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ABSTRACT

The monograph presents essential components of a decision making sequence used to incorporate formalized family assessment and service planning procedures into two existing early intervention programs in Massachusetts. The 1-year effort used a consultant to: (1) redefine screening and assessment processes to include both child and family centered dimensions; (2) identify and critically evaluate formalized instruments used to assess family needs and strengths; (3) develop alternative individual family service plan (IFSP) formats; and (4) develop revised intake, screening, diagnostic, and service planning processes which reflect statutory requirements, contemporary research findings, and best clinical judgement. The monograph contains six sections and appendixes. After an introduction and overview, Part II looks at the context for family assessment and intervention including Public Law 99-457 and research findings. Methods of reviewing and analyzing family assessment instruments are presented in Part III with sections on classes of available measures and criteria for test selection. Discussed in Part IV are implications of family assessment for program organization and design. Part V considers development of an IFSP format, and Part VI briefly notes training/technical assistance implications. Seven appendices provide information on measures of social support and family behavior, significant life stressor scales, and quality of caregiving environment scales. Contains a list of over 100 references. (DB)

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I. INTRODUCTION AND OVERVIEW

Concern and interest for young children and their families have reached unparalleled levels of prominence within the past two years. This amplified attention to the early childhood period originates from multiple sources. Research advances in the field of infant behavior have resulted in improved understanding of the learning capacities of newborns, the role of perinatal risk in compromising growth and development, and the enormous impact of life experiences on the psychologic development of the infant. Until recently, many parents were led to believe that their infants could not taste fluids, were incapable of sensing odors, and experienced marginal feeling of pain. Studies have indicated that, in fact, neonates are excellent discriminators of taste, and can detect their own mother's fragrance by four days of age (Lipsitt, 1986).

Dramatic changes are also evident in the prevalence of families within which a parent assumes child care responsibilities on a full time basis. More precisely, while approximately 34% of all mothers of children less than three years of age were engaged in positions outside of the home in 1975, the corresponding figure for 1986 is 51%. Similar increases are noted for mothers of children three to five years of age as well, and projections indicate that approximately 70-80% of mothers of preschool children will become members of the work force in the next decade (U.S. Department of Labor, 1987). These trends have prompted several lines of interesting and controversial research inquiry (Belsky, 1985; Belsky and Steinberg, 1979) which though inconclusive, have added impetus to the overall concern.

Mass publications have also contributed to the visibility of the issue by featuring cover stores on the amazing capacities of infants. A recent issue of Time magazine asked of newborns: "What do they know?", "When do they know it?" Child care and family issues have become so substantive that they

also currently assume a dominant role in political platforms and agenda, and articulating a "vision" which regards and strengthens commitments to children and families is no longer considered unique but rather essential.

Central to the escalation in interest in young children has been a significant acknowledgement of special needs infants, toddlers, and their families. This attention has both empirical as well as legislative underpinnings. Numerous studies published within the last decade have identified both short term as well as persevering benefits of early intervention services (Berrueter-Clement, 1984; Garland, 1981; McNulty, 1983; Schweinhart, 1980). While there remain several instrumentation, methodological, and sampling complexities. nevertheless, the prevailing mentality is that early intervention programs constitute a powerful habilitative and preventative force.

So persuasive has the body of literature become that the re-authorization of the Education of the Handicapped Act in 1986 (P.L. 99-457; Part H.) included provisions for states to launch major program development initiatives, underwritten by the Federal Government, such that by 1991, a comprehensive, national early intervention system would result. While this legislation granted states considerable latitude in conceptualizing and articulating a system, it did prescribe fourteen essential components which must be represented in each statewide plan, including such issues as a definition of the population to be served, continuum of child and family services, intra and interagency case management processes, comprehensive system of personnel development, and child surveillance procedures.

A stipulation in the legislation which perhaps has prompted greatest attention relates to conducting family assessments and developing individualized family service plans (IFSPs) for each child and family served by an EI program. In brief, the statute requires the creation of policies which provide

for an evaluation of family needs to assist in the development of infants and toddlers, and to generate an IFSP which portrays child and family needs and strengths, and the manner in which those needs will be met. In acknowledgement of the enormous complexity of this process, and also of the need for an information base upon which meaningful policy could be crafted, the Department of Public Health, which serves as the lead administrative agency for early intervention (EI) services in Massachusetts, collaborated with two existing programs and a consultant, Thomas T. Kochanek, Ph.D., in order to embark upon a program development and field trial experience which would systematically and thoughtfully address the following representative family assessment and service planning questions.

1. What family traits and/or circumstances are most indicative of current need for service and furthermore, are powerful predictors of special needs in children subsequent to school entry?

2. What standardized measures exist to assess these traits and/or circumstances?

3. Given the adoption of these measures in select EI programs, how many children and families would be deemed eligible for service?

4. Given the children and families identified, what services are most appropriate and responsive to their needs? Do these needs necessitate an expansion of the existing EI continuum of services?

5. Given the identified needs and service required, what alternative means exist for documenting, monitoring, and evaluating services within the context of the IFSP?

Since January, 1987, the entire staff of two EI programs have had ongoing meetings with the consultant in order to; (1) re-define screening and assessment processes which include both child and family centered dimensions; (2) identify and critically evaluate formalized instruments used to assess family needs and strengths; (3) develop alternative IFSP formats which are congruous with definitions and select instruments; and (4) develop revised intake, screening, diagnostic, and service planning processes which reflect statutory requirements, contemporary research findings, and best clinical judgement. Each program has, in fact, generated a data collection and IFSP process which was initiated in February, 1988.

The primary purpose of this monograph is to convey the essential components of a decision making sequence used to incorporate formalized family assessment and service planning procedures into existing EI programs. It is critical to note that the intent of this document is not to impose or recommend adoption of a specific approach, but rather to convey those sequential activities and decisions which are critical to the development of responsible practices. As such, the organization and content of this document reflects both information and a series of questions which should assist in guiding programs through this decision making framework.

It is also important to note that incorporating family assessment and service planning activities into EI programs is not an isolated activity, but rather a process which prompts complex questions regarding the intent and design of early intervention services. For example, evaluating family assessment measures cannot occur independent of legitimate queries which examine existing eligibility criteria and the manner in which services are configured on behalf of specific children and their families. As a result, the decision making process must move beyond simple instrumentation searches, and permit

exploration of attitudinal, philosophical, and professional differences regarding the primary mission of early intervention, its target population, and its range of appropriate services.

Finally, the feasibility of including sample protocols of all instruments reviewed extends far beyond the capability of this document. As an alternative, representative instruments and complete references are included which will hopefully eventuate in efficient and economic implementation of recommended practices.

II. CONTEXT FOR FAMILY ASSESSMENT AND INTERVENTION

A. Historical Overview of Services to Families in Early Intervention

In reviewing the roles which families assumed in early intervention programs within the last decade, it becomes apparent that while the importance of family involvement was acknowledged, this participation typically focused upon the adjunctive role of parents in the development and education of their children (Guralnick and Bennett, 1987). In certain instances, parents assumed major instructional responsibilities, with the content and direction of activities determined primarily by various professionals. In other cases, parents were expected to "generalize" the center based program into the home, and reinforce skills which were a core ingredient in the intervention curriculum. Parents were also provided with information on community services, usually in a group format. These services were provided with minimal variation, and led Bristol and Gallagher (1982) to comment that "it is not unusual to visit programs for high risk or handicapped infants that have highly individualized programs for each infant, but only a single package for involving parents" (p. 149).

The etiology of this preoccupation with child competence is attributable, in large part, to the language and expectations of P.L. 94-142 (1975), originally crafted for school age children. Inherent within the initial version of the Act was an emphasis upon assessment of learning and behavioral deficit, with intervention directed only to those diagnosed deficiencies. So powerful was this message that special educators devoted countless hours to identifying weaknesses, and to designing instructional activities which eliminated or altered these deficiencies. These heroic efforts were documented in the individualized education program (IEP).

A second contributing factor relates to the paucity of available standardized tools useful for evaluating family functioning. Many instruments do not meet even minimally acceptable psychometric standards, and more importantly, are designed (theoretically and clinically) to identify the pathological basis of dysfunctional family interactions. This information has not been useful in developing child centered objectives and furthermore, most EI programs do not assume the psychotherapeutic identity which is embodied in many of these scales.

Finally, the majority of university based training programs, irrespective of academic discipline (e.g., education, physical therapy, speech and language pathology), emphasize the acquisition of competencies which pertain only to assessing and intervening with children, not their primary caregivers. As such, both experientially and attitudinally, clinicians manifest a child centered approach to the exclusion of examining family needs, resources, capabilities, and support systems.

B. P.L. 99-457 (Part H.) Stipulations

As indicated earlier, the Education of the Handicapped Act amendments in 1986 urge states to "develop and implement a comprehensive, coordinated multidisciplinary, interagency program of early intervention services for handicapped infants, toddlers, and their families." States are afforded a two year planning period during which time policies are to be developed that ensure an "evaluation of the function of each handicapped infant and toddler and the needs of families to appropriately assist in the development of the child." Each child and family served will have an IFSP comprised of the following information.

1. A statement of the infant's or toddler's present levels of physical development, cognitive development, language and speech development,

psycho-social development, and self-help skills, based on acceptable objective criteria.

2. A statement of the family's strengths and needs relating to enhancing the development of the family's handicapped infant or toddler.

3. A statement of the major outcomes expected to be achieved for the infant and toddler and the family, and the criteria, procedures, and timelines used to determine the degree to which progress toward achieving the outcomes are being made and whether modifications or revisions of the outcomes or services are necessary.

4. A statement of specific early intervention services necessary to meet the unique needs of the infant or toddler and the family, including the frequency, intensity, and the method of delivering services.

5. The projected dates for initiation of services and the anticipated duration of such services.

6. The name of the case manager from the profession most immediately relevant to identified needs of the child and family who will be responsible for the implementation of the plan and coordination with other agencies and persons.

7. The steps to be taken supporting the transition of the handicapped toddler to services provided by school districts.

C. Research Findings

1. Predictive Validity Studies

More than a century ago, one of the first studies was made regarding the relationship between early medical events and subsequent appearance of various

handicaps (Little, 1861). Ensuing years have witnessed a number of investigations which have attempted to isolate factors predictive of subsequent learning and/or behavioral competency. In predicting intellectual functioning for example, studies using single predictor variables such as anoxia (Corah et al., 1956), prematurity (Wiener, 1962), and neurological status (Parmelee and Michaelis, 1971) have shown little or no correlation with subsequent measures of intelligence.

Other studies that have examined isolated factors as well as the interaction of multiple indices report results only marginally more encouraging (Denhoff, Hainsworth and Hainsworth, 1972; Levine et al., 1977). Similarly, Sigman and Parmelee (1979) found that even using a wide range of risk variables (e.g., obstetrical complications, newborn neurological examination, visual attention, Gesell Developmental Scales), the categorization of infants based on the risk score system had limited predictive value with respect to later measurement of mental, motor, and language indices. In short, longitudinal developmental predictions based upon constitutional factors alone are weak and inaccurate.

What becomes apparent therefore, is that a child's development cannot be predicted independent of caretaking experiences. Powerful cross-cultural evidence by Susser et al. (1985) underscore the impact of social environment on mental performance in that epidemiologic surveys in Sweden have discovered the prevalence of severe developmental disabilities to be approximately .3%, comparable to rates observed in the United States. Conversely, the prevalence of mild mental retardation in Sweden is about .4%, ten times lower than rates reported in the United States.

Recent studies which have compared the predictive power of child centered measures with ecological factors (Bee et al., 1982; Mitchell et al., 1985; Siegel, 1985) have suggested that: (1) isolated measures of child performance,

particularly prior to 24 months of age, are of little utility in predicting subsequent behavior; and (2) environmental factors and parent/child interaction (Home; Caldwell and Bradley, 1976) have greater power in predicting the occurrence of cognitive, language, and motor deficiencies in school age children. Other investigations (Kochanek et al., 1987; Broman et al., 1985; Nichols and Chen, 1981) have also identified the critical role of ecological factors, specifically maternal education, as a statistical determinant of learning, behavioral, and cognitive deficiencies. Fortunately, recent studies have moved beyond such static indicators (e.g., level of educational attainment) and have begun to articulate the processes and maternal behaviors which relate to subsequent child competence (Dunst et al., 1987; Barnard and Bee, 1985; Mitchell et al., 1985).

Finally, Sameroff et al. (1987) has offered additional insight into multiple risk models by examining the impact of ten factors on verbal IQ scores derived at four years of age. Specific risk factors included such conditions as maternal anxiety and mental health, stressful life events, family social support, occupation and education levels, and mother/child interactive behaviors. Results indicated that as the number of risk factors increased, intellectual performance decreased, with the difference between the lowest and highest groups being approximately 30 IQ points. Of greatest interest is that no child centered information was entered into the multiple risk analyses, yet the two groups noted above differed by about two standard deviations.

Significant implications of the above data are as follows.

1. Early detection and intervention efforts must broaden in definition and scope. The degree of risk or the severity of potential developmental disability for infants cannot be accurately predicted by the occurrence of any one traumatic prenatal or neonatal event. Studies

that have followed a medical model of disease, attempting to identify a linear relationship between cause and outcome, have produced disappointing results. In fact, evidence suggests that selecting children for programs based upon isolated factors (e.g., SES) provides no assurance that those most in need will be served.

2. Screening models must include sources of data beyond that presented by the child alone. Longitudinal studies report complex interactions between a child's physical, neurological, and developmental status and the environmental context within which a child is reared (Werner et al., 1971). Assessing newborn and early developmental status is of equivalent importance to caregiver response and adaptation to the developing child.

3. Surveillance programs should be serial in their operation. Because of the instability of findings reported in several studies (Levine et al., 1977), screening outcomes should not be simply binary in nature (i.e., refer for diagnostic testing; exit from system), but rather reflect an ongoing process with the frequency and content of examination determined by the type and extensiveness of special need revealed through multi-factorial screening data.

Overall, research findings from predictive validity studies may be succinctly summarized as follows.

1. Screening/assessment models must include sources of data <u>beyond</u> child competence measures and/or traumatic prenatal and neonatal events.

2. Screening/assessment models must include ecological factors both at the <u>macroscopic</u> (e.g. maternal education) and <u>microscopic</u> (e.g.,

maternal/child interaction; family needs/resources/support systems) levels.

3. Screening/assessment models must be serial and multivariate in design, and reflect an ongoing process which discriminates between transient and permanent problems and takes into account child/environment transactions.

2. Program Efficacy Studies

Due to the extreme variability which exists within and among early intervention programs, it is extraordinarily difficult to advance unequivocal statements concerning the effectiveness of EI services (Simeonsson et al., 1982). For example, the definitions of handicapped and high risk populations are often ambiguous, and do not adequately account for severity dimensions or the presence of additional, secondary disabling conditions. Secondly, many studies lack adequate detail regarding the precise nature of the treatment provided and therefore, definitive findings about what works for whom, and under what conditions, continues to elude specificity. Yet another confounding factor methodologically relates to inadequate attention devoted to the selection of proper comparison groups as well as random assignment techniques.

