

Ithaca College Digital Commons @ IC

Ithaca College Theses

2002

Assessment of father's needs in early intervention care

Jane L. McGowan
Ithaca College

Follow this and additional works at: http://digitalcommons.ithaca.edu/ic_theses



Part of the [Occupational Therapy Commons](#)

Recommended Citation

McGowan, Jane L., "Assessment of father's needs in early intervention care" (2002). *Ithaca College Theses*. Paper 176.

This Thesis is brought to you for free and open access by Digital Commons @ IC. It has been accepted for inclusion in Ithaca College Theses by an authorized administrator of Digital Commons @ IC.

ASSESSMENT OF FATHER'S NEEDS IN
EARLY INTERVENTION CARE

A Thesis Presented to the Faculty
of the School of Health Sciences and Human Performance
Ithaca College



In Partial Fulfillment of the
Requirements for the Degree
Master of Science

By

Jane L. McGowan

May 2002

Thesis Advisor: Carole Dennis, ScD, OTR/L, BCP

Committee Member: Barbara Hansen, MS, OTR/L

Abstract

Survey research was conducted to identify fathers' needs in early intervention care and to establish if those needs are being met by current programming. Fathers' time spent in services was also examined to determine if a relationship exists between time spent in services and perception of met needs. 37 fathers of children involved in early intervention, ages three to forty-eight months, residing in Central New York were surveyed. Means and standard deviations were calculated to determine items fathers' perceived as important. These descriptive statistics were then compared to those of program ratings to determine if fathers' needs are being met. Pearson product moment correlations were performed to establish a relationship between met needs and time spent in services were conducted.

Overall, fathers' needs are being met by early intervention programming. Fathers' valued individual items organized into themes of timing of services, interventionists' perceptions of the child, and involvement and control in the intervention process. Findings showed that fathers' time with service providers was negatively related to perceptions of satisfaction with service. This may indicate that fathers who spend time in service may be more critical and demanding of the services they receive.

Ithaca College
School of Health Sciences and Human Performance
Ithaca, NY

CERTIFICATE OF APPROVAL

This is to certify that the Thesis of

Jane L. McGowan

Submitted in partial fulfillment of the requirements for the degree of
Master of Science in the Department of Occupational Therapy, School of Health Sciences
and Human Performance at Ithaca College has been approved.

Thesis Advisor: _____

Committee Member: _____

Candidate: _____

Chair, Graduate Program in Occupational Therapy: _____

Dean of Graduate Studies: _____

Date: August 1, 23, 2002

Acknowledgments:

I want to thank Carole Dennis, my thesis advisor and Barbara Hansen my thesis committee member for their hard work and assistance throughout this research project.

Without their help and support, I could not have completed this thesis.

I would also like to thank the occupational therapy department as a whole for their contribution to my education.

In addition, I would like to express my heartfelt thanks to my friends and family members for their support and encouragement throughout my research. I especially would like to thank Debbie Ferris for helping me to keep on track and keeping me company during the all-nighters.

Dedication

I would like to dedicate this thesis to my parents, Gordon and Janet McGowan. Thank you for your love, support, and encouragement throughout this project and throughout my life. I would not have made it without your love and prayers. I love you both.

Table of Contents

Table of Contents	1
List of Tables	2
Chapter 1: Introduction.....	3
Background	3
Problem Statement.....	6
Purpose of the Study	7
Significance of the Study	7
Research Questions.....	8
Basic Definitions of Terms	8
Chapter 2: Literature Review.....	10
Background to Servicing Children with Disabilities.....	10
Parents' Perceptions of Family-Centered Care	20
Fathers' Needs Differ From Mothers' Needs.....	23
Importance of the Father's Role	25
Father's Relationship with His Children.....	27
Father's Program Involvement	30
Conclusion.....	33
Chapter 3: Methodology.....	35
Subjects and Selection Method	35
Operationalization of Concepts into Variables	35
Measurement Instruments	36
Procedures.....	39
Design for Analyzing and Interpreting Data.....	39
Limitations, Delimitations, and Assumptions	40
Summary	42
References.....	43
Bibliography	48
Introduction to Chapter 4.....	51
Chapter 4: Manuscript	52
Literature Review	53
Problem Statement.....	61
Purpose of Study.....	62
Participants.....	62
Measurement Instruments.....	64
Results.....	66
Discussion	69
Conclusion.....	73
References.....	75
Appendix A: All College Review Board for Human Subjects Research.....	83
Appendix B: Brass Tacks Survey Plus.....	89
Appendix C: Participant's Information Survey	96
Appendix D: Mailing Materials	99

List of Tables

Table 1: Descriptive Statistics of Ratings of Importance	79
Table 2: Descriptive Statistics of Program Satisfaction Ratings	80
Table 3: Percentages of Categorized Program Ratings	81
Table 4: Internal Consistency of the Brass Tacks Plus	82

Chapter 1: Introduction

When a child is born with a disability the whole family is affected by the child and by the disability (Case-Smith, 1993). Both the mother and the father are important individuals in the life of any child. Currently, early intervention programs are established under a family-centered model of care, which means they are supposed to serve not only the child but also the whole family, including the father. Often fathers are neglected in this process. This neglect may be due to the gender stereotypes that are attached to the roles of mother and father. To truly serve the family, fathers must not be overlooked because they are an important part of the family.

Background

The Law: P. L. 94-142 and Revisions

In 1975, Congress passed the Education for All Handicapped Children Act (P. L. 94-142) (Hanft, 1988). This law stated that all children had the right to receive a free and appropriate education. The law included children five to twenty-one years of age, except when educational programs for younger children already existed. In 1986, the federal government recognized the need to provide services to children younger than five years of age. Part B, serving children three to five years of age, and Part H, serving children zero to three years of age, were added to the original act and its name was changed to the Education of the Handicapped Act (P. L. 99-457) (Hanft, 1988). In 1990 the law changed once more and became known as Individuals with Disabilities Education Act (IDEA). Part C of IDEA provided states with money to implement and maintain early intervention programs for infants and toddlers with disabilities (Maruyama et al., 1999).

With the introduction of the amendments to Education of the Handicapped Act and IDEA, early intervention programs shifted their focus from a child and medically centered model to one that is family-centered. Family-centered care is a model of service in which the family structures and guides the services that they are provided. Each family must have an individualized family service plan (IFSP), and service providers must tailor interventions to the whole family not just the child with a disability. This means service providers are able to aid parents in their need of information, child-care, and pursuit of family well-being (Maruyama, Chandler, Clark, Dick, Lawlor, & Jackson, 1999). This shift in focus is a major change in early intervention programs.

Why Fathers are Important

Research has shown that the father-child relationship affects and enhances the cognition, personal-social development, and sex-role identification of a developing child (Turbiville, Turnbull, & Rutherford-Turnbull, 1995). Most people today would not argue that mothers are very important in the lives of their children but this research shows that fathers are also important in their lives.

Couples that have a child with a disability have an additional stress placed on their families (Gallagher, Cross, & Scharfman, 1981). This makes it more difficult for the family to cope with the problems that they face. Both the mother and father acting together can help the family through a stressful time. Research has shown that fathers' involvement in the family and support for fathers helps to decrease stress that is present in families that have a child with special needs (Gallagher, Cross, & Scharfman, 1981). Fathers have an important role in the family. They not only aid their child in his or her

development but their involvement in the family provides assistance through stressful times.

Fathers Not Participating in Services

Although, family-centered services are mandated in early intervention and fathers play an important role in the development of their children, many fathers are not involved with their children with disabilities' services (Hadadian & Merbler, 1995a). One father commented about involvement with services by saying, "A father regularly involved in obtaining services frequently finds he is not expected to participate in decisions about daily treatment, education, and care of the child, particularly a child with a disability" (Davis & May, 1991, p. 90). This statement points to the stereotypes of the mother and father roles in the family as being problematic. In traditional stereotypes the mother is the traditional parent to act as an information source, primary recipient of parent interventions, and most likely to participate in support groups (Hadadian & Merbler, 1995a). Since the mother has played this traditional role, many service providers have become biased toward relying on the mother more than the father. One reason fathers are not involved may be because they do not feel that they are supposed or expected to be involved. Through research, Turbiville and her colleagues (1995) have found this gender bias to be true. These researchers, caution service providers to ensure that they are allowing mothers and fathers to make the decision regarding the father's level of involvement. Providers need to also be sure they are not making that decision for the families they service through their practice and policies (Turbiville, Turnbull, & Rutherford-Turnbull, 1995). It is important to remember that fathers who desire to be involved in early intervention services should be given the opportunity and encouraged.

Juliet Schor, in her book, *The Overworked American* (1992), discusses that in recent years the stereotypical roles of the mother and father have begun to change. Fathers are beginning to take a greater role in child-care and helping to complete housework. This contrasts with their stereotypical role as provider for the family. Many mothers are also changing their roles by seeking employment outside the home. Although fathers are assisting with work within the home, the mother is still primarily responsible for that work (Schor, 1992). This shows that as the roles of mothers and fathers begin to change they are changing at a slow pace. Even as society's gender roles are changing many families still use the traditional gender roles to assign responsibilities. Often this means the mother is the primary caregiver for a child with a disability. This provides another opportunity for leaving fathers out of early intervention because they may not be involved or only minimally involved in the care of their children. Fathers need to be supported in their willingness to participate even if it is at a minimal level (Stoneman & Manders, 1998). Early interventionists must work harder to look beyond traditional gender stereotypes and to include fathers when the father desires involvement.

Problem Statement

Early Intervention programs most often function under a family centered model for the delivery of service. Both therapists and families have performed evaluations of this program. Just as early interventionists have focused their attention on mothers, research has followed this example and made the primary focus mothers. Mothers are the primary family members who evaluate these services and fathers' views are often neglected (Davis & May, 1991). Some research is available about fathers' perceptions of service, but we currently do not know if the amount of time fathers spend with service

providers relates to an increased positive perception of services. With the limited information we know about fathers' perceptions and time spent with providers, we are unable to determine if fathers as part of the whole family are being served to their satisfaction by the current family-centered model of early intervention.

Purpose of the Study

The purpose of this study is to specifically examine the perceptions of fathers involved in early intervention programming regarding their children with disabilities. This study will examine their perceptions of what needs are being met by early intervention services. It will also allow fathers to express what services are most valued by them. This study will also determine if the amount of time fathers spend with service providers is related to their perceptions of family-centered care.

Significance of Study

The federal government mandates family-centered care for all early intervention services. In order to fully provide this type of care early interventionists must be including the father and meeting the needs of fathers. By only meeting the mother's needs early interventionists are not providing services for the whole family. This study will help to examine fathers' needs and provide areas which services can be improved upon to better meet fathers' needs. Under the Individuals with Disabilities Education Act, occupational therapy is considered a primary service in early intervention care (Hanft, 1988). It is important for occupational therapists to incorporate knowledge about fathers and their perceptions into their interventions because of their role as primary service providers.

This study also examines the relationship between fathers' time spent engaged in services and perceptions of their met needs. This is an important area of discussion because it may expose the needs based around fathers' time and scheduling of services. It will provide service providers with information about how much time fathers are able to be involved and what they want to be involved in during their limited time schedules.

This study is also important for families of children with disabilities. By understanding the needs of fathers, practitioners can better serve families as a whole. This study may also show how to better involve families in service and help to eliminate some of the stress that families with children with disabilities feel.

Research Questions

The first research question is: what are issues of importance to fathers that early intervention programming may address? A second question is: is the early intervention service model of family-centered care meeting fathers' needs? The last research question to be investigated is: does the amount of time fathers spend engaged in services and with their children correlate to their perceptions of met needs?

Basic Definition of Terms

Developmental delay: a broad term used to describe a child who is behind in the normal developmental sequence motorically, cognitively, socially, emotionally or in language.

Early intervention: a service provided for families with a child between the ages of zero and three-years old that either has or is at risk for a delay in their physical, cognitive, communication, social or emotional development.

Family Centered Model of Care: a practice model for delivery of early intervention services that is directed by the family and the family determines their needs, what they want in care, and how services should be provided.

Father: the male individual that is involved in the child's life.

Chapter Two: Literature Review

The purpose of this literature review is to examine fathers' perceptions of need within family-centered early intervention practices. Early intervention is a service that is provided to families with children ages 0 to 3 that have or are at risk of developmental delay (Case-Smith, 1993). Fathers play a large role in child development (Turbiville, Turnbull, & Rutherford-Turnbull, 1995). Therefore, including the father as well as the mother in early intervention services is beneficial to the developing child and the whole family (Davis & May, 1991). The first section in this review will discuss a background of early intervention laws, early intervention programming, and its evolution into family-centered practice. The next three sections describe parent's perceptions of needs, how mothers and fathers differ in their needs' perception, and the importance of the role of the father in both the family and early intervention programming. A final section discusses further research needed in these areas.

Background to Servicing Children with Disabilities

Education of the Handicapped Act's Transition to IDEA

The Education for All Handicapped Children Act (P. L. 94-142) was passed in 1975 to provide education to all children (children with and without disabilities) (Hanft, 1988). It has evolved through various amendments to include children birth through twenty-one years of age (Hanft, 1988). In 1990, Congress changed P. L. 99-457's name to the Individuals with Disabilities Education Act (IDEA) and amended the law (Maruyama, Chandler, Clark, Dick, Lawlor, & Jackson, 1999). IDEA provides children 3 to 21 years of age the right to a free and appropriate education. It also requires states to establish early intervention programs for infants and toddlers with disabilities and

provides money to establish and maintain these programs (Maruyama et al., 1999). This has allowed more children to gain access to therapy services and education.

Early Intervention Programs and Family-Centered Care

With the enactment of IDEA, early intervention programs have been created to serve children with delays in their cognitive, physical, communication, social or emotional, and adaptive development (Maruyama et al., 1999). These services also provide intervention for children who have a physical or mental diagnosis that puts them at a high risk for developmental delays (Maruyama, et al., 1999). In early intervention programming, children may receive services including assistive technology services and devices, audiology, family training, counseling, home visits, and parent support groups. Services may also include: diagnostic and evaluative medical services, nursing services, nutrition services, occupational therapy, physical therapy, psychological services, service coordination services, social work services, special instruction, speech-language pathology, vision services, health services, and transportation services (New York State Department of Health, 1998). These services may be provided in a variety of settings including the home, the community, facility or center-based setting, or a combination of settings. Early intervention programs currently operate under a family-centered model. This means services are provided for the whole family, not just the child. Also, under this model, parents play a vital role in directing the services their family receives (New York State Department of Health, 1998).

Early Intervention's Shift in Focus

In 1986, when P.L. 99-457 was passed (an amendment to Education of the Handicapped Act), early intervention programs shifted their focus from a child-centered

model to one that is family-centered (Hanft, 1988). The child-centered model put the child as the primary focus of treatment and did not provide funding to allow therapists to help to meet the families' needs. Family-centered care has three important principles as its foundation. The principles are: parents know best and want the best for their children, each family is distinctive, and within a supportive family and community a child can function at his or her greatest potential (King, G., Law, M., King, S., Rosenbaum, P., 1998). Families served under early intervention work with service providers to develop an individualized family service plan (IFSP). Service providers must address the needs of the family, not just the child with a disability (Maruyama, et al., 1999). This shift in focus represents a major change in the manner in which services are provided to young children.

Defining Family-centered care

One difficulty that service providers and researchers face is the lack of a clear and commonly accepted definition of the family-centered model of service. In 1991, Dunst and his fellow researchers studied family centered practice and found 4 models that stress family involvement.

Professional-centered models. In professional-centered models, families are identified as needing assistance, but professionals determine the needs and develop the treatment plans (Dunst et al., 1991). This means the service providers are in control in the relationship with the families. In this model, professionals, because of their training in providing early intervention care, are considered the best people to decide what needs should be provided for the family. Families are viewed as incapable of identifying and meeting their own needs (Dunst et al., 1991). This model focuses on the whole family,

but may also result in family needs' not being met. Service providers may have different values than the family and therefore focus the services on what they deem as important and not on what the family views as important.

Family-allied models. In family-allied models, professionals structure the intervention but use the family in implementing it (Dunst et al., 1991). In this model, service providers still have control but use families as a tool in the services they provide. Service providers also guide intervention based on what they view as important for the family (Dunst et al., 1991). This model may cause more stress for the family because family members are asked to help provide services. Also, families' true needs may not be met because the family does not direct their service.

