puts a constraint against the time of T&Cs and managers. DTM is the dedicated, *forced [italics added]* one-on-one time in what would otherwise be a day of scrambling around, checking lesson plans and reading modules from the trainers' perspective.

While she acknowledges the challenge of time as cited by others as a disadvantage, she also points out the value in having the DTM provides as a mandatory training approach.

A different perspective in terms of disadvantage centered on the isolation and limited input provided by the individualized classroom format of the debriefs. The director describing this issue indicated:

> Sometimes you can hardly keep them on track to what they need to focus on because they want to turn it into a gripe session about stuff that is going on in their room or scheduling issues. Things that aren't really training related. I think when you are doing some of the brainstorming you don't have maybe the other people that are not necessarily in that room who could throw in their ideas on what was a good project, something that happened with them in the past, maybe a guidance technique where they have been successful. They don't have that sharing and networking really outside of their room. (Kristal)

A caregiver brought light to both sides of the issue and even offered a potential solution by saying:

> I know at one time our trainer wasn't doing debriefs but she would do trainings as a group with a particular age group. Seemed like she wasn't getting to us. I was jealous. I think the curriculum was hit hard in the inspection and she had to focus on those rooms. But now that everything is fine, she has more time to work with all the age groups. For a while we were having meetings by age group. I like the age group meetings because you get all the rooms talking and sharing concerns making sure

that everybody can check each other's work. They give ideas on our rooms and we do the same. (Penelope)

This affinity to "age group" meetings helps address the issue of isolation but lends itself to the issue of the need for effective facilitation skills as evidenced by one trainer's comments:

> Sometimes it's hard to keep people on track because they do want to talk about other issues that are bothering them. If their supervisor or director is not approachable, I think a lot of times they will come to the T&C because you do have more one-on-one interactions with them so they tend to come to you for every little problem and then they want to talk about that during your debrief time. It's really hard to keep people on track. Sometimes it's like herding cats. (June)

Finding an appropriate outlet for conversations not related to the training seemed to be a common issue. One assistant director reflected on several different trainers she had witnessed conducting DTM debriefs:

> Some trainers I have worked with are strong and do DTM very well. Others are not so hot and don't understand it themselves. If they don't get it the staff is not going to get it. We actually had complaints from staff that they like debriefs with particular trainers but with others they don't get anything out of it. Making sure we have competent trainers that know what they are supposed to be doing is key. Air Force should invest in a cloning machine and clone certain people. (Victoria)

Ariel, one of the DTM Implementation Leads, suggested that when trainers are ineffective, staff become frustrated by it and therefore in the absence of an effective facilitator, the debrief could be perceived as a waste of time and a disadvantage. When one considers the scheduling and time committed to it, a trainer could view the debrief as a time consumer because setting up individual trainings requires so many more clock hours rather than a one-time large group event each month.

From these responses, it appears skills in effective facilitation of conversations may indeed be a useful avenue for future training initiatives in support of DTM. Alicia, the lead T&C, describes this specific training need:

> We need to train our trainers on working with adult learners, we have really kinda missed the boat on that piece. Sometimes in our trainings, we get so bogged down in the process of do this, put it on this page and then do this in a certain way. We focus too much on procedures. We forget the content. What is DAP? How does it look? Feel?

One caregiver, April, viewed the idea of having the debrief outside of the classroom being a disadvantage. She stated,

> sometimes it's hard to know what she's talking about because we meet in her office instead of the room so that we can see things she is actually pointing out. Having the debrief in the room would make it more identifiable. (April)

This particular caregiver comment is supported in one of the archival documents, which was one of the handouts disseminated during the initial regional training. This particular document is a copy from a slide presentation discussing the shift from "training" to "staff development" and states that one of the limitations of the former large

group, generic style of training is that there is no "clear connection" between training and implementation as it pertains to supporting staff in applying training topics to their actual classrooms. Having the debrief take place in a location outside of the classroom was another suggestion during the DTM implementation training. The decline in retention of information over time and space is part of the issue with conducting live observations and strengthens the urgency to complete the debrief within a short time span after the observation has been conducted. The failure to do so results in caregivers being unable to recall particular incidents that may be cited during the debrief. Perhaps a video observation could address this disadvantage and also help with the scheduling issue so often cited as a challenge and/or disadvantage in the participant interviews.

Research Question Four: Unclear Portions and Processes Requiring Additional Support. The fourth and final research question in this study focused on needed resources, desired changes, sources of additional information and remaining questions to be answered to provide increased support for the sustainment of the Developmental Training Model. The sources of data to answer this question were participant interviews, input from various key stakeholders and a review of archival data such as the questions and answer posted on the DTM website following implementation.

Identified Need for Additional Resources. To begin formulating an answer to this particular question, the researcher asked participants to identify what resources were needed to ensure more successful implementation of the DTM. Most of the respondent answers focused on the need for additional staffing, internet access, training/education and increased availability of print materials. Table 10 provides a listing of the frequency of responses for each resource.

Table 10.

Needed Resources

Resources	**Frequency of Responses**		
	Caregivers	T&Cs	Directors
Additional print Materials	2	1	1
Computer/Internet Access	3		1
Manpower/Staffing	2	2	3
Education/Training	4	4	2

Each participant provided multiple responses and that all responses fell into one of the four categories listed above. Although most respondents indicated an availability within their center of certain print resources, there was a plea for updated and a wider variety of additional print materials (e.g., special needs information, parent education, developmentally appropriate practice). In terms of staffing, there were multiple requests for additional staffing to ease the burden and provide coverage for staff attending debrief sessions. In response to the question one director, Kristal, succinctly stated, "Bodies. Always having staff rotate so you can get people out of the room to do the DTM is difficult." In addition to classroom staffing, a trainer identified the need for an additional trainer to assist with conducting the required number and frequency of debriefs and observations. She proposed:

> I would ask for another trainer to help with DTM. We have so many staff. I know trainers are allotted based on working with 200 children but it's about the staff not how many children. It's about the number of rooms, teams, new staff. All those components weigh in and we just don't have enough trainers to go around. Supporting all the program we have to support in the flight. In order for us to do an exceptional job we need at least one more. If we don't get it, we are still held accountable to get it done. I could use someone to help with all of the filing that is required. I would also like to see our programs have enough staff that we aren't always scrambling. We are always short. I know we aren't the only base. We shouldn't be so short but we are always robbing Peter to pay Paul. (Noelle)

Internet Access (to include computer training) was requested to support individual caregiver's requests for specialized information and to help identify community resources particularly with regard to providing care for special needs children. The desire for additional training and education opportunities centered primarily on funding for college courses and the ability to attend national conferences for early care and education professionals. One trainer described the need as:

> . . . to be able to visit other programs and attend workshops where they can go out and meet other caregivers. That in itself is the important part. The workshop is important but just to be able to be in the field and out in the grouping to be able to be around other people in the same field to be able

> to talk and communicate with them is where the true training is and that is what they are not getting. (Clarissa)

Extending this thought one caregiver requested:

> Bringing in an outside opinion. Sometimes we get into a rut. To get new ideas it would be nice to have an outsider's view. At my last base, we had a lot of consultants come in and train. I got a lot out of it and thought it was beneficial. At that time I was still new to early childhood and it was new and fun and fresh to me. I think it's important especially for people who have been here a long time to be exposed to something new. (Mya)

Likewise, one caregiver cited a request for more training to take place "during" the debrief itself stating:

> If we could add more training during the debrief. For instance, if we have children with special needs, . . . we need to work with those children. Maybe at that particular DTM, they can give us some suggested books or websites that we can go and get ideas on things we can do for that particular child or particular children. It depends on what the need at that time is in your classroom if you could get help in that area. (Amy)

This was an interesting comment in light of the "Common Pitfalls to Avoid" listed in the DTM training manual which was another one of the archival documents reviewed as part of this study. On the list of pitfalls was "assuming you--the trainer-- are the expert." The guidance in the manual reminds trainers to help staff identify topics that would be helpful for them "whether or not you currently have expertise in that particular area" and encourages them to help the staff generate solutions to meet their needs. This seems to

reinforce what the caregiver, Amy, is asking for in the above comment. Along that train of thought, one trainer's request for the initial implementation training materials sheds some light on why this type of training may be missing from some of the interviews. Her comment regarding the need for additional resources was:

> I would really like to have the initial DTM book so I know what the people who went to the first training learned. I would have it right in front of me to look at and read. Maybe a tape or DVD so that you could review once in a while…if there was a real good website where we could go into and submit questions and didn't have to go through the whole chain of command. If it was okay to talk to whomever I needed to talk to about questions. Or even a network of people out there that have questions because there aren't a lot of people I know who are really clear on what is expected of them. They still have questions. I think at one time there was talk of having people come in and review how your DTMs are going. Someone to observe us observing and watch our debriefs. Especially for new trainers or people that are just now coming in. That would be good. (June)

This trainer recognized her own lack of awareness about the DTM process and provides many suggestions on how to fill the gap for information that appears to exist since the earlier implementation training. Likewise, another trainer responded almost verbatim with her statements:

> Maybe if I had had the first training and could have heard someone explain it. More formalized training right away is needed for new T&Cs.