One of the most significant limitations of efficacy studies conducted to date is a preoccupation with child level of functioning (Shonkoff and Hauser-Cram, 1987). While parental lack of knowledge or cognitively and emotionally impoverished parent/child interactional patterns have been the target of behavioral interventions of EI programs, the effects of these treatments have not been systematically examined. Despite this empirical void, impressive data exist which imply that perinatal complications have a greater impact on later development for children raised in poor environmental conditions (Werner, 1977)

and as such, underscore the need for determining outcomes on caregiving environments in additional to child developmental competence.

While the threats to internal validity (Campbell and Stanley, 1966) noted above cannot be minimized, it is important and also possible to attempt to identify efficacious program elements which are robust across studies, and to galvanize isolated bits of evidence which, when viewed as a gestalt, assist in identifying significant findings and charting a meaningful course of future inquiry. To this end, what follows is a very brief overview of efficacy literature pertaining to environmental, biological, and established risk children with particular emphasis upon areas of family functioning which have been associated with enhanced child outcomes, and thus are worthy of attention in conceptualizing family assessment processes.

Programs for Environmentally At Risk Children

The majority of programs in this cluster of studies have served children from socially, educationally, and economically disadvantaged families. Most of the children who participated in these programs represented minority populations residing within urban areas. Programs typically began at infancy and extended through the preschool period.

With respect to child outcome, of the nine studies (Bryant and Ramey, 1987) which reported serial IQ scores, six revealed statistically significant differences between experimental and comparison groups. Of greater importance is the fact that infancy intervention projects support an intensity hypothesis; that is, home visits alone did not substantially alter intellectual development at age two. However, home visits in addition to medical and educational intervention or parent focused training produced moderate effects on IQ. Furthermore, providing day care plus family services were associated with the greatest improvement in intellectual development.

With respect to long term effects, the Consortium for Longitudinal Studies (Lazar et al., 1982) conducted a 20 year follow up study of project participants and reported three principal findings: (1) program recipients were less likely to be retained or referred for special education services; (2) experimental group children were more achievement oriented; and (3) enrolled parents had higher educational and occupational aspirations for their children than control families. Similar findings were reported by Schweinhart and Weikart (1980) who indicated that program graduates were employed more often, had higher incomes, and made less use of public assistance programs that did comparison groups.

In summary, data appear to suggest that children from socially disadvantaged families benefit intellectually from sustained and comprehensive alterations of the caregiving environment. Data also appear to support a transactional hypothesis in that infant intellectual behavior can be modified with the acquisition and application of specific competencies by primary caregivers. As such, cognitive development can be potentially influenced by systematic efforts aimed at the dyadic interactional system of infants and their caregivers.

Programs for Biologically At Risk Children

While the low birthweight neonatal intensive care unit (NICU) graduate is the most prevalent constituency in this cohort, other common at risk conditions include perinatal asphyxia, central nervous system infection and/or trauma, and sustained hypoxia. Clearly, the concept of elevated risk must be viewed judiciously since, for the majority of biologic insults, most infants will not manifest the developmental complications for which they have increased risk (Scott and Masi, 1979).

In reviewing neonatal intervention programs, it becomes apparent that there has been a shift away from exclusively newborn and infant directed models, common prior to 1980, toward a more family centered approach which emphasizes and facilitates parent/infant exchanges. Interventions aimed at enhancing such dyadic interactional patterns have multiple expressions, typically including a component of infant "readiness" for contact, and also a section on parent instruction in initiating and maintaining an appropriate dialogue with the newborn.

A comprehensive review of 17 neonatal developmental intervention studies (Bennett, 1987), which included primarily interventions occurring during hospitalization, revealed equivocal findings. Examining dependent measures which included developmental, medical, and parental outcomes, data reported suggest that positive effects are generally short term, with subsequent developmental differences rarely reported at one year of age. While the methodological compromises described earlier have adversely affected these findings, the accumulated evidence does not yield a verified set of intervention recommendations. At the clinical level however, it would appear that programs which attempt to facilitate effective parenting strategies which incorporate extended home visitation and follow up components have the greatest likelihood of achieving meaningful results. Moreover, interventions which focus upon teaching parents methods of caregiving, and altering their perceptions, attitudes, and behaviors appear to promote developmental strides which further reinforce and elicit behaviors necessary for fostering growth and development (Field, 1982).

Programs for Established Risk Children

Despite wide variation in etiology, children of established risk present with impairments in cognition, information processing, and problem solving

accompanied by delays in motor, communication, language and socio/emotional development. This population can be further sub-divided into those with Down Syndrome vs. children with global developmental delay, presumably due to biologic origin, and associated disorders such as cerebral palsy and sensory deficiencies.

For children with Down Syndrome, studies have repeatedly discovered that declines over time in cognitive performance can be significantly reduced or entirely eliminated during the period in which early intervention services are provided (Hanson and Schwarz, 1978, Kysela et al., 1981; Rynders and Horobin, 1980). While an inadequate number of followup studies have been conducted to date relative to the perseverance of this positive effect, it appears indisputable that programs can stabilize development in Down Syndrome infants and toddlers, and provide a model to ensure continuous progression of these children, regardless of their entry level abilities.

With respect to the etiologically heterogeneous group of globally delayed children with verifiable biological bases, a series of 14 studies (Guralnick and Bricker, 1987) reveal inconsistent findings. While this group of studies appears to be more adversely affected by the methodological problems noted earlier, nevertheless, data suggest only modest gains in general areas of development, with virtually little or no attention devoted to parental outcomes.

Overall, evidence suggests that the decline in intelligence with increasing age which has been observed with Down Syndrome children can be prevented; data are less dramatic for infants whose delays are attributable to a biological basis. From a programmatic perspective, important dimensions to consider include social support networks (O'Connor, 1983), and program designs which are somewhat less artificial and isolated but rather rely more upon established family routines and priorities.

In addition to the above studies, Carl J. Dunst and his colleagues have launched a creative, comprehensive programmatic research effort which has focused upon the role which social support plays in promoting adaptations to the rearing of special needs children. In brief, Dunst et al. (1987) postulate that social support has direct and indirect influences on parent well-being, family integrity, parent/child interactions, and child behavior and development. Dependent measures in these studies have included parental well-being and coping, family integrity and adaptations, parental styles of interaction, and child developmental competence. Studies have indicated (Dunst et al., 1988) that social support not only accounts for a significant amount of variance in the dependent measures, but also proves to be the most significant mediating variable, even when compared to parent and child characteristics and formal (i.e., professional) sources of support.

Additional studies exist (Trivette and Dunst, 1986) which provide further substantiation that health and well-being, time demands placed upon the parents by the child, family integration, and parent perceptions of child functioning were, in part, affected by the helpfulness of a family's informal social support network. Overall, these and other studies (Cohen and Syme, 1985; Crnic et al., 1983) have found that support plays a significant role in affecting parent, family, and child functioning, and adds to a growing body of evidence which suggests a family systems perspective to assessment and intervention.

Finally, in a meta-analytic evaluation of 31 studies which examined the effects of EI services on handicapped children, Shonkoff and Hauser-Cram (1987) reported that not only were services effective in prompting child developmental progress, but also that the most successful programs included those which directed intervention at parent/infant dyads as well as revealed purposeful, extensive opportunities for parent involvement.

In summary, a review of program efficacy literature for special needs infants and toddlers reveals the following principal implications.

1. Programs for special needs children in which planned, extensive parental involvement occurs show significantly greater effects than programs with little or no parental participation.

2. Programs for special needs children which target their efforts on parents and children together appear to be more successful than programs which work with either parents or children in isolation.

3. Intervention projects for environmentally at risk infants/toddlers support an intensity hypothesis and also indicate that day care and family intervention seem to account for the most significant gains in cognitive abilities.

4. Studies have found that social support plays a significant role in affecting parent, family, and child functioning, and can buffer the effects of both infancy risk and stressful life events.

III. REVIEWING AND ANALYZING FAMILY ASSESSMENT INSTRUMENTS

A. Classes of Available Measures

Consistent with predictive validity and program efficacy studies presented, four areas of family functi : ng appear to have demonstrated value and impact; these respective areas include:

Family Needs, Resources, and Strengths

Social Support Network

Significant Life Stressors

Characteristics of the Caregiving Environment

It is critical to note that a wide array of standardized family assessment instruments exist which are not reflected in the above domains. While several of these measures present adequate psychometric characteristics and have been used in numerous research applications, their utility within an IFSP context remains untested. For example, the Family Environment Scale (Moos and Moos, 1981) is a measure of social climate which focuses upon the description of interpersonal relationships among family members, directions of personal growth emphasized in the family, and on the basic organizational structure of the family. Similarly, the Family Assessment Device (Epstein, Bishop and Baldwin, 1982) is an instrument designed on the premise that individual behavior cannot be evaluated independent of the family unit and in fact, individual dysfunction emanates from family dysfunction. The common denominator among such i .stru-ments is the orientation to underlying pathology, and thus, the goal of assessment is to identify the specific nature of these pathological mechanisms such that therapeutic intervention may be directed to these deficit areas. Again, while these instruments have been widely used for planning and evaluating therapeutic intervention with families, clearly, EI programs must critically evaluate not only the theoretical and philosophical bases of such

instruments, but also assess the extent to which they yield information which assists in functional decision making (e.g., screening, program eligibility, IFSP content).

It is also important to reiterate that the intent of this monograph is not to recommend adoption of specific measures, but rather to convey information and a process through which programs can reach thoughtful decisions regarding family assessment and IFSP processes. To this end, complete reference documents (Dunst and Trivette, 1985; Dunst et al., 1987; Olson et al., 1982) must be consulted, however to facilitate the review process, a matrix of measures of social support and family behavior (Dunst and Trivette, 1985) is included in Appendix A. in addition to reliability and validity data in Appendix B. It must be emphasized that this is not intended to serve as an end point, but rather a stimulus for a comprehensive search and analysis.

What follows is a brief overview of the skills and factors represented within each of the above domains as well as select, representative instruments within each area.

1. Family Needs, Resources, and Strengths

Bronfenbrenner (1975) has convincingly argued that while "intervention programs must place major emphasis on involving the parent directly in activities fostering the child's development, many families live under such oppressive circumstances that they are neither willing or able to participate; inadequate health care, poor housing, lack of education, low income, and the necessity for full time work rob parents of time and energy to spend with their children (pp. 465-466). As a result, the goal of family assessment and service planning (Hobbs et al., 1984) should be to identify unmet needs, and assist in ensuring access to community based services which coincide with these needs.

Dunst et al. (1987) have impressively articulated and translated this recommendation into a needs based family assessment and intervention process. In brief, this process regards the family and not the child as the unit of intervention, and is designed to identify needs and aspirations expressed by families, not inferred by professionals, as the focus of intervention. Subsequent to parent articulation of family needs, primary emphasis is placed upon amplifying the family's formal and informal social support network as the vehicle through which these needs will be met. Accordingly, a unique shift is required in the manner in which professionals fulfill their responsibilities; that is, roles which engender less direct intervention around needs, and more focus upon alternative ways in which needs can be met independently by families. As such, adoption of this perspective requires a re-analysis of the way in which programs define their help-giving responsibilities and behaviors.

Within this model, the four operational components include: family needs and aspirations, family strengths and capabilities, social support network, and inventory of resources. The help giving behaviors employed by professionals are intended to "enable and empower" families to use and/or develop skill in order to secure resources for meeting needs. Needs may be identified through structured interview techniques or needs-based assessment scales, however, in all instances, the process highly regards the family's perspective in defining current needs and future directions.

Abstracted below are a variety of needs based instruments which reflect this model; actual protocols are included within Appendix C. It is crucial to note that as these measures and specific items are reviewed, it is imperative to anticipate, describe, and resolve the complications inherent within the adoption of such instruments. For example, needs are as dynamic and fluid as are families; consequently, the assessment process becomes much more of an ongoing process rather than a static, annual event, and this may prompt the

need for a re-examination of the assessment and IFSP process, transdisciplinary team meetings, clinical supervisory practices, and time frames associated with assessment and IFSP completion. Secondly, conflicts are likely to occur between family vs. professionally determined needs and goals, and therefore, strategies must be created which resolve such areas of disagreement.

Family Resource Scale (Leet and Dunst, 1987)

The Family Resource Scale (FRS) is a self-report inventory designed to measure the adequacy of resources in households with young children. The scale has 31 items which are ordered from most to least basic, and for each, a five point Likert scale expresses the severity of each need. Therefore, beyond the qualitative, clinical outcome data, two quantifiable expressions are derived: (1) total number of needs, and (2) perceived severity of identified needs.

Resource Scale for Teenage Mothers (Dunst, Leet, Vance, and Cooper, 1987)

The Resource Scale for Teenage Mothers is substantially similar to the FRS in design, content, and purpose; its unique feature is that it includes select items which are most likely to affect households of adolescent mothers. The outcome data derived from this measure are identical to those emanating from the Family Resource Scale.

Family Needs Scale (Dunst, Cooper, Weeldreyer, Snyder, and Chase, 1987)

The Family Needs Scale measures the extent to which a family has a need for various forms of resources and support. The scale includes nine categories of need (e.g., food and shelter, financial, child care, transportation) which are expressed by 41 items, each rated on a five point scale. Outcome data include total number of need areas in addition to the perceived importance of expressed needs. The FNS was specifically designed for intervention purposes

and as such, is particularly helpful in eliciting family identified needs which can then prompt discussion and further elaboration of expressed needs as well as alternative ways in which needs can be resolved.

A Survey of Family Needs (Bailey and Simeonsson, 1985)

A Survey of Family Needs is a checklist completed by parents which attempts to elicit information regarding essential needs including finances, social support, information regarding community based services, and overall family functioning and methods of conflict resolution. Major features of this questionnaire include its ease of completion, and items which are functional and have broad based applicability. In addition, the items provide useful prompts in quickly identifying unmet needs, and in providing opportunities for parents to elaborate on these needs and the ways in which assistance has been and/or could be provided.

The Coping Inventory (Zeitlin, 1985)

The Coping Inventory is based upon a transactional model which postulates that coping with stress is a four step process: determination of meaning, decision making, coping efforts, and evaluation of outcome. Within this assessment process, data are collected which identify the concerns, stressors, coping resources, and vulnerabilities of the family. Information is collected through self-report instruments, structured interviews, checklists, and informal interactions. The model presumes that intervention services need to focus on enhancing the personal resources of the family that support effective coping efforts.

2. Social Support Network

Considerable evidence exists which indicates that social support can substantially influence familial well being (Patterson and McCubbin, 1983), parental styles of interaction (Trivette and Dunst, 1987), child temperament (Affleck et al., 1986), and child behavior and development (Crnic et al., 1986). Different forms and types of support, particularly that which matches identified needs, promotes positive caregiver interactional styles which in turn influence child competence.

From an operational point of view, support can be differentiated between informal sources (e.g., friends, relatives) vs. formal sources (e.g., professionals and agencies). Of enormous interest is that research has indicated that informal support from personal network members has powerful stress buffering influences, and that the effects of informal support are generally greater from that attributable to formal support.