Family-focused model. The third type of model described is a family-focused model (Dunst et al., 1991). In this model families and professionals work together to meet the needs of the family but professionals are still seen as having the commanding position and giving guidance to the family. This model allows families to have more control over the type of services provided, but families are still viewed as only minimally capable of directing their services (Dunst et al., 1991). Since this model gives greater power to the families more of the families' needs may be met because families are able to influence their care. This model is one that stresses cooperation between families and service providers.

Family-centered model. The family-centered model is the fourth type Dunst and his colleagues discuss (1991). In this model families are the driving force of the program. Professionals serve primarily as instruments that families use to enhance their success. This model allows families to direct their care, so it is most likely that practices

operating under this model will meet families' needs. Professionals' main role in this model is to empower families to make their own decisions and to be competent in managing their care (Dunst et al., 1991). This model gives the power to the family and professionals are merely the tools families use to meet their needs.

Each early intervention program within the United States implements a different degree of family involvement. Therefore, it is difficult to compare and generalize practice guidelines throughout the United States (Dunst, et al., 1991). A study conducted by Wesley and colleagues (1997) supports the findings that family-centered care is not implemented to the same degree across the United States. They found that parents and practitioners agreed that parents should have a voice in their child's care but perhaps not a full partnership. This idea is an example of Dunst et al.'s family-focused model of care (1991). These studies show the need for early intervention teams to better define their practices and clarify their family involvement in order to provide both professionals and parents with the best possible model of care.

Importance of Family-centered care

In 1996, Trivette, Dunst, Boyd, and Hamby found that the program type and helping practices created significant differences within their study population. They found families perceived increased control when programs were family-centered, allowing frequent interaction between parents and providers, and employed providers who used empowering practices. Trivette and his fellow researchers (1996) describe empowering practices as encouraging families to participate in decision-making and directing their services. Enabling families to direct services and communicating with families about their needs and priorities gives families a greater sense of control (Trivette, et al., 1996).

This shows family-centered programs are important in empowering families for decision-making and structuring the future of children with disabilities.

Another issue in the family-centered debate is parents' and professionals' disagreement about the appropriate extent of family-centered care (Bjork-Akesson & Granfund, 1995). Researchers have found that both parties want family-centered care in their early intervention programs, but the parents studied may prefer a lesser role than professionals desired. The parents they studied preferred not to have a complete partnership with professionals in family-centered care. Parents saw themselves as playing a lesser role in child assessment, setting goals, and the intervention process. Parents wanted service providers to have more control in these aspects of care (Bjork-Akesson & Granfund, 1995). Parents in this study did not want to assume the responsibility of being a therapist living in the home. They wanted a lesser role that still allowed them to participate in services but that did not require them to take on this responsibility. Professionals, however, wanted parents to be more involved in the early intervention process (Bjork-Akesson & Granfund, 1995). This preference is reflected in the family-focused model that Dunst and his colleagues describe (1991). This also shows that the level of family-centered care is a preference of individual families. In this case families are still directing their care because they are telling providers what they want. Providers need to monitor and adjust their services to respond to parents' needs and preferences in programming.

The studies reviewed above have all shown the importance of listening to families and adjusting services to family needs. This is a form of family-centered care and shows its importance because parents want their perceptions heard by service providers.

Although a full partnership may not be the type of care a family desires, family-centered care elements can still be implemented. This may happen by allowing families to direct their care by voicing their needs but not necessarily being the agent that gives the care.

Family-centered care and Occupational Therapy

The shift in focus not only changed the program of early intervention but also has affected the disciplines that provide service under the early intervention framework.

Occupational therapy is one discipline that is a primary early intervention service provider. Since occupational therapists have this role they must serve their clients in a family-centered model.

Jane Case-Smith (1998) outlines 12 principles for occupational therapists treating under the family-centered early intervention model. The first principal she describes is understanding the family structure and subsystems. This means understanding who is a part of the family and who is involved in the child's life, including the child's parents and extended family. This also means understanding what roles each member plays in the family because each family member affects the other. Therapists must understand how involved each family chooses to be, how adaptable each family member is, and in what ways the family communicates with one another (Case-Smith, 1998). By better understanding the family, an occupational therapist is better able to meet the family's needs.

The second principle is meeting the family's concerns (Case-Smith, 1998). In order to meet this principle, occupational therapists must listen to the family and understand their needs associated with early intervention care and their child with special needs. Each family is unique and has unique needs. Also, as time passes, the family's

concerns may change and the therapist must be able to adapt their treatment to the families needs at the particular moment in time (Case-Smith, 1998).

Building on family resources is the next principle (Case-Smith, 1998).

Understanding the family and their strengths will help occupational therapists adjust their services to use the family's strengths to overcome other problems. Also, understanding the community's resources allows therapists to plan treatments utilizing these resources, which will help the family cope (Case-Smith, 1998).

Respecting family diversity and cultural backgrounds is the next principle cited (Case-Smith, 1998). This means that occupational therapists must understand the family in their cultural context and provide services to the family which are culturally relevant. Acknowledging personal characteristics is an important principle that the occupational therapist should meet. Every family, as well as each family member, brings his or her own personality and character to programming. Understanding this and creating services that work for each person involved is important in including the whole family (Case-Smith, 1998).

Sharing information and promoting partnerships and collaboration are two important occupational therapy principles cited (Case-Smith, 1998). This means helping the family understand their child's disability as well as giving the family the information they desire and need. It also means working together to meet the goals established by the family (Case-Smith, 1998). The partnership between the family and the service provider is a key aspect of Dunst et al.'s (1991) definition of family-centered care.

Providing individualized, flexible, and accessible services is important so that therapists can meet the individual needs of the family (Case-Smith, 1998). This principle

emphasizes the differences in each family and how each family needs a program specifically designed to meet the family's needs and accommodate its schedules. Providing this type of service will facilitate the partnership of the family and service provider (Case-Smith, 1998).

Acknowledging personal characteristics is the next principle cited (Case-Smith, 1998). Personal characteristics of family members can affect how they relate to the child with disabilities as well as how they relate to service providers. One's history, educational levels, background, and personality all play a role in shaping the person. Understanding each family member's characteristics will help the therapist to understand how to relate to the family member and meet his or her individual needs (Case-Smith, 1998).

Accessing services that promote integration of the child and family into the community is important because a family is not independent of the community (Case-Smith, 1998). Helping our clients participate in the community in order to meet role expectations is part of our responsibility as occupational therapists. Encouraging social support also is important to families in order to help families cope. Looking for ways community organizations can offer support is one possibility therapists may use (Case-Smith, 1998).

Encouraging recreation, social support, and respite is another important principle for occupational therapists to follow (Case-Smith, 1998). Recreation and leisure are among occupational therapy's primary performance areas (Case-Smith, 1998). In two research studies that investigate fathers, recreation was cited as one area where fathers felt they needed more guidance (Hadadian & Merbler, 1995a; Linder & Chitwood, 1984).

Fathers are often the parent that plays physically with the child where mothers use educational play (Pruett, 1987). This knowledge opens an important door for occupational therapists' interaction with families. Our assistance to help the family find recreational activities that the whole family can enjoy is very important and needed according to the research. Enjoyable recreation for the whole family is important but so is respite care. Respite care is valuable so that families can have a break from caring for their child with special needs for rest or recreation (Case-Smith, 1998).

Establishing interdisciplinary team collaboration and facilitating interagency collaboration are the last principles Case-Smith cites (1998). This is important so that the whole team works together to serve the family. The team can better assist the family with a spirit of collaboration than can independent therapists. Teams that are formed from multiple agencies also need collaboration to provide beneficial services to the family. Multiple agency teams involve individuals that work for different employers. Without communication between team members, individual service providers may give families confusing or conflicting information (Case-Smith, 1998).

These principles reflect the shift to family-centered care by emphasizing the importance of the family and collaboration with them. These principles do not lead occupational therapists to strive to practice under a certain model of family-centered care, so the confusion is still present in occupational therapy as in early intervention. Research is continuing to evaluate perceptions of service providers, as well as families, about this movement, and to evaluate this new model of service as well as examine the level of family involvement. Much of this research reflects the mothers' and service providers' perceptions, but does not include the fathers' perceptions. Early intervention programs

are now practicing family-centered care and must be evaluated to determine if the needs of the child and whole family are being met appropriately.

Parents' Perceptions of Family-Centered Care

Parents who have a child with a disability begin a journey the day the child is born. Their child, as well as their whole family, has many needs that require attention in order to be fulfilled. Early intervention care is available to help these families through the child's early years of development. Researchers have closely examined early intervention care to pinpoint the factors that make these programs a success as well as the factors that hinder their success.

Factors that Facilitate Family-centered care

Parents as well as service providers have evaluated early intervention programming through surveys. This type of evaluation allows service providers to structure programming to better serve its participants' needs. In one large, randomly sampled study performed by Dinnebeil, Hale, and Rule (1999), the characteristics that enable and hinder family-centered care were examined from both parent and provider points of view. Service delivery, the way in which a family receives services, was the number one priority for both parties. Service delivery included staffing, flexible schedules and service locations, the use of home visits, and the use of a combination of group and individual therapy. Open communication within the team as well as the values and attitudes of the administration also effects the program climate, according to study participants.

These results relate with McWilliam, Tocci, and Harbin's (1998) study that looked at the responses from 6 service providers and the 72 families for whom they

provided service and examined their perceptions about family-centered care. Seven themes of qualities of early intervention care were highlighted in the interviews with participants. These included responsiveness, sensitivity, positiveness, service orientation, child skills, community skills, and friendliness.

Responsiveness was defined as the ability to attend to parents' needs and concerns (McWilliam, et al., 1998). This relates directly to the flexible service delivery options that respondents in Dinnebeil's study cited (1999). Sensitivity is showing an understanding of families' needs, which also relates to flexibility. These are related because by understanding parents' needs, priorities, and concerns, therapists can adjust their delivery in order to be sensitive to family needs. This means therapists need to be flexible in their program structure so they can be sensitive to the needs of the family. Service orientation includes providers familiarizing themselves with the family and the family's needs. This is also part of flexibility because service providers need to be adjustable in order to individualize treatment and provide for the well being of the whole family. This also includes helping the child develop skills the family views as important.

Friendliness, which includes service providers having an open and honest relationship with families also relates to communication, as described in the Dinnebeil study. Service providers as well as parents value open communication and a willingness to include everyone in team meetings and planning sessions (Dinnebeil, et al., 1999; McWilliam, et al., 1998). These themes highlight what families and service providers view as important in family-centered care. As providers structure their services these values should be incorporated to better satisfy the needs of families.

Barriers in Family-centered care

Scholars have looked not only at the qualities of family-centered care but also at barriers to it. One common barrier is in flexible scheduling (Dinnebeil, Hale, and Rule, 1999, McWilliam, Tocci, and Harbin, 1998). Flexible schedules and nontraditional hours of service, are important when meeting the needs of and including the whole family in early intervention care. In a recent study that examined child-care and father involvement in the United States it was found that child-care providers often do not meet the demands of families because of their traditional hours of service (i.e. 8am to 6pm Monday through Friday). Families must look to other methods of obtaining child-care for their children when they need care during nontraditional work hours. Frequently fathers who work the traditional hours are available to meet child-care needs because there is no other alternative (i.e. Mother is at work during the nontraditional hours) (Casper & O'Connell, 1998). Therefore, fathers may be more available during nontraditional hours. This plausible conclusion may relate to the field of early intervention because flexible scheduling may allow fathers to be able to be more involved in service provision for their children with special needs. By providing flexible hours of service, early intervention providers may be able to include more family member in their interventions and meet more of the family needs.

One study showed that both parents and service providers rated flexibility in programming as one of the lowest performance areas in their program (King, G., Law, M., King, S. Rosenbaum, P., 1998). This is of interest because in the Dinnebeil et al. and McWilliams et al. studies flexibility was shown to be a key factor in good family-

centered care. Clearly, programs that cannot offer flexibility of service provision are posing a barrier to effective early intervention.

Hadadian and Merbler (1995b) discuss two other barriers to family-centered care. One is not identifying services and the second barrier is in the lack of understanding the value of both the mother and the father in a child's development. Many services may be available to a family that qualifies for early intervention care but the family may not be aware of the service. Service providers need to examine parents' needs and then identify and match programs in order to meet those needs. This will help to ensure that families are receiving all the services that can benefit them. When parents' needs are not known, families may miss out on some services that may be valuable to them.

Studies have been conducted to realize the significance of the whole family being involved in service delivery. However, many studies examine early intervention practices but only emphasize the mother's role in the programs. These studies provide good information but do not help to eliminate the second barrier that was cited by Hadadian and Merbler (1995b) because they do not include the father in their sampling. In recent years, more studies have looked at the father's role in early intervention and have begun to find ways to overcome both barriers. This shows that research is working to overcome this barrier by examining what different family members' needs are in early intervention care. This will help service providers better meet the needs of the whole family and include the whole family in the early intervention program.

Fathers' Needs Differ from Mothers' Needs

Understanding that fathers' needs differ from mothers' needs may help early intervention programs overcome some barriers to services. Mothers and fathers have

different experiences of parenthood, especially when a child with special needs is born into the family. The mother is often viewed as the primary care giver and a strong bond often develops between the mother and the child because of mother's involvement in the child's life (Davis & May, 1991). The father's relationship with the child is often jeopardized because fathers may experience a loss of self-esteem, increases in depression, and marital distress. These problems are often the result of the father not coping well with the child's disability. Often, the father also does not have the support he needs to cope. These problems that the father experiences also affect the mother of the child with special needs, as the father is not an isolated member of the family (Vadasy, Fewell, Meyer, & Greenberg, 1985). When the father is affected the whole family is affected.

Parents of children with special needs have also been shown to differ in areas that involve time demand, coping, and well-being subscales (McLinden, 1990). Both mothers and fathers have significant time demands that cause stress. Mothers have reported having difficulty dividing their time between their child with special needs and the rest of the family or household. Fathers reported feeling that the family's schedule revolves around the child with special needs and view this as problematic (McLinden, 1990). Fathers' stress level is also related to the development of their child with special needs. When the child is not developing at a normal rate fathers often become discouraged and feel isolated because their child is different. Helping fathers understand this development and how service providers are assisting the child in development through early intervention may help fathers' stress level. This may positively affect the father's stress level because the father will be given more information about his child and the ways providers are helping the child to develop. Once the father understands this process and

is able to talk about it he may find more positive ways to cope which will affect his stress level (Hadadian, 1994).

Although stress is a common issue for both parents, studies have shown that mothers find more positive coping strategies to use than fathers (McLinden, 1990). This finding shows an area of need for fathers. Helping mothers balance their time and helping fathers use more positive coping strategies are two areas of early intervention care that would be useful for families. Increasing emphasis on fathers in early intervention may also be important to the family as a whole because research has shown mothers who are supported by their husbands relate better to their children emotionally (Hadadian, 1994). No individual member of the family can be viewed separately because each member's thoughts, feelings, and attitudes affect the family as a whole (Case-Smith, 1998).

Importance of the Father's Role

Traditional Role and Shift in Last Few Decades

The father's role in the family has changed over the last few decades. Traditionally, the father was viewed as the provider and the mother as having the responsibility for the home and child-care duties (Pruett, 1987). Now fathers are more likely to be present at their child's birth and be more involved in the everyday care of their child. This allows fathers to have a greater bond with their children (Davis & May, 1991). Juliet Schor (1992), who studied the American labor force as well as household labor, has also found that recently men are more willing to help out at home and take care of the children. This role has increased among fathers because in many families both the father and the mother are employed (Casper & O'Connell, 1998). Pruett (1987) agrees

with this research but cites other reasons for the shift in traditional roles as well. He suggests that the increasing divorce rate, the softening of sexual stereotyping, and the ability to work at home have also helped shift the father's role to one of a nurturer in the home (Pruett, 1987). All of these events allow fathers a greater amount of time to spend with their children and care for them.