> Finding time to look for the forms on the website is hard to do. It's hard to do paperwork effectively. We need better tools. I could see someone pencil whipping the documents . . .. My peers went to original training, I email another T&C but she hasn't been either. I try to look on the websites but can't find what I need. I just do what I think is right. I learned from looking at what the previous T&C had done and then followed suit. (Arysta)

Somewhat of a surprise to the researcher, there was also one caregiver who requested:

> It would be nice to have a DVD on the whole program of DTM. Maybe if management took one or two of us with them to training when they go. When people go to training for a week, they come back and may have lost some of it over the weekend or in the translation. People tend to interpret things differently on their own. (Donnica)

In reviewing this response, the caregiver seems to indicate there may be some portion of DTM that has not been clearly articulated to the staff and expresses a desire to gain this knowledge for herself. Likewise, one director stresses the need for additional training on DTM in describing her request for additional resources as needing:

> More training on DTM provided to trainers, directors would be very beneficial. If someone with corporate knowledge could come in and hands on work with them. More than a once a year training or a one time training. I went to training one time but it was three years ago and that was it. I think we are pushing people thru training one time and expecting

them to get it like that. It would be great if every MAJCOM [a collective group of bases under the same "major command" leadership] had people in each area that could go around and work with people as trainers. (Victoria)

Changes Needed

In terms of needed changes for continued implementation of the Developmental Training Model, the responses seemed to reiterate many of the challenges, advantages and resources needed in that the recurring themes in the responses focused on additional training, standardization of information on the DTM process, adaptations to the timing and frequency of debriefs and a reduction in the amount of required paperwork. Echoing the request for changes in scheduling, a caregiver remarked:

> The only thing I would change is maybe the scheduling. I know they do it how and the way they do it because that's when they have the most staff. I just dread going to the meetings because I know when I get back I am going to have all those crying babies. I would like a morning and afternoon person that were the same break people coming in for that one hour. If I could, that would be fine. It would be the only thing I would change about it. (Donnica)

Yet another caregiver, Ashley, responded in a similar fashion with a request for a change that, "If we have to be replaced, find someone who is familiar with the kids. Especially with the age group." This quest for continuity of care during DTM support functions appeared a number of times from other caregivers during the responses to

challenges. On a different note, another caregiver's request for change centered on how training is disseminated initially:

> I could have benefited from more training than the four hours in the room with the mentor before you start doing breaks. I don't know about my coworkers but I wasn't sure what I was doing. I know it's hard with turnover and they have to make you start working right away but it would be good if you knew more before you started. (Sheri)

Another caregiver indicated there was a need for more frequent classroom observations. In agreement with this line of thinking, one trainer simply wanted "more time" to conduct observations, the flexibility to extend debrief sessions past the one hour when needed and time to prepare before an observation and gather training resources before a debrief. On the other side of this request, one trainer quipped:

> When I heard about the two day turnaround to give a debrief, that is not realistic in a center-based program . . .. I think the paperwork is intensive but it's also important. I think to even think about doing it all electronically is even further fetched. We don't even have email so I don't see that happening. I think the process is wonderful but it's difficult at first because we have to hone in on NAEYC criteria plus the AF regulations. It takes time before we can get that down to where it's second nature but it's going to take time. I just hope we are allowed to have that time. (Noelle)

Looking for answers on DTM, Marty, who is a director, indicated a desire for change to "Standardize the paperwork into a handbook or on a website where we can pull

it down. Provide regular recurring training on the process for T&Cs." Likewise, one trainer commented:

> I would ask they send something out such as information. I know you can't send hard copies to every single base and trainer. What we need is information. But at least we could know how to get the information and have it posted when changes are made so we know about them right away and know how to implement the changes. Because not every trainer will be able to go to a training and not all of them will bring back the correct information. Their interpretation is different than your interpretation. Some will take better notes than others. So you are getting someone else's view on it, which I think has always been a problem. Then you have those people who don't like to share. It would be better to have that information come directly from the person who put it together. (June)

Myra, one of the DTM Implementation Leads, suggested an added, more formalized component such as a "weekly team meeting" where the director, assistant director and the training and curriculum specialist sit down with a standardized agenda that includes center business as well as feedback on the training program which would help minimize scheduling issues, potential caregiver performance concerns and provide a forum for collaboration between the key players responsible for the operation of the program. By adding such a team meeting, this may help address some of the challenges and perceived disadvantages mentioned throughout this chapter.

Jordan, another DTM Implementation Lead, emphasized there has always existed a need to relook the overall implementation, to make improvements and to eliminate redundancy:

> We just rolled it out. It was never intended to be the cure. It was always to be a live tool that grew and was shaped accordingly. Its original format may or may not work as the Air Force's needs change. It all needed to be looked at and adjusted. Especially with the new accreditation, there were changes needed . . . it is all tied together. If we haven't made changes, I see that as a failure.

Current Understanding

When asked how they rated their "current understanding" of DTM, Caregiver responses ranged from Sheri who stated, "I feel very comfortable. It's very simple and very easy . . . " to Donnica who believed " . . . sometimes I am not totally clear on what the final product is supposed to be." In similar fashion, Fredericka indicated, "I'm not really sure. We just call it training. No one actually talks about it." These comments indicate that perhaps at these locations, management had proceeded with the implementation as instructed but had spent little time further expounding or offering refreshers on the intended purpose and rationale for using the DTM approach. Another caregiver, Amy, offered "I understand it is to enrich the program and to help me and the children achieve better for the benefit of the program." While another elaborated even further to the opposite extreme:

> This is one of those honest answers that I would never say to anyone else especially since they paid for me to go. I was at the conference. I thought

> that was supposed to be a conference to train on the process. I came home with nothing to give anybody else. My answers were all highlighted and vague because I could not pin point any one thing to say I understand the process better. There were great workshops at the conference. I did get new ideas. But when they sat us down for the day that was supposed to be set aside for DTM training, I really didn't get it quite frankly. There were people up there who obviously knew what they were talking about. I felt like they jumped from one area to the other. I walked out of there thinking I thought this was supposed to be about the DTM and I never really got that information. I couldn't even tell you what they did talk about. I know it sounds bad or that I wasn't paying attention but it was like they talked a little about professionalism, a little about how to implement things from the workshop in the classroom. I am sure they talked about DTM and maybe they used wording that I didn't understand. I was really excited about going and being able to get information and knowledge to bring back. They wanted the people who attended the conference to do a training for everybody else. Thank God we didn't because I had no idea what I would have told them or turned it into any kind of training other than sharing the ideas from the workshops. (Mya)

This particular comment carries a great deal of weight because this caregiver had been employed throughout the PACAF pilot and the AF-wide implementation and was currently serving as a room lead. It indicates the critical importance of continued training focus and communication of the purpose of DTM to those in the classroom. If the room

lead is the conduit for information from management to the classroom assistants, it is even more critical to ensure they have a working knowledge of the DTM process and that they have a mechanism to provide feedback on what is working and where improvements in the training process may be made. This particular room lead was honest in her assessment of having walked away with a minimal understanding. Although other caregivers in the study did not recognize their initial training as being substantial, the common theme among their responses is that they understood the fundamental purpose of DTM being to provide training to their specific classroom issues. Transition and curriculum specialists' comments were more similar to one another in nature with one remarking:

> I'm probably at 85 percent or 90 percent now. I think even with this last training, we need practice. The staff are patient and I explain to them that they need to help me with the process as far as thinking of goals collaboratively and brainstorming training topics. So far so good. (Noelle)

Another T&C scored her understanding:

> . . . nine out of 10. I think I understand the process and all the aspects except I still struggle with writing the goals. Finding the time to sit down and actually think it all through in my head before time to have the session with the caregivers. Thinking about how I am going to process it through for them to get them where I want them to be. Leading them to write their goals. (Clarissa)

The recurring input from T&Cs was that they pretty much understood what it was they were to do but were not as comfortable with the particulars of how to go about doing it. Additionally, most felt they needed a source of information to provide them with ongoing guidance in accomplishing the various tasks. Details about the type of particular support requested will be discussed later in this chapter.

Directors seemed to rate their understanding fairly high as well with declarations such as Tammy who reported, "I'd say 9.5 out of 10 because once it was in place and we got the scheduling down then everything kind of fell into place and we didn't really have any problems." Another remarked on the lack of updates and additional training:

> My understanding is pretty good but I know things have changed since the first training I went to like the forms. I believe now it's all of AF doing it not just PACAF. I think the process in the way we talk to staff has changed (trying to pull info out so they can come up with it on their own). I think that is still the goal. Learning things like when managers do an observation for new employees, knowing that the trainer is supposed to do that. I think there are little bits and pieces of the process that have changed and that information has not trickled down to everyone yet. I think it's still little things not the main meats and potatoes just the minor tweaks over the last couple of years that haven't made it down to everyone . . . or to me. I also don't think everyone like our current trainer has been trained on DTM. Some, although they were trained even if they went to the conference. Like any job some people pick it up faster. (Victoria)

However, one discussed her understanding as:

> Limited. As a director I don't really know what's going on. I only know what the trainer tells me. I don't keep up with her paperwork. I think as a director we have so many other things that we focus on that we leave the DTMing up to the trainer. She gives us feedback on what's happening. (Marty)

Director responses seem to echo and build upon the trainers' responses in terms of their desire for additional information on the mechanics of the process. It was clear to them that there was a certain way to proceed but they were not as clear on what that way may be. Additionally, most recognized there had been some updates to the DTM process instructions but they were not aware of what those were.