The attributes of social support which are typically assessed include size, density, connectedness, frequency of contact, and the perceived helpfulness or satisfaction with support provided. The inclusion of social support dimensions within the family assessment process is useful in that it provides a structured opportunity to identify not only social isolation but more importantly, to precisely portray the existence and strength of connections between expressed needs and support systems, both formal and informal. Representative instruments in the domain are as follows and are included in Appendix D.

Carolina Parent Support Scale (Bristol, 1983)

The Carolina Parent Support Scale (CPSS) was designed to assess both the availability and perceived adequacy of supports available to parents. The scale examines both informal (e.g., family, friends, neighbors) and formal (e.g., respite care) support systems, and for those sources available, rates

their perceived helpfulness. The scale also includes both two parent as well as single parent versions. Studies which have been completed with this instrument have indicated that perceived adequacy of informal support is significantly related to successful adaptation for families with seriously involved children.

Family Support Scale (Dunst, Trivette, and Jenkins, 1987)

The Family Support Scale (FSS) measures the extent to which different sources of support exist and are helpful to families rearing young children. The scale includes 18 items which identify the availability of various sources of informal and formal support and if available, their perceived helpfulness. In addition to the clinically relevant data derived from the instrument, two quantifiable outcomes are evident: total number of available supports and parental perceptions of helpfulness.

Inventory of Social Support (Trivette and Dunst, 1987)

The Inventory of Social Support provides an alternative method for describing the types of assistance provided by various individuals, groups, and agencies. The respondent reports not only "frequency of contact" information, but also answers a range of concrete questions (e.g., "Who helps you learn about services for your child and family?; Who hassles with agencies and individuals when you can't get what you need or want?") which attempt to identify specific sources of assistance. The agents of support and types of aid provided are organized into a matrix format in order to facilitate a "graphic display" of the parent's network in terms of both source and type of support. The ISS yields a wealth of information regarding informal and formal supports, utilization of and access to such supports, and a representation of the degree to which these supports have assisted in resolving common areas of need and potential conflict.

Personal Network Matrix (Trivette and Dunst, 1987)

The Personal Network Matrix (PNM) is highly similar to the Inventory of Social Support, but is somewhat less structured in that the respondent is requested to list a maximum of ten needs or projects (as compared to the predetermined questions on the ISS) and furthermore, to indicate which members of their support network could provide assistance for each expressed need. Two versions of the scale exist; the first includes preselected groups and persons while the second allows the respondent to insert specific members of the support network. Resembling the format of the ISS, the Personal Network Matrix provides a visual portrayal of a respondent's support system, and yields quantitative (frequency of contact) and qualitative (dependability) information which is again useful in establishing need/support system relationships.

3. Significant Life Stressors

Several studies have reported that environmental stresses related to caregiving place a child at significantly greater risk for adjustment problems later in childhood, and furthermore, such stress can magnify the adverse effects of infancy risk factors (O'Grady and Metz, 1987). Additional studies provide support for the cumulative stress hypothesis which asserts that psychological disorder emerges as a consequence of multiple risk factors that combine interactively to retard normal development (Werner and Smith, 1982).

While the empirical base for the relationship between life stress and adverse outcomes is well established, and furthermore, that standardized instruments exist which reliably identify such stressful events and forces, assessment within this domain is not without complication. More specifically, several measures include items which families are highly unlikely to disclose upon referral to an EI program (e.g., substance abuse or addiction, domestic violence, sexual assault). Even in the event of revealing this information,

such disclosures usually involve ethical or legal reporting obligations. While these professional obligations clearly must be honored, functional questions can also be raised regarding the utility of these data to craft an IFSP. While caution must certainly be exercised in using such instruments, they can reveal information which greatly assists in understanding current family functioning.

Representative instruments in this domain, included in Appendix E., are as follows.

Family Inventory of Life Events and Changes (McCubbin, Patterson, and Wilson, 1982)

The Family Inventory of Life Events and Changes (FILE) is a 72 item self-report inventory which is designed to measure the normative and non-normative events which a family has experienced. As a family change inventory, all events encountered by family members are recorded since, from a family systems perspective, experiences to one member affect all family members. Families are typically dealing with several stressors concurrently, and as such, the FILE yields an index of cumulative risk. Conceptual dimensions measured by the instrument include: parenting and marital strains, pregnancy and childbearing strains, finances, and family and work transitions. A total sum score of "No" responses is used for scoring; higher scores imply lower stress.

Life Experience Survey (Sarason, Johnson, and Siegal, 1978)

The Life Experiences Survey is a list of events which may have adverse effects on family functioning. The scale measures the impact (extremely negative to positive) of the occurrence of such events on the individual. Areas assessed include changes in personal events (pregnancy, abortion, major illness), financial status, the work environment, and family status and

membership. An adaptation of the LES by Barnard (1985) is included within Appendix E.

4. Characteristics of the Caregiving Environment

A final component to a comprehensive family assessment process involves an appraisal of the overall home environment. Within this domain, dyadic interactional patterns are important, however, it has been reported that these interactions are significantly affected by the context within which they occur (Garber, 1988). Therefore, this assessment must include parental characteristics and behaviors, organization of the physical environment, and methods of parent/child engagement and responsiveness. It is also important that these data be interpreted within the family cultural and ethnic context.

Perhaps the greatest concern in this area is that inferential judgement assumes a significant role in the assessment process, and given certain individual biases and beliefs, family interactional patterns can be misinterpreted. In addition, while a great deal of attention has been devoted to identifying atypical interactions, little effort has been directed to defining those behaviors which, without variation, facilitate well being and developmental competence. In the absence of this empirical consensus, the role of individual interpretation becomes very dominant, and moreover, creates potential conflict between professionals and caregivers. Representative instruments, included within Appendix F., are as follows.

Home Observation for Measurement of the Environment (Bradley and Caldwell, 1984)

The HOME inventory is a 45 item scale with items clustered into six subscales: emotional and verbal responsiveness, acceptance of child, organization of physical and temporal environment, provision of appropriate play materials, maternal involvement with the child, and opportunities for variety

in daily stimulation. Information needed to score the scale is obtained through a combination of observation and interview of the child's primary caregiver, completed in the home with the child present and awake. Studies have indicated that HOME scores are significantly correlated with school failure and as such, this instrument includes parent behaviors and environmental traits which are presumed to assume a major role in a child's developmental pathway.

Nursing Child Assessment Feeding Scale (Barnard, 1978)

The Nursing Child Assessment Feeding Scale (NCAFS) was designed to describe the repertoire of infant and maternal behaviors brought to the interactional process of feeding. The NCAFS, for use with children from birth to one year of age, is comprised of 76 items organized into six subscales, four of which describe the adult's behavior, and two of which describe the child's behavior. They include: parent's sensitivity to cues, parent's response to child's distress, social-emotional growth fostering, cognitive growth fostering, child's clarity of cues, and child's responsiveness to parent. The Feeding Scale permits a structured, clinical view of a process which is usually familiar and well rehearsed for both members of the dyad.

Nursing Child Assessment Teaching Scale (Barnard, 1978)

The Nursing Child Assessment Teaching Scale (NCATS), designed for children from birth to three years of age, includes 73 items which are organized around the six subscales noted above for the NCAFS. The teaching scale is intended to describe a mother teaching her infant a specific sensori-motor task. In contrast to the feeding scale, the teaching interaction is quite brief and is also much more novel for the parent and infant, and thus allows one to examine the adaptive patterns of the dyad outside of their well rehearsed routines. Justification for use of such interactive scales is that the parent's behavior

appears to be significantly correlated with a child's later mental performance and receptive language.

B. Criteria for Test Selection: Level 1

In conceptualizing a decision making process which attempts to integrate major research findings and implications, and also includes a thorough analysis of alternative measures and the implications of their adoption, a two tiered review and developmental process is recommended. At the first level, significant issues which must be addressed include the functional use (e.g., screening and assessment decisions, IFSP development) of select measures and the manner in which they are integrated into ongoing program operations. In addition, careful appraisal of the technical adequacy of specific instruments would also occur at this level.

The second stage of review and development occurs at the clinical level, typically by a group of interdisciplinary staff and parents. The primary intent of this process is to critically analyze family assessment measures and approaches relative to actual service delivery. As such, focal issues include feasibility and intrusiveness of select measures, examining relationships between measures and overall program organization, capability, and purpose, and time and effort factors. Specific areas to be addressed within the initial stage of this process are as follows.

1. Screening and Program Eligibility Decisions

Two of the key decision points in early intervention programs include screening and program eligibility. Screening traditionally involves a periodic review of the total population in order to identify those children and families for whom a more detailed evaluation is indicated. Program eligibility decisions typically involve the collection of assessment data that may include norm

referenced or clinical testing procedures which accurately establish baseline levels of child developmental functioning as well as family needs, strengths, and resources.

While other detailed manuscripts exist relative to collecting child centered data for either decision function (Meisels and Wasik, 1988; Harbin, 1988), the utility of family focused measures in making reliable and valid screening and eligibility judgements remains, for the most part, untested. Accordingly, important questions to be addressed are as follows.

1. What is the relationship between the type of child and family assessment data collected (i.e., quantitative, qualitative, or both) and the methodology of team decision making? If the multi/transdisciplinary team has adopted a style which substantively relies upon clinical observation and inference, then measures which generate such information (e.g., structured interviews, open ended queries and prompts) may be most useful.

2. What is the relationship between the screening/assessment data collected and definition of the population to be served? If broad based, non-specific definitions of the eligible population exist, then measures which yield quantitative results may be unimportant. Conversely, if eligibility criteria are developed which are intended to accommodate only seriously involved children and their families, then family centered dimensions may need to yield quantitative results which assist in identifying a small segment of the population which is most in need of service.

As programs begin to conceptualize screening models designed to identify developmentally disabled as well as high risk children and their families,

several significant implications from existing literature are noteworthy (Kochanek, 1987).

1. That the primary goal of the screening process is to identify all children from birth to three with developmental anomalies as well as vulnerable, low resource families within which children are at a substantial risk for subsequent school failure. The concept of limited resources is not restricted to tangible areas (e.g., income, housing, medical care, nutrition), but also includes maternal/primary caregiver characteristics such as parenting skills, social/emotional competence, ability to access and appropriately utilize community services, alternative modes of dealing with adversity, access to intrafamilial and extrafamilial support systems, and interpersonal and intrapersonal competence.

2. That in order to minimize decision making error, the screening process should be a two-tiered model which reflects different degrees of specificity at each level. To the maximum extent possible, the screening model should be incorporated into all existing programs/ services (e.g., Maternal and Child Health neonatal screening, EPSDT, Preventive Pediatric Services). Moreover, the basis for a decision regarding need for additional diagnostic testing shall be made according to three sources of information: (a) child characteristics, (b) parental traits, and (c) maternal/child interaction.

3. That due to significant variation in child developmental pathways as well as ongoing changes in family status, all children and families should be examined serially over time on multiple occasions between birth and three years of age. Judgements regarding the need for

additional evaluation would be based upon evidence of jeopardy at individual time points as well as from determination of cumulative risk.

2. IFSP Development

Given the fact that one of the major objectives of family assessment is to prepare a comprehensive treatment plan, several important considerations exist at this stage of the instrument review process.

1. To what extent do the family centered measures yield information useful in developing statements of current need, resources, strengths, and support systems?

2. To what extent do results facilitate prioritizing needs and prompting a series of objectives or plans which coincide with these needs?

3. To what extent do results assist in portraying the relationship between identified needs, existing resources, and the adequacy or incongruity between the two?

4. To what extent do results assist in developing an appropriate division of responsibility between professionals and family members relative to stated objectives?

5. To what extent do results assist in specifying a method and process for intra and interagency service coordination in response to identified needs? Within this process, is there information which assists in acknowledging and supporting families in coordinating these services independently?

6. To what extent do results assist in determining fulfillment or completion of stated objectives (assuming repeated administration of measures)?

3. Program Evaluation

The major issue to be addressed in this area is the extent to which data collected are useful in examining change in family members, status, and functioning over time. Significant issues are as follows.

1. To what extent are the measures sensitive to the dynamic nature of family needs, crises, and resources? Do the organization and format of the measure permit and encourage ongoing assessment rather than merely annual review?

2. Does periodic assessment yield data which examine progress towards stated objectives? In those instances of minimal progress, does the measure suggest barriers or impediments which require resolution?

3. Do the measures include criteria against which progress towards stated family objectives may be determined? Does this format facilitate both parent and professional appraisal?

4. Technical Adequacy

Beyond the functional questions advanced above, a critical set of factors must also be analyzed relative to the technical adequacy (i.e., psychometric characteristics) of select measures. While several publications (Salvia and Ysseldyke, 1985) provide detailed presentations in this area, major considerations are as follows.

Reliability is a significant factor in evaluating the psychometric properties of a measure or scale. The concept of reliability involves the stability or consistency of scores obtained when successive measures are taken with the same instrument or with equivalent measures. Reliability coefficients serve three purposes: (1) to estimate the instrument's relative freedom from measurement error; (2) to estimate an individual's true score; and (3) to determine the standard error of measure-ment. Factors which affect test reliability include the method used to calculate the reliability coefficient, test length, test-retest interval, and variation within the environment within which test data are collected. Reliability coefficients may range from .00 (total absence of reliability) to 1.00 (perfect reliability); generally, a coefficient of .80 is viewed as a minimally acceptable standard.

Validity refers to the extent to which an instrument measures what it purports to measure. Four categories of validity are important.

1. Content validity indicates whether the test covers a sufficiently representative sample of the behavioral domain under consideration.

2. Predictive validity involves testing the effectiveness of a measure against future performance in the areas allegedly measured by the test.

3. Concurrent validity is determined by comparing test performance and some criterion data that are available at the time of testing.

4. Construct validity indicates the extent to which a test is viewed as a measure of a particular theoretical construct or trait.

Validity is an essential characteristic of any measure to be used for decision making purposes. Adequate norms, reliability, and lack of bias are

all necessary conditions for validity and as such, each factor should be analyzed separately and carefully.

C. Criteria for Test Selection: Level 2

1. Clinical and Parental Judgement

P.L. 99-457 encourages EI professionals of all disciplines to participate in family assessment and intervention, activities traditionally within the purview of social workers, nurses, and psychologists. As a program begins the transition from the child-focused IEP to the child and family-focused IFSP, several issues are noteworthy.

First of all, all professionals on the team will need to develop competency in administering the family assessment tools within the context of their initial efforts to establish trusting relationships with families (McGonigel and Garland, 1988). Additionally, skills in interviewing, exploratory inquiry, and use of clinical observation will require refinement and amplification.

The enthusiasm, support, and comfort level of professionals and families with respect to the use of formalized instruments and methods are essential components in the successful implementation of this process. Assessment instruments are merely tools. They can facilitate the diagnostic process, however, will be useful only to the extent to which professionals and families find that they shed light on issues perceived to be of importance in designing an intervention plan.

The perspective which professionals and parents bring to the IFSP process provides a substantive basis for a program development strategy. As such, inclusion of EI professionals and parents in a collaborative, decision making format is recommended. Ideally, this process will mirror the aspirations of a

program for the ways in which parents and staff will subsequently work together to co-author Individual Family Service Plans. As early as possible in the planning process therefore, both team professionals and parents should be involved. Such collaboration can provide information regarding the hurdles which the program will need to attend to, identify specific training and technical assistance needs, and reveal expectations and concerns of both staff and parents regarding the process.