As parents' traditional roles are shifting, health-care and early intervention programs need to shift also. One father stated that after having a child with developmental delay he found his parental role has clung more to the traditional role with less involvement in the child's life (Davis & May, 1991). Many times in health care settings, the mother is looked at as the primary caretaker of the child and the father is looked at as the provider and the one with the strength to hold the family together (Davis & May, 1991). This causes men to be overlooked in the system. Another father stated, "I have often envied the emotional support afforded to women from female therapists, nurses, counselors, and teachers. In exactly the same circumstances, the same level of support is not usually offered to men," (Davis & May, 1991, p. 89). This quote suggests that fathers are not receiving the same support as mothers. This is another possible reason fathers have fewer coping skills than mothers. These observations made by fathers show how health-care and early intervention has not adjusted to the parents' role shift or towards the family-centered care focus of including the whole family, even the father.

Economics is another factor that affects fathers as child-care providers. One study that used data from the Survey of Income and Program Participation has tied fathers engaging in child-care to recessions in the economy (Casper & O'Connell, 1998).

They found that as unemployment levels began to climb so did the number of fathers engaged in child-care. This relates to the researchers' finding that in families that had a higher economic status, fathers were less likely to be involved in caring for their children. They also found that fathers were more likely to help with the children when the mother and father were not working the same hours. In families with more than one preschooler fathers were more likely to care for their children because child-care by external resources would be a large expense (Casper & O'Connell, 1998).

This data may be important for early interventionists to understand. In fact, in two smaller studies conducted in 1984 and 1995, researchers found that fathers who were not interested in participating in services usually gave an economic reason that decreased available time to engage in services (Hadadian & Merbler, 1995a; Linder & Chitwood, 1984). Early interventionists should have opportunities for fathers to participate in services or allow them to be involved at different, less time-consuming levels but understand if they do not become involved.

Father's Relationship with His Children

A father's relationship with his child plays a major role in his child's development (Pruett, 1987). Cognitive development, social-emotional development, and sexual identity are three areas of child development that research has shown are affected by father involvement. Fathers also play with their child differently than mothers (Pruett, 1987). These areas all show that fathers do have a different relationship with their children than mothers.

Cognitive development of the child. Frank Pedersen, a psychologist at the National Institute of Child Health and Human Development studied fathers and their

children (Pruett, 1987). He found that mental and motor development scores of six-month-old infants were increased in relationship to the father's active involvement with the child. The higher the level of involvement the higher the mental and motor developmental scores (Pruett, 1987). Problem-solving skills have also been shown to increase with paternal involvement. Fathers often encourage their infants to solve intellectual and physical challenges while exploring the environment. This encouragement helps problem-solving skills to develop (Pruett, 1987).

Yogman, Kindlon, & Earls (1995) conducted a study that examined IQ and father involvement. They found that in African American families, increased cognitive behavior in infants was related to father involvement. The infants with higher IQ scores had more paternal involvement. This shows that fathers who spend time with their infants can help the child's cognitive development. Their results support research that fathers play a valuable role in their infants' cognitive development (Yogman, Kindlon, & Earls, 1995).

Another study that examined father-infant relations using the NCAST Teaching Scale may contradict these findings (Nakamura, Stewart, & Tatarka, 2000). These researchers found that fathers and their infants scored significantly lower than the normative sample (mothers and their infants) on the Cognitive Growth Fostering subscale. This means that fathers showed less skill than mothers in fostering their infants' cognitive growth (Nakamura, Stewart, & Tatarka, 2000). This is of interest because many studies have shown that fathers do positively affect and foster their infants' cognitive development. Nakamura and her fellow researchers (2000) also were able to conclude from their findings that fathers scored lower than mothers in providing infants

with an environment that is favorable to cognitive development. Nakamura and her colleagues commented that the assessment may not allow fathers to show their true range of parenting skills and does not look at the alternative ways fathers help to foster cognitive growth, such as in physical play. Their research was also limited because it was a small sample size and a sample of convenience (Nakamura et al, 2000). Despite the Nakamura et al. study, evidence is available to show that fathers do have a positive relationship to the cognitive development of their infants.

Social emotional development of the child. Social development has been related to father's involvement in his child's life. Ross Parke found that when fathers were more involved with their child's care taking needs (bathing, dressing, diapering, etc.), the infants were more socially responsive and able to tolerate stressful situations (Pruett, 1987). Another study carried out over three years focused specifically on children with disabilities, and found that the child's social competence was strongly predicted by the father's view of the child. The father's view may be affected significantly by his understanding of the child's disability and how he is coping with the disability (Pruett, 1987). This study shows that fathers need more information about their children's disability in order to understand it. Early intervention personnel are professionals can help to provide this information to the father.

Sexual identity of the child. Sexual identity is another area of development where it is shown that fathers have influence (Turbiville, Turnbull, & Rutherford Turnbull, 1995). Researchers have shown that fathers tend to differ more in their behavior toward male and female children than do mothers. Fathers also set the example for boys by

serving as a role model for masculinity and encourage feminine behavior in girls (Turbiville, Turnbull, & Rutherford-Turnbull, 1995).

Play in childhood. Fathers tend to use a more physical and rough style of play (Pruett, 1987). Mothers are more likely to use more toy-mediated play and tend to pick up their children to carry out nurturing and care-taking activities (Pruett, 1987). Yogman and his fellow researchers (1995) found that fathers' involvement in the lives of their preterm infants are in the areas of play instead of care-taking activities.

Father's Program Involvement

It has been shown that mothers and fathers need different features in early intervention programs (Frey, Fewell, & Vadasy, 1989). When fathers are involved in early intervention programming the whole family benefits, not just the father of the child with special needs. Findings have shown that when fathers are involved with services, it decreases stress in the family as well as decreases marital problems (Frey, Fewell, & Vadasy, 1989). This finding is important because it shows how the fathers' role affects the well-being of the family, particularly the parent's marriage. Since fathers have a positive affect on the family when they are involved in early intervention services meeting fathers' needs is just as important as meeting mothers' needs, which research has shown are often met.

When fathers are engaged in programs that fit their needs they experience less depression, less fatigue, less guilt and better decision-making ability (Vadasy, Fewell, Greenberg, Dermond, & Meyer, 1986; Vadasy, Fewell, Meyer, & Greenberg, 1985). This means that fathers may be able to function better in the family. Wives of husbands engaged in early intervention programs also have shown more positive feelings about

themselves as well as their family circumstance (Vadasy, Fewell, Greenberg, Dermond, & Meyer, 1986; Vadasy, Fewell, Meyer, & Greenberg, 1985). A father's involvement in early intervention has an overwhelming affect on both parents in addition to the well-being of the family.

Markowitz (1984) conducted phone interviews with program coordinators to examine the idea of fathers participating in early special education programs. He found that program coordinators said that mothers welcome father involvement because it lessens their burden of being the only connection between the family and the special education programs (Markowitz, 1984). With less of a burden mothers may also experience less stress. Just as a father often cares for his children more during times of economic decline, familial stress was also cited as a variable of a father's involvement (Casper & O'Connell, 1998, Markowitz, 1984). Program coordinators reported that fathers are more involved during times of emotional stress in families because they want to provide extra support and they are less involved when families are less stressed (1984). This is another variable of fathers' involvement that program coordinators should examine. They need to find a way to keep fathers involved all the time (not just during periods of economic decline and family stress). This is because the whole family benefits from his involvement. A significant limitationⁿ to Markowitz's research about how families feel about father participation is that he only asked program coordinators and did not directly survey families. His research relies on the observations of providers rather than the parents themselves.

While not every father will become the primary parent to care for and carry out home programs with the child having special needs, fathers have been shown to perform

well in this role. Russell & Matson (1998) observed three fathers with their children implementing a behavioral program. The fathers demonstrated that they could implement this program well. The fathers were the primary parent to carry out the home behavioral program with the children. All fathers increased the correct use of both instructions and consequences while their children increased in their behavioral compliance in the program (Russell & Matson, 1998). This shows that fathers may be an excellent resource to help early interventionists maintain a home program.

No matter how or to what level fathers are involved in early intervention programming research has shown that there has been a benefit to the child and the family when fathers are involved (Vadasy, Fewell, Greenberg, Dermond, & Meyer, 1986; Vadasy, Fewell, Meyer, & Greenberg, 1985). This is an important issue that early intervention service providers should remember. Encouraging involvement even on a limited basis will help the family function at a better level and therefore will be providing service to the whole family.

Stress on the caregiver, as well as other family members, is a major concern in family-centered care (Thompson, 1997). Stress is negatively related to empowerment (Thompson, 1997). Families that are empowered are better able to request the services they need, and are provided with more complete programs (Mahoney & Filer, 1996). Involving fathers in early intervention program may help to alleviate some stress in the family and help families to be empowered in their programs.

Research has shown fathers' value certain areas of early intervention programming. These areas may be useful to service providers in order to encourage involvement from fathers. In two surveys that asked fathers to rank priorities in early

intervention programming, the researchers found that fathers' first priority was information (Hadadian & Merbler, 1995a; Linder & Chitwood, 1984). This information specifically dealt with assisting with the child's education and therapy programs, resources concerning their child's special needs, and community resources to meet child and family needs. Both studies showed that fathers prefer to receive information through films and tapes and secondly through workshops with hands-on experience. (Hadadian & Merbler, 1995a; Linder & Chitwood, 1984).

Conclusion

Early intervention programs are continuing to evolve to a family-centered approach. This evolution has caused programs and researchers to not only evaluate their program format but also to examine the role of each member in the family. Serving both parents has shown to be needed in order to support the environment in which the child is growing and developing. Mothers have been the primary focus of research for many years because they are usually the primary caregiver and communicator for the family. Fathers are increasingly taking on additional responsibility in the family and the care of their children and therefore need to be included and encouraged. They are not only taking a more active role in the care taking of their children but have been shown to have an important role in the development of their children. Therefore programs should include and encourage involvement of fathers in order to have true collaboration with families. Levels of family-centered care may also be an individual choice within each family. Service providers allowing families to make decisions on the level of involvement of each parent and the extent of decision-making power they choose is also important.

The literature has called for a greater emphasis on fathers because of their significance in the family and to their child's development (Hadadian, 1994, Vadasy, Fewell, Meyer, & Greenberg, 1985). Research has also shown that early intervention programs have not shifted their views of fathers from traditional roles to the current roles fathers play in the family and in the lives of their children (Davis & May, 1991; Pruett, 1987). Examining fathers' perceptions of what they need and what they find valuable in early intervention programming is important in developing programs that meet fathers' needs effectively and foster their involvement in programming. Also, evaluating current programs to identify if fathers' needs are being met in family-centered care is important for early interventionists to understand ways to improve their services.

Investigating fathers' time spent involved with service providers is also an important aspect of early intervention care. It is of interest to see how this influences fathers' views of the care they are receiving. This will also show if fathers are being engaged in services and if the services they are involved in are meeting the needs they have expressed. Fathers are an important part of the family and because of this they need to be served by early intervention programs.

Chapter 3: Methodology

Family-centered care in early intervention is purported to meet the needs of all family members. Much of the research has examined the mothers' needs; fathers' needs have often been overlooked. For this research project, I surveyed fathers involved in early intervention programs to answer the following research questions. What are the issues of importance to fathers that early intervention programming may address? The second question is: to what degree is the early intervention service model of family-centered care meeting fathers' needs? The third research question is: does the amount of time fathers spend engaged in services relate to their perceptions of met needs?

Subjects and Selection Method

The subjects of this study were fathers of children with disabilities who were currently receiving early intervention services when the surveys were mailed. The term father in this study refers to the male individual involved in the child's life. All fathers that participated in this study were at least 18 years of age. Fathers were recruited through the county health department's Children with Special Care Needs Program in both Tompkins and Cortland counties in central New York State. Mailings were sent to 281 families in Tompkins County and 77 families in Cortland County. This was a sample of convenience and no random sampling occurred. The Office of Community Health Services generated a list from their current database of families receiving early intervention care. Surveys were sent to all 358 families within these databases.

Operationalization of Concepts into Variables

Several factors about fathers and their families influence fathers' perceptions of service. Perceptions of services were based on the father's evaluation of the services

received and their importance to him. The Brass Tacks Plus' 5-point Likert importance scale was used to identify fathers' issues of importance. The Brass Tacks Plus' 5-point Likert program scale was used to identify the degree to which needs were met by the services. The amount of time a father spent engaged in early intervention services was measured by the father's self-report on the Participant's Information Survey. Also on this survey, participants were asked to complete an overall rating of both the services and access to the services provided to them.

Measurement Instruments

There were two survey instruments that participants were asked to fill out and return to the researcher. The first is the Brass Tacks Plus (Appendix B₁) and the second is the Participant's Information Survey (Appendix B₂).

Brass Tacks Plus

The Brass Tacks Plus is a survey that was adapted to meet the needs of this project. It is comprised of *The Brass Tacks, a Family Report*, which was created by McWilliam and McWilliam (1993) to assess parents' perceptions of family-centered priorities in early intervention programs and questions from other studies that surveyed fathers involved in early intervention.

The Brass Tacks, a Family Report. The McWilliams' *The Brass Tacks, a Family Report*, consists of 24 statements and asks participants to rate how important the statement is to the participant (importance rating scale) and how well the program performs the statement (program performance scale) using a 5-point Likert scale. A rating of a three or higher on the importance rating scale indicated an important need. A rating of a four or higher on the program performance scale indicated a met need. The 24

statements concern multiple parts of early intervention programming included: entering the program, annual assessments, developing and writing intervention plans, and services provided to your child and family. *The Brass Tacks, a Family Report* has been tested by the McWilliams (1993) for reliability and validity (McWilliam, Snyder, Harbin, Protern, & Munn, 2000). *The Brass Tacks, a Family Report* was developed from a 75-question instrument describing family-centered services. A chunk wise regression procedure was used to determine items that best predicted the final score. The items fit into four domains of early intervention practice: referral and program entry, child and family assessment, intervention planning, and day-to-day services. Regression analysis was used to find the 24 questions this survey contains. These items were found to predict 63-83% of the variance of the total score (McWilliam et al., 2000).

After the authors determined the 24 items that would be used to establish *The Brass Tacks, a Family Report*, they ran data analyses on the test (McWilliams et al., 2000). Using Cronbach's alpha, internal consistency of the scores was reported as .94. The researchers also used t-tests to determine test-retest reliability. These scores were not significantly different which suggests that the test is stable over time (McWilliam et al., 2000).

The Brass Tacks Plus. For the purposes of this research, *The Brass Tacks, a Family Report* was modified by adding an additional column, asking participants if they felt informed about the particular statement. This increased the strength of the study because it allowed the researcher to eliminate a rating of performance from the data analysis when fathers gave ratings to items about which they felt uninformed. Eight additional questions were also added, which were adapted from previous surveys of

fathers engaged in early intervention services completed by Linder & Critwood in 1984 and adapted in 1995 by Hadadian & Merbler. Select questions were rewritten and placed in the same format as *The Brass Tacks, a Family Report*. The questions were chosen because they asked about issues that fathers in the earlier surveys had deemed as important.

Participant's Information Survey

The Participant's Information Survey was a demographic survey created by the researcher. It deals with the demographics of the whole family and had questions specific to the mother and father. The survey also inquired about the amount of time the father spent with his child and with service providers. This instrument was created for the purpose of this study.

Field-Testing

Both surveys were field-tested prior to the mailings. For the purposes of field-testing the survey, four fathers who have young children were asked to complete the survey and make comments. Three of the fathers had been involved in early intervention services or therapy services. After reviewing the comments, items were checked for clarity, and rewritten when necessary. In addition to field-testing, the survey was reviewed by four faculty members in the Occupational Therapy Department at Ithaca College. All four of the faculty members have worked in the field of early intervention. This process ensured the surveys asked what they were intended to ask and were clearly phrased so participants could choose the most appropriate answers.

Procedures

Fathers of young children ages zero to four, who were currently receiving early intervention services or transitioning out of early intervention services, were mailed a packet. The packet included a recruitment letter (Appendix C₁), an informed consent form (Appendix C₂), two surveys (Appendix B₁ & B₂), and a stamped, self-addressed envelope. The surveys included the Brass Tacks Survey Plus and the Participants Information Survey. 281 surveys were mailed to families in Tompkins County and 77 surveys were mailed to families in Cortland County.

These survey tools took no more than 30-45 minutes of the father's time to complete. The informed consent form was a tear-off form. This did not require a signature from the participant but indicated that returning the survey implied consent. The subjects' names did not appear on the surveys in order to assure anonymity and confidentiality. Fathers were asked to return the completed surveys in a stamped addressed envelope included in the packets. Prior to sending out the packets, this research study was approved by the Ithaca College Human Subjects Review Board (Appendix A).