In reviewing the archival documents, evaluations from the 2004 regional trainings closely align with the comments above. When asked what trainees would like more information about following the regional training, the evaluations included comments such as "how to manage your time if you are the only T&C covering the flight," "organization, scheduling and documentation," "goal writing, debrief techniques," "facilitating small groups, human development" and "training in communication and listening." One participant simply responded to this question with "WOW." These comments were made nearly two years before the participants in this study echoed almost identical sentiment.

Sources of Information

With what seems like quite a bit of uncertainty about the process, the researcher followed up the question on understanding with one that asked where individuals go for additional information if they have questions on DTM. Most questions from caregivers and directors seem to point toward the trainer as their primary resource. Amy, a caregiver, said

> Many times I go to the trainer because that is what she is here for. If she can't help me, I go to the assistant director or director. But normally she has always been able to answer my questions or at least point me in the right direction where I can take it from there and find out for myself.

One assistant director expressed frustration with not having "access" to a source for information:

> Where I go and where I'd like to go are two different things. We have to go to our flight chief. We have to follow that chain of command. Where I would like to go is straight to the source. I find it extremely frustrating that you have to go through five different people and then wait two weeks for an answer. I don't see why if we know someone who has the answer whether they be in PACAF or another base . . . why can't we email them directly if we copy the flight chief? I think we need access to a direct source. (Victoria)

Three of the four remaining directors indicated they would seek information from the trainer or additional source such as a colleague or a major command specialist.

This reliance on the trainer as the primary focal point is congruent with the role of the trainer as defined by the Military Child Care Act (MCCA) of 1989, which mandated hiring of a Training and curriculum specialist to provide oversight of the staff training and curriculum development. As Table 11 indicates, a high number of both caregivers and directors look to the trainer as their resource for additional information with regard to DTM which inherently meets the intent of the MCCA.

Table 11.

Sources of Information

Role	**Sources of Information**	**Number of response**
Caregivers	Colleagues	2
	Director	3
	Internet	2
	Resources (e.g. books)	2
	Trainer	7
Directors	Colleagues	1
	Trainer	3
	Major command specialist	2
Trainers	Agency website	1
	Colleagues	2
	Internet	1
	Resources	1

Having identified the source of additional information for the other role players, this same question posed to trainers indicated most turn to colleagues for answers, as they are sometimes at a loss themselves. One trainer explained it this way:

> I network with people. I would like to say that I could ask someone above me but I don't think that that would be allowed. I think if I could get permission to speak with someone at PACAF [major command] that would be good. I sometimes check the website. There is information there. I have to check to see if it's new or up to date. I think sometimes our supervisors are not always well versed on what is happening or what needs to happen with this process. They don't know and don't always understand. I think that's why we need a process where we can ask higher up people and get the answers we need. (Noelle)

Another T&C had expressed similar thoughts of not having a reliable source of information:

> I haven't gone anywhere. I would like to have a place to go. I don't even know who I would talk to. At my last base, the other trainer came about a month after I did and she didn't know anything about DTM. The one trainer who had been there already hadn't gone to the training. So I think we need a network of trainers going around that really know their stuff and maybe it will be different. (June)

A third trainer described her quest for information as, "Peers went to original training, I email another T&C but she hasn't been either. I try to look on the websites but can't find what I need. I just do what I think is right. I learned from looking at what the previous

T&C had done and then followed suit" (Arysta). When delving through the various T&C responses, it is apparent that the trainers are at a loss for information, particularly current and new information. Although some identified the website Q&A as an informal source of additional DTM training, at the time of the interviews it had not been updated in nearly a year. Ariel, one of the DTM Implementation Leads felt part of the reason for this is that questions came in pretty consistently at the beginning of the DTM implementation but then dwindled off in subsequent years. Additionally, although a manual had been developed in the early stages to provide some formal training, there were no current updates available. Ariel suggested:

> We need some kind of available of a base line level training so that someone new comes in doesn't hear about it secondhand. Right now we do not have a net to train new people as soon as they come in. They are left to their own devices, reading the manual or hearing it from someone else. I've seen the most success when they were able to receive mentoring or have someone work side-by-side with them as they are learning the DTM process. Programs where we have done it seem to be more successful. A solid knowledge of child growth and development we have to keep feeding the trainers professionally so they are on the cutting edge of current trends and practices in their profession. I don't think we do a good job of that.

Myra, another DTM Implementation Lead reflected on an experience she had at a base and said she knew first hand that "DTM was extinct after just two years at one of the first locations to implement it . . .. The problem is if we are expecting managers to learn

DTM through picking up a manual that is completely contrary to the premise of DTM." In total, both base level and stakeholder responses were consistent in reflecting that there was limited informal and formal training available on current expectations for DTM.

Questions Remaining to Be Answered

In looking at what types of questions still exist at the base level, a variety of topics surfaced from those that pertained to the process itself, to a desire for updated information and also more fundamental questions regarding the underlying philosophy of DTM. One question from a caregiver indicated a misconception about the purpose of DTM:

> When I went to a training one time something confused me. When the managers were talking about it, they said this would be a process that weeded out people where we would have the best of the best working here. I am kinda confused how are we really going to do that? We still have the people who make the mistakes and once in a while they are written up. Not very often but still we have the same people working here. How are we getting the best of the best? Right now our staffing shortage is in such a way that they hire everybody if they put in an application. But by doing that…how do the bad ones go? It's frustrating because you are dealing with those people into they do leave. So I am still waiting for the best of the best. (Donnica)

Similar comments that indicate miscommunication existed among all the roles are listed below with the first two being from caregivers, the next two from directors and the final two from trainers:

I know she explained the purpose but maybe a different person could tell me what the purpose is. I don't always understand why we are doing it. In the old system, training got old. If I know what it's about, I could let the people in my room know. (Ashley)

I don't know what DTM stands for or what it is. Yes we do debriefs but no one ever told me that this was the same as DTM. (Fredericka)

I'd like more information about all the changes that have come down. (Kristal)

Mostly little tweaking things like the forms you are supposed to use and who is responsible for what. Making sure that I have it straight in my mind what the goal is. I think I do from what they told us at training. I think I have a good grasp but validating that. (Victoria)

Hopefully when I am briefed on the latest changes those questions will be cleared up. It's just really wanting to know what changed. I guess the language and the forms. I hope that will all be clear. (June)

Hearing it from the horse's mouth of how the parts fit into a whole. I need a safe avenue for asking stupid questions without the rolling of eyes. If you call other T&Cs you have to wonder do they have any more knowledge than I do. I can't contact our command specialist without permission but who else knows? When I need to know? (Arysta)

Questions and comments of this sort indicate a wide range of variability on understanding the purpose in all three roles, the process and the expected outcomes of using DTM. The fact that all three roles had questions of a basic nature point to a need

for “refresher” training as well as an established point of contact for on-going questions as they arise. Both staff and management seem thirsty for a source of information that is both knowledgeable and easily accessible. One of the key stakeholders, Ariel, felt the real need centered on the fact that T&Cs were possibly not skilled enough. She felt only about 75% could identify what is wrong in a classroom with just about 50% of them knowing how to facilitate a discussion with staff based on what they have seen. Her response seemed to echo the need for various types of additional training for those in T&C roles. This weak link in the process was further validated in one of the archival documents. In a June 2005 email regarding the purpose of the Phase Two DTM regional training, the Air Force Lead Training and curriculum specialist stated that the training would focus on the “developmental content behind DTM” as opposed to the logistics of DTM. It stated “I think we are all in agreement that the programs have worked out the logistics . . . what is missing is meaningful child development content during the debrief and goal setting process” (K. Storc, personal communication, June 13, 2005).

In reviewing all of the above responses to the fourth research question, the researcher was able to gain a better idea of what portions of the Developmental Training Model remain unclear and require additional support in order to maintain effectiveness. The most prevalent and pressing concerns centered around one theme and that was the lack of information on the expected processes of DTM itself. Despite the acknowledgement of perceived benefits associated with the training, it seemed that time and time again, respondents echoed the lack of training and availability of current information on the process. Anastasia, a major command specialist,

> I think the Air Force as a whole can't be too much different than the bases represented in my command. I would think right now the focus needs to be on what can we do to get the majority of them where they need to be in order to provide the quality and type of training that staff need and deserve.

Analise, another major command specialist who summarized the lack of information as follows, echoes her point:

> We would like to know what the Air Force is going to do. I am disappointed that we aren't further along. The process needs to be re-energized. It is an excellent tool. It would clarify and assist people in understanding the criteria, which is mostly included in our compliance checklist. Bringing the tools to mesh better so people understand that if they do the correct things through quality programming it would be much easier to build an accreditation portfolio because they would have done the job. The two processes are not separate they are the same.