Attention to the diversity of families served within a program provides a guide for parent representation. Relevant factors include cultural/ethnic communities, fathers as well as mothers, and representative family coping styles, structures, and ideologies (Chandler et al., 1986). Significant dimensions of the decision making process which parents need to address include the appropriateness of specific instruments and methods relative to vocabulary, format, and applicability to family priorities and cultural norms, and congruence with family expectations regarding the goals of early intervention.

Professionals provide an equally important perspective derived from their experiential background, academic training, and from the diversity of families with whom they have been engaged. They contribute significantly to the decision making process by addressing such issues as the relationship between specific measures and the primary concerns of families, clinical and face validity of various tools, relevance of instruments to families of divergent educational and ethnic backgrounds, differential utility of select measures with families whose children are at biological, established and/or environmental risk, and specific training needs inherent within such new assessment paradigms.

2. Relationship Between Measures and Population Served

The adoption of specific family assessment measures permits programs to collect new information on existing families and in addition, may allow new families to be judged as eligible for EI services. Consequently, programs must carefully and thoughtfully assess their ability and interest in not only assuming responsibility, in conjunction with the family, for newly identified needs (e.g., housing, transportation, child care), but also in perhaps serving complex families who present with needs that the program is inadequately equipped to handle or philosophically feels that other providers are perhaps more appropriate intervenors.

The selection of assessment measures must be integrally related to the characteristics of the families served by a program. Achieving the best match between tools, methods of assessment, and families served is of primary importance in the planning and decision making process. For example, cultural norms will affect a family's willingness to complete various assessment tools. Important considerations with respect to specific ethnic groups served are as follows.

Is it acceptable for "outsiders" to be involved in family business?

What constitutes a concern legitimate enough for "outsider" involvement, and what are the accompanying feelings for family members (e.g., embarrassment, anger)?

Who is the gatekeeper within the family through whom all outsiders must go?

What are the normative routes for help-seeking and social support within the culture?

What is the meaning of having a child with a disability within the culture?

Do families served have adequate facility with the English language to ensure reliable and valid results? Will assessment tools need to be translated into other languages for optimal results?

Each family is unique in structure, strengths, and functioning style, and thus attention to these and other questions related to cultural issues will assist the program in instrument selection. Parents representing the diverse groups served by a program can be the most helpful guides in this decision making. Significant factors to be considered include belief systems, interactive patterns, cultural definitions of normality and deviance, attitudes toward help-givers, and normative avenues for social support and problem-solving (McGoldrick et al., 1982). Staff members native to the ethnic groups served by the program can also provide insight. Educational background of families also becomes an important consideration in selecting instruments and methods, particularly with respect to looking at the complexity of self-report measures (e.g., vocabulary, concepts, format). The anxiety and risk involved for parents who are not confident about their reading and writing skills may be considerable, and must be handled in a sensitive manner by the professional.

The choice of instruments will substantively affect the process for both families and professionals. Measures are of clinical value only insofar as they create a window of opportunity for dialogue between a parent and professional. A clinician's expertise in active listening, effective inquiry, and insightful interpretation of content and emotions provide the basis for creating a meaningful and collaborative plan of action (Winton and Bailey, 1988).

There are also unique challenges which adolescent parents may be addressing in the context of early intervention (Herzog et al., 1986; Dunst et al., 1986; Crockenberg, 1986), some of which may include: differentiating from the family of origin and establishing a peer support system; acquiring child caregiving skills; developing self-sufficiency in meeting their own and their child's basic needs for shelter, clothing, food, and transportation; and perhaps, completing an educational program. The priorities which are embedded in these needs must be identified within a family assessment process if it is to be meaningful for adolescent parents in early intervention.

Fathers must also be accommodated, particularly if family responsibilities are divided according to a clear division of labor. Assessing maternal needs only is inadequate, and can inadvertently contribute to creating an unrealistic burden for the mother to speak on behalf of all family members. Exclusion of fathers in the assessment process conveys a message that they need to resolve their concerns and priorities independently (May, 1988), yet this may not reflect a program's philosophical stance.

3. Relationship Between Measures and Program Intent, Organization, and Philosophical Orientation

A significant issue which all programs will need to resolve in this developmental process is the overall relationship between the assessment methodology and the stated objectives of the program itself. Of importance here is that a high degree of congruence is desirable between information collected and services available. If indeed programs do not possess the capability or interest in addressing needs and conflicts which may emerge from the assessment process (e.g., housing, parental education and employment), then measures which elicit this information should not be adopted.

Yet another factor worthy of consideration in this planning process relates to the information gathering process itself. More precisely, the format of several measures are either parent self-report in design or demand the clinical judgement and inference of the professional. Philosophically, if diagnostic teams believe that the data gathering and needs determination process reside exclusively with the professional community, then family self-report measures would be in conflict with this perspective. Conversely, if programs assume that families must reveal their needs and priorities, then measures which require professional inferential judgement regarding family needs and dynamics may not be particularly helpful.

The selection of assessment measures will communicate to families, EI professionals, and community service agencies what the program perceives to be important with respect to needs, concerns, and priorities of families. Moreover, these measures will also convey the need for a collaborative relationship between parents and professionals, the key decision-making role of parents, program eligibility criteria, and the role of other informal and formal support systems in intervention.

4. Intrusiveness

Establishing trust between parents and professionals is the first step in the creation of a working relationship (Friedman and Friedman, 1982). This implies a communication of respect for a family to share information about itself slowly and in accordance with its own timetable. Such an evolution may be in conflict with established policies which require IFSP completion within relatively narrow time frames. EI professionals will need to develop a delicate balance between collaboratively developing meaningful IFSPs while also allowing families the space needed to reflect their priorities over time. Guidelines which may be useful in dealing with this dilemma are as follows.

1. Select measures which address parent priorities and strengths, rather than tools which depend upon a professional's assessment of parental deficiencies. The intent of information gathering is to assist in problem solving, not to determine causality (Trivette, 1987; Bristol, 1987). A strength-oriented approach is much more likely to increase trust than one which focuses on family pathology.

2. Select measures which address the areas perceived by both parents and professionals as within the purview of the program's direct focus (McGonigel and Garland, 1988).

3. Conceptualize a dynamic, evolutionary assessment process in which needs and priorities can be addressed over time in synchrony with the family's trust level and interest in sharing these needs and priorities with the professional.

4. Ensure that the clinical expertise of the early inte-vention professional is well developed. Families may not identify something as a need if they believe the problem is irresolvable (Dunst et al., 1987). In addition, professionals who are unaccustomed to appraising family structures, functions, and stresses may be reluctant to follow up on verbal and non-verbal communications by family members, an essential aspect of family needs identification. Training activities and continuing support for EI professionals are critical in developing new and unfamiliar helping behaviors related to the family need/ resource identification process.

5. Time, Motion, Effort, and Cost Factors

Beyond the evaluation of various measures and methodologies at a clinical level, several significant administrative and feasibility issues also warrant attention in this developmental process. For example, the majority of mature, sophisticated EI programs have well developed definitions and procedures for screening, assessment, and IEP processes. Adoption of specific measures, while infinitely useful at a clinical, decision making level, may prove so costly (e.g., professional expenditure of time or adverse impact upon financial reimbursement formula) that their adoption would compromise the integrity of the program. As such, field trial periods are worthy of consideration which would permit initiation of time and motion studies. Final decisions therefore, would result from parent and professional appraisal, the extent to which data collected facilitated the screening, assessment, and IFSP process, and cost information.

A second major area of consideration relates to the competencies requisite to implementing a comprehensive child and family assessment process. As previously indicated, while EI professionals possess highly developed and refined child focused skills, expertise in dealing with family assessment and intervention may be somewhat uneven, both within and across programs. Consequently, administrators will need to develop a series of training and technical assistance activities which ensure qualititative implementation of screening and assessment processes. Depending upon the necessary length and intensity of such training activities, this may prompt a series of considerations related to cost effective use of personnel time, effort, and resources, and may be influential in determining the format and content of the assessment process.

IV. IMPLICATIONS OF FAMILY ASSESSMENT FOR PROGRAM ORGANIZATION AND DESIGN

A. Definition of Population Served: Screening, Assessment, and Eligibility Policies

P.L. 99-457 creates a rich opportunity for programs to not only provide quality services to developmentally disabled children, but also to articulate and implement more comprehensive and aggressive efforts devoted to prevention. To the extent that programs are interested in both of the above challenges, screening and assessment models which incorporate child and family focused measures must be developed. While studies presented earlier are enormously helpful in drafting such multivariate models, no reliable and valid process or decision making equation has yet been created. Consequently, as such experimental models are developed, careful field trial periods are mandatory prior to widescale adoption. Significant evaluation questions which must be addressed in such pilot projects are as follows.

1. What differences exist in the population identified by the proposed screening model in contrast with existing referral pathways and casefinding techniques? What specific factors in the model account for these differences?

2. What contribution does each screening factor (i.e., child and family) make to key decisions such as of screening, program eligibility, assessment, and IFSP development?

3. Does the significance of specific screening factors change over time, and if so, how can this dynamic quality be incorporated into a systematic screening process for children from birth to five and their families?

Adoption of family measures within EI programs carries with it the opportunity to view eligibility from a fresh and novel vantage point. While generating risk responsive, coordinated, and comprehensive IFSPs remains as the principal outcome of child and family assessment, commitments to specific measures will invariably prompt a range of complex questions regarding not only the eligible EI population, but also the manner in which this population is most appropriately served. Programs will need to develop appropriate and technically sound implementation plans such that the above representative questions may be answered.

B. Continuum of Services

Clearly, adoption of family focused measures in EI programs will identify voids in the existing range of service options, both for children as well as families. For example, parents may express interest in the use of integrated settings (e.g., family and center based day care environments), and accordingly, programs may need to develop a productive, collaborative, and mutually supportive relationship with the overall child care community. Furthermore, a range of family needs may emerge from the assessment process for which programs, up to this point in time, have not been responsible. While the intent here is not to suggest that EI sites must directly assume ownership of all identified service needs, it is apparent that new affiliations may be required between EI and other community based programs. As such, an implication of the family assessment process may be greater effort devoted to community outreach as well as creating models and processes for coordinating among many more external providers than that which previously existed.

Development of a family assessment strategy reflects a new and evolving continuum of early intervention services which are family-centered, and move beyond a narrow interest in only certain family members (typically the mother)

to an interest in the well-being of the family as a whole within the context of its community relationships. Such services will require a "reciprocity of responsibility among individuals, families, and communities" (Hobbs et al., 1984). Jeppson (1988) describes the aspects of such family-centered care as including:

- a view of the family as continuous in a child's life, while service providers and systems are transitory
- a focus which goes beyond a child's special needs toward an interest in family well-being and in normative developmental processes
- a comprehensive, flexible, and accessible service system offering a range of choices to families including parent-to-parent support programs, equipment exchange options, transportation assistance, and both weekend and evening services

As early intervention programs begin to implement systematic family assessment practices, diverse and dynamic family needs and priorities will be identified. Accordingly, new and creative methods of providing service will be mandatory. The insights of Hobbs et al. (1984) and Dunst et al. (1987) provide direction as programs struggle to meet this challenge. The principle of parsimony points to developing interventions that always move from least drastic to more drastic, from more normative to less normative, from least intensive to more intensive (Friedman and Friedman, 1982).

Families are strengthened to a greater extent if professionals work to facilitate already established informal support networks rather than substituting it with formal supports (Hobbs et al., 1984). Families are empowered by professionals to a greater extent if the helper can assist families in finding

ways to develop reciprocity within their informal support networks (Dunst et al., 1987); professional intervention is seen as a last resort.

It is to be expected that families will require highly varying degrees of professional involvement. Recognizing that no one program can or should meet all the needs of all families, linkages between service systems takes on critical importance and cannot be underestimated. In addition, developing intervention approaches which continually support the movement of families toward their expressed level of independence from professional intervention also becomes a desired outcome.

C. Case Management

Significant implications are evident for the case management process as professionals implement the family assessment and service planning sequence. Exceptional skill is involved in sorting out the roles, responsibilities, and agendas of formal service providers, in assessing the potential for utilizing informal resources, in accessing or advocating for additional services, and most importantly, in developing a collaborative relationship with parents to support their highest level of independent functioning.

Consider the case management implications for the following hypothetical children/families referred for early intervention services.

Chris N. is 12 months old and has multiple delays in development. He was born cocaine-addicted to his 18 year old parent, Trisha N., who has a four year history of drug addiction. Trisha's family of origin has been involved with protective services throughout her childhood. Chris has been in the care of the same foster mother since leaving the hospital one month after his birth. Trisha visits him irregularly and therefore, is out of compliance with the service plan developed by her protective services worker. Trisha reports that she wants to regain custody of him, but because of her involvement in a drug

treatment program, the visiting plan has been difficult to comply with. Her drug counselor considers drug treatment to be the highest priority for Trisha at the present time. The protective services worker is under legal constraints to arrive at a recommendation for the court within the next six months regarding a permanent disposition with respect to custody of Chris. A referral to early intervention was arrived at unilaterally by the protective services worker, with the hope that Chris' delays in development could be addressed, and also to provide Trisha one more opportunity to demonstrate her interest in regaining custody of her child. Trisha has agreed to being involved with early intervention as a means of increasing her chances of getting her child back. She is doubtful about its usefulness for herself, but is worried about her son's delays and wants him to receive the professional help he needs.

Michelle H. is a three month old infant, about to leave the hospital to go home for the first time. She was born three months premature, has seizures resulting from birth trauma, and is considered at high risk for developmental delays. Michelle is the first child born to Fran and Peter H., both of whom work full-time at professional jobs. Fran's maternity leave will be over within 30 days. The previous arrangement for day care, which had been made before Michelle's birth, is no longer viable due to Michelle's special care needs. Fran is considering requesting half-time employment. This schedule would provide enough income for the family and would allow Fran to attend to the continuing medical, developmental, and emotional needs of Michelle. Michelle's hospital primary care nurse has become very attached to Michelle, Fran, and Peter. She suggested, in planning for Michelle's move to home, that the parents involve themselves with home care assistance from the community VNA and with developmental intervention services from the community early intervention program. In addition, it was recommended that followup regarding Michelle's medical needs be provided by the hospital. The parents have agreed

to this plan. In addition to the hospital's referral efforts, Fran has contacted both the VNA and the early intervention program to request services. While Fran and Peter are appreciative of all the professional help they and their daughter have received and will continue to receive, they continue to be in a state of shock regarding the disparity between their previous expectations for themselves to function independently as parents and the reality of their current dependence on professionals in caring for their daughter.

Clearly, the identification of family needs/priorities/resources and an assessment of the involvement of other service providers in these two hypothetical situations are essential to the development of a comprehensive early intervention treatment plan. Fortunately, models exist (Imber-Black, 1988) which provide a useful structure within which these case management needs may be addressed. In brief, the components of this representative model include:

1. Review of which systems are involved, and of each provider's perceptions regarding family needs, strengths, and goals, and clarification of responsibilities of service providers in the intervention process.