Design for Analyzing and Interpreting Data

This survey research project was descriptive in its nature. The Brass Tacks Plus is based on a 5-point Likert scale. This data were considered interval in nature. The Participant's Information Survey asked fathers to fit themselves into categories in order to complete the survey. This made the data nominal in nature. Two questions on the Participant's Information Survey asked fathers to rate services based on a 5-point Likert scale.

To analyze items from the Brass Tacks Plus, data were entered and the means and standard deviations were examined for the importance rating scale items. This descriptive data analysis was examined to find what items were most important to fathers.

To examine how well early intervention programs met fathers' needs the data were investigated further. The answers of fathers who indicated they were not informed about a statement were eliminated. The means and standard deviations of the program performance scale data were then compared to the importance rating scale means and standard deviations to examine if those needs that were important to fathers were being met by the early intervention services. After this calculations for each item were performed to determine the percentage of fathers that disagreed with the statement (ratings of 1 or 2), fathers that felt neutral to the statement (ratings of a 3), and fathers who agreed with the statement (ratings of a 4 or 5).

The data from the Participant's Information survey were analyzed by completing a Pearson product moment correlation. This aided the examination of results by looking at a relationship between time spent in services and perception of service. The Statistical Package for Social Sciences, Version 11.0 (SPSS) (SPSS, 2001) computer program was used for this analysis.

Limitations, Delimitations, and Assumptions

Limitations and Delimitations

In order to conduct a feasible study it was necessary to limit the sample of this study. Therefore it only included fathers involved in early intervention programs in Tompkins and Cortland Counties in Central New York. Due to this sample of convenience, there was no randomization of subjects and the generalizability of this study

may be compromised. Generalizability is greater when a sample is larger and more diverse because the sample is similar to a greater part of the population (Bailey, 1991). Targeting a small sample in one geographic area makes the sample less likely to be representative of the whole population of fathers involved in early intervention care. This makes it less generalizable.

Fathers who respond to the surveys may have also caused limitations in this project. Respondents to the survey may have been more likely to feel strongly about this topic than others and therefore biased the results. This may have caused the survey's results to display needs of fathers that are not representative of the whole population of fathers involved in early intervention.

The Brass Tacks Plus, which was designed by the researcher and used in this research, may also limit the data because it was not checked for reliability and its return rate was low. This may be important because *The Brass Tacks, a Family Report* was standardized on a population of both mothers and fathers. So this tool may not prove to be reliable for fathers. However, the researcher did examine the internal consistency of the survey, which showed it is a valid tool for this population. Reliability and validity of survey tools are important in establishing a good study. If the tools are not reliable or valid, the results may not show a true picture of the current early intervention services. Low return rates will affect this because with a smaller sample the results are less generalizable and less likely to be representative of early intervention services across the country.

Assumptions

A few assumptions were made in this research study. First, it was assumed that the fathers who participated in this survey are representative of fathers engaged in early intervention programs. Second, it was assumed that the fathers involved in the survey gave an accurate and honest account of the time spent with their child and engaged in early intervention services. It was also assumed that fathers would be able to give accurate information about their child and the services provided to their family.

Summary

This chapter has outlined a detailed description of the methodology involved in this research project. The project was carried out through survey research on fathers involved in early intervention programs.

References

- Bailey, D. M. (1991). *Research for the health professional: a practical guide (2nd ed.)*. Philadelphia: F. A. Davis Company.
- Bjork-Akesson, E., Granlund, M. (1995). Family involvement in assessment and intervention: Perceptions of professionals and parents in Sweden. *Exceptional Children, 61*(6), 520-536.
- Case-Smith, J. (1998). Foundations and Principles. In J. Case-Smith (Ed.), *Pediatric occupational therapy and early intervention (2nd ed.)* (pp. 3-25). Boston: Butterworth-Heinemann.
- Casper, L.M. & O'Connell, M. (1998). Work, income, and the economy, and married fathers as child-care providers. *Demography, 35*(2), 243-250.
- Davis, P. B., May, J. E. (1991). Involving fathers in early intervention and family support programs: issues and strategies. *Child Health Care, 20*(2), 87-92.
- Dinnebeil, L.A., Hale, L.M., Rule, S. (1999). Early intervention program practices that support collaboration. *Topics in Early Childhood Special Education, 19*, 225-235.
- Dunst, C. J., Johanson, C., Trivette, C. M., Hamby, D. (1991). Family-oriented early intervention policies and practices: Family-centered or not? *Exceptional Children, 58*(2), 115-126.
- Frey, K.S., Fewell, R.R., Vadasy, P.F. (1989). Parental adjustment and changes in child outcome among families of young handicapped children. *Topics in Early Childhood Special Education, 8*(4), 39-57.

- Gallagher, J.J., Cross, A., & Scharfman, W. (1981). Parental adaptation to a young handicapped child: the father's role. *Journal of the Division for Early Childhood*, 3, 3-14.
- Hadadian, A. (1994). Stress and social support in fathers and mothers of young children with and without disabilities. *Early Education & Development*, 5(3), 226-235.
- Hadadian, A., Merbler, J. (1995a). Fathers of young children with disabilities: how do they want to be involved. *Child and Youth Care Forum*, 24(5), 327-338.
- Hadadian, A., Merbler, J. (1995b). Parents of infants and toddlers with special needs: sharing views of desired services. *Infant-Toddler Intervention: The Transdisciplinary Journal*, 5(2), 141-152.
- Hanft, B. (1988). The changing environment of early intervention services: Implications for practice. *American Journal of Occupational Therapy*, 42, (11), 724-731.
- King, G., Law, M., King, S., Rosenbaum, P. (1998). Parents' and service providers' perceptions of the family-centeredness of children's rehab services. *Physical and Occupational Therapy in Pediatrics*, 18(1), 21-40.
- Linder, T.W., & Chitwood, D. G. (1984). The needs of fathers of young handicapped children. *Journal of the Division for Early Childhood*, 8(2), 133-139.
- Mahoney, G., & Filer, J. (1996). How responsive is early intervention to the priorities and needs of families? *Topics in Early Childhood Special Education*, 16, 437-457.
- Markowitz, J. (1984). Participation of fathers in early childhood special education programs: an exploratory study. *Journal of the Division for Early Childhood*, 8, 119-131.

- Maruyama, E., Chandler, B. E., Clark, G. F., Dick, R. W., Lawlor, M. C., Jackson, L. J. (1999). *Occupational therapy services for children and youth under the individuals with disabilities education act* (2nd ed.). Bethesda, MD: The American Occupational Therapy Association, Inc.
- McLinden, S. E. (1990). Mothers' and fathers' reports of the effects of a young child with special needs on the family. *Journal of Early Intervention, 14*(3), 249-259.
- McWilliam, P. J., & McWilliam, R. A., (1993). *The Family Report/Brass Tacks-Evaluation Version*. Chapel Hill, NC: University of North Carolina at Chapel Hill.
- McWilliam, R. A., Snyder, P., Harbin, G. L., Porter, P., Munn, D. (2000). Professionals' and families' perceptions of family-centered practices in infant-toddler services. *Early Education & Development, 11*(4), 519-538.
- McWilliam, R. A., Tocci, L. Harbin, G. L. (1998). Family centered services: Service providers' discourse and behavior. *Topics in Early Childhood Special Education, 18*(4), 206-228.
- Nakamura, W.M., Stewart, K.B., Tataraka, M.E. (2000). Assessing father-infant interactions using the NCAST teaching scale: a pilot study. *American Journal of Occupational Therapy, 54*(1), 44-51.
- New York State Department of Health. (1998). *The early intervention program: a parent's guide*. Albany, New York: Author.
- Pruett, K. D. (1987). *The nurturing father*. New York, NY: Warner Books.
- Russell, D., Matson, J. (1998). Fathers as intervention agents for their children with developmental disabilities. *Child & Family Behavior Therapy, 20*(3), 29-49.

- Schor, J. B. (1992). *The overworked American: the unexpected decline of leisure*. New York, NY: Basic Books.
- Statistical Package for the Social Sciences. (2001). SPSS for Windows (Version 11.0) [Computer Software]. Chicago: SPSS, Inc.
- Stoneman, Z. & Manders, J.E. (1998). Partnerships with families. In W. Umansky & S.R. Hooper (Eds.), *Young children with special needs* (3rd ed.) (pp.72-91). Columbus, OH: Merrill.
- Thompson, L., Lobb, C., Elling, R., Herman, S., Jurkiewicz, T., Hulleza, C. (1997). Pathways to family empowerment: Effects of family-centered delivery of early intervention services. *Exceptional Children*, 64(1), 99-114.
- Trivette, C. M., Dunst, C. J., Boyd, K., Hamby, D. W. (1996). Family-oriented program models, helpgiving practices, and parental control appraisals. *Exceptional Children*, 62(3), 237-249.
- Turbiville, V.P., Turnbull, A.P., Rutherford Turnbull, H. (1995). Fathers and family-centered early intervention. *Infants and Young Children*, 7(4), 12-19.
- Vadasy, P.F.; Fewell, R.R.; Greenberg, M.T.; Dermond, N.L.; Meyer, D.J. (1986). Follow-up evaluation of the effects of involvement in the fathers program. *Topics in Early Childhood Education*, 6(2), 16-31.
- Vadasy, P.F., Fewell, R.R., Meyer, D.J., & Greenberg, M.T. (1985). Supporting fathers of handicapped young children: preliminary findings of program effects. *Analysis and Intervention in Developmental Disabilities*, 5, 151-163.

Wesley, P. W., Buysse, V., Tyndall, S. (1997). Family and professional perspectives on early intervention: An exploration using focus groups. *Topics in Early Childhood Special Education, 17*, 435-456.

Yogman, M. W., Kindlon, D., Earls, F. (1995). Father involvement and cognitive/behavioral outcomes of preterm infants. *Journal of the American Academy of Child Adolescent Psychiatry, 34*(1), 58-66.

Bibliography

- Able-Boone, H., Goodwin, L. D., Sandall, S. R., Gordon, N., & Martin, D. G. (1992). Consumer based early intervention services. *Journal of Early Intervention, 16*(3), 201-209.
- Anderson, J., Hinojosa, J. (1984). Parents and therapists in a professional partnership. *American Journal of Occupational Therapy, 38*(7), 452-461.
- Bailey, D. B., Buysse, V., Edmondson, R., Smith, T. M. (1992). Creating family-centered services in early intervention: Perceptions in 4 states. *Exceptional Children, 58*(3), 298-309.
- Bailey, D. B., McWilliam, R. A., Darkes, L. A., Hebbler, K., Simeonsson, R. J., Spiker, D., Wagner, M. (1998). Family outcomes in early intervention: a framework for program evaluation and efficacy research. *Exceptional Children, 64*(3), 313-329.
- Brazelton, T. B. & Cramer, B. G. (1990). *The Earliest Relationship*. Reading: Addison-Wesley Publishing Company, Inc.
- Brookes-Gunn, J., Berlin, L. J., Leventhal, T., Sidle Fuligni, A. (2000). Depending on the kindness of strangers: current national data initiatives and development research. *Child Development, 71*(1), 257-268.
- Case-Smith, J. (1993). Occupational therapy in family-centered early intervention. In J. Case-Smith (Ed.), *Pediatric occupational therapy and early intervention* (pp.1-29). Boston: Andover Medical Publishers.
- Dunst, C. J., Leet, H. E., Trivette, C. M. (1988). Family resources, personal well-being, and early intervention. *Journal of Special Education, 22*(1), 108-116.

- Eiserman, W. D., Weber, C., McCoun, M. (1995). Parental and professional roles in early intervention: A longitudinal comparison of the effects of two intervention configurations. *Journal of Special Education, 29*(1), 20-44.
- Gavidia-Payne, S., Stoneman, Z. (1997). Family predictors of maternal and paternal involvement in programs for young children with disabilities. *Child Development, 68*(4), 701-717.
- Hamblin-Wilson, C., Thurman, S. K. (1990). The transition from early intervention to kindergarten: parental satisfaction and involvement. *Journal of Early Intervention, 14*(1), 55-61.
- Hinojosa, J. & Anderson, J. (1991). Mother's perceptions of home treatment programs for their preschool children with cerebral palsy. *American Journal of Occupational Therapy, 45*(3), 273-279.
- Lawlor, M. C., Mattingly, C. F. (1997). The complexities embedded in family centered care. *American Journal of Occupational Therapy, 52*(4), 259-267.
- Mahoney, G. & Bella, J. M. (1998). An examination of the effects of family-centered early intervention on child and family outcomes. *Topics in Early Childhood Special Education, 18*(2), 83-94.
- Mahoney, G., O'Sullivan, P., Dennebaum, J. (1990). A national study of mother's perceptions of family-focused early intervention. *Journal of Early Intervention, 14*(2), 133-146.
- McBride, S. L., Peterson, C. A. (1997). Home-based early intervention with families of children with disabilities: Who is doing what? *Topics in Early Childhood Special Education, 14*, 209-233.

- McWilliam, R. A., Lang, L., Vandivere, P., Angell, R., Collins, L. & Underdown, G. (1995). Satisfaction and struggles: family perceptions of early intervention services. *Journal of Early Intervention, 19*(1), 43-60.
- Rosenbaum, P., King, S., Law, M., King, G., Evans, J. (1998). Family-centered services: A conceptual framework and research review. *Topics in Early Childhood Special Education, 18*(1), 1-20.
- Stedman, D. J. (1977). Early childhood intervention programs. In B. M. Caldwell & D. J. Stedman (Eds.), *Infant education: A guide for helping handicapped children in the first three years* (pp.1-13). New York: Walker & Co.
- Trivette, C. M., (1998). How much is enough: training issues regarding family-centered practices. *Journal of Early Intervention, 21*(2), 111-113.
- Upshur, C. C. (1991). Mother's and father's ratings of benefits of early intervention services. *Journal of Early Intervention, 15*(4), 345-357.
- Viscardis, L. (1998). The family-centered approach to providing services: A parent perspective. *Physical and Occupational Therapy in Pediatrics, 18*(1), 41-53.
- Warfield, M.E., Hauser-Cram, P., Krauss, M.W., Shonkoff, J.P., & Upshur, C.C. (2000). The effect of early intervention services on maternal well-being. *Early Education & Development, 11*(4), 499-517.

Introduction to Chapter 4

This thesis is submitted as a manuscript thesis. Due to this nature, Chapter 4 is the final chapter. It is written in the manner of a manuscript, which combines the traditional thesis chapters: introduction, literature review, methodology, results, discussion, and conclusion into one final chapter. This manuscript has been prepared in the traditional manner that is seen in many professional journals in allied health.

Chapter 4: Manuscript

Early intervention services are designed to serve families who have a child between the ages of zero to three who either has or is at risk of acquiring a cognitive, physical, communication, social, emotional, or adaptive delay in development (Maruyama, Chandler, Clark, Dick, Lawlor, & Jackson, 1999). Services are also provided to children who have a physical or mental diagnosis that puts them at a high risk for developmental delays. These services were established to meet the needs of these children and their families in 1986, under the federal law, Education of the Handicapped Act (P. L. 99-457) (now called Individuals with Disabilities Education Act) (Maruyama et al., 1999). This also marked the evolution from a child-centered model into a family-centered model for early interventionists (Hanft, 1988).

Family-centered care has three important principles as its foundation. The principles are: parents know best and want the best for their children, each family is distinctive, and within a supportive family and community a child can function at his or her greatest potential (King, G., Law, M., King, S., Rosenbaum, P., 1998). Under this model, service providers must address the needs of the family, not just the child with a disability (Maruyama, et al., 1999). This shift in focus represents a major change in the manner in which services are provided to young children and allows therapists and service providers to serve the whole family and their needs, rather than focusing solely on the child's problems and development.

When a child is born with a disability the whole family is affected by the child and by the disability (Case-Smith, 1993). Both the mother and the father are important individuals in the life of any child and are to be included in services provided to the

family. Often fathers are neglected in this process. This neglect may be due to the gender stereotypes that are attached to the roles of mother and father (Pruett, 1987). Hadadian and Merbler (1995b) identify the lack of understanding the value of both the mother and the father in a child's development as a barrier to family-centered care. To truly serve the family, fathers' needs must not be overlooked.