The points made by Anastasia and Analise, are manifested on numerous occasions by other stakeholders and other base level respondents. All seem to be asking a similar question of the "Air Force's" intention as well as emphasizing the point that the "two processes" of accreditation and compliance (with official regulations) are integrated. It is interesting to note that this was very similar to one of the participant questions following the 2003 initial introductory training that preceded the DTM implementation. According to the archived evaluations, the participant had inquired as to "how the inspection process will work with DTM" thereby demonstrating this concern of DTM in regards to compliance inspections existed from the very beginning.

Overarching Themes

As a culminating activity, the researcher looked at various themes that surfaced across the responses and compared those themes first by position and then by location to see if any trends emerged. The themes identified included "perceived as providing valuable training," "ownership of the process," "identified improvement in self or others," "lack of clarity," "non-familiar," "perceived as challenging," "frustrated" and "insufficient resources." The first three themes focused on DTM as a positive outcome and participant responses were reviewed for key phrases such as, "They pretty much feed you all the information you need, a lot of resources, a lot of training and a lot of explanations" or "I love this training system." In evaluating ownership of the process, participant responses were examined for phrases that indicated equal participation in the DTM process. In examining responses about understanding of DTM and its purpose, phrases that indicated lack of clarity or familiarity were also extracted. For instance, "I don't know what DTM stands for or what it is." The researcher distinguished between the two themes defining "lack of clarity" as having to do with understanding the specifics of the process and "unfamiliar" as general lack of knowledge about DTM. With regard to the final three themes, participant responses were coded for words such as "struggle," "it's too hard" and "we are lacking."

After coding the responses, the themes were analyzed by roles of the various respondents as demonstrated in Table 12 below.

Table 12.

Comparison of themes by position

	Caregiver (8 total)	**Trainer** (4 total)	**Director** (4 total)
Perceived as providing valuable training	5	4	2
Ownership of the Process	2	4	1
Identified Improvement in self/others	4	3	1
Lacks clarity	5	3	1
Non-familiar	3	1	0
Perceived as challenging	3	4	3
Frustrated	3	2	2
Insufficient resources	1	2	4

There were several key findings that stood out as worthy of discussion. For instance, 100% of the trainers had responses that indicated they perceived the training to be valuable. While on the one hand, this seems like an expected statement considering they are the point person responsible for successful DTM implementation at their location. On the other hand, it indicates a particular level of buy-in and belief in the process, which appears to have impacted five of the eight caregivers to respond in kind.

Additionally, one of the DTM implantation leads, Myra, also cited the lack of clarity at the "flight chief" level as a challenge. In most bases the flight chief is the person who supervises the trainers and holds them accountable for their jobs. There are very few flight chiefs who were ever trainers since most come through the management side as directors. Anastasia, a major command specialist, agrees with the point Myra makes in reference to flight chief's lacking clarity on the process and questions the appropriateness of their role being the one that holds the trainer accountable:

> I think if we expect for flight chiefs to have more knowledge about the DTM process, I think that is where we may have missed the boat. When we [command specialists] go in and sit in on a debrief, our job is to debrief the debrief. I don't know that flight chiefs do that or in many cases if they even could. Because they didn't go through the whole process of learning how it should look and be. They received only "surface" training. I don't think they know all of the detailed pieces of the training . . . Having been a T&C and understanding that position and knowing that you are not directly supervised, I don't know if the answer is to put their supervision under the director or not. But we have to have someone monitor the quality of training they are providing, even if it's as simple as looking at the 1098s [Air Force form] and the debrief form. You can look at the ITP [Individualized Training Plan] and see if they are missing the boat on goals and methods, which typically they are.

The concept that maintaining an effective handle on the DTM process and its benefits requires the ability to see value in the process from the flight chief to set the

expectations was echoed by several other stakeholders as well. These comments seem to suggest that this may be a role that requires additional support and clarification on the overall DTM process.

Another area found to be noteworthy was the fact that none of the directors responded in a manner that would indicate they were unfamiliar and only one lacked clarity in terms of the process. Of particular surprise was the fact that only two of the eight caregivers indicated ownership in the process. Most responses referred to DTM as something that was "done to" them as opposed to "done with" them. Only one director's responses included identification of improvement in self or others. While self is understandable, it seems odd that more directors would not have verbalized improvement in others. Particularly considering they are the ones responsible for identifying growth in staff members and providing performance feedback on an annual basis. Also noteworthy was the occurrence of three of the four directors and all four of the trainers finding challenges with the implementation. Most of these challenges were described as issues with scheduling. Echoing frustration across the roles, there were a fair number of respondents who discussed the added workload presented by the DTM implementation in terms of additional paperwork, tasks and the lack of current information and training on the process. As to be expected, all of the directors cited insufficient resources to support successful implementation of DTM. Most of their responses centered on needing more manpower to support staff coverage during the debrief sessions.

Overall, the caregivers most commonly cited themes were that DTM was perceived as providing valuable training and that there was a lack of clarity about the expected process. Trainers' highest number of responses aligned with the themes of

providing valuable training, ownership of the process and presentation of challenges. For the directors, the two most common themes were insufficient resources and the perception of the challenges posed by DTM implementation.

To provide an additional layer of analysis, the same themes were examined across case study locations as represented by Table 13.

Table 13.

Cross-case Analysis

	Andersen (4 Total)	**Elmendorf** (4 Total)	**Hickam** (4 Total)	**Luke** (4 Total)
Perceived as providing valuable training	4	2	2	3
Ownership of the Process	3	1	1	2
Identified Improvement in self/others	3	1	1	3
Lacks clarity	2	2	3	2
Non-familiar	2	1	0	1
Perceived as challenging	2	3	2	3

Frustrated	2	1	3	1
Insufficient resources	3	1	2	1

To provide this analysis, all of the locations responses were grouped together and accounted for in each of the themes. From this level of examination, some interesting trends appeared. Andersen and Luke had the highest number of respondents who perceived the training as valuable. These two locations also had the highest occurrences of the themes surrounding ownership of the process and identification of improvement. This could be attributed to a number of things but perhaps most salient is that these were the two locations that expressed higher levels of progress in resolving some of the most pressing challenges such as scheduling. Although both locations still experienced scheduling issues, both management teams expressed a system of collaboration that had yielded some level of success in providing regular opportunities for debriefs to take place within the center.

Chapter Summary

The examination of the impact of the Developmental Training Model on staff development in Air Force Child Development Programs took a look at four primary questions centered around perceived job training satisfaction; on-going training support; challenges, successes, advantages and disadvantages as well as needed clarification and support. The answers to each question have been addressed in the preceding sections. In general, the majority of base level respondents felt positive toward the implementation of DTM at least initially. One caregiver, Sheri, indicated she loved the new approach and felt it provided a method for caregivers to learn from others. Other caregivers and management responded in kind that the system was more personalized, allowed for

individualization and provided more communication between the trainer and the classroom staff. Several base level respondents and key stakeholders held high hopes that this model provided a mechanism for the bases to raise classroom quality and provide an overall more enhanced program for children and parents. When breaking down the five formal steps of the DTM process, most of the discussion centered around three key areas: observations, debriefs and goal setting/writing. Comments focused on the techniques needed to conduct the debrief, feelings associated with participation in a debrief and the critical role that scheduling and timing of a debrief plays. Perhaps most salient in all of the responses regarding this area was the need for skills such as conversation techniques, rapport building and time management.

In answering the question on whether training had been sufficient to support implementation of the model, the responses indicate it had not been. While some participants were able to benefit from the Phase Two training, most had received little to no additional training since that time. Additionally, most respondents implied "word of mouth" had been the source of any recent training. Respondents indicated frustration that systems originally put into place such as the "Frequently Answered Questions" page on the community website had not been maintained. Likewise, the initial attempt to use video-teleconferencing as a method of providing on-going updates seemed to have fallen by the way side during the second year of implementation. One of the key stakeholders, Alicia, phrased the issue like this " . . . we had the Q&A thing. It's out on our website. Navigating it [the website] is hard and I don't know if there have been any recent updates. Again . . . it's kind of we roll things out and then we are done." Although there was great debate over whether there was still a place for large group training, there was an

overwhelming indication of the value of small group training versus large group training with most respondents yielding an affirmative response of DTM being an improved model over previous training models. Myra, one of the DTM Implementation Leads argued that although she is not such a fan of large group trainings per se, she was a fan of the interfacing and mingling time across age groups. She reflected on the effect on the program's morale when staffs have the opportunities to be together in large groups,

> . . . safety in numbers is something important, that programs still need for the whole mass to network, socialize and share common issues . . .. I think that is a disadvantage certainly but not a strong enough disadvantage that I would say scrap it and go back to the old way. (Myra)

Ingrid, also an Implementation Lead offered this perspective:

> Research is pretty clear that you have to individualize experiences for teachers or else it would be meaningless. You have to make sure it is developmentally targeted. Large group trainings can be inspiring and can give them information. Whether that can be applied to their practice of teaching is less clear.