2. Analysis of the pattern of relationships between families and each system. For example, with respect to the two families described above, important distinctions exist between Trisha's history of relationships with social service agencies (long-standing and authoritarian in quality) and Fran/Peter's relationships with professionals (recent in inception and more peer-like in quality).

3. Analysis of the relationships of service providers with each other, formally and informally.

4. Clarification of the varying perceptions of appropriate boundaries between families and service systems, and among various service providers. Difficulties may exist when a family has perceptions different than that of the service provider concerning degree of involvement. A family may desire more privacy, while an agency feels a need to know more about family functioning and routines. Similarly, a family may seek more information about an agency which may tend to release information parsimoniously.

5. Clarification of the myths or beliefs families and service systems have about each other, based on long-standing involvement or on specific critical incidents for either party.

The principal objectives of a case management model are twofold: (1) to reduce fragmentation and duplication in service delivery; and (2) to enable families to acquire skills for accessing, utilizing, evaluating, and advocating for services via formal and informal resource avenues. Such models are dynamic rather than linear or static (Friedman, 1988), and serve as the "glue which holds the system together" (Aaronson, 1988). Significant considerations in conceptualizing a case management, or service advocacy and coordination model, are as follows.

1. Model must articulate a "needs determination" process which accommodates both parental and professional perspectives as well as child and family needs.

2. Model must portray a process for accessing resources which correspond to identified needs.

3. Given needs determination, process must accommodate both intra and interagency service provider coordination and communication.

4. Process must include a mechanism for monitoring service effectiveness, identifying new needs, recording needs/service utilization relationships and eliminating duplication of services.

5. Model must articulate a continuum of dependence/independence which permits and encourages both varying and increasing degrees of "active" assumption of case management functions by families.

6. Model must include requisite training activities for parents and professionals regarding the overall process and facilitate and support families achieving a maximum level of independence.

7. Model must articulate a flexible decision-making process regarding primary case manager designation with families involved with multiple service providers.

In developing a service advocacy and coordination model consistent with the above principles, perhaps the most complex issue relates to the extent to which families can independently assume responsibility for such functions. The origin of this complexity relates not only to developing ways in which such independence and skill can be accurately assessed, but also in creating experiences which prompt, encourage, and support families in achieving a maximum level of independence consistent with their interest and ability.

A second dimension of this complexity surrounds the fact that varying perceptions exist in the professional community with regard to the extent to which families should indeed serve as their own case managers. Clearly, given substantial variability in opinion by both professionals and parents on this

issue, no unitary solution or model exists. However, in developing a model which is consistent with an overall family assessment strategy, careful evaluation by both families and service providers is essential. To this end, what follows is a self-appraisal inventory which is intended for potential use within the assessment process. It is critical to note that this inventory is designed to serve as a stimulus for discussion among parents and professionals within the context of the developmental, decision making process portrayed in this monograph.

SERVICE ADVOCACY AND COORDINATION:

A SELF-APPRAISAL FOR PARENTS AND PROFESSIONALS

Participation in early intervention programs involves an ongoing process of identifying, accessing, evaluating, and coordinating services for children and families. This process is most effective when parents and professionals develop a collaborative relationship, and together ensure that all necessary services are secured and well coordinated.

The purpose of this self-appraisal inventory is to describe the manner in which this process is functioning, and the role which both parents and professionals assume in its implementation. The inventory is designed to be completed upon intake, and is updated at six month intervals thereafter.

Each major component of the inventory includes items which are intended to be jointly rated by parents and professionals. In those instances where consensus on ratings is not evident, individual ratings should be reported. Please note that there are no "right" or "desired" ratings on these items; as such, you are encouraged to use the full continuum to reflect your perceptions at any given point in time. The inventory is intended to not only describe current status, but also serve as a stimulus for establishing future goals.

1.0 Identification of Child and Family Needs

Parent

desires professionals to identify and prioritize child/family needs	identifies child/family needs via family and professional input	identifies child/family needs independent of professional input

Professional

relies upon parents to reveal significant child/family needs	solicits family's perspective in conjunction with professional judgement	identifies child/family needs independently of family input

2.0 Access to Community Based Services and Resources

2.1 Knowledge of Resources: Parent

relies upon professionals to make available pertinent information	requests information from professionals as supplement to existing knowledge	maintains resource directory independently

Knowledge of Resources: Professional

relies upon parents to generate resource information	shares available information with families upon request	maintains resource directory and selectively reveals information based upon professional judgement

2.2 Access to Resources: Parent

relies upon professionals to secure access to necessary and desired services

negotiates shared responsibility for resource access with professionals

assumes responsibility for securing resources independently

Access to Resources: Professional

expects parents to pursue resources consistent with identified needs

develops plan for shared responsibility for resource access

assumes full responsibility for resource access

3.0 Coordination of Services

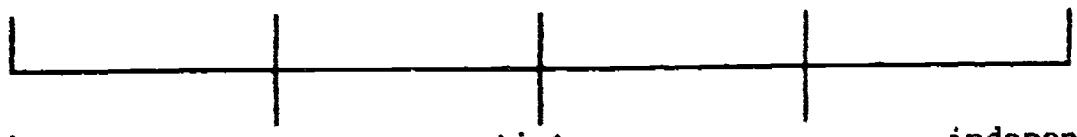
3.1 Service Coordination: Parent

relies upon professionals to communicate with and coordinate service providers, both internal and external to EI	establishes shared division of responsibility between professionals and family members for service coordination	independently coordinates multiple service providers

Service Coordination: Professional

expects parents to communicate with and coordinate service providers	develops plan for shared responsibility for service coordination	assumes full responsibility for coordinating intragency and interagency providers

3.2 Conflict Resolution: Parent

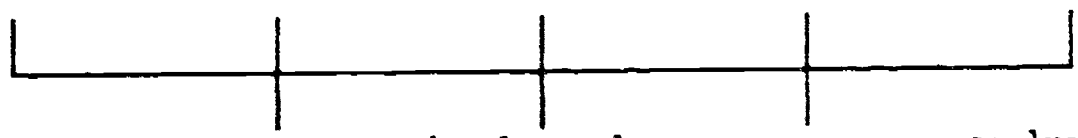


relies upon professionals to resolve difficulties with service access, duplication, or fragmentation

negotiates mutual division of labor with professionals for conflict resolution

independently resolves difficulties with service access

Conflict Resolution: Professional



expects parents to independently resolve difficulties with service access and fragmentation

develops plan for shared responsibility for conflict resolution

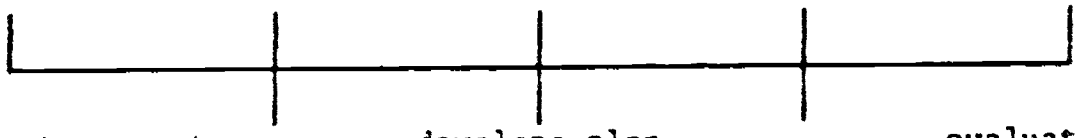
resolves difficulties on behalf of parent

4.0 Evaluation and Revision of Services

Parent

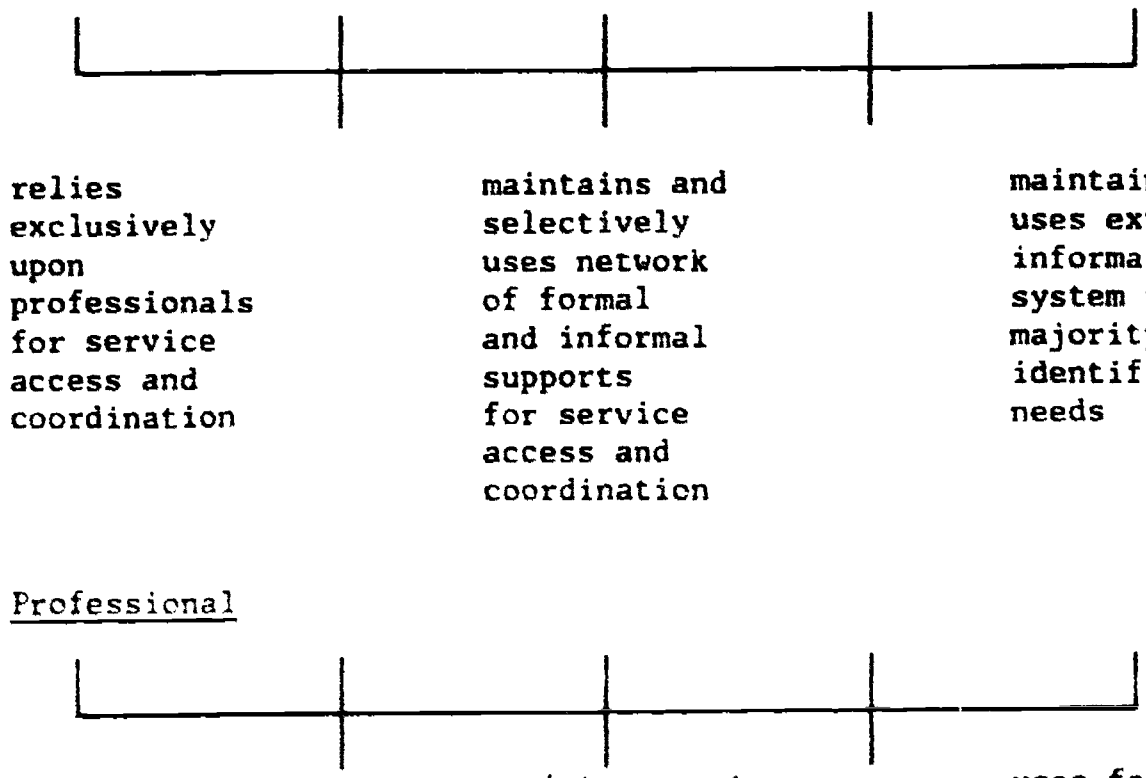
relies upon professional judgement regarding adequacy of services	develops criteria for evaluating services in collaboration with professionals	evaluates and pursues revision of services independent of professional input

Professional



expects parent to reveal service inadequacies and pursue appropriate modification	develops plan with family for assessing services, including identification of appropriate standards of care	evaluates services independently and negotiates revision according to professional judgement

5.0 Utilization of Support System



V. DEVELOPING AN IFSP FORMAT

A. IFSP Components as Defined by P.L. 99-457

Essential components of an IFSP as defined by P.L. 99-457 are as follows.

1. A statement of the infant's or toddler's present levels of physical development, cognitive development, language and speech development, psycho-social development and self-help skills, based on acceptable objective criteria.

This section appears to be congruent with the current IEP format. It is important to note however, that several IFSP forms recently developed (Dunst, 1987; Bruder, 1987) specifically list child strengths as well as needs. This allows parents to view their child's unique skills as well as developmental needs, and permits a more complete and balanced portrayal of child level of functioning.

2. A statement of the family's strengths and needs relating to enhancing the development of the family's handicapped infant or toddler.

This segment of the IFSP is designed to accommodate findings via the family assessment process. The value of including family strengths cannot be overemphasized. Professional recognition of family abilities is an essential component in the development of trust between families and professionals. Furthermore, Dunst et al. (1988) define needs, not as family deficiencies, but rather as family "aspirations, projects, aims, priorities", those things which the family considers important enough to devote time and energy. This distinction is critical in that it supports the professional acting in a facilitating, consulting role, rather than a dominating role with regard to setting priorities for intervention.

Secondly, this stipulation implies that all the strengths/needs considered in an IFSP should relate to the child's development. Based on results of

studies conducted with families, Dunst et al. (1987) advance an approach which legitimately takes into account those situations in which a family's priorities are not always child related, but unless addressed, will prevent the family from focusing on the child's development (e.g., lack of basic resources such as housing, transportation, food). Needs statements regarding a family's role in promoting the child's development should be made only to the extent that parents identify this as a focal concern.

3. A statement of the major outcomes expected to be achieved for the infant and toddler and the family, and the criteria, procedures and timelines used to determine the degree to which progress toward achieving the outcomes are being made and whether modifications or revisions of the outcomes or services are necessary.

Adoption of IFSP formats in early intervention programs requires an orientation which emphasizes strengths, needs, and resources. The following table summarizes issues which perhaps will warrant attention in this developmental process, and which attempt to identify significant considerations in the transition from IEPs to IFSPs.

Table 1.

Comparison of IEP and IFSP Practices on Select Dimensions

Issue	IEP	IFSP
Focus of needs assessment	child developmental needs	child and family strengths/needs/resources
Decision-making process regarding intervention priorities	goals primarily determined by professionals	parents and professionals have equal status in decision-making
Focus of intervention	specific gains in the child's developmental status	the child within the context of the family, and the well-being of all family members and of the family as a unit
Time frames of goal setting	long-term goals are established (i.e. annual, to be evaluated quarterly)	process must reflect the dynamic needs and priorities of families
Locus of intervention	identification of the early intervention services to be provided to meet child goals	identification of all formal and informal resources needed/accessed, with early intervention services identified as part of a more comprehensive plan
Role of EI professional	emphasis on the direct intervention efforts by EI professionals with children and parents relative to child goals	emphasis on the roles of both parents and EI professionals in addressing identified needs of child and family; professional roles of resource facilitator and consultant assume higher prominence

4. A statement of specific early intervention services necessary to meet the unique needs of the infant or toddler and the family, including the frequency, intensity, and the method of delivering service.

Dunst et al. (1987) caution against the notion, embedded in this stipulation, that "more is better". If a broadened perspective of intervention is to be developed, then as discussed earlier, services which are community based, normative for young children and their families, and which draw on a family's actual or potential informal support network as well as other service systems would take precedence.

5. The projected dates for initiation of services and the anticipated duration of such services. The name of the case manager from the profession most immediately relevant to the infant's and toddler's or family's needs will be responsible for the implementation of the plan and coordination with other agencies and persons.

While this stipulation underscores the importance of case management activities within early intervention, it does not clarify the potential for parents to serve as their own case managers, or in partially assuming case management responsibilities. This is a disempowering message to families and should be assessed by each EI program carefully.

6. The steps to be taken supporting the transition of the handicapped toddler to services provided by school districts.

This stipulation requires that attention be paid to creating a planned series of activities to ensure the smooth transition of children from early intervention to other preschool settings. Essential here is the development of policies which will facilitate collaborative planning among EI programs, school districts, other health care and social service providers, and families.

B. Static vs. Dynamic Formats

Family assessment strategies which are truly needs based support frequent changes in the specification of needs, methods, and outcomes (Dunst et al., 1987), and regard the use of a spiraling approach in which there is continuous movement between needs identification and service provision (Turnbull, 1988). Such an ongoing process accommodates not only newly identified needs as the family/service provider relationship strengthens, but also allows for unanticipated crises and events in the lives of families which may necessitate revisions in intervention priorities.

Early intervention programs may discover that the relatively static formats currently used to portray goals and objectives in IEPs are not well suited for the synergistic process noted above. Consequently, IFSP forms will need to be created which acknowledge this ongoing needs identification process, and which will accept both new needs statements and intervention goals while preserving the fluidity and continuity of existing services.