Literature Review

Traditional Role and Shift in Last Few Decades

The father's role in the family has changed over the last few decades. Traditionally, the father was viewed as the family's provider and the mother as having the responsibility for the home and child-care duties (Pruett, 1987). However, the father's role in the family has changed over the last few decades. Now fathers are more likely to be present at their child's birth and be more involved in the everyday care of their child. This allows fathers to have a greater bond with their children (Davis & May, 1991). Juliet Schor (1992), who has studied household labor, has also found that men are more willing to help out at home and take care of the children. Casper & O'Connell (1998) believe that this role has increased among fathers because in many families both the father and the mother are employed. Pruett (1987) agrees with this research but cites other reasons for the shift in traditional roles as well. He suggests that the increasing divorce rate, the softening of sexual stereotyping, and the ability to work at home have also helped shift the father's role to one of a nurturer in the home (Pruett, 1987). All of these events allow fathers a greater amount of time to spend with their children and care for them. As parents' traditional roles are shifting, health-care and early intervention programs need to shift also. One father stated that after having a child with

developmental delay he found that early intervention service providers expected that he would maintain a more traditional role, with less involvement in the child's life (Davis & May, 1991).

Economics is another factor that affects fathers as child-care providers. A study that was conducted by using data from the Survey of Income and Program Participation has tied fathers engaging in child-care to recessions in the economy (Casper & O'Connell, 1998). They found that as unemployment levels began to climb so did the number of fathers engaged in child-care. Fathers were found to be more likely to help with the children when the mother and father were not working the same hours. In families that had a higher economic status, fathers were less likely to be involved in caring for their children. Families with more than one preschooler had fathers that were more likely to care for their children because child-care by external resources would be a large expense (Casper & O'Connell, 1998). These data may be important for early interventionists to understand. Early interventionists should have opportunities for fathers to participate in services but understand if they do not become involved or allow them to be involved at different, less time-consuming levels.

Father's Relationship with His Children

A father's relationship with his child plays a major role in his child's development (Pruett, 1987). Areas of development that he may influence strongly include cognitive, social, and emotional development, sexual identity, and the development of play skills.

Cognitive development of the child. Frank Pedersen, a psychologist at the National Institute of Child Health and Human Development, found that mental and motor development scores of six-month-old infants were increased in relationship to the father's

active involvement with the child (Pruett, 1987). Problem-solving skills have also been shown to increase with paternal involvement. Fathers often encourage their infants to solve intellectual and physical challenges while exploring the environment (Pruett, 1987).

Yogman, Kindlon, and Earls (1995) conducted a study that examined intelligence quotient (IQ) and father involvement. They found that in African American families, infants with higher IQ scores were more likely to have had more paternal involvement.

Social emotional development of the child. Ross Parke found that when fathers were more involved with their child's care-taking needs (bathing, dressing, diapering, etc.), the infants were more socially responsive, and better able to tolerate stressful situations (Pruett, 1987). Another study carried out over three years focused specifically on children with disabilities, and found that the children's social competence was strongly predicted by the father's view of the child. The father's view may be affected significantly by his understanding of the child's disability and by his ability to cope with the disability (Pruett, 1987).

Sexual identity of the child. Sexual identity is another area of development where it is shown that fathers have an influence. Turbiville, Turnbull, & Rutherford-Turnbull (1995) have shown that fathers tend to differ more in their behavior toward male and female children than do mothers. Fathers set an example for boys by serving as a role model for masculinity and encourage feminine behavior in girls (Turbiville, Turnbull, & Rutherford-Turnbull, 1995).

Play in childhood. While mothers tend to use more toy-mediated play and tend to pick up their children to carry out nurturing and care-taking activities, fathers use a more physical and rough style of play (Pruett, 1987). Yogman and his fellow researchers

found that fathers' involvement in the lives of their preterm infants are in the areas of play instead of care-taking activities (1995). This may be especially important because father's play may foster intellectual development (Yogman et al., 1995).

Fathers' Needs Differ from Mothers' Needs

Understanding that fathers' needs differ from mothers' needs may help early intervention programs overcome some barriers to service. Mothers and fathers have different experiences of parenthood, especially when a child with special needs is born into the family (Davis & May, 1991). A strong bond often develops between the mother and the child because of the mother's involvement in the child's life. The father's relationship with the child is often jeopardized because fathers may experience a loss of self-esteem, increases in depression, and marital distress. These problems may occur because the father may have difficulty coping with the child's disability, and may not have the necessary supports to manage these issues. Fathers' experiences due to these problems also affect the mother of the child with special needs, so the father is not an isolated member of the family (Vadasy, Fewell, Meyer, & Greenberg, 1985).

Father's Program Involvement

Research has shown that fathers are not isolated members of the family and that mothers and fathers need different things from early intervention programs (Frey, Fewell, & Vadasy, 1989; Vadasy, Fewell, Meyer, & Greenberg, 1985). When fathers are involved in early intervention programming the whole family benefits, not just the father of the child with special needs. Findings have shown when fathers are involved with early intervention programming, stress in the family and marital problems decrease (Frey, Fewell, & Vadasy, 1989). This finding is important because it shows how the father's

role affects the well-being of the family, particularly the parent's marriage. In current research, it has been shown that mothers often find their needs met by early intervention programs. The father is just as important and his needs also should be provided for.

When fathers are engaged in programs that fit their needs they experience less depression, less fatigue, less guilt and better decision-making ability (Vadasy, Fewell, Greenberg, Dermond, & Meyer, 1986; Vadasy, Fewell, Meyer, & Greenberg, 1985). This means that fathers may be able to function better in the family. Wives of husbands engaged in early intervention programs also have shown more positive feelings about themselves as well as their family circumstance (Vadasy, Fewell, Meyer, & Greenberg, 1985, Vadasy, Fewell, Greenberg, Dermond, & Meyer, 1986). A father's involvement in early intervention has an overwhelming affect on both parents in addition to the well-being of the family.

Markowitz (1984) conducted phone interviews with service providers to examine the idea of fathers participating in early special education programs. He found that service providers said that mothers welcome father involvement because it lessens their burden of being the only connection between the family and the special education programs (Markowitz, 1984). With this reduced burden, mothers may also experience less stress. Just as a father often cares for his children more during times of economic decline, familial stress was also cited as a variable of a father's involvement (Casper & O'Connell, 1998, Markowitz, 1984). Service providers reported that fathers are more involved during times of emotional stress in families because they want to provide extra support and they are less involved when families are less stressed (1984). This is another variable of father's involvement that service providers should examine. Service

providers need to find a way to keep fathers involved all the time (not just during periods of economic decline and family stress) because the whole family benefits from his involvement. A significant limitation to Markowitz's research about how families feel about father participation is that he only asked the program coordinators and did not directly survey families. His research relies on the observations of providers rather than the parents themselves.

While not every father will become the primary parent to care for and carry out home programs with the child having special needs, fathers have been shown to perform well in this role. Russell and Matson (1998) observed three fathers with their children implementing a behavioral program. The fathers demonstrated that they could implement this program well as the primary parent to carry it out. All fathers increased the correct use of both instructions and consequences while their children increased in their behavioral compliance in the program (Russell & Matson, 1998). This shows that fathers may be an excellent resource to help early interventionists maintain a home program.

No matter how or to what extent fathers are involved in early intervention programming, research has shown that there has been a benefit to the child and the family when fathers are involved (Vadasy, Fewell, Meyer, & Greenberg, 1985, Vadasy, Fewell, Greenberg, Dermond, & Meyer, 1986). This is an important issue that early intervention service providers should remember. Encouraging involvement even on a limited basis will help the family function at a better level and therefore will be providing service to the whole family.

Stress on the caregiver, as well as other family members, is a major concern in family-centered care (Thompson, 1997). Stress is negatively related to empowerment

(Thompson, 1997). Families that are empowered are better able to request the services they need, and therefore are provided with more complete programs (Mahoney & Filer, 1996). Research has shown that the fathers' involvement in the family and support for fathers helps to decrease stress that is present in families that have a child with special needs (Gallagher, Cross, & Scharfman, 1981). This research is another positive reason for early interventionists to work on involving fathers in programming.

Parents of children with special needs have also shown to differences by gender in areas that involve time demand, coping, and well-being (McLinden, 1990). Both mothers and fathers have significant time demands that cause stress. Mothers have reported having difficulty dividing their time between their child with special needs and the rest of the family or household. Fathers reported feeling that the family's schedule revolves around the child with special needs and view this as problematic (McLinden, 1990). Fathers' stress level is also related to the development of their child with special needs. When the child is not developing at a normal rate fathers often become discouraged and feel isolated because their child is different. Helping fathers understand this development and how service providers are assisting the child in development through early intervention may help fathers' stress level. This may positively affect the father's stress level because the father will be given more information about his child and the ways providers are helping the child to develop. Once the father understands this process and is able to talk about it he may find more positive ways to cope which will affect his stress level (Hadadian, 1994).

Although stress is a common issue for both parents, studies have shown that mothers find more positive coping strategies to use than fathers (McLinden, 1990). This

finding shows an area of need for fathers. This is significant because helping mothers balance their time and helping fathers use more positive coping strategies are two areas of early intervention care that would be useful for families. Increasing emphasis on fathers in early intervention may also be important to the family as a whole because research has shown that mothers who are supported by their husbands relate better to their children emotionally (Hadadian, 1994). No individual member of the family is separate because each member's thoughts, feelings, and attitudes affect the family as a whole (Case-Smith, 1998). As early intervention seeks to improve its family-centered care, understanding that care for the family means caring for each member is valuable.

Fathers Not Participating in Services

Although family-centered services are mandated in early intervention, and fathers play an important role in the development of their children, many fathers are not involved with the services their children with disabilities' receive (Hadadian & Merbler, 1995a). One father commented on involvement with services by saying, "A father regularly involved in obtaining services frequently finds he is not expected to participate in decisions about daily treatment, education, and care of the child, particularly a child with a disability" (Davis & May, 1991, p. 90). This statement points to the stereotypes of the mother and father roles in the family as being problematic. In traditional stereotypes the mother is the traditional parent to act as an information source, primary recipient of parent interventions, and most likely to participate in support groups (Hadadian & Merbler, 1995a). Since the mother has played this traditional role, many service providers have become biased toward relying on the mother more than the father. One reason fathers are not involved may be because they do not feel that they are supposed or

expected to be involved. Through research, Turbiville and her colleagues (1995) have found this gender bias to be true. These researchers caution service providers to make sure that they are allowing mothers and fathers to make the decision regarding the father's level of involvement and that they are not directing that decision for the families they serve through their practice and policies (Turbiville, Turnbull, & Rutherford-Turnbull, 1995). It is important to remember that fathers who desire to be involved in early intervention services should be given the opportunity and encouraged.

Problem Statement

Fathers and mothers differ in their experiences of parenthood and early intervention programming. Although these differences exist, fathers' views of programming have been neglected and mothers are the primary family members who evaluate these services (Davis & May, 1991). Some research is available about fathers' perceptions of service, but we currently do not know if the amount of time fathers spend with service providers relates to an increased positive perception of services. Understanding fathers' time may provide service providers vital information about fathers' needs based around time and scheduling of services. With the limited information we know about father's perceptions and time spent with providers we are unable to determine if fathers as part of the whole family are being served to their satisfaction by the current family-centered model of early intervention. Understanding the needs of fathers will enable the field of early intervention as well as the field of occupational therapy to strengthen the services they provide to families and their children with disabilities.

Purpose of the Study

The purpose of this study is to specifically examine perceptions of fathers of children with disabilities regarding early intervention care. This study will examine their perceptions of what needs are being met by early intervention services. It will also allow fathers to express what services are most valued by them. This study will also determine if the amount of time fathers spend with service providers is related to their perceptions of family-centered care. This research was guided by the following questions:

1. What are issues of importance to fathers that early intervention programming may address?
2. Is the early intervention service model of family-centered care meeting fathers' needs?
3. Does the amount of time fathers spend engaged in services and with their children correlate to their perceptions of met needs?

Participants

As participants of this study, fathers were recruited through the county health department's Children with Special Care Needs Program in both Tompkins and Cortland Counties in Central New York State. The term father in this study refers to the male individual involved in the child's life, who is at least 18 years of age. Mailings were sent to 281 families in Tompkins County and 77 families in Cortland County. Each packet mailed included a recruitment letter, an informed consent form, the Participant's Information Survey, the Brass Tacks Plus, and a stamped, self-addressed envelope. The Office of Community Health Services generated a list from their current database of

families receiving early intervention care. Surveys were sent to all 358 families within these databases.

38 participants returned surveys (10.6% response rate). One survey was not used because the child was six years old. The fathers in this sample were between the ages of twenty and sixty-three. Their children ranged in ages from three to forty-eight months and had been receiving services from one to 30 months. Thirty-three of the participants were natural fathers, two were adoptive/foster parents, one was a stepfather, and one was a grandfather/adoptive parent. 94.6% of the children involved in early intervention lived in the same home as the father. Thirty-one of the fathers were married, four were in committed relationships, one was separated, and one was not involved with the child's mother.

Tompkins County and Cortland County differed slightly in their demographic information. The majority of participants from Tompkins County reported an average family income range of \$50,001 - \$75,000, where as the majority of respondents from Cortland County reported an average family income of \$35,000 or greater. The educational level of the majority of fathers in Tompkins County was a Bachelor's degree or beyond (64.3%). The father's educational level for the majority of participants from Cortland County had an Associate's degree or less (77.8%). On average, fathers reported spending between 0 and 112 hours per week with their child and between 0 to 24 hours per month with their service provider. 40.5% of fathers reported spending no time with their service provider.

Measurement Instruments

There were two survey instruments that participants were asked to fill out and return to the researcher. The first was the Brass Tacks Plus (Appendix B₁) and the second was the Participant's Information Survey (Appendix B₂).

Brass Tacks Plus

The Brass Tacks Plus is a survey that has been adapted to meet the needs of this project. It is comprised of *The Brass Tacks, a Family Report*, which was created by McWilliam and McWilliam (1993) and questions from other studies that surveyed fathers involved in early intervention.

The Brass Tacks, a Family Report. The McWilliams' *The Brass Tacks, a Family Report*, consists of 24 statements and asks participants to rate how important the statement is to the participant (importance rating scale) and how well the program performs the statement (program satisfaction scale) using a 5-point Likert scale. A rating of a three or higher on the importance rating scale indicated an important need. A rating of a four or higher on the program satisfaction scale indicated a met need. The 24 statements concern multiple parts of early intervention programming including: entering the program, annual assessments, developing and writing intervention plans, and services provided to your child and family.

The Brass Tacks, a Family Report has been tested by the McWilliams (1993) for reliability and validity (McWilliam, Snyder, Harbin, Protern, & Munn, 2000). *The Brass Tacks, a Family Report* was developed from a 75-question instrument describing family-centered services. A chunk wise regression procedure was used to determine items that best predicted the final score. The items fit into four domains of early intervention

practice: referral and program entry, child and family assessment, intervention planning, and day-to-day services. Regression analysis was used to find the 24 questions this survey contains. These items were found to predict 63-83% of the variance of the total score (McWilliam et al., 2000).

After the authors determined the 24 items that would be used to establish *The Brass Tacks, a Family Report*, they ran data analyses on the test (McWilliams et al., 2000). Using Cronbach's alpha, internal consistency of all the scores was reported as .94. The researchers also used t-tests to determine test-retest reliability. The scores in these were not significantly different which suggests that the test is stable over time.

The Brass Tacks Plus. For the purposes of this research, I added an additional eight questions to the McWilliams' survey, as well as another column asking participants if they felt informed about the particular issue. The eight questions were adapted from other surveys of fathers engaged in early intervention services completed by Linder & Critwood in 1984 and adapted in 1995 by Hadadian & Merbler. Select questions were rewritten and placed in the same format as the Brass Tacks Survey. Adding the additional column allowed participants to indicate if they felt informed about the particular statement. This increased the strength of the study because it allowed the researcher to distinguish between a poor rating of performance due to uninvolved and not knowing the answer from an actual poor rating.

Participant's Information Survey

The Participant's Information Survey was a demographic survey created by the researcher. It deals with the demographics of the whole family and had questions specific to the mother and the father. The survey also inquired about the amount of time

the father spends with his child and with service providers. This instrument was created for the purpose of this study.