Ariel, another DTM Implementation Lead, believed DTM was better because it had returned trainers back to the classroom after a time when it seemed they only went in on special occasions to gather info on program quality. In looking at challenges, the three primary ones cited included time management, filing and documentation and scheduling. Responses ranged from the increased amount of paperwork duties associated with DTM to an identified deficiency in staffing levels both in classroom staff as well as trainers. Several successes were highlighted in the time since DTM was implemented

and included improved quality and increased communication between caregivers within the room and also between caregivers and management. Advantages seemed to echo the successes in that caregivers reported feeling more ownership of their staff development and the happenings of their classrooms. They also reported more feelings of being valued. Ariel, a key stakeholder, made reference to the fact several staff have reported feeling "professionally valued" by having such an amount of time and energy dedicated to their classroom practice. She mused " . . . not just from being observed for an hour but sitting down talking to the T&C and their colleagues. It's more than most of them have ever had devoted to them" (Ariel). Along these lines, management also cited advantages in feeling they were more aware of what was happening in the program and better able to target needed support in the correct direction than previous to implementation of DTM. Disadvantages included the amount of time needed to apply the model correctly, disruption to classroom routines due to observations or debriefs as well as one caregiver who reported a feeling of isolation due to the now limited large group trainings. As for areas of additional support and clarification, there were many identified resources in terms of providing a reliable source for current information as well as resources to support the content of the training delivered in the debrief.

In summary, the most salient themes across all four research questions centered around DTM being perceived as providing valuable training while allowing caregivers to have ownership of the process. The areas requiring additional focus if the model is to be continued would include clarifying its usage, providing more resources in terms of staffing and early care and education trends and instituting an on-going mechanism for current training on the Developmental Training Model.

CHAPTER FIVE: Conclusion

This dissertation was organized into five chapters. The purpose of the current study was to create an explanatory and descriptive crosscase and within case analysis of the impact that the Developmental Training Model had on staff development in Air Force Child Development Programs. Chapter one laid the framework of the study and described the question at hand, which was to examine the impact of the Developmental Training Model on staff development in Air Force Child Development Programs. With an increasing number of children spending extended hours in child care, the necessity of training personnel properly and ensuring they have access to the latest information on child development becomes even more important. In many locations, child care wages are low and therefore turnover becomes an issue. To address the issue, programs must find a method of rewarding employees by providing professional development and inspiring personal achievement. This quest presents even more of a challenge for military child care programs facing involuntary turnover due to the transient nature of the military community. For those who remain employed, many are military spouses concerned with their own unique issues such as separation due to the military member's deployment or anxiety concerning reintegration upon their return. While the Military Child Care Act of 1989 mandated several reforms that addressed the issue, nearly two decades had passed since its implementation. Based on the sweeping changes that were made, President Clinton proclaimed the DoD child care system as a "model for the nation." The temptation to rest on those laurels could have been hard to resist. However, recognizing that traditional large group, theme-based training efforts were the best approaches to deal with many of the deficiencies of that earlier era, the Air Force knew

these methods were no longer sufficient enough to inspire or develop today's caregivers to their full potential. In light of this, the Developmental Training Model (DTM) was conceived and implemented across Air Force Programs. The model provided individualized, small-group training that was relevant, based on reflective practice and offered a chance for caregivers to build upon their skills. This chapter puts forth the theory that DTM provided a positive impact on programs in the onset but said impact was limited by the lack of sustained support to ensure successful usage after implementation.

Chapter two provided an overview of related research and stated what the researcher believed to be the significance of the study, to include its purpose and applications and information on why the study was important. Also included was a detailed description of the history of the Air Force Child Development Program as it relates to training and staff development. Additionally, chapter two provided a thorough review of the related literature on staff development with particular focus on early care and education programs. Most relevant to this particular study was the theory of situational leadership based on the notion that there are "many right ways" for leaders and the method that works best is one that is both adaptive to the situation and the individual being led. The Developmental Training Model is grounded in situational leadership theory. It incorporates a leader (the staff trainer) observing staff performance in their classroom and engaging in a discussion (debrief) that builds upon reflective practice to address potential areas for growth. The leader uses the knowledge gained in the observation to determine which approach to use with staff on a particular task or skill development. In some cases, the debrief may require more input and direction from the trainer. This is particularly true in the case of new, inexperienced staff or in some

instances long-term staff taking on a new challenge. This ability to flex one's leadership style based on the individual and the current context has been discussed repeated throughout the literature (Goleman, Boyatzis & McKee, 2002; Klinger, 2004; Sheerer, 1997). The DTM also includes an opportunity to set goals and build upon current skill sets, which in the spirit of situational leadership provides challenging experiences based on the range of staff's developmental levels. The model provides an opportunity for staff to engage in team building with a supportive leader while using self-reflection to help develop the skills necessary. It also provides the opportunity to meet with staff regarding their own classroom performance, which adds to the relevancy and credibility of the training being received. Wood and Thompson (1993) supported this practice that particular situations are more suited to this type of smaller group presentation of ideas as opposed to mass dissemination to a larger audience. Due to the particular nuances of working in a military setting, child care leaders must remain agile in their approach and methodology when nurturing staff in their development. Stressors such as deployment, reassignment and isolation from traditional extended family structures impact an employee's ability to receive guidance and instruction which is a clear example of the type of low task, high relationship support described by Norris and Vecchio (1992) for what they deemed "intermediate-maturity" followers. Landry (2005) proposed that employees who were motivated and well trained would contribute to increased program quality. Considering the program quality issues once faced by the military child care system, a training model like the DTM that encourages intrinsic motivation through self-reflection and personal achievement should prove ideal for addressing some of those earlier concerns.

In chapter three, the researcher described the case study methodology for this dissertation to include the research design, the base locales and information on how the data were collected and would be analyzed. It set forth the four research questions to be examined through the lens of the findings. Chapter four provided an in-depth look at the results and the data gathered for each of the four research questions. It included rich, descriptive data on each of the four locations and the participants involved in the study to provide the reader with an idea of the culture of the staff who tend to be employed in military child care settings. Additionally, it outlined emerging themes from each of the case study locations as well as from the roles perspective. The summary of these chapters will be discussed in further detail in the following sections.

Chapter five provides a final overview of the contents of the previous chapters and includes discussion and results, conclusions, recommendations for continued DTM implementation, limitations and recommendations for future research and the implications for staff development in early care and education settings.

Results and Discussion

This chapter provides a brief review of the purpose and research questions of the current study. It will also cover the relationship between this study, the findings, and the connection to the relevant literature. This study contributes to the current research on staff development in early care and education settings. The research questions that form the basis of this study were designed to support the development of this exploration and the descriptive characteristics of the four case study locations at Andersen Air Force Base, Elmendorf Air Force Base, Hickam Air Force Base and Luke Air Force Base. The questions were also used to explore differences between roles (e.g., caregivers, directors

and trainers) and to take a closer look at stakeholder opinion in determining impact of DTM implementation.

With regard to the first research question, "How do employees perceive staff development since the implementation of the Developmental Training Model?" the majority responded positively in terms of impact on their professional development. This is consistent with the findings of Wood and Thompson (1993) who found that particular information is best imparted in smaller, more personalized settings than to a large group. Several respondents in the study indicated feeling more connected with the trainer and the ability to ask classroom-specific questions they may not otherwise ask at a center-wide training. Some felt that having the trainer "in their room" provided them with a level of comfort and trust that the trainer understood the issues they were facing in regard to particular child and parent concerns. These findings also echoed Truscott and Truscott (2004) and Engstrom & Danielson (2006) who stated that training provided in an authentic setting yields a better context for learning. One of the findings of the study was that participants felt favorable toward DTM due to the ability to reflect on training in terms of what was happening in their respective classroom. Their comments described the value in the relevancy of the information that had been relayed to them as part of classroom team debriefs.

In terms of the second research question, "Has on-going training on the Developmental Training Model been sufficient to sustain perceived benefits of implementation?" The responses and historical data indicated there had not been. Research findings from Schweinhart (2003) and Riley and Roach (2006) support the continuing need for both reflective practice and a systematic training delivery method for

the management staff, to include Training and curriculum specialists in order for DTM to be maintained at a high level of quality. Participants in the study often reported having no central place to seek out current information or support for staff development. Many expressed frustration with the perceived lack of information and availability of on-going training. Key stakeholders also voiced concern over the sustainability of the model due to the fragmented and sporadic dissemination regarding developments and adaptations since implementation of the DTM.

The third research question, "What are some of the challenges, successes, advantages and disadvantages programs have faced since implementation of the Developmental Training Model?" provided a great number of responses that centered around time consumption and the difficulty in scheduling. Joyce and Showers (1988) cited similar issues in terms of time constraints being a difficult part of the process when it comes to reflective practice and staff development. Likewise, one of the findings of this study was that although the majority of participants found the model to provide valuable information, there were numerous concerns from trainers regarding the amount of time needed to prepare for and conduct a debrief. Several comments were also made regarding the feeling of being overwhelmed due to the amount of time needed to accurately document and follow-up on training goals. From staff, time constraints manifested themselves in terms of being able to fully participate in the debrief for an hour at a time when staffing shortages could not provide effective coverage. Staff were also concerned that the hour was not enough time to fully discuss concerns and reflect on meaningful goals to address said concerns. Management echoed both trainers' and caregivers' sentiments as they were often the ones held responsible for resolving the

issues surrounding time.