C. Family Driven vs. Professionally Driven Goals

Extensive documentation exists in the literature with regard to the inherent complexity of the parent/professional relationship; underlying this complexity is that the perspectives of parents and professionals are often different (Bailey, 1987). To some extent, these disparities have emerged from training programs for service providers which have reinforced a model in which professional opinion has more validity than the perspective of parents (Darling, 1983; Iris, 1988). Representative examples include training models which support professionals:

- taking full responsibility for the wellbeing of children in their care

- not sharing vulnerabilities with parents

- developing strategies to get parents to comply with professional prescriptions, even when they have been objected to overtly or covertly

- being concerned with circumscribed areas of a child's functioning rather than the whole child within the context of the family

- maintaining control of the information which parents receive about their children

- using, as a measure of professional competence, facility in writing reports on children which are replete with the technical terms of the discipline

Current societal presses regarding professional ethics, liability, and technology can contribute to undermining professional efforts to develop collaborative approach in which parents and providers are both perceived as being resourceful, having equal status, and being an equal partner in evaluating the services provided (Tyler et al, 1983; Bailey, 1987; Winton and Bailey, 1988; Dunst et al., 1987). Considerable controversy exists on this issue, particularly with respect to family needs identification and goal setting. Bailey (1987) recommends that professionals not elude differences in values or priorities, but rather engage in dialogue for resolving these differences. A professional can facilitate the process by envisioning and encouraging the creation of multiple alternatives with families. Clearly, instances exist in which, due to safety concerns for the child or family members, a professional will need to exert greater control (e.g., mandated reporting of child abuse or neglect). However, if the groundwork has been established for true and meaningful collaboration, such situations can be handled without jeopardizing the relationship.

VI. TRAINING/TECHNICAL ASSISTANCE IMPLICATIONS

A. Family Assessment Skills

The acquisition of competency in two major domains is essential to the implementation of a comprehensive family assessment and service planning process: (1) administration and interpretation of assessment measures, and (2) conducting family focused interviewing and collaborative goal setting. Early intervention professionals will need training experiences, both didactic as well as clinical, which focus on the development of technical knowledge for the administration and interpretation of assessment tools. Within this context, information dealing with family systems theory, normative, developmental family life cycles, and family structure and interaction processes are all critical content areas.

Effective communication involves an ability to "join" families, and to identify and support family strengths. Although program staff may be very comfortable in conversing with parents about their children, they may experience considerable discomfort when it comes to discussing family needs/functioning/resources. Training strategies focused on developing proficiency in family-focused interviewing also will need to assume high priority.

B. Family Focused Intervention

As programs prepare to implement a family assessment and service planning process, several areas of competency enhancement and development will need to occur; major areas of concentration in this training and technical assistance sequence are as follows.

1.0 Understand the family

1.1 elicit the family's priorities for the child and for themselves, recognize and address the effects of various individual characteristics on the growth and development of the child and family

1.2 understand how a child with special needs affects parents, siblings, the extended family, and the community

2.0 Establish and maintain relations with the family

2.1 successfully initiate first contacts with families, even when they have not sought information

2.2 explain to parents the role of the interventionist in working with the child and family

2.3 form and maintain satisfactory working relationships with infants, toddlers, and families

2.4 work with culturally different families in a non-biased and non-value-laden way

2.5 communicate respect for the values, ideas, suggestions, and priorities of the family

2.6 organize and encourage parent involvement in all phases of the program

2.7 address areas of disagreement with families honestly in a supportive and non-value-laden way

2.8 facilitate family decision-making concerning the needs of the child without imposing personal biases or supplanting family authority

2.9 translate and interpret technical information (e.g., test results) to families in understandable language

3.0 Assess issues/needs within families

3.1 discern whether a problem requires intervention or not

3.2 help families identify their needs and strengths

3.3 help families identify and acknowledge their concerns about their own needs, their child with special needs and/or other children

3.4 engage parents in evaluating their child's progress and skill acquisition

3.5 help families evaluate their progress, set new goals, and devise strategies and criteria for evaluating future progress

4.0 Meet family needs

4.1 help families integrate the child's specialized routines into normal family activities

4.2 create stimulating programs that draw on the child's strengths and that are consistent with the family's lifestyle

4.3 encourage the family to rely appropriately on informal as well as formal support systems

4.4 facilitate effective group support for parents' and siblings' education

4.5 plan intervention strategies congruent with the parents' style of learning

4.6 enhance parental competence, confidence, and self-esteem

4.7 decrease or increase intervention time when appropriate

4.8 support the family's increasing independence

4.9 successfully terminate relationships with families when appropriate

5.0 Encourage the child's development within the context of family routines and activities

5.1 explain the effects of various handicapping conditions on development

5.2 explain to parents the nature of child development and sequences of skill acquisition

5.3 discuss with parents the various medical, educational, and therapeutic techniques for special needs children

5.4 involve families in developing goals for the child and strategies to meet them

5.5 help families increase behaviors that positively affect the child's development and decrease behaviors that negatively affect it

6.0 Help families use support systems

6.1 help families identify and use state, federal, and community resources available to them

6.2 act as an advocate for families and help them acquire advocacy skills

7.0 Theory and research

7.1 major theories of family development and functioning

7.2 relevant research on the family's role in the development of the very young child

7.3 major theories of the family's role in the development of the child with special needs

7.4 relevant research on the family's role in the development of the child with special needs

In conclusion, P.L. 99-457 creates an enormous opportunity for states to develop comprehensive polices which will affect the health, well-being, and social and educational competence of young children and their families. The nucleus of such a dynamic and integrated system will be comprised of a precise and thoughtful appraisal of the needs of children and their families, and furthermore, will test the upper limits of our ability to create responsive, meaningful, and cost effective services which coincide with these needs. To the extent that states are committed to developing prospective plans which capitalize upon this opportunity for both intervention and prevention, careful attention to the developmental process described herein will hopefully provide a context and perspective for generating viable and creative solutions.

Appendix A.

A Guide to Measures of Social Support and Family Behaviors*

*From Dunst, C.J. and Trivette, C.M. (1985). A Guide to Measures of Social Support and Family Behaviors. Chapel Hill: Technical Assistance Development System, Monograph Number 1.

Table 1

Measures of Social Support and Family Behavior

Scales	Source	References (see page 9)	Social Support			Well-Being		Coping	Family Integrity	Parent Attitudes	Child Expectations	Reliability and Validity data available on Table 2
			Intrafamily	Kinship	Extrafamily	Physical	Emotional					
"Ask About Your Child" Questionnaire	Meyers, Mink & Nihira	132								X	X	
Adolescent-Family Inventory of Life Events and Changes	McCubbin, Patterson, & Wilson	124	X	X	X		X	X	X			X
Affect Balance Scale	Bradburn	10, 39					X					
Affect Intensity Measure	Larsen	39, 107								X		X
Affectometer	Kammann & Flett	89, 102								X		X
Beck Depression Inventory	Beck	8, 29				X	X					
Behavior Stress Index	Carweth & Gottlieb	23, 86					X					
Bipolar Traits Inventory	Schaefer & Edgerton	175								X	X	
Carolina Parent Support Scale	Bristol	14	X	X	X							
Child Expectation Scale	Dunst	42									X	
Community Interaction Checklist	Wahler	195, 196, 197, 198	X	X	X							
Coping Help Inventory for Parents	McCubbin, McCubbin, Nevin & Cauble	121, 122						X				X
Daily Interaction Rating Form	Hirsch	80, 81	X	X	X							X
Delinition Scale	Bristol	13								X		
Delighted-Terrible Scale	Andrews & Withey	4					X					
Differential Personality Questionnaire (Well Being Subscale)	Tellegen	89, 191					X					
Dual Employed Coping Scales	Skinner & McCubbin	182						X				
Family APGAR	Smilkstein	48, 183, 184	X					X				X
Family Adaptation and Cohesion Evaluation Scales	Olson	151, 152, 153, 154, 171	X					X	X			X
Family Coping Inventory	McCubbin, Bass, Wilson & Dahl	119						X				X
Family Cross Oriented Personal Scales	McCubbin, Olson & Larsen	123	X	X	X		X					
Family Educational Atmosphere Survey Instrument	Fotheringham	61, 62, 64	X					X		X	X	
Family Environment Scale	Moos	141, 144, 162	X				X	X	X			X
Family Functioning Index	Pless & Satterwhite	160, 161	X									
Family Functioning Scale	Fotheringham	63, 65	X					X				
Family Interview Schedule	Broadhurst	17, 19	X	X	X							

Family Interview Scale	Bronfenbrenner	17, 19	X	X	X							
Family Inventory of Life Events and Changes	McCubbin, Patterson & Wilson	125	X	X	X		X	X	X			X
Family Inventory of Resources for Management	McCubbin, Comeau & Harkins	120	X			X	X					X
Family Relationships Index	Holahan & Moos	92	X									X
Family Resource Scale	Leet & Dunst	109	X	X	X		X					
Family Responsibility Inventory	Schaefer & Edgerton	180	X									
Family Stress Index	Miller	134				X	X					
Family Support Scale	Dunst, Jenkins & Trivette	43	X	X	X							X
Family System Rating Scales	Lewis, Beavers, Gossett & Austin-Phillips	112	X	X								X
General Psychological Well-Being Schedule	Dupuy	39, 53				X	X					
Group Environment Scale	Moos	140, 142		X	X		X	X				
Gurin Scale	Gurin, Veroff & Feld	39, 77					X			X		X
Happiness Measures	Fordyce	89, 60										
Health Status Scale	Kisch, Kovner, Harris & Kline	104				X						
Home Quality Rating Scale	Meyers, Mink & Nihira	133, 146	X	X								
How-I-Feel Questionnaire	Spielberger, Monteuri, Lushene	185					X					X
Impact on Family Scale	Stein & Riessman	186, 187	X	X			X	X				
Index of General Affect	Campbell, Converse & Rodgers	20								X		
Index of Psychiatric Symptoms	Gurin	76				X	X					X
Instrumental-Expressive Support Scale	Lin, Dean & Ensel	113			X							
Interpersonal Support Evaluation List	Cohen & Hoberman	90	X	X	X							X
Interview Schedule for Social Interaction	Crnic, Greenberg, Ragozin, Robinson & Basham	32	X	X	X							
Inventory of Parent's Experiences	Crnic, Ragozin, Greenberg & Robinson	34	X	X	X							X
Inventory of Socially Supportive Behaviors	Barrera & Ainlay	6, 7, 172, 188, 190	X	X	X							
Langer Mental Health Scale	Langer	105, 126				X	X					
Life Experience Survey	Sarason, Johnson & Siegel	173	X	X	X							
Life Satisfaction Scale	Dunst & Vance	51					X	X				

Marital Adjustment Scale	Locke & Wallace	117	X										X
Marital Coping Resources Questionnaire	Monroe	137, 138	X										X
Maternal Attitude Scale	Colder, Weiss, & Greenbaum	31										X	
Maternal Developmental Expectations/ Childrearing Attitudes	Field	58, 59, 69									X		
Maternal Social Support Index	Pascoe, Loda, Jeffries & Earp	155	X	X	X								
Mood Survey	Underwood & Fleming	191					X						
Parent Needs Inventory	Fewell, Meyer & Schell	56	X					X					
Parent Role Scale	Gallagher, Cross, Scharfman	36, 70, 71 179, 191	X										X
Parent Role Scale, Revised	Fewell, Meyer, Vadasy & Greenberg	57	X										
Parent as Educator Interview	Schaefer & Edgerton	176, 178									X	X	X
Parental Expectation Scale	Schaefer & Edgerton	174									X	X	
Parenting Stress Index	Abidin	1					X						X
Perceived Social Support	Procidano & Heller	161	X		X								
Perceived Stress Index	Jacobs & Munz	100					X						
Pregnancy Support Scale	Dunst & Vance	52	X	X	X								
Profile of Mood States	McNair, Lorr & Droppleman	129					X						
Psychological Well Being Index	Bradburn & Caplovitz	11, 66					X						
Psychosocial Kinship Network Inventory	Pattison	116, 156, 157, 158	X	X	X								
Quality of Life Scale	Beach	169, 170					X						
Questionnaire on Family Support Systems	Fewell, Belmonte & Ahlersmeyer	55	X	X	X		X	X					
Questionnaire on Resources and Stress	Holroyd	41, 96, 97, 98, 99	X	X	X	X	X		X	X	X		
Questionnaire on Resources and Stress for Siblings	Greenberg, Vadasy & Meyer	75	X	X			X			X	X		
Questionnaire on Resources and Stress: Revised	Greenberg	74	X	X			X			X	X		
Questionnaire on Resources and Stress: Short Form	Friedrich, Greenberg & Crnic	67	X	X			X		X	X	X	X	
Recent Life Changes Questionnaire	Rahe	166	X	X	X								
Resource Index	Mansell & Norris	115	X	X	X	X							

Satisfaction with Parenting Scale	Ragozin, Basham, Crnic, Greenberg & Robinson	164, 165								X	X	
Satisfaction with Life Scale	Diener, Emmons, Larsen & Griffin	39, 40					X					
Satisfaction with Social Network Scale	Stokes	188, 189	X	X	X							
Schedule of Recent Experiences	Holmes & Rahe	95	X	X	X							
Self Rating Depression Scale	Zung	204				X	X					
Social Assets Inventory	Schaefer & Edgerton	177								X	X	
Social Network List	Hirsch	82, 85, 162	X	X	X							
Social Network Rating Scale	Hirsch	83	X	X	X							
Social Network Scale	Kaplan	103, 118, 135	X	X								
Social Readjustment Rating Scale	Holmes & Rahe	94	X	X	X							
Social Relationship Scale	McFarlane	127, 128	X	X		X						X
Social Resource Measures	Zautra, Beier & Cappel	203	X	X	X							
Social Support Measure	Crnic, Greenberg, Ragozin, Robinson & Basham	33	X	X	X							
Social Support Rating Scales	Carveth & Gottlieb	24	X	X	X							
Social Support Life Events Questionnaire	Shumgar & Leslau	181	X	X								
Social System Scale	Hirsch	84, 85, 89	X	X	X							
Survey for Parents of Children with Handicapping Conditions	Moore, Hamerlynck, Barsh, Spieker & Jones	139	X	X	X		X					
The Adaptive Potential for Pregnancy Scale (TAPPS)	Nuckolls	147, 148, 149	X	X	X							
Traditional Social Support Index	Holahan & Moos	91, 93	X	X	X							
Work Environment Scale	Moos & Insel	143			X		X	X				
Work Relationships Index	Holahan & Moos	93			X		X	X				X

Appendix B.

Reliability/Validity of Measures of Social Support and Family Behaviors*

*From Dunst, C.J. and Trivette, C.M. (1985). A Guide to Measures of Social Support and Family Behaviors. Chapel Hill: Technical Assistance Development System, Monograph Number 1.