Field-Testing

Both surveys were field-tested prior to the mailings. For the purposes of field-testing the survey, four fathers who have young children were asked to complete the survey and make comments. Three of the fathers had been involved in early intervention services or therapy services. After reviewing their comments, items were checked for clarity, and rewritten when necessary. In addition to field-testing, the survey was reviewed by four faculty members in the Occupational Therapy Department at Ithaca College. Three of the faculty members have worked in the field of early intervention. This process ensured that the surveys asked what they were intended to ask and were clearly phrased so participants could choose the most appropriate answers.

Results

Brass Tacks Plus

Internal consistency for this administration of the Brass Tacks Plus was determined through the use of Cronbach's α -coefficient. Program satisfaction scale items, importance rating scale items, and total section items were analyzed. Scores ranged from .53 to .98 (Table 4).

Question 1

In order to determine what issues of early intervention programming are important to fathers, responses to the Brass Tacks Plus were analyzed. Each question was examined by looking at the mean and the standard deviation (*SD*) of the importance rating scale scores of the instrument. Table 1 displays these results. After examining

each question, the mean of each section was also studied. Section 1, Entering the Program was found to be most important to fathers ($M = 3.90$, $SD = 0.70$). Day-to-day services were examined in parts 4 and 5 and were found to be the least important to fathers ($M = 3.62$, $SD = 1.08$, $M = 3.07$, $SD = 1.26$, respectively).

Question 2

The mean score of the program satisfaction scale and the mean score of importance rating scale were compared on all items to determine if fathers' needs were being met by early intervention programming. A rating of 3 and higher (3 = important, 4 = very important, 5 = critical) on the importance rating scale indicated an important need while a rating of 4 and 5 (4 = agree, 5 = strongly agree) on the program satisfaction scale indicated a met need. Fathers were also asked to indicate whether or not they felt informed about each program statement. These answers were taken into consideration, when deriving the mean of each question; fathers' program satisfaction ratings were not included if they indicated that they felt uninformed about the statement. Table 2 displays the results of fathers' program satisfaction ratings.

To further analyze this issue, program satisfaction ratings were examined in greater detail for fathers that indicated that the statement was important to them on the importance rating scale. The category of disagree was established by using fathers' ratings of a one (strongly disagree) or a two (disagree). The neutral category was created for those fathers who indicated a program satisfaction rating of a three (neither agree nor disagree). Ratings of four (agree) and five (disagree) were classified as agree. These results are displayed in Table 3.

Question 3

Pearson product moment correlations were used to examine the relationship between the amount of time fathers reported spending in early intervention services and fathers' perception of service. They were also used to examine the relationship between the amount of time fathers reported spending with their children and their perception of service. A significant, moderate negative correlation was found between the amount of time fathers reported spending with service providers and their satisfaction with services ($r = -.36, p < .05$). Once an outlier was removed from this group no significant relationship remained ($r = -.12, ns$). No relationship was found between the amount of time fathers reported spending with their service providers and the rating of met needs on the Brass Tacks Plus ($r = -.04, ns$). No relationship was found between the amount of time fathers reported spending with their children and their perceptions of services ($r = -.10, ns$).

Additional Analyses

Additional analyses were completed that did not relate to the research questions. Other correlations were found in the surveys that related to both parents' current employment status. These were found by using a Spearman's rho correlation because the data were nonparametric in nature. The mother's working situation was moderately related to the amount of time the father reported spending with his child ($r = .38, p < .05$). The father's working situation was moderately and negatively correlated to the amount of time that he reported spending with his service provider ($r = -.47, p < .01$).

Through the use of independent sample t tests (two-tailed analyses), responses of fathers who felt informed were correlated with the responses of fathers whom feel

uninformed with respect to the amount of time spent in services and the length of time they were involved in services. No significant difference was found between these two groups.

Discussion

Question 1

Overall, fathers found program entry to be the most important section on this survey. Significant items of importance to fathers were identified. The items may be categorized into three themes, which include timing of services, interventionists' perceptions of the child, and involvement and control in the intervention process. Timing of services shows that fathers value staff meeting their needs right away and beginning services in a timely manner. This theme has been cited in a past study. In the McWilliam, Tocci, and Harbin (1998) study they labeled this theme as responsiveness. Responsiveness was described as taking action when parents expressed a need or a complaint. The theme of timing of services shows that fathers also value service providers taking action to meet their needs.

Items valued by fathers in the second theme, the interventionists' perceptions of the child, included staff liking, finding positive qualities in their child, and emphasizing the child's strengths. Fathers valued interventionists having a positive view of their child. This theme may also be seen in the 1998 study of McWilliam, Tocci, and Harbin. These researchers described a theme of positiveness as including having faith in parents' skills, being nonjudgmental, being positive about the child's maturation, and being passionate about working with families. The items valued by fathers in the Brass Tacks

Plus survey are evident in the theme of positiveness described by McWilliam and his fellow researchers.

Fathers also indicated that they valued a third theme, involvement and control in the intervention process. Items included in this theme were being invited to discussions, being given information, being listened to, and offered choices about services. This is an important finding because it shows that fathers desire involvement to some extent in early intervention programming. This finding is concurrent with findings in the 1984 Linder and Chitwood study and the 1995 Hadadian and Merbler study. Since this is the father's desire, service providers should make every attempt possible to allow them to be involved. Often fathers are working during intervention times. Further investigation needs to be done into ways fathers can be involved if their work hours coincide with their child's services times during the day. Service providers need to make time to talk to fathers during the times they are available because fathers' value involvement. By investigating ways to involve fathers and vary schedules, the barrier of flexible scheduling cited by Dinnebeil, Hale, and Rule in their 1999 study and McWilliam, Tocci, and Harbin in their 1998 study can be eliminated.

Hadadian (1994) study showed that when a child is not developing at a normal rate fathers often become discouraged and feel isolated because their child is different. This may be another reason fathers' value receiving information. Providing fathers with information to assist them in understanding their child's development and how service providers are assisting the child in development through early intervention may help to decrease fathers' stress level.

This theme also shows that fathers value the feeling of control and want to be empowered. It supports the conclusion that fathers do want the early intervention care model to be one that is truly family-centered. This finding is concurrent with the 1996 study by Trivette, Dunst, Boyd, and Hamby, which showed that family-centered programs are important in empowering families for decision-making and structuring the future of children with disabilities.

Recreation involving their child was another topic that fathers found important (recreational ideas $M = 3.68$ and recreational programming $M = 3.22$). They valued service providers suggesting recreational ideas for their child and them to participate in as well as recreational activities provided by the program for fathers and children to participate in (Table 1). These results related to earlier studies, which examined fathers' perception of service by Linder and Chitwood (1984) and Hadadian and Merbler (1995), who found similar results. This may result from the way fathers have been shown to interact with their children because fathers tend to use play in their interactions rather than care-taking activities (Pruett, 1987).

Fathers in this sample did not value communication and interrelational items. These included items such as providing ways to communicate with my spouse, social events with other families, and group discussions with other parents. This finding relates to the finding that fathers of preschoolers cited items that involved relating to others such as other children or families and friends in relation to their child with a disability as their lowest priority (Hadadian & Merbler, 1995).

Question 2

Overall, fathers were satisfied with the services they were provided and with those that they rated as important (80% or more fathers agree that most items they valued are occurring in early intervention programs). Items involving parent communication, social events, and workshops all involved a 50% or lower agreement rate among fathers who valued the statement. This indicates that these services are not occurring or being offered to fathers. These may be three areas that early intervention programs could improve upon. Further investigation is needed to examine if there are additional services fathers' value or additional needs that exist other than the ones on this survey instrument.

Question 3

The amount of time fathers spend in services was found to negatively relate to their satisfaction with the services they receive. This means that the more time fathers spend in services the more negatively they rate them. This may be a result of fathers being more familiar with the services they receive and therefore more critical of these services. It may also mean that fathers are not receiving services that fulfill the needs they have in relationship to their child with special needs. Due to the outlier in this study, further investigation into fathers' time in relationship to early intervention services will also be needed. Understanding more about fathers' time and how to meet fathers' needs of involvement while considering their time restraints will improve the family-centered care aspect of services.

Additional Analyses

Working situations of both the mother and the father seemed to play an important role in the findings of this research. The more time the mother works the more time the

father spends with his child. The less time the father works the more time he spends with his child also. These findings support other studies that examined mothers' and fathers' time in relationship to their families and their work (Casper & O'Connell, 1998, Shore, 1992). This study also showed that the more time fathers spend with their children, the more they spend with their service provider. This is another important factor of fathers' involvement. It is important because as more mothers are working outside the home more fathers are spending time with their children and therefore spending more time with service providers than they did in previous years. This is another reason that fathers' needs must be met in early intervention programming because fathers are now playing a more significant role in services.

Time fathers spend with service providers did not significantly differ for fathers who felt informed or uninformed about the services provided to them. This shows that actual time spent in services does not necessarily equate with feelings of being informed. This indicates that fathers receive information about early intervention programming in other ways. Additional investigations into ways fathers are informed about what is occurring in their program as well as how fathers connect with service providers outside the time when the child receives services would be useful in understanding more about this issue. It may also assist in finding ways to keep fathers informed and involved when they are unable to be present during services because of scheduling or other time restraints.

Conclusion

This study showed that the programs that are provided to fathers are meeting fathers' needs. Although fathers' time in services is limited (overall ranged 0 to 24 hours

per month on average), fathers do want to be involved. Fathers' time spent in services does seem to correlate to their perception of need, which indicates that early intervention service providers must strive to include the father and meet his needs to best serve the whole family under the family-centered care model.

Due to the small sample size and limited response rate of this study and geographic distribution, the generalizability may be compromised. In addition, fathers that responded to this survey may feel strongly about the topic at hand and may have been more likely to respond than other fathers, which may bias the results. Due to these factors more research is needed in this area to add to the family-centered care body of literature on fathers. Further investigation into fathers' areas of needs and time in respect to services are needed to ensure that early intervention programs are serving fathers under the model of family-centered care.

References

- Case-Smith, J. (1993). Occupational therapy in family-centered early intervention. In J. Case-Smith (Ed.), *Pediatric occupational therapy and early intervention* (pp.1-29). Boston: Andover Medical Publishers.
- Casper, L.M. & O'Connell, M. (1998). Work, income, and the economy, and married fathers as child-care providers. *Demography*, 35(2), 243-250.
- Davis, P. B., May, J. E. (1991). Involving fathers in early intervention and family support programs: issues and strategies. *Child Health Care*, 20(2), 87-92.
- Dinnebeil, L.A., Hale, L.M., Rule, S. (1999). Early intervention program practices that support collaboration. *Topics in Early Childhood Special Education*, 19, 225-235.
- Frey, K.S., Fewell, R.R., Vadasy, P.F. (1989). Parental adjustment and changes in child outcome among families of young handicapped children. *Topics in Early Childhood Special Education*, 8(4), 39-57.
- Gallagher, J.J., Cross, A., & Scharfman, W. (1981). Parental adaptation to a young handicapped child: the father's role. *Journal of the Division for Early Childhood*, 3, 3-14.
- Hadadian, A. (1994). Stress and social support in fathers and mothers of young children with and without disabilities. *Early Education & Development*, 5(3), 226-235.
- Hadadian, A., Merbler, J. (1995a). Fathers of young children with disabilities: how do they want to be involved. *Child and Youth Care Forum*, 24(5), 327-338.
- Hadadian, A., Merbler, J. (1995b). Parents of infants and toddlers with special needs: sharing views of desired services. *Infant-Toddler Intervention: The Transdisciplinary Journal*, 5(2), 141-152.

- Hanft, B. (1988). The changing environment of early intervention services: Implications for practice. *American Journal of Occupational Therapy, 42*(11), 724-731.
- King, G., Law, M., King, S., Rosenbaum, P. (1998). Parents' and service providers' perceptions of the family-centeredness of children's rehab services. *Physical and Occupational Therapy in Pediatrics, 18*(1), 21-40.
- Linder, T.W., & Chitwood, D. G. (1984). The needs of fathers of young handicapped children. *Journal of the Division for Early Childhood, 8*(2), 133-139.
- Mahoney, G., & Filer, J. (1996). How responsive is early intervention to the priorities and needs of families? *Topics in Early Childhood Special Education, 16*, 437-457.
- Markowitz, J. (1984). Participation of fathers in early childhood special education programs: an exploratory study. *Journal of the Division for Early Childhood, 8*, 119-131.
- Maruyama, E., Chandler, B. E., Clark, G. F., Dick, R. W., Lawlor, M. C., Jackson, L. J. (1999). *Occupational therapy services for children and youth under the individuals with disabilities education act* (2nd ed.). Bethesda, MD: The American Occupational Therapy Association, Inc.
- McLinden, S. E. (1990). Mothers' and fathers' reports of the effects of a young child with special needs on the family. *Journal of Early Intervention, 14*(3), 249-259.
- McWilliam, P. J., & McWilliam, R. A., (1993). *The Family Report/Brass Tacks-Evaluation Version*. Chapel Hill, NC: University of North Carolina at Chapel Hill.
- McWilliam, R. A., Snyder, P., Harbin, G. L., Porter, P., Munn, D. (2000). Professionals' and families' perceptions of family-centered practices in infant-toddler services. *Early Education & Development, 11*(4), 519-538.

- McWilliam, R. A., Tocci, L. Harbin, G. L. (1998). Family centered services: Service providers' discourse and behavior. *Topics in Early Childhood Special Education, 18*(4), 206-228.
- Pruett, K. D. (1987). *The nurturing father*. New York, NY: Warner Books.
- Russell, D., Matson, J. (1998). Fathers as intervention agents for their children with developmental disabilities. *Child & Family Behavior Therapy, 20*(3), 29-49.
- Schor, J. B. (1992). *The overworked American: the unexpected decline of leisure*. New York, NY: Basic Books.
- Thompson, L., Lobb, C., Elling, R., Herman, S., Jurkiewicz, T., Hulleza, C. (1997). Pathways to family empowerment: Effects of family-centered delivery of early intervention services. *Exceptional Children, 64*(1), 99-114.
- Trivette, C. M., Dunst, C. J., Boyd, K., Hamby, D. W. (1996). Family-oriented program models, helpgiving practices, and parental control appraisals. *Exceptional Children, 62*(3), 237-249.
- Turbiville, V.P., Turnbull, A.P., Rutherford Turnbull, H. (1995). Fathers and family-centered early intervention. *Infants and Young Children, 7*(4), 12-19.
- Vadasy, P.F.; Fewell, R.R.; Greenberg, M.T.; Dermond, N.L.; Meyer, D.J. (1986). Follow-up evaluation of the effects of involvement in the fathers program. *Topics in Early Childhood Education, 6*(2), 16-31.
- Vadasy, P.F., Fewell, R.R., Meyer, D.J., & Greenberg, M.T. (1985). Supporting fathers of handicapped young children: preliminary findings of program effects. *Analysis and Intervention in Developmental Disabilities, 5*, 151-163.

Yogman, M. W., Kindlon, D., Earls, F. (1995). Father involvement and cognitive/behavioral outcomes of preterm infants. *Journal of the American Academy of Child Adolescent Psychiatry*, 34(1), 58-66.

Table 1

Descriptive Statistics of Ratings of Importance

Statement	Fathers <i>N</i> = 36	
	<i>M</i>	<i>SD</i>
Referral & Program Entry	3.90	0.70
1. Personal information	3.69	0.93
2. Parent choice	3.66	1.06
3. Staff listens	3.57	1.01
4. Immediate assist.	3.94	0.94
5. Fast contact	4.19	0.71
6. Value child	4.28	0.88
Child and Family Assessment	3.77	0.75
1. Choose times	3.70	0.88
2. Parent's questions	3.85	1.03
3. Parent choice	3.41	1.04
4. Child ability	3.76	1.06
5. Parents present	4.03	0.92
6. Fast results	3.51	1.18
7. Assessment report	4.27	0.76
Intervention Planning	3.72	0.83
1. Parents present	3.94	0.92
2. Parents' goals	3.64	1.03
3. Goal in one year	3.79	1.08
4. Parents' ideas	3.79	1.11
5. Parent choice	4.03	0.74
6. Others' needs	3.22	1.34
Day-to-Day Services	3.62	1.08
1. Compliment parent	3.52	1.18
2. Compliment child	3.94	1.07
3. Staff access	3.76	1.06
4. Other family	3.64	1.25
5. Info. Access	3.53	1.31
Additional Day-to-Day Services	3.07	1.26
1. Recreational ideas	3.68	1.27
2. Recreational programming	3.22	1.58
3. Behavior issues	3.18	1.53
4. Parent Communication	2.70	1.42
5. Coping Methods	2.88	1.41
6. Social Events	2.73	1.46
7. Workshops	3.12	1.52
8. Group Discussions	2.73	1.57

Note. Importance ratings were as follows: 1 = Not Important, 2 = Somewhat Important, 3 = Important, 4 = Very Important, 5 = Critical.