The final research question, "What portions of the Developmental Training Model are unclear or require additional support in order to maintain effectiveness?" yielded responses that pointed to an uncertainty regarding paperwork, processes and resources on DTM expectations and updates. Stager and Fullan (1992) surmised, " . . . Mastery involves strong initial teacher education, and continuous staff development throughout the career." (p.6). This point was reflected for both front line staff who expressed feelings of anxiety about the lack of quality training they were receiving and for trainers who felt disconnected from information and on-going training for themselves. This lack of access to self-development in their own profession was suggested to have negatively impacted their ability to effectively provide and sustain higher quality training for front line staff. In order for DTM to continue to have a positive impact, it is critical that those responsible for its daily implementation at the base level have access to current information on its application, use and implementation.

Findings and Conclusions

The findings of the current study have suggested there are eight major themes of impact on staff development that emerged during this study. As described in chapters three and four, these themes included: "perceived as providing valuable training," "ownership of the process, "identified improvement in self or others" "lack of clarity," "non-familiar," "perceived as challenging," "frustrated" and "insufficient resources." All eight of the themes offer insight to how the case study teams in each of the locations have been impacted by the implementation of the Developmental Training Model. How each participant responded in light of the role they held as well as the differences among the

locations was also considered important to this study.

Caregivers as a group tended to respond favorably toward the training they had received as a result of implementation. Most indicated they were able to see growth in themselves and improvements in the quality of care offered in their classrooms as a direct result of the new training approach. In the words of one caregiver, “The more I know I can do more in the room and that’s good for everyone. It’s also good for my co-workers too because we can work together” (Fredericka). Ownership of their professional development within a collaborative setting was evident in several responses regarding goal-setting and the feeling of satisfaction upon reaching a goal or making improvements. This is the type of “dynamic and integrated” approach Klinger (2004) suggests in terms of weaving the context, the content and the process to facilitate staff development. One caregiver explained, “It was always good talking to her because she would make sure everything was clear before we left” (Sheri). “Another stated, I really love the debriefing and setting goals with them to try and come up with something new” (Amy). This ability to build upon earlier successes and to work individually with the trainer was mentioned throughout the interviews with words such as “pride” and “valued” used to describe the process. One caregiver having worked in child care programs outside of the Air Force reflected, "I like the Air Force because they really take care of us. They [the trainers] are very smart and they don’t leave us alone. They are always pushing us to learn and do more. It’s good” (Fredericka). This is just one of several testaments to the connection with the leadership resulting in increased job satisfaction that Wech (2002) suggests.

In terms of differences among study locations, Andersen and Luke had the highest numbers of respondents describing the training they received as valuable. This coincided

with the fact that of all four case study locations, these two bases were also the ones who had found a working solution to what was voiced in several interviews as the biggest challenge: scheduling observations and debriefs. This is the type of "concerted organizational action" Joyce and Showers (1988) describe as a critical component needed to facilitate effective reflective practice. The assistant director at Andersen described the following,

> We [the director and the trainer] also agreed that no matter what, the debrief was going to take place it didn't matter who had to step in the classroom to cover the debrief it had to happen. We didn't want to start making excuses . . .. The training needed to happen. (Victoria)

Perhaps having mitigated this daunting stressor allowed participants and trainers to gain more from the process. There seemed to be very little difference among locations in the frequency of responses related to the process "lacking clarity" and requiring "additional resources." For instance, one major command specialist reflected on her experience in providing oversight and guidance on DTM to several bases. She believed the DTM was a good "system" and had the makings to provide what the bases needed to strengthen quality. However, she stated most of the management and training staff responsible for its implementation was at a loss for information on the most effective application of the model. She surmised, "It's the lack of training, experience with the system. The people that have been around didn't get it the first time so it's not about the system. It's about everything else" (Deborah). Almost in concert, one trainer remarked

> I need to become more comfortable with doing DTMs the correct way . . . it is different than what we were doing at my last base. It's not implementing the

updated changes yet. So it would be nice if everybody could be on the same page just to get a good idea of the correct way to do it because I want to do it the right way. (June)

Throughout this study, there were numerous varied expressions from trainers and directors using terms such as "at a loss for information," "no one to ask" and "I need updated information." Campbell and Milbourne, 2005 remind us of what is at stake in terms of providing sufficient on-going training not only for caregivers but also for those responsible for DTM implementation, "Professional development activities, by themselves or in combination with other strategies, offer a cost-effective means for effecting change in the quality of childcare" (pg. 12).

In a revealing portion of one of the interviews, one of the key stakeholders of the DTM implementation, attempted to summarize the most pressing issues with its success. She recalled, "The challenges are to pick up the pieces and start from scratch. No matter what we adopt. In order for anything to work, we must have a plan to follow up. First at the base, then as an Air Force" (Analise). Her comment takes on more credibility when one considers this particular stakeholder has been working in a variety of positions within military child care programs for nearly three decades. Her point comes from years of first-hand experience having started her career as a caregiver, then working later as a flight chief responsible for child care programs in a variety of on-base settings and in her most recent position as a command specialist overseeing several bases. She knows all too well what the needs of the base personnel are and has seen "change" come and go over the years. She speaks from a place of experience that has taught her a valuable lesson of the need for sustainment and support in regard to DTM or any other approach.

Her comment supports the findings of Gallagher and Clifford (2000) that in order to have competent staff, it will take more than just one strategy and most importantly, it must be a continuous process that provides the very type of "follow" up as called for by the key stakeholder above.

The author believes that although the model is an improved delivery system over previous training methods and has increased communication between the training and curriculum specialist and classroom staff, sufficient training and resources were not in place to ensure the intent of the model could be sustained over time.

Recommendations

The primary recommendation for increased impact of the Developmental Training Model would be to define a quantitative measure of effectiveness. When ascertaining impact, it is difficult to know whether the model is having the desired effect upon staff development without first defining what the objectives should encompass. Additionally, examining outcomes as it relates to the effect staff development has on children's experiences in the program would be an ideal starting point. Additional recommendations for continued implementation of DTM would include providing a centralized resource point where staff and management can seek answers to procedural questions as well as additional professional development resources to support training discussed in debriefs. One finding among trainers was that most understood the basic concept of DTM in terms of using reflective practice as a vehicle to staff development; however the majority were in search of answers on the best way to achieve this. From the caregiver perspective, it is important to provide a mechanism to explain the process and their role in it. One caregiver identified this lack of understanding,

> I don't think a lot of the staff know what DTM is, I kinda know as a mentor. I think they need a refresher course for the "staff on what it is and what the papers are for that they have to sign . . . explaining their goals. I know I have heard staff asking what it's about, they aren't too familiar. (Penelope)

Additionally, there is a need to establish an on-going, periodic method of training either online or in person to allow interactive question and answer sessions. One interesting finding in the study was that both caregivers and directors tended to identify the "trainer" as their source for information on DTM. However, the majority of trainers indicated their source of information was lacking. One major command specialist framed it as

> I think with all the turnover in T&C positions people have not been exposed to the initial training. That is the issue . . . She qualifies because she has the education but doesn't have the experience or the initial DTM training, therefore she will start at a deficit. (Deborah)

This would also allow those responsible to solicit feedback from those who are using the DTM to help in shaping and making future adaptations to the model.

Another important area for consideration would be to provide additional professional development to the wide range of trainers based on what knowledge they currently possess. Training should encompass the wide range of professional development topics to reach those in need of rudimentary developmentally appropriate practice as well as challenge those seasoned trainers who are working with staff who are ready for the "next" level. It would prove valuable to provide information on current research about children's development as well as how to work with adult learners on a

regular, recurring basis to shore up the knowledge that each trainer has would prove valuable. It would also prepare trainers to work with the wide spectrum of staff they encounter each day.

Limitations of the Study

When answering what was easiest/difficult to implement, some respondents identified only one item while others identified multiple items. Requiring respondents to choose the single most easy/difficult item might have impacted answers and differentiated levels of ease or difficulty among the individual steps of DTM if they had to choose only one for each category. The researcher believes this is why the three easiest items to implement were also cited as the three hardest.

In addition, the researcher intentionally chose a limited number of bases for the purpose of conducting multiple case studies. A larger number of bases may have yielded different responses and the opportunity to interview individuals with more varied experiences in relation to DTM. For instance, the majority of management and caregiving staff in the current study's locations were relatively stable. However, there are other locations considered to be "short" tour assignments (typically two or less years) where front line staff may have experienced two or three turnovers in the director and training and curriculum specialist positions since implementation. For the most part, the participants in this study had first hand knowledge and access to the initial DTM training. Taking a look at bases where neither management nor caregiving staff had attended those first trainings might have provided a different set of results.