Table 2

Reliability and Validity of the Scales

Scales	References (see page 9)	Reliability				Validity	
		Internal Consistency	Short-Term Test-Retest	Long Term Test-Retest	Alternate Forms	Factor Structure (# of Dimensions)	Criterion
Adolescent Family Inventory of Life Events and Changes	124	r_s = .67 - .89	r_s = .69 .90			6	r_s = .13 and .16 with Health Locus of Control (Wallston, Wallston, & DeVellis, 1978)
Affect Intensity Measure	39, 107, 194						Diener (1984) reported moderate to high correlation with Mood Survey (Underwood & Froming, 1980)
Affectometer	4, 10, 39, 102						r = .73 with Bradburn Affect Balance (Bradburn, 1969) r = .63 with Delighted-Terrible Scale (Andrews & Withey, 1976)
Coping-Help Inventory for Parents	121, 122, 141	r_s = .71 .79				3	r_s = .09 - .36 with Family Environment Scale (Moos, 1974)
Daily Interaction Rating Form	80, 81, 85						r = .53 with Social Systems Scale (Hirsch, 1979)
Family APGAR	38, 160, 183, 184	r_s = .24 .67 r = .93					r = .80 with Family Functioning Index (Pless & Satterwhite, 1973)
Family Adaptation and Cohesion Evaluation Scales	151, 152, 153, 154, 171	r_s = .80 .91	r_s = .80 .84			4	
Family Coping Inventory	119	r_s = .71 .86				3 5	t_s = 2.01 - 4.58 ($p < .05$) between the Maintaining Family Integrity; Developing Interpersonal Relationships and Social Support; Managing Psychological Tension and Strain; Acceptance of Lifestyle and Optimism; Developing Self Reliance and Self Esteem; and Balanced Coping Strategy subscales for distressed vs. nondistressed wives

Family Inventory of Life Events and Changes	125, 141					9	r_s = .14 – .41 between intrafamily strains and Family Environment Scale (Moos, 1974) r_s = .06 – .24 between total scale scores and Family Environment Scale (Moos, 1974)
Family Inventory of Resources for Management	120, 141	r = .89 r_s = .44 – .85				6	r_s = .02 – .46 with Family Environment Scale (Moos, 1974)
Family Relationships Index	92	r = .89					
Family Support Scale	43, 96	r_s = .75 – .85	r = .91	r = .47		6	r_s = .18 – .21 with Questionnaire on Resources and Stress - Poor Health and Mood, Excess Time Demands, Lack of Family Integration, and Limits of Family Opportunity subscales (Holroyd, 1973)
Family System Rating Scales	112	r_s = .37 – .82					r_s = .30 – .90 with Global Family Health Pathology Scale (Lewis, et al., 1976)
Happiness Measures	10, 39, 60, 108		r_s = .67 – .86				Diener (1984) reported high to substantial correlation with Affect Balance Scale (Bradburn, 1969)
Impact on Family Scale	186, 187	r_s = .60 – .88				4	
Instrumental Expressive Support Scale	113, 130					5	r = .55 with Medalie Goldbourt Scale (Medalie & Goldbourt, 1976)
Interview Schedule for Social Interaction	32	r_s = .50 – .69				3	
Inventory of Socially Supportive Behaviors	5, 6, 7, 172 188, 190	r = .94	r = .88 r_s = .41 – .91			4	r_s = .32 – .42 with Arizona Social Support Interview Schedule (Barrera, 1980)
Marital Adjustment Scale	117	r_s = .84 – .90					r = .47 with independent measure of adjustment t = 17.5 ($p < .01$) between adjusted [illegible]

Marital Coping Resources Questionnaire	137, 138	r = .77	r = .69				
Parent Role Scale	36, 70, 71, 179, 193		r_s = .63 – .96				
Parent as Educator Interview	176, 178	r_s = .88 – .90		r = .81	r = .91		r_s = .41 – .72 with teacher ratings of child's intelligence
Perceived Social Support	163	r = .90	r = .83				
Questionnaire on Resources and Stress: Short-Form	8, 67					4	r_s = .01 – .67 with Beck Depression Inventory (Beck, 1967)
Social Relationship Scale	127, 128		r_s = .62 – .99 r_s = .54 – .94				t_s 2.71 – 3.84 between parents and therapists
Work Relationships Index	93	r = .88					

Appendix C.

Family Needs, Resources, Strengths Scales

Family Resource Scale
Resource Scale for Teenage Mothers

Family Needs Scale
A Survey of Family Needs

Family Resource Scale

Hope E. Leet & Carl J. Dunst

Name _____ Date _____

This scale is designed to assess whether or not you and your family have adequate resources (time, money, energy, and so on) to meet the needs of the family as a whole as well as the needs of individual family members. For each item, please circle the response that best describes how well the needs are met on a consistent basis in your family (that is, month-in and month-out).

To what extent are the following resources adequate for your family:	Does Not Apply	Not at All Adequate	Seldom Adequate	Sometimes Adequate	Usually Adequate	Almost Always Adequate
1. Food for 2 meals a day	NA	1	2	3	4	5
2. House or apartment	NA	1	2	3	4	5
3. Money to buy necessities.....	NA	1	2	3	4	5
4. Enough clothes for your family	NA	1	2	3	4	5
5. Heat for your house or apartment	NA	1	2	3	4	5
6. Indoor plumbing/water	NA	1	2	3	4	5
7. Money to pay monthly bills	NA	1	2	3	4	5
8. Good job for yourself or spouse/partner.	NA	1	2	3	4	5
9. Medical care for your family	NA	1	2	3	4	5
10. Public assistance (SSI, AFDC, Medicaid, etc.)	NA	1	2	3	4	5
11. Dependable transportation (own car or provided by others)	NA	1	2	3	4	5
12. Time to get enough sleep/rest	NA	1	2	3	4	5
13. Furniture for your home or apartment ...	NA	1	2	3	4	5
14. Time to be by yourself.....	NA	1	2	3	4	5
15. Time for family to be together.....	NA	1	2	3	4	5
16. Time to be with your child(ren).....	NA	1	2	3	4	5
17. Time to be with spouse or partner.....	NA	1	2	3	4	5
18. Time to be with close friend(s).....	NA	1	2	3	4	5
19. Telephone or access to a phone.....	NA	1	2	3	4	5
20. Babysitting for your child(ren).....	NA	1	2	3	4	5
21. Child care/day care for your child(ren)	NA	1	2	3	4	5
22. Money to buy special equipment/ supplies for child(ren)	NA	1	2	3	4	5
23. Dental care for your family	NA	1	2	3	4	5
24. Someone to talk to	NA	1	2	3	4	5
25. Time to socialize	NA	1	2	3	4	5
26. Time to keep in shape and look nice.....	NA	1	2	3	4	5
27. Toys for your child(ren).....	NA	1	2	3	4	5
28. Money to buy things for yourself.....	NA	1	2	3	4	5
29. Money for family entertainment	NA	1	2	3	4	5
30. Money to save	NA	1	2	3	4	5
31. Time and money for travel/vacation	NA	1	2	3	4	5

Source: C. J. Dunst, C. M. Trivette, and A. G. Deal (1987). Enabling and Empowering Families: Principles and Guidelines for Practice. Cambridge, MA: Brookline Books.

Resource Scale for Teenage Mothers

Carl J. Dunst, Hope E. Leet, Sherra D. Vance, & Carolyn S. Cooper

Name _____ Date _____

This scale is designed to see whether or not you have adequate resources (money, time, energy, etc.) to meet your own needs and the needs of your child(ren). For each item please circle the number that best describes how well the needs are met on a day-to-day basis.

To what extent are the following resources adequate for your family and/or your child(ren):	Does Not Apply	Not at All Adequate	Seldom Adequate	Sometimes Adequate	Usually Adequate	Almost Always Adequate
1. Food for 2 meals a day	NA	1	2	3	4	5
2. House or apartment	NA	1	2	3	4	5
3. Money to buy necessities	NA	1	2	3	4	5
4. Enough clothes for you and your child(ren)	NA	1	2	3	4	5
5. Heat for your house or apartment	NA	1	2	3	4	5
6. Indoor plumbing/water	NA	1	2	3	4	5
7. Money to pay monthly bills	NA	1	2	3	4	5
8. Medical care for you and your child(ren)	NA	1	2	3	4	5
9. The time and resources (transportation, child-care, etc.) necessary to complete school	NA	1	2	3	4	5
10. Public assistance (SSI, AFDC, Medicaid, etc.)	NA	1	2	3	4	5
11. Dependable transportation (own car or provided by others)	NA	1	2	3	4	5
12. The time and resources (transportation, child-care, etc.) necessary to hold down a job	NA	1	2	3	4	5
13. Time to get enough sleep/rest	NA	1	2	3	4	5
14. Furniture for your home or apartment	NA	1	2	3	4	5
15. Time to be by yourself	NA	1	2	3	4	5
16. Time to be with your child(ren)	NA	1	2	3	4	5
17. Time to be with spouse or boyfriend	NA	1	2	3	4	5
18. Telephone or access to a phone	NA	1	2	3	4	5
19. Knowledge of birth control methods	NA	1	2	3	4	5
20. Babysitting for your child(ren)	NA	1	2	3	4	5
21. A safe environment to live in	NA	1	2	3	4	5
22. Dental care for you and your child(ren)	NA	1	2	3	4	5
23. Someone to talk to	NA	1	2	3	4	5
24. Time to be with friends	NA	1	2	3	4	5
25. Knowledge of how to take care of your child(ren)	NA	1	2	3	4	5
26. Time to keep in shape and look nice	NA	1	2	3	4	5
27. Toys for your child(ren)	NA	1	2	3	4	5
28. Money to buy things for yourself	NA	1	2	3	4	5
29. Money for family entertainment	NA	1	2	3	4	5
30. Money to save	NA	1	2	3	4	5
31. Time and money for travel/vacation	NA	1	2	3	4	5

Source: C. J. Dunst, C. M. Trivette, and A. G. Deal (1987). Enabling and Empowering Families: Principles and Guidelines for Practice. Cambridge, MA: Brookline Books.

Family Needs Scale

Carl J. Dunst, Carolyn J. Cooper, Janet C. Weeldreyer, Kathy D. Snyder, & Joyce M. Chase

Name _____ Date _____

This scale asks you to indicate if you have a need for any type of help or assistance in 41 different areas. Please circle the response that best describes how you feel about needing help in those areas.

To what extent do you feel a need for any of the following types of help or assistance:	Does Not Apply	Almost Never	Seldom	Sometimes	Often	Almost Always
1. Having money to buy necessities and pay bills.....	NA	1	2	3	4	5
2. Budgeting money.....	NA	1	2	3	4	5
3. Paying for special needs of my child.....	NA	1	2	3	4	5
4. Saving money for the future.....	NA	1	2	3	4	5
5. Having clean water to drink.....	NA	1	2	3	4	5
6. Having food for two meals for my family.....	NA	1	2	3	4	5
7. Having time to cook healthy meals for my family.....	NA	1	2	3	4	5
8. Feeding my child.....	NA	1	2	3	4	5
9. Getting a place to live.....	NA	1	2	3	4	5
10. Having plumbing, lighting, heat.....	NA	1	2	3	4	5
11. Getting furniture, clothes, toys.....	NA	1	2	3	4	5
12. Completing chores, repairs, home improvements.....	NA	1	2	3	4	5
13. Adapting my house for my child.....	NA	1	2	3	4	5
14. Getting a job.....	NA	1	2	3	4	5
15. Having a satisfying job.....	NA	1	2	3	4	5
16. Planning for future job of my child.....	NA	1	2	3	4	5
17. Getting where I need to go.....	NA	1	2	3	4	5
18. Getting in touch with people I need to talk to.....	NA	1	2	3	4	5
19. Transporting my child.....	NA	1	2	3	4	5
20. Having special travel equipment for my child.....	NA	1	2	3	4	5
21. Finding someone to talk to about my child.....	NA	1	2	3	4	5
22. Having someone to talk to.....	NA	1	2	3	4	5
23. Having medical and dental care for my family.....	NA	1	2	3	4	5
24. Having time to take care of myself.....	NA	1	2	3	4	5
25. Having emergency health care.....	NA	1	2	3	4	5
26. Finding special dental and medical care for my child.	NA	1	2	3	4	5
27. Planning for future health needs.....	NA	1	2	3	4	5
28. Managing the daily needs of my child at home.....	NA	1	2	3	4	5
29. Caring for my child during work hours.....	NA	1	2	3	4	5
30. Having emergency child care.....	NA	1	2	3	4	5
31. Getting respite care for my child.....	NA	1	2	3	4	5
32. Finding care for my child in the future.....	NA	1	2	3	4	5
33. Finding a school placement for my child.....	NA	1	2	3	4	5
34. Getting equipment or therapy for my child.....	NA	1	2	3	4	5
35. Having time to take my child to appointments.....	NA	1	2	3	4	5
36. Exploring future educational options for my child....	NA	1	2	3	4	5
37. Expanding my education, skills, and interests.....	NA	1	2	3	4	5
38. Doing things that I enjoy.....	NA	1	2	3	4	5
39. Doing things with my family.....	NA	1	2	3	4	5
40. Participation in parent groups or clubs.....	NA	1	2	3	4	5
41. Traveling/vacationing with my child.....	NA	1	2	3	4	5

Source: C. J. Dunst, C. M. Trivette, and A. G. Deal (1987). Enabling and Empowering Families: Principles and Guidelines for Practice. Cambridge, MA: Brookline Books.

[redacted] - FAMILIES 8/83 Child's Name/ID _____

Date: ___/___/___ Child's Birthdate ___/___/___

_____
Respondent's relationship to child

A Survey of Family Needs

Listed below are some of the needs expressed by parents of special children. We are interested in what you would like help with. Please read each statement. If it is definitely not a need for you at this time, circle number 1. If you are not sure about whether you would like help in this area, circle number 2. If it is definitely a need for you and you would like help at this time, please circle number 3.

NEED	I definitely do not need help with this	Not Sure	I definitely need help with this
A. Needs for Information			
1. I need more information about my child's condition or disability	1	2	3
2. I need more information about how to handle my child's behavior	1	2	3
3. I need more information about how to teach my child	1	2	3
4. I need more more information on how to play with or talk to my child	1	2	3
5. I need more information on the services that are presently available for my child	1	2	3
6. I need more information about the services that my child might receive in the future	1	2	3
7. I need more information about how children grow and develop	1	2	3
B. Needs for Support			
1. I need to have someone in my family that I can talk to more about problems	1	2	3
2. I need to have more friends that I can talk to	1	2	3

NEED	I definitely do not need help with this	Not Sure	I definitely need help with this
3. I need to have more opportunities to meet and talk with other parents of handicapped children	1	2	3
4. I need to have more time just to talk with my child's teacher or therapist	1	2	3
5. I would like to meet more regularly with a counselor (psychologist, social worker, psychiatrist) to talk about problems	1	2	3
6. I need to talk more to a minister who could help me deal with problems	1	2	3
7. I need reading material about other parents who have a child similar to mine	1	2	3
8. I need to have more time for myself	1	2	3
Explaining to Others			
1. I need more help in how to explain my child's condition to his/her siblings	1	2	3
2. I need more help in explaining my child's condition to either my parents or my spouse's parents	1	2	3
3. My spouse needs help in understanding and accepting this child's condition	1	2	3
4. I need help in knowing how to respond when friends, neighbors, or strangers ask questions about my child's condition	1	2	3
5. I need help in explaining my child's condition to other children	1	2	3
Community Services			
1. I need help locating a doctor who understands me and my child's needs	1	2	3
2. I need help locating a dentist who will see my child	1	2	3

NEED	I definitely do not need help with this	Not Sure	I definitely need help with this
3. I need help locating babysitters or respite care providers who are willing and able to care for my child	1	2	3
4. I need help locating a day care center or preschool for my child	1	2	3
5. I need help in getting appropriate care for my child in our church or synagogue nursery during church services	1	2	3
Financial Needs			
1. I need more help in paying for expenses such as food, housing, medical care, clothing, or transportation	1	2	3
2. I need more help in getting special equipment for my child's needs	1	2	3
3. I need more help in paying for therapy, day care, or other services my child needs	1	2	3
4. I or my spouse need more counseling or help in getting a job	1	2	3
5. I need more help paying for babysitting or respite care	1	2	3
6. I need more help paying for toys that my child needs	1	2	3
Family Functioning			
1. Our family needs help in discussing problems and reaching solutions	1	2	3
2. Our family needs help in learning how to support each other during difficult times	1	2	3
3. Our family needs help in deciding who will do household chores, child care, and other family tasks	1	2	3
4. Our family needs help in deciding on and doing recreational activities	1	2	3

Appendix D.