Table 2
Descriptive Statistics of Program Satisfaction Ratings

Statement	Fathers		
	<i>n</i>	<i>M</i>	<i>SD</i>
Referral & Program Entry	36	4.17	0.59
1. Personal info.	35	4.14	0.65
2. Parent choice	34	4.15	0.74
3. Staff listens	34	3.97	0.80
4. Immediate assist.	34	4.21	1.04
5. Fast contact	32	4.28	.92
6. Value child	35	4.66	0.68
Child and Family Assessment	34	3.85	0.70
1. Choose times	32	4.19	0.78
2. Parent's questions	30	3.97	0.93
3. Parent choice	25	3.60	1.00
4. Child ability	32	4.03	0.93
5. Parents present	31	4.13	0.92
6. Fast results	30	3.63	1.13
7. Assessment report	32	4.53	0.57
Intervention Planning	35	3.82	0.58
1. Parents present	33	3.94	0.92
2. Parents' goals	34	3.64	1.03
3. Goal in one year	32	3.79	1.08
4. Parents' ideas	32	3.79	1.11
5. Parent choice	31	4.03	0.74
6. Others' needs	28	3.22	1.34
Day-to-Day Services	35	3.98	0.74
1. Compliment parent	31	4.00	1.00
2. Compliment child	34	4.38	0.85
3. Staff access	30	4.00	0.74
4. Other family	31	4.19	0.79
5. Info. access	28	3.82	1.09
Additional Day-to-Day Services	35	3.19	0.99
1. Recreational ideas	30	4.13	0.94
2. Recreational programming	23	4.04	0.98
3. Behavior issues	25	3.48	1.19
4. Parent Communication	23	3.09	1.08
5. Coping Methods	26	3.31	1.12
6. Social Events	20	3.00	1.38
7. Workshops	18	3.17	1.29
8. Group Discussions	20	3.10	1.37

Note. Program satisfaction ratings were as follows: 1 = Strongly Disagree, 2 = Disagree, 3 = Neither Agree Nor Disagree, 4 = Agree, 5 = Strongly Agree

Table 3

Percentages of Categorized Program Ratings

Statement	<i>n</i>	Disagree	Neutral	Agree
Referral & Program Entry				
1. Personal info.	32	3.13%	6.25%	90.63%
2. Parent choice	30	0.00%	6.67%	93.33%
3. Staff listens	29	0.00%	13.79%	86.21%
4. Immediate assist.	32	6.25%	6.25%	87.5%
5. Fast contact	32	6.25%	3.13%	90.63%
6. Value child	34	2.94%	2.94%	94.12%
Child and Family Assessment				
1. Choose times	30	3.33%	10.00%	86.67%
2. Parent's questions	27	3.70%	7.40%	88.89%
3. Parent choice	20	5.00%	20.00%	75.00%
4. Child ability	28	3.57%	0.36%	92.86%
5. Parents present	29	3.45%	10.34%	86.21%
6. Fast results	22	4.55%	13.64%	81.82%
7. Assessment report	31	0.00%	3.23%	96.77%
Intervention Planning				
1. Parents present	31	0.00%	6.45%	93.55%
2. Parents' goals	26	15.38%	15.38%	69.23%
3. Goal in one year	28	3.57%	14.29%	82.14%
4. Parents' ideas	29	3.45%	3.45%	93.10%
5. Parent choice	29	0.00%	0.00%	100.00%
6. Others' needs	21	4.76%	14.29%	80.95%
Day-to-Day Services				
1. Compliment parent	26	3.85%	7.69%	88.46%
2. Compliment child	29	0.00%	3.45%	96.55%
3. Staff access	26	0.00%	19.23%	80.77%
4. Other family	28	0.00%	7.14%	92.86%
5. Info. access	23	4.35%	8.70%	86.96%
Additional Day-to-Day Services				
1. Recreational ideas	26	3.85%	7.69%	88.46%
2. Recreational programming	18	0.00%	16.67%	83.33%
3. Behavior issues	16	6.25%	18.75%	75.00%
4. Parent Communication	12	8.33%	41.67%	50.00%
5. Coping Methods	17	5.88%	29.41%	64.71%
6. Social Events	12	16.67%	41.67%	41.67%
7. Workshops	14	21.43%	35.71%	42.86%
8. Group Discussions	10	20.00%	20.00%	60.00%

Notes: *n* refers to the number of fathers who rated the item as important.

Table 4

Internal Consistency of the Brass Tacks Plus

Sections ^a	Number of Items	α - coefficient ^b
Referral & Program Entry	12	.88
Program Rating Items	6	.74
Importance Items	6	.85
Child and Family Assessment	14	.92
Program Rating Items	7	.87
Importance Items	7	.88
Intervention Planning	12	.85
Program Rating Items	6	.53
Importance Items	6	.88
Day-to-Day Services	10	.95
Program Rating Items	5	.88
Importance Items	5	.92
Additional Day-to-Day Services	16	.96
Program Rating Items	8	.90
Importance Items	8	.93
Total Brass Tacks Plus	64	.98
Program Rating Items	32	.92
Importance Items	32	.97

^aInformed items were not included in this analysis. ^b α represents Cronbach's coefficient of internal consistency.

Appendix A

ALL COLLEGE REVIEW BOARD
FOR
HUMAN SUBJECTS RESEARCH

COVER PAGE

Investigator: Jane McGowan, Occupational Therapy Graduate Student
 Department: Occupational Therapy Department
 Telephone: (607) 277-6427
 Project Title: Assessment of Father's Needs in Early Intervention Care

Abstract: (Limit to the space provided)

Best practice in early intervention service for infants and toddlers with special needs mandates a model of family-centered care, where the child is viewed as part of a family system and the whole family is supported. However, these services are frequently directed toward the mother-child dyad. Understanding more about fathers and their role within early intervention services will help practitioners serve the needs of the whole family. This study examines the needs and perceptions of fathers of children with disabilities who participate in early intervention services. In addition, this study also examines the relationship between father's perceptions of services and reported needs with the amount of time they spend in services. Approximately 60 fathers from central New York will be recruited to participate in this research study. Fathers will be asked to complete 2 surveys that examine their needs and perceptions of the early intervention service they are involved in. This data will be used to describe fathers needs and perceptions of services, as well as how their perceptions of services correlate with their time spent involved in services.

Proposed Date of Implementation: December 1, 2001

Jane McGowan, Graduate Student Carole Dennis, Sc.D., OTR/L, BCP, Faculty Advisor
 Print or Type Name of Principal Investigator and Faculty Advisor

Jane McGowan Carole Dennis
 Signature (Use blue ink) Principal Investigator and Faculty Advisor

ALL COLLEGE REVIEW BOARD
FOR
HUMAN SUBJECTS RESEARCH

CHECKLIST

Project Title: Assessment of Father's Needs in Early Intervention Care
Investigator: Jane McGowan, Graduate Student

<u>Investigator Use</u>	<u>HSR Use Only</u>	<u>Items for Checklist</u>
<input checked="" type="checkbox"/>	<input type="checkbox"/>	1. General information
<input checked="" type="checkbox"/>	<input type="checkbox"/>	2. Related experience of investigator(s)
<input checked="" type="checkbox"/>	<input type="checkbox"/>	3. Benefits of the study
<input checked="" type="checkbox"/>	<input type="checkbox"/>	4. Description of subjects
<input checked="" type="checkbox"/>	<input type="checkbox"/>	5. Description of subject participation
<input checked="" type="checkbox"/>	<input type="checkbox"/>	6. Description of ethical issues/risks of participation
<input checked="" type="checkbox"/>	<input type="checkbox"/>	7. Description of recruitment of subjects
<input checked="" type="checkbox"/>	<input type="checkbox"/>	8. Description of how anonymity/confidentiality will be maintained
<input checked="" type="checkbox"/>	<input type="checkbox"/>	9. Debriefing statement
<input checked="" type="checkbox"/>	<input type="checkbox"/>	10. Compensatory follow-up
<input checked="" type="checkbox"/>	<input type="checkbox"/>	11. Appendix A – Recruitment Statement
<input checked="" type="checkbox"/>	<input type="checkbox"/>	12. Appendix B – Informed Consent Form (or tear-off Cover Page for anonymous paper and pen/pencil surveys)
<input type="checkbox"/>	<input type="checkbox"/>	13. Appendix C – Debriefing Statement
<input type="checkbox"/>	<input type="checkbox"/>	14. Appendix D – Survey Instruments
<input type="checkbox"/>	<input type="checkbox"/>	15. Appendix E – Glossary to questionnaires, etc.

Items 1-8, 11, and 12 must be addressed and included in the proposal. Items 9, 10, and 13-15 should also be checked if they are appropriate – indicate “NA” if not appropriate. This should be the second page of the proposal.

Ithaca College
Human Subjects Proposal

1. General Information about the study:

Funding: There is no external funding for this study. The occupational therapy department may allocate funds for copying and mailing of surveys.

Where and When conducted: Surveys will be distributed in Tompkins, Cortland, Broome, Chemung, Schuyler, Tioga, Cayuga, and Seneca counties of New York State. Survey mailing and data collection will begin in December 2001 and continue through March 2002. Data analysis will take place at Ithaca College, and will begin in the spring semester of 2002 and will continue until completed.

2. Related experience of the researcher: I am currently an occupational therapy graduate student. I have completed four years of undergraduate studies and received a Bachelor of Science degree in Occupational Science. My coursework that directly applies to my research knowledge includes Biostatistics (670-39000), Research Seminar (672-49500), and Research Methods (673-67000). These courses have involved reading, studying, understanding data analysis, and analyzing research studies. In addition to my coursework, I have completed a three-month clinical internship in occupational therapy. During this experience, I worked with people and gained a better understanding of the needs of patients and their families during the course of treatment. These experiences will help me to carry out this research study.

Dr. Dennis has taught graduate and undergraduate courses for several years and has worked with six students as a thesis advisor. She has also completed and presented many studies that deal with young children with disabilities and their families. She is an expert in both early intervention and family-centered care.

3. Benefits of the study: This study will benefit the field of early intervention as well as the profession of occupational therapy. There will be no direct benefit to the fathers involved in the study except the knowledge that their participation may result in increased recognition that fathers are an integral part of the early intervention team. Early intervention care will benefit by more fully considering fathers' needs and what affects their role in the family. This knowledge may better equip early intervention service providers in offering service and support to families. Occupational therapy (OT) will benefit from this study because it is a holistic profession that empowers clients to meet their role expectations. OT will gain a better understanding of the whole family by understanding more about fathers and their role in the early intervention services.

4. Description of subjects: The subjects of this study will be fathers of children with disabilities who are currently receiving early intervention services. The term father will refer to the male individual involved in the child's life. It is expected that all will be 18 years of age and able to read. I hope to have approximately 60 fathers participate in this study.
5. Description of subject participation: Fathers of young children who receive early intervention services will be mailed a packet that will include a recruitment letter (Appendix B), an informed consent form (Appendix A), two surveys (Appendix C₁, and C₂), and a stamped, self-addressed envelope. Fathers who agree to participate in this study will be asked to complete the surveys and return them in the envelope provided. The surveys will include the Participants Information Survey (Appendix C₁), and the Brass Tacks Survey Plus (Appendix C₂). These surveys tools should take no more than an hour of the fathers' time.
6. Ethical Issues-Description: This research study will be conducted in survey format. Although there is little risk associated with the surveys this study may cause some fathers to feel uncomfortable answering personal family questions. Fathers may also hesitate to answer some questions that are specific to their family because of this discomfort or embarrassment they experience due to their family situation.
Minimizing Risk: The identity of fathers who participate in this study will be unknown to the researcher. Fathers participating in this study will be informed that their identity will not appear on any of the survey material nor will their identity be released in anyway. They will be assured that the information gathered from the survey will not be viewed critically but used to gain a better understanding of fathers' needs in order to provide better early intervention care. Fathers may refuse to answer any questions and may withdraw from the study at any time.
7. Recruitment of Subjects: Mailing lists of families that receive early intervention services will be created by clerical staff in the Office for Children with Special Care Needs in the surrounding counties including: Tompkins, Cortland, Broome, Chemung, Schuyler, Tioga, Cayuga, and Seneca counties. The researcher will collate and prepare each survey for mailing and deliver them to each office from which they will be mailed. Parents will receive a recruitment letter explaining the project and the benefits of this research to entice participation in this project.
8. Confidentiality/Anonymity of Responses: In order to maintain confidentiality, fathers will read an informed consent form that informs them that completing and returning the surveys to the researcher implies their consent to participate in the study. The identity of the participants will be unknown to the researcher. No identifying information will appear on the surveys. Each survey will be coded. The first and second surveys will have corresponding numbers in order to compare the two surveys.

9. Debriefing: No debriefing statement is necessary.
10. Compensatory Follow-up: No compensatory follow-up will be necessary due to the fact that no negative outcomes are predicted.
11. All required appendices are attached, and include:
 - Appendix A: Informed Consent
 - Appendix B: Recruitment Letter
 - Appendix C₁: Participants' Information Survey
 - Appendix C₂: Brass Tacks Survey


ITHACA

Ithaca College
350 Job Hall
Ithaca, NY 14850-7012
(607) 274-3113
(607) 274-3064 (Fax)

Office of the Provost and
Vice President for
Academic Affairs

DATE: November 14, 2001

TO: Jane McGowan
Occupational Therapy Graduate Student
Ithaca College

FROM: Garry L. Brodhead, Associate Provost 
All-College Review Board for Human Subjects Research

SUBJECT: Assessment of Father's Needs in Early Intervention Care

The All-College Review Board for Human Subjects Research has received your request for review of the above named proposal. The proposal has been reviewed and the Board authorizes you to begin the study. This approval will remain in effect for a period of one year from the date of authorization.

The Board did, however, have the following consultative comments:

Appendix A and Appendix B should include an estimated participation time.

The fourth sentence in Appendix A should be revised to read *I am asking you to fill out...* and the fifth sentence should be revised to read *...and are at least 18 years of age.*

The questions on the Survey Instrument should be reviewed for grammar.

Question 14 should include an under 18 category. Only the subjects participating in the study must be at least 18 years of age or older. Some of the mothers may be under 18.

After you have finished the project, please complete the attached Notice-of-Completion Form and return it to my office for our files.

Best wishes for a successful study.

/lw

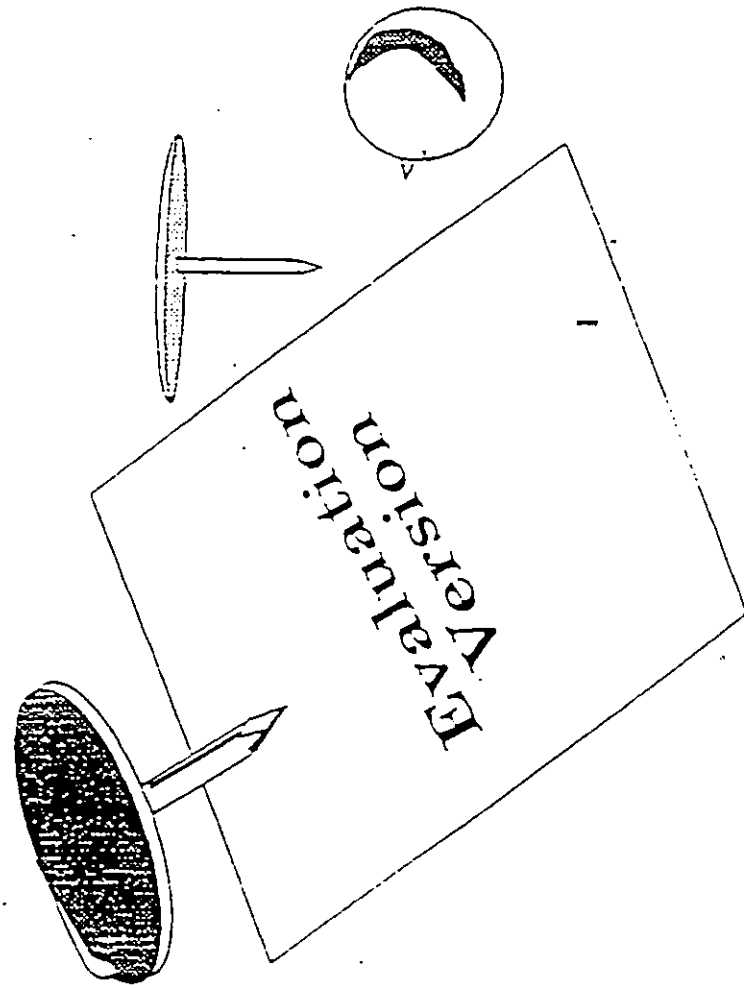
Attachment

c: Carole Dennis, Faculty Advisor

Appendix B

Brass Tacks

The Family Report



P. J. McWilliam

R. A. McWilliam

1993
Frank Porter Graham Child Development Center
The University of North Carolina at Chapel Hill

THE FAMILY REPORT INSTRUCTIONS

STEP 1: READ EACH STATEMENT CAREFULLY

Read each statement carefully and consider whether or not you think this is true of your experiences with the early intervention program Your child is currently enrolled in.