Another limitation is that considering the primary pool of caregiver staff is military spouses, the base mission or "context" may have impacted how well the DTM

approach worked or did not work. Likewise, the context had some affect on the sustainability of the model as well. Although ongoing training may have been limited, were staffs at particular locations more or less likely to take advantage of what was available? Factors such as accessibility to training may have rendered particular locations more or less able to take advantage of training opportunities. For instance, if the base was experiencing severe staff shortages, was staff able to attend training?

Also, the study did not look at or account for the common stressors, which exist depending on the type of base in which the child care setting is housed? Examining the wide variety of base missions, would there have been differences found in bases considered to be "training" bases where a large proportion of the population is in a transient student status as opposed to a "high deployment" base where the military member frequently leaves the spouse to deploy overseas? For instance, is "buy-in" stronger for those seeking a sense of belonging with the classroom team due to a spouse's deployment?

One theme that was not fully pursued as it was outside the scope of the current study is the idea of cost. Many respondents mentioned a need for supplemental resources to ensure effective implementation of the DTM. However, are these costs realistic or sustainable? In other words, there is a cost to extra personnel to provide classroom coverage and also for caregiver wages due to additional training time "on the clock." Most programs operate "at cost" and do not earn a profit so what is the likelihood they could sustain the additional stress on the current budget? This study did not look at the economic feasibility of sustaining DTM based on current manpower and budget resources, which gives the impression that current standards are not enough. On the

contrary, current resources may have been found to be quite sufficient with an effective time manager or scheduler. Without knowing the impact of cost on how the model is applied, a considerable amount of information about its potential sustainability is lost.

In summary, adding a qualitative questionnaire would have provided greater opportunity to evaluate the impact across the Air Force. It would have provided a method to ascertain the impact of certain variables such as those mentioned above. In addition to known variables, it could have provided the researcher with the impact of unknown factors as well.

Recommendations for Future Studies

Based on this research of the impact of the Developmental Training Model on staff development in Air Force Child Development Programs, it would be beneficial to examine the impact in the following ways:

1. The current study looked only at impact within the facility-based Child Development Center, which serves younger children from infancy to kindergarten. Examine the impact of the model in Air Force Family Child Care homes which are home-based child care settings where the adult caregiver typically works alone rather than in a team setting. Likewise, is the impact different in Youth Programs, which serve older children where adults typically work in larger facility-wide teams as opposed to self-contained classrooms? Valuable information may be gained by taking a look at DTM in the varied contexts and determining what role the difference in child care setting might play. This is particularly true with regard to in-home care where there are multiple ages of children and the times of care tend to be non-traditional hours such as nights

and weekends. Equally interesting would be determining the impact on after school programs where continuity of care is interrupted by the school day.

2. Measure job satisfaction in terms of reduced employee turnover. At the time of this study, these data were not consistently available across the Air Force Child Development Centers. Taking a closer look at long-term employees as well as those who have resigned could yield interesting insight into what motivates employees in terms of job satisfaction and their propensity to remain or leave the child care field. Researching commonalities in training style preferences among those who resigned within the first year as well as those who have been employed for ten or more years could lend additional insight into what adult learning needs DTM meets or fails to meet.

3. Conduct similar research with a larger population and examine trends across personality types. Does the model lend itself more favorably to extroverts who are more likely to be comfortable discussing their concerns in a debriefing? An examination of personality types would reveal more information not only about the impact on the staff but would also provide information on the various trainers' abilities to apply the model. Likewise, is the model more suited for particular styles of adult learners? In examining some of the responses, the suggestion of a "manual" to read or a "video" to watch was made by several participants in the study. Those who attended one or more of the various DTM trainings mentioned the format in clear detail suggesting that it impacted their ability to digest the material and apply it once they returned to their respective bases.

4. Add a quantitative measurement and a longitudinal case study approach to examine pre/post job training satisfaction for new employees. Researchers should measure at orientation and again upon the first year anniversary of employment. In the past few years there has been increased focus on outcomes of staff development in early care and education as it pertains to the quality of care children receive. Recent studies may exist that could shed light on the current research and offer new insight into some of the findings. If this study were to be repeated, adding a quantitative pre/post measure of job satisfaction may provide additional explanations of when and where the job training satisfaction actually develops in the continuum of recent employment. Additionally, a more in depth look at variables such as caregiver and management turnover, formal education and military child care experience could be examined in relation to their impact on the application of skills learned in training.

5. Conduct a study that examines the role leadership plays in the application of DTM. In particular, play close attention to whether the method in which the model is currently being applied is from more of a mentoring perspective as opposed to a coaching style. This is suggested in response to the recurring comments that “real training” was not occurring in some of the debrief sessions.

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Appendix A

Sample Classroom Observation #1

Date: 10 Dec 04 (9-10 am) Room: Toddler #4 Ratio: 13 children, 2 caregivers

- Children's art work and photographs attractively displayed
- Clearly defined play spaces in all developmental domains
- Housekeeping area - "real" food boxes on shelves and dress-up clothes (food and clothes in messy piles on floor and shelves)
- Play dough with cookie cutters at table
- Easel not open
- Water table not open
- Range of developmentally targeted materials (blocks, puzzles, manipulatives) around the room on shelves and scattered on the floor

Chaotic feeling in room: children wandering, climbing on shelves, tables, climbing up steps at diaper-changing table. Many conflicts: children hitting, pushing, screaming at each other. Children moving quickly from play dough to blocks to housekeeping. Little sustained play. Room cluttered with toys; caregivers appear frustrated.

Teacher 1-is changing diapers. Intermittent, warm, real connections with children during diapering; seems distracted by confusion in room; tries to re-direct child climbing steps at diaper-changing table: *"Climb down and show me your car."*
Child starts to climb down, then climbs up again when Teacher 1's attention is directed to Donald climbing on a nearby table. She attempts to monitor wandering/climbing/fighting children from changing table --- calling out rules: *"Donald, we don't climb on tables. Keep your feet on the floor*." To screaming child whose doll was grabbed from her hand: "*We don't hit our friends. Use your words." "Sam, use walking feet. I don't want you to fall."* Children continue climbing, running and screaming. They do not respond to her.

Teacher 2-sitting at play dough table with 3 children –helping them extract play dough from cookie cutters and repeatedly asking for help. She is calling to wandering children across the room: *"Susanna, come join us." "Ray, why are you throwing toys? Come play with play dough*." Children do not respond. Teacher 2 attempts 'open-ended' conversation with children at table*: "What did you do this weekend?" "What are you making*?" The only response from Asia: *"Make me a turtle."*

Teacher 2-announces Clean-Up Time, sings the "Clean-up Song" (no one cleans up), then moves to the library calling children to join Circle Time. Three children come, wait (for others to join?) and wander off. Teacher 2 repeats "It's time for Circle," and then leaves the library to respond to 2 children fighting. Circle Time never happens.

End of observation

Appendix B

Sample Observation De-brief Form

Staff Name: Arylinda Dunn **Debrief Date: 11 Dec 04**
Observer: Onissya Barnes Room #: Toddler A Observation Date: 10 Dec 04

Add'l Team Members Observed: Tre' Don

Use this form to summarize observations (from NAEYC/NSACA Criteria) and identify potential training topics.

ON TARGET: Variety of cultures seen in literacy and creative arts materials; Respect for children's work evidenced in attractive display of artwork; Room environment is designed to support development of a variety of domains (large motor, literacy, enrichment areas); Several charts support emerging math and cognitive reasoning skills

FOCUS ITEMS: ☑ Debriefed

☑ Redirecting behavior in the affirmative to prevent inappropriate behaviors helps children understand what they should do --- When behaviors are unsafe or harmful to others, next time try using proximity for reinforcement as you say things like "Hands to yourself" and "Use your words"

❑ Provide activities and ensure materials support children's development; removing clay from cookie cutters may be frustrating for young toddlers who have not developed fine motor skills

☑ Focus on the intentionality behind open-ended questions; try to relate them to what the Child is doing at the time

☑ Remember that play is a child's "work" and be mindful of interruptions --- if some children are able to engage in parallel play without assistance from the caregiver, then focus time on working with other children who seem to wander and may have difficulty engaging in sustained play

TRAINING PROVIDED / GOALS NEEDED: Topics discussed during this feedback session should be documented on the 1098. Goals set as a result of this team discussion should be documented on the ITP Goal Setting Form.

Appendix C

Individual Training Plan--Goal Setting and Staff Development

Employee Name: ***Linda D.***
Training Period: ***Dec 2004***

AIR FORCE FAMILY MEMBER PROGRAMS

INDIVIDUAL TRAINING PLAN (ITP)

SEMI-ANNUAL EVALUATION AND STAFF DEVELOPMENT

Goal	Method (How?)	Due Date / Employee Initials	Completion Date / T&C Initials
1. *Support children's emergent literacy Date: 4 Nov 04	Create charts such as family boards, favorite things, etc.	18 Nov 04 LD	22 Nov 04 **CB**
2. *Respect children's work Date: 4 Nov 04	Attractively display artwork and emerging handwriting	18 Nov 04 LD	26 Nov 04 **CB**
3. Respect children's autonomy and solitary/parallel play Date: 4 Nov 04	Provide several of the same popular toys for children to play alone or near another child; avoid hovering over and interrupting children who are playing peacefully	11 Nov 04	
4. Follow schedule that is based on children's needs vs. adults Date: 11 Dec 04	Allow children more time if their play is more deeply involved; provide clear indications when changes in the schedule will occur (e.g. "ten minutes until lunch")	21 Dec 04	
5. Expand opportunities to increase children's receptive language Date: 11 Dec 04	Provide simple directions to children such as "Books belong on the shelf" or "Teeth are for biting *food*."	12 Dec 04	
6. Provide immediate redirection for unsafe behaviors Date: 11 Dec 04	Move physically closer to child to help re-direction; use expressive language such as "hitting hurts, soft touches"	12 Dec 04	

Use an asterisk (*) to identify goals set during the 6-month Evaluation Meeting.