Social Support Scales

Carolina Parent Support Scale
Family Support Scale
Inventory of Social Support
Personal Network Matrix

SUPPORT PROJECT
CIREPH II
(May 1983 Version)

CAROLINA PARENT SUPPORT SCALE

CHILDHOOD VERSION
(Two-Parent Families)

Code = 7 if NC
Code = 8 if NA
Code = 9 for Column #20

NA = Not Available
NC = Available, but No Contact with them

	NA	NC	NOT AT ALL HELPFUL	SOMEWHAT HELPFUL	MODERATELY HELPFUL	QUITE HELPFUL	EXTREMELY HELPFUL
2. Husband (or wife)	NA	NC	0	1	2	3	4
3. My relatives	NA	NC	0	1	2	3	4
4. My husband's (or wife's) relatives	NA	NC	0	1	2	3	4
5. My own children	NA	NC	0	1	2	3	4
6. Friends	NA	NC	0	1	2	3	4
7. Other parents of children with special needs (informal)	NA	NC	0	1	2	3	4
8. Parent group for parents of special children	NA	NC	0	1	2	3	[illegible]
9. Neighbors	NA	NC	0	1	2	3	4
10. Babysitter	NA	NC	0	1	2	3	4
11. Medical doctor	NA	NC	0	1	2	3	4
12. Church or synagogue	NA	NC	0	1	2	3	4
13. TEACCH parent services	NA	NC	[illegible]	[illegible]	2	[illegible]	[illegible]
14. Other parent training or counseling	NA	NC	0	1	2	3	4
15. TEACCH program	NA	NC	0	1	2	3	[illegible]
16. Other special education program	NA	NC	0	1	2	3	4
17. Mental Health Center	NA	NC	0	1	2	3	4
18. Developmental Evaluation Center (DEC)	NA	NC	0	1	2	3	4
19. Social Services	NA	NC	0	1	2	3	[illegible]
20. Day Care Program	NA	NC	0	1	2	3	[illegible]
21. Respite Care Program	NA	NC	0	1	2	3	4

(1-40)

Bristol, 1979, revised [illegible] 1983

[illegible] with permission, from the [illegible] by [illegible]

...SUPPORT PROJECT
...CHECH II
...ay 1983 Version)

CAROLINA PARENT SUPPORT SCALE

CHILDHOOD VERSION
(Single-Parent Families)

FOR FSU Use ONLY
Card Number: ___ (1-2)
(Duplicate Columns 73-19)

Code = 8 1...

- = Not Available
C = Available, but No Contact with them

	NA	NC	NOT AT ALL HELPFUL	SOMEWHAT HELPFUL	MODERATELY HELPFUL	QUITE HELPFUL	EXTREMELY HELPFUL
1. My boyfriend/partner	NA	NC	0	1	2	3	4
2. Child's father	NA	NC	0	1	2	3	4
3. My relatives	NA	NC	0	1	2	3	4
4. Child's father's relatives	NA	NC	0	1	2	3	4
5. My own children	NA	NC	0	1	2	3	4
6. Friends	NA	NC	0	1	2	3	4
7. Other parents of children with special needs (informal)	NA	NC	0	1	2	3	4
8. Parent group for parents of special children	NA	NC	0	1	2	3	4
9. Neighbors	NA	NC	0	1	2	3	4
10. Babysitter	NA	NC	0	1	2	3	4
11. Medical Doctors	NA	NC	0	1	2	3	4
12. Church or synagogue	NA	NC	0	1	2	3	4
13. (Name of Program) parent services	NA	NC	0	1	2	3	4
14. Other parent training or counseling	NA	NC	0	1	2	3	4
15. (Name of Program) educational program for child	NA	NC	0	1	2	3	4
16. Other special education programs	NA	NC	0	1	2	3	4
17. Mental Health Center	NA	NC	0	1	2	3	4
18. Developmental Evaluation Center (DEC)	NA	NC	0	1	2	3	4
19. Social Services	NA	NC	0	1	2	3	4
20. Early Intervention	NA	NC	0	1	2	3	4
21. Respite Care Program	NA	NC	0	1	2	3	4

(...)

...ol, 1979, revised 1981, 1983

...with permission, from the book of scale booklets by D. Dunst

Family Support Scale

Carl J. Dunst, Vicki Jenkins, & Carol M. Trivette

Name _____ Date _____

Listed below are people and groups that oftentimes are helpful to members of a family raising a young child. This questionnaire asks you to indicate how helpful each source is to your family. Please circle the response that best describes how helpful the sources have been to your family during the past 3 to 6 months. If a source of help has not been available to your family during this period of time, circle the NA (Not Available) response.

How helpful has each of the following been to you in terms of raising your child(ren):	Not Available	Not at all Helpful	Sometimes Helpful	Generally Helpful	Very Helpful	Extremely Helpful
1. My parents	NA	1	2	3	4	5
2. My spouse or partner's parents	NA	1	2	3	4	5
3. My relatives/kin	NA	1	2	3	4	5
4. My spouse or partner's relatives/kin	NA	1	2	3	4	5
5. Spouse or partner	NA	1	2	3	4	5
6. My friends	NA	1	2	3	4	5
7. My spouse or partner's friends	NA	1	2	3	4	5
8. My own children	NA	1	2	3	4	5
9. Other parents	NA	1	2	3	4	5
10. Co-workers	NA	1	2	3	4	5
11. Parent groups	NA	1	2	3	4	5
12. Social groups/clubs	NA	1	2	3	4	5
13. Church members/minister	NA	1	2	3	4	5
14. My family or child's physician	NA	1	2	3	4	5
15. Early childhood intervention program	NA	1	2	3	4	5
16. School/day care center	NA	1	2	3	4	5
17. Professional helpers (social workers, therapists, teachers, etc.)	NA	1	2	3	4	5
18. Professional agencies (public health, social services, mental health, etc.)	NA	1	2	3	4	5
19. _____	NA	1	2	3	4	5
20. _____	NA	1	2	3	4	5

Source: C. J. Dunst, C. M. Trivette, and A. G. Deal (1987). Enabling and Empowering Families: Principles and Guidelines for Practice. Cambridge, MA: Brookline Books. May be reproduced.

INVENTORY OF SOCIAL SUPPORT

Carol M. Trivette Carl J. Dunst

NAME _____ DATE _____

DIRECTIONS

This questionnaire asks about people and groups that may provide you help and assistance. The scale is divided into two parts. Please read the instructions that go with each part before completing each section of the questionnaire.

Listed below are different individuals and groups that people often have contact with face-to-face, in a group, or by telephone. For each source listed, please indicate how often you have been in contact with each person or group during the past month. Please indicate any person or group with whom you have had contact not included on the list.

How frequently have you had contact with each of the following during the past month:	Not At All	Once or Twice	Up To 10 Times	Up To 20 Times	Almost Every-Day
1. Spouse or Partner	1	2	3	4	5
2. My Children	1	2	3	4	5
3. My Parents	1	2	3	4	5
4. Spouse or Partner's Parents	1	2	3	4	5
5. My Sister/Brother	1	2	3	4	5
6. My Spouse or Partner's Sister/Brother	1	2	3	4	5
7. Other Relatives	1	2	3	4	5
8. Friends	1	2	3	4	5
9. Neighbors	1	2	3	4	5
10. Church Members/Minister	1	2	3	4	5
11. Co-Workers	1	2	3	4	5
12. Babysitter, Daycare or School	1	2	3	4	5
13. Private Therapist for Child	1	2	3	4	5
14. Child/Family Doctors	1	2	3	4	5
15. Early Childhood Intervention Program	1	2	3	4	5
16. Health Department	1	2	3	4	5
17. Social Service Department	1	2	3	4	5
18. Other Agencies	1	2	3	4	5
19. _____	1	2	3	4	5
20. _____	1	2	3	4	5

INSTR

Listed below are 12 different types of help and assistance that people sometimes need and 13 different assistance listed, please indicate which persons or groups you go to when you need these types of help

Which persons or groups listed to the right provide you help or assistance with each of the following:	Myself	Spouse or Partner	My Children	My Parents	Spouse or Partner's Parents	Sister/ Brother	Spouse or Partner's Sister/ Brother	Other Relatives
1. Who do you go to for help or to talk with?								
2. Who helps take care of your child?								
3. Who do you talk to when you have questions about raising your child?								
4. Who loans you money when you need it?								
5. Who encourages or keeps you going when things get hard?								
6. Who accepts your child regardless of how (s)he behaves or acts?								
7. Who helps you with household chores?								
8. Who do you do things with to have fun, just relax, or joke around?								
9. Who takes the time to do things with your child?								
10. Who takes you and your child places when you need transportation?								
11. Who hassels with agencies and individuals when you feel you can't get what you need or want?								
12. Who helps you learn about services for your child and family?								

UCTIONS

people and groups who sometimes are asked for help and assistance. For each of the 12 types of help and . Indicate who provides you help by checking the appropriate box for the person or group you ask for help.

Friends	Neighbors	Church Members/ Minister	Co-Workers	Babysitter, Day care or School	Private Therapist for Child	Child/ Family Doctors	Early Childhood Intervention Program	Health Depart.	Social Services Depart.	Other Agencies

PERSONAL NETWORK MATRIX

Carol M. Trivette Carl J. Dunst

NAME _____ DATE _____

DIRECTIONS

This questionnaire asks about people and groups that may provide you help and assistance. The scale is divided into three parts. Please read the instructions that go with each part before completing each section of the questionnaire.

Listed below are different individuals and groups that people often have contact with face to face, in a group or by telephone. Please indicate for each source listed how often you have been in contact with each person or group during the past month. Please include any other person or group with whom you have had contact not included on our list.

How frequently have you had contact with each of the following during the past month:	Not At All	Once or Twice	Up To 10 Times	Up To 20 Times	Almost Every Day
1. Spouse of Partner	1	2	3	4	5
2. My Children	1	2	3	4	5
3. My Parents	1	2	3	4	5
4. Spouse or Partner's Parents	1	2	3	4	5
5. Sister/Brother	1	2	3	4	5
6. Spouse or Partner's Sister/Brother	1	2	3	4	5
7. Other Relatives	1	2	3	4	5
8. Friends	1	2	3	4	5
9. Neighbors	1	2	3	4	5
10. Church Members	1	2	3	4	5
11. Minister, Priest, or Rabbi	1	2	3	4	5
12. Co-Workers	1	2	3	4	5
13. Baby Sitter	1	2	3	4	5
14. Day Care or School	1	2	3	4	5
15. Private Therapist for Child	1	2	3	4	5
16. Child/Family Doctors	1	2	3	4	5
17. Early Childhood Intervention Program	1	2	3	4	5
18. Hospital/Special Clinics	1	2	3	4	5
19. Health Department	1	2	3	4	5
20. Social Service Department	1	2	3	4	5
21. Other Agencies	1	2	3	4	5
22. _____	1	2	3	4	5
23. _____	1	2	3	4	5

Source: C. J. Dunst, C. M. Trivette, and A. G. Deal (1987). Enabling and Empowering Families: Principles and Guidelines for Practice. Cambridge, MA: Brookline Books.

INSTRUCTIONS

This part of the scale asks you to do two things: (1) Begin by listing up to 10 needs or activities that are of concern to you. We call these things projects because they require our time and energy. Projects include things like finding a job, paying the bills, finishing school, playing with our children, going on vacation, teaching your child how to eat, and so on. (2) After you have listed up to 10 projects, please indicate which persons or groups you could go to if you need help with any of the projects. Indicate who would provide you help by checking the appropriate box for the person or group that you would ask.

Which person or groups to the right would you go to for help with any of these projects:	Myself	Spouse or Partner	My Children	My Parents	Spouse or Partner's Parents	Sister/ Brother	Spouse or Partner's Sister/ Brother	Other Relatives	Friends	Neighbors	Church Members/ Minister	Co-Workers	Baby Sitter, Day care or School	Private Therapist for Child	Child/ Family Doctors	Early Childhood Intervention Program	Health Dept.	Social Services Dept.	Other Agencies
Projects																			
1.																			
2.																			
3.																			
4.																			
5.																			
6.																			
7.																			
8.																			
9.																			
10.																			

Whenever a person needs help or assistance, he or she generally can depend upon certain persons or groups more than others. Listed below are different individuals, groups, and agencies that you might ask for help or assistance. For each source listed, please indicate to what extent you could depend upon ecch person or group if you needed any type of help.

To what extent can you depend upon any of the following for help or assistance when you need it:	Not at All	Sometimes	Occasionally	Most of the Time	All of the Time
1. Spouse or Partner	1	2	3	4	5
2. My Children	1	2	3	4	5
3. My Parents	1	2	3	4	5
4. Spouse or Partner's Parents	1	2	3	4	5
5. My Sister/Brother	1	2	3	4	5
6. My Spouse or Partner's Sister/Brother	1	2	3	4	5
7. Other Relatives	1	2	3	4	5
8. Friends	1	2	3	4	5
9. Neighbors	1	2	3	4	5
10. Church Members	1	2	3	4	5
11. Minister, Priest, Rabbi	1	2	3	4	5
12. Co-Workers	1	2	3	4	5
13. Baby Sitter	1	2	3	4	5
14. Day Care or School	1	2	3	4	5
15. Private Therapist for Child	1	2	3	4	5
16. Child/Family Doctors	1	2	3	4	5
17. Early Childhood Intervention Program	1	2	3	4	5
18. Hospital/Special Clinics	1	2	3	4	5
19. Health Departments	1	2	3	4	5
20. Social Service Department	1	2	3	4	5
21. Other Agencies	1	2	3	4	5
22. _____	1	2	3	4	5
23. _____	1	2	3	4	5

Source: C. J. Dunst, C. M. Trivette, and A. G. Deal (1987). Enabling and Empowering Families: Principles and and Guidelines for Practice. Cambridge, MA: Brookline Books. May be reproduced.

Appendix E.

Significant Life Stressor Scales

Family Inventory of Life Events and Changes
Life Experience Survey

FILE

Hamilton I. McCubbin, Joan M. Patterson & Lance R. Wilson

I. Intra-Family Strains