STEP 2: RATE THE EXTENT TO WHICH YOU AGREE OR DISAGREE

Use the column labeled "Do You Agree or Disagree?" Circle the number on the 5-point rating scale (ranging from STRONGLY DISAGREE-1 to STRONGLY AGREE-5) that best reflects how much you agree or disagree with each statement based upon your own experiences with the program your child is enrolled in.

STEP 3: INDICATE HOW IMPORTANT YOU THINK EACH PRACTICE IS

Use the column labeled "How Important is This?" to indicate how important you think each practice (statement) is in providing high-quality services to children and their families. Circle the number on the 5-point rating scale (ranging from NOT IMPORTANT-1 to CRITICAL-5) to indicate your opinion about how services should be provided.

STEP 4: INDICATE WHETHER YOU FEEL INFORMED ABOUT THIS ISSUE

Use the column labeled "I Feel Informed About This Program" to indicate whether you are informed about each practice (statement) the early intervention program offers. Circle yes or no to indicate if you feel knowledgeable about this issue.

Please BE HONEST IN YOUR RATINGS as they will be used to guide changes in providing early intervention services to children and their families. Also, please remember that YOUR RESPONSES ON THE QUESTIONNAIRE WILL BE KEPT STRICTLY CONFIDENTIAL. No one who provides services to you will see your questionnaire or be aware of how you responded. Only a summary of all families' ratings will be reported.

PART #1: ENTERING THE PROGRAM

THE FAMILY REPORT

Please think back to the time when you first talked to and met the staff members of the early intervention program-when you first enrolled your child. This may have consisted of a phone call, a visit to the center, or a home visit from a staff member. It probably also involved completing several forms.

Statement	Do You Agree or Disagree?					How Important is This to You?					I Feel Informed About This Issue.	
	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Not Important	Somewhat Important	Important	Very Important	Critical	Yes	No
1. The information I was asked about myself, my child, and my family seemed reasonable. (It didn't seem unnecessary or too nosy).	1	2	3	4	5	1	2	3	4	5	Y	N
2. I was given choices as to how and where program staff got to know my child and my family. (For example, I chose the time and the place for meeting the staff.)	1	2	3	4	5	1	2	3	4	5	Y	N
3. Staff members listened more than they asked questions or gave advice.	1	2	3	4	5	1	2	3	4	5	Y	N
4. Staff members addressed my concerns on the very first contacts with them. (For example, they answered my questions or suggested things I could do to help my child).	1	2	3	4	5	1	2	3	4	5	Y	N
5. We began receiving services soon after our first contact with the program.	1	2	3	4	5	1	2	3	4	5	Y	N
6. From the very beginning, staff members seemed to like my child and saw my child's good qualities.	1	2	3	4	5	1	2	3	4	5	Y	N

PART #2: ANNUAL ASSESSMENTS

THE FAMILY REPORT

According to the law, children receiving early intervention services must be tested at least once a year. This testing may be done by the staff members who provide services to your child or it may be done by another agency (e.g., a clinic, a developmental evaluation center, or by professionals in private practice). Please think about the last time your child was assessed (tested).

Statement	Do You Agree or Disagree?					How Important is This to You?					I Feel Informed About This Issue.	
	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Not Important	Somewhat Important	Important	Very Important	Critical	Yes	No
1. I had a choice about the date, time, and place of my child's most recent assessment.	1	2	3	4	5	1	2	3	4	5	Y	N
2. The professionals asked me what questions I wanted answered by the assessment.	1	2	3	4	5	1	2	3	4	5	Y	N
3. The professionals gave me choices about how my child should be assessed (the type of testing done).	1	2	3	4	5	1	2	3	4	5	Y	N
4. The professionals emphasized those things that my child can do instead of what my child can't do.	1	2	3	4	5	1	2	3	4	5	Y	N
5. The professionals invited me to be present at all discussions about my child's assessment results.	1	2	3	4	5	1	2	3	4	5	Y	N
6. The professionals told me the results of the assessment on the same day it was done.	1	2	3	4	5	1	2	3	4	5	Y	N
7. I was shown or given a copy of all assessment reports written by the professionals.	1	2	3	4	5	1	2	3	4	5	Y	N

PART #3: DEVELOPING & WRITING INTERVENTION PLANS

THE FAMILY REPORT

According to the law, every child and their family receiving early intervention services must have a new intervention plan (IFSP or IEP) written every year. Among other things, the intervention plan must include the goals for your child and family (what will be worked on) and the strategies for accomplishing goals (services provided, teaching methods, or activities). Please think about how the last intervention was developed for your child and family in rating the following statements.

Statement	Do You Agree or Disagree?					How Important is This to You?					I Feel Informed About This Issue.	
	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Not Important	Somewhat Important	Important	Very Important	Critical	Yes	No
1. Staff members made it possible for me to be present at all discussions about the intervention plan developed for my child and family.	1	2	3	4	5	1	2	3	4	5	Y	N
2. My child's intervention plan only includes goals that I think are important.	1	2	3	4	5	1	2	3	4	5	Y	N
3. Most of the goals written on my child's intervention plan can probably be accomplished over a year's time.	1	2	3	4	5	1	2	3	4	5	Y	N
4. Staff members listened to my ideas about ways to teach my child or how I think my child learns best.	1	2	3	4	5	1	2	3	4	5	Y	N
5. Staff members offered me choices about the types of services my child and family could have.	1	2	3	4	5	1	2	3	4	5	Y	N
6. Staff members gave me information about ways to meet goals they identified but that could not be met by the services their program offers (e.g., continuing education, marriage counseling, financial assistance, employment).	1	2	3	4	5	1	2	3	4	5	Y	N

PART #4: SERVICES PROVIDED TO YOUR CHILD AND FAMILY THE FAMILY REPORT

In rating the following statements, please think about the ongoing interactions you have with the staff members of the program your child is enrolled in, as well as the types of services that are offered by the program.

Statement	Do You Agree or Disagree?					How Important is This to You?					I Feel Informed About This Issue.	
	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Not Important	Somewhat Important	Very Important	Critical	Yes	No	
1. Staff members tell me that they appreciate the knowledge, skills, and creativity I use in caring for and teaching my child.	1	2	3	4	5	1	2	3	4	5	Y	N
2. Staff members always say something positive about my child.	1	2	3	4	5	1	2	3	4	5	Y	N
3. Other staff members (speech therapist, physical therapist, psychologist) are available to talk to me when I want them to.	1	2	3	4	5	1	2	3	4	5	Y	N
4. The early intervention program provides opportunities for other members of my family to be involved in my child's intervention program if I want them to be (for example, husband/wife, siblings, grandparents).	1	2	3	4	5	1	2	3	4	5	Y	N
5. The early intervention program provides opportunities for me to get information related to children with special needs that might be of interest to me or other members of my family (books, journals, newsletters, legislation reports, conference announcements, special speakers, research articles, videotapes).	1	2	3	4	5	1	2	3	4	5	Y	N

Part #4B: Services Provided to Your Child and Family Continued

Statement	Do You Agree or Disagree?					How Important is This to You?					I Feel Informed About This Issue.	
	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Not Important	Somewhat Important	Important	Very Important	Critical	Yes	No
1. The early intervention program provides me with ideas of how to participate in recreational activities with my child.	1	2	3	4	5	1	2	3	4	5	Y	N
2. The early intervention program provides me with recreational activities for my child and I to participate in.	1	2	3	4	5	1	2	3	4	5	Y	N
3. The early intervention program provides me with guidance of what I should do when my child misbehaves.	1	2	3	4	5	1	2	3	4	5	Y	N
4. The early intervention program provides me with ideas of better ways to communicate with my spouse or significant other about issues concerning my child with special needs.	1	2	3	4	5	1	2	3	4	5	Y	N
5. The early intervention program provides me with ways to cope with my friends and family in relation to my child with special needs.	1	2	3	4	5	1	2	3	4	5	Y	N
6. The early intervention program provides me with social events for me to participate in with other families with child with special needs.	1	2	3	4	5	1	2	3	4	5	Y	N
7. The early intervention program holds workshops (hands on) to provide me with information about my child with special needs.	1	2	3	4	5	1	2	3	4	5	Y	N
8. The early intervention program provides me with opportunities for group discussions with other parents with children with special needs.	1	2	3	4	5	1	2	3	4	5	Y	N

Appendix C
Participants Information Survey

Please circle the best available answer (unless otherwise indicated). Only answer questions you feel comfortable answering but you are urged to complete as many as possible.

1. How old is your child with special needs? _____
2. What is the gender of your child with special needs?
 - a. Male
 - b. Female
3. Does that child live with you?
 - a. Yes
 - b. No
4. How long has your child with special needs been receiving early intervention services? _____
5. How many hours a week on average do you spend with your child with special needs (this may include play time, care-taking time, etc.)? _____
6. How many hours a month on average do you spend with your early intervention service providers? _____
7. How many hours a week on average does your child receive early intervention services? _____
8. Which of the following describes your relationship with the mother of the child with special needs?
 - a. married
 - b. widowed
 - c. divorced
 - d. separated
 - e. not involved
 - f. committed relationship
 - g. other _____
9. What is your relationship to your child with special needs?
 - a. Natural Father
 - b. Adoptive or Foster Parent
 - c. Stepfather
 - d. Grandfather
 - e. Other relative
 - f. Other _____

10. How many children do you have? _____
11. What is the highest level of education you have completed?
- 8th grade or less
 - partially completed high school (9th, 10th or 11th grade)
 - high school graduate
 - vocational/technical school degree program
 - associates degree
 - bachelors degree
 - masters degree
 - doctoral program or beyond
12. What is your present age? _____
13. What is your family's average yearly income?
- Less than \$15,000
 - \$15,001 – \$25,000
 - \$25,001 – \$35,000
 - \$35,001 – \$50,000
 - \$50,001 - \$75,000
 - \$75,001 - \$100,000
 - \$100,000 or greater
14. What describes your current working situation? (Circle all that apply)
- Full Time
 - Part Time
 - Presently Not Working
 - At Home
 - At an Office
 - More than One Job
15. I am satisfied with my access to the services that are available to me.
- | | | | | |
|------------|-----------|---------|-----------|-----------|
| Not At All | Not | | | Very |
| Satisfied | Satisfied | Neutral | Satisfied | Satisfied |
| 1 | 2 | 3 | 4 | 5 |
16. Considering all factors, how satisfied with your early intervention program are you?
- | | | | | |
|------------|-----------|---------|-----------|-----------|
| Not At All | Not | | | Very |
| Satisfied | Satisfied | Neutral | Satisfied | Satisfied |
| 1 | 2 | 3 | 4 | 5 |

17. I feel that the responsibility of educating my child with special needs is:
- a dual responsibility of both parents
 - the child's mother's responsibility
 - my responsibility
 - a dual responsibility of both parents and the school
 - a dual responsibility of the child's mother and the school
 - a dual responsibility of myself and the school
 - the school's responsibility
 - other: _____
18. I am interested in participating in services offered by my early intervention program for fathers.
- Yes
 - No, primarily because

The following questions pertain to the child's mother/guardian. Please answer them to the best of your ability.

19. What is the highest level of education that your child's mother/guardian has completed?
- 8th grade or less
 - partially completed high school (9th, 10th or 11th grade)
 - high school graduate
 - vocational/technical school
 - associates degree
 - bachelors degree
 - masters degree
 - doctoral program or beyond
20. What is the age of this child's mother/guardian? _____
21. What describes your child's mother/guardian's current working situation?
(Circle all that apply)
- Full Time
 - Part Time
 - Presently Not Working
 - At Home
 - At an Office
 - More than One Job

Appendix D
Tear-Off Informed Consent

As part of my graduate research in occupational therapy, I am conducting a study to gain a greater understanding of fathers' needs in early intervention care. This is important to ensure that the whole family is being served under the model of family-centered care in early intervention. Learning more about fathers' needs will help service providers structure their care to better encompass the whole family. I am asking you to fill out the two attached surveys. It should take you no more than 45 minutes to complete the two surveys. Please only complete these surveys if you are the father (male individual involved in the life of the child with special needs) and are at least 18 years of age. You may withdraw from the study at any time.

When you have completed the surveys please return them in the enclosed self addressed stamped envelope. Do not write your name anywhere on the surveys or the attached envelope.

Please tear off this cover page and keep it for your records. Thank you for your help with this research.

Jane McGowan, BS, OTS
Occupational Therapy Department
Ithaca College
(607) 277-6427



Your Partner for a Healthy Community

Children with Special Care Needs Programs
401 Harris B. Dates Drive
Ithaca, NY 14850
(607) 274-6644

Dear Father:

The Tompkins County Health Department is working in cooperation with Jane McGowan, graduate student in occupational therapy at Ithaca College to research fathers' perceptions of services in the early intervention program.

Current research contains a limited understanding of fathers' needs. This research project will help providers to better understand your role in the family and your needs in relation to the services provided by early intervention care practitioners.

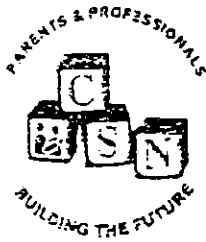
Jane is hoping to involve fathers (the adult male individual involved in the child's life) of children with special needs from central New York as participants in this research study. Your participation in this project will be greatly appreciated.

I encourage you to take a few minutes to review Jane's cover letter, surveys and consent forms. If you are interested in participating in this anonymous project please review the letter of consent and fill out each survey. They need to be returned to Jane McGowan in the stamped returned addressed envelope by no later than January 21, 2002.

Thank you for your cooperation with this study. Jane will look forward to your responses. If you have any questions or concerns about participation or the study itself please feel free to call Ellen Brazauskas at 274-6644 or Jane McGowan at 277-6427.

Sincerely,

Ellen Brazauskas, RN, EIOD
Supervisor Community Health Services



Children With Special Needs Division Early Intervention Program

Cortland County Health Department
60 Central Avenue ♦ Cortland, New York 13045-2746
Phone: 607-756-3439 ♦ Fax: 607-753-5136

Dear Father:

The Cortland County Health Department is working in cooperation with Jane McGowan, graduate student in occupational therapy at Ithaca College to research fathers' perceptions of services in the early intervention program.

Current research contains a limited understanding of fathers' needs. This research project will help providers to better understand your role in the family and your needs in relation to the services provided by early intervention care practitioners.

Jane is hoping to involve fathers (the adult male individual involved in the child's life) of children with special needs from central New York as participants in this research study. Your participation in this project will be greatly appreciated.

I encourage you to take a few minutes to review Jane's cover letter, surveys and consent forms. If you are interested in participating in this anonymous project please review the letter of consent and fill out each survey. They need to be returned to Jane McGowan in the stamped returned addressed envelope by no later than February 15, 2002.

Thank you for your cooperation with this study. Jane will look forward to your responses. If you have any questions or concerns about participation or the study itself please feel free to call Cathy Feuerherm at 756-3439 or Jane McGowan at 277-6427.

Sincerely,

A handwritten signature in cursive script that reads 'Cathy Feuerherm'.

Cathy Feuerherm
Director of the Children with Special Needs Division
Cortland County Health Department