Appendix D

Individual Training Plan – Semi-Annual Evaluation and Staff Development

Employee Name: ***__Linda D.__***
Training Period: ***Dec 2004____***

AIR FORCE FAMILY MEMBER PROGRAMS

INDIVIDUAL TRAINING PLAN (ITP)

SEMI-ANNUAL EVALUATION AND STAFF DEVELOPMENT

Observations should be summarized below (considering On Target, Focus Item, and Goals) with input from the Manager, T&C, and Employee. During evaluation, goals are generated and documented on the front page of the ITP Goal Setting Form (marked with an *)

Employee Name: _____

_____

_____

_____

T&C Name: _____

_____

_____

_____

Director's Name: _____

_____

_____

_____

Employee Signature/Date: _____ **Director's Signature/Date: _____**

Appendix E

Interview Questions (Base Level Participants)

Interview Questions

1. What is your name?
2. Age (under or over 35?)
3. What position do you hold?
4. How long have you been in this position?
5. How long have you worked at this base?
6. What previous position (if any) have you held in child care at this base?
7. When were you first introduced to DTM?
8. What years (if any) were you employed in child care at a previous base?
9. When was your initial training on the Developmental Training Model (DTM)?
10. Describe the initial training you received on DTM?
11. What did you think of the process when you first used DTM?
12. What portion of DTM did you find easy to implement?
13. What portion of DTM was difficult to implement?
14. What additional training (if any) have you received on DTM?
15. How do you rate your current understanding of DTM?
16. What challenges do you experience in relation to DTM?
17. What success have you experienced in relation to DTM?
18. How do you feel DTM compares to previous training methods?
19. What are the advantages of DTM?
20. What are the disadvantages of DTM?
21. What resources are needed to ensure more successful implementation of DTM?
22. What changes would you suggest for more successful usage of DTM?
23. Where do you go for additional information and answers on questions about DTM?
24. What questions do you have about DTM?

Please discuss any additional information you would like to add on DTM.

Appendix F

Additional Interview Questions (Key Stakeholders)

Additional Interview Questions

1. What is your name?
2. What was your role/job during the DTM implementation?
3. Describe your experience (if any) related to staff training?
4. When were you first introduced to DTM?
5. Describe any previous direct care experience working in a child care setting.
6. What are your general beliefs about the impact of DTM?
7. What feedback have you had on the implementation of DTM?
8. What challenges do you perceive in relation to DTM?
9. What success have you experienced in relation to DTM?
10. How do you feel DTM compares to previous training methods you have utilized?
11. What are the advantages of DTM?
12. What are the disadvantages of DTM?
13. What resources are needed to ensure more successful implementation of DTM?
14. What changes would you suggest for more successful usage of DTM?
15. Where do you go for additional information and answers on questions about DTM?
16. What questions do you have about DTM?

Please discuss any additional information you would like to add on DTM

Appendix G

Approved Protocol

The University of Oklahoma

OFFICE FOR HUMAN RESEARCH PARTICIPANT PROTECTION

IRB Number: 11072
Approval Date: November 21, 2005

November 22, 2005

Candace Bird
Advanced Programs
1610 Asp Avenue, HAS 400
Norman, OK 73019

RE: The Impact of the Development Training Model in Air Force Child Development Programs

Dear Ms. Bird:

On behalf of the Institutional Review Board (IRB), I have reviewed and granted expedited approval of the above-referenced research study. This study meets the criteria for expedited approval category 6 & 7. It is my judgment as Chairperson of the IRB that the rights and welfare of individuals who may be asked to participate in this study will be respected; that the proposed research, including the process of obtaining informed consent, will be conducted in a manner consistent with the requirements of 45 CFR 46 as amended; and that the research involves no more than minimal risk to participants.

This letter documents approval to conduct the research as described:

IRB Application Dated: November 17, 2005
Consent form - Subject Dated: October 05, 2005
Survey Instrument Dated: October 05, 2005
Protocol Dated: October 05, 2005

As principal investigator of this protocol, it is your responsibility to make sure that this study is conducted as approved. Any modifications to the protocol or consent form, initiated by you or by the sponsor, will require prior approval, which you may request by completing a protocol modification form. All study records, including copies of signed consent forms, must be retained for three (3) years after termination of the study.

The approval granted expires on November 20, 2006. Should you wish to maintain this protocol in an active status beyond that date, you will need to provide the IRB with an IRB Application for Continuing Review (Progress Report) summarizing study results to date. The IRB will request an IRB Application for Continuing Review from you approximately two months before the anniversary date of your current approval.

If you have questions about these procedures, or need any additional assistance from the IRB, please call the IRB office at (405) 325-8110 or send an email to irb@ou.edu.

Cordially,

Grayson Noley, Ph.D.
Vice Chair, Institutional Review Board

Ltr_Prot_Fappv_Exp

660 Parrington Oval, Suite 316, Norman, Oklahoma 73019-3085 PHONE: (405) 325-8110 FAX: (405) 325-2373

701-A-1

University of Oklahoma
Institutional Review Board
Informed Consent to Participate in a Research Study

Project Title: **The Impact of the Developmental Training Model on Staff Development in Air Force Child Development Programs**
Principal Investigator: Candace M.E. Bird
Department: Advanced Programs

You are being asked to volunteer for a research study. This study is being conducted at various Air Force bases as well as at locations where persons involved with the implementation of Developmental Training Model are currently located. You were selected as a possible participant because you have knowledge of the implementation of the Developmental Training Model. Please read this form and ask any questions that you may have before agreeing to take part in this study.

Purpose of the Research Study

The purpose of this study is: To assess successes/challenges of Air Force Child Development Staff Training since the Developmental Training Model (DTM) was implemented in Air Force Child Development Programs.

Number of Participants

About 36 people will take part in this study.

Procedures

If you agree to be in this study, you will be asked to do the following: Answer a series of questions in a phone or face-to-face interview, which will be audiotaped. The researcher will also make written notes throughout the interview. The interview will last approximately 90 minutes. Audiotapes will be destroyed after the investigator finishes transcribing all notes.

Length of Participation

Participation will last for the duration of the phone/face-to-face interviews. The interviews will be conducted between January and August 2008.

This study has the following risks:

The study has no physical, psychological, economical or similar risks.

Benefits of being in the study are

The benefits to participation are: providing the Air Force with feedback on the successes and challenges of DTM and helping shape future training on and revisions of the DTM.

Confidentiality

In published reports, there will be no information included that will make it possible to identify you without your permission. Research records will be stored securely and only approved researchers will have access to the records.

There are organizations that may inspect and/or copy your research records for quality assurance and data analysis. These organizations include the OU Institutional Review Board.

Compensation

You will not be reimbursed for your time and participation in this study.

Voluntary Nature of the Study

Participation in this study is voluntary. If you withdraw or decline participation, you will not be penalized or lose benefits/services unrelated to the study. If you decide to participate, you may decline to answer any question and may choose to withdraw at any time.

Waivers of Elements of Confidentiality

Your name will not be linked with your responses unless you specifically agree to be identified. Please select one of the following options

_____ I consent to being quoted directly.

_____ I do not consent to being quoted directly.

Audio Recording of Study Activities

To assist with accurate recording of participant responses, interviews may be recorded on an audio recording device. You have the right to refuse to allow such recording without penalty. Please select one of the following options.

I consent to audio recording. ___ Yes ___ No.

Contacts and Questions

If you have concerns or complaints about the research, the researcher(s) conducting this study can be contacted at (940) 337-1780 or Candy.Bird@ou.edu. The advisor for this study is Dr. Priscilla Griffith and she can be reached at (405) 325-1508 or Pgriffith@ou.edu. You are encouraged to contact the researcher if you have questions or if you have experienced a research-related injury.

If you have any questions about your rights as a research participant, concerns, or complaints about the research and wish to talk to someone other than individuals on the research team or if you cannot reach the research team, you may contact the University of Oklahoma – Norman Campus Institutional Review Board (OU-NC IRB) at 405-325-8110 or irb@ou.edu.

APPROVED JAN 23 2008 OU-NC IRB

APPROVAL AUG 27 2008 EXPIRES

You will be given a copy of this information to keep for your records. If you are not given a copy of this consent form, please request one.

Statement of Consent

I have read the above information. I have asked questions and have received satisfactory answers. I consent to participate in the study.

Signature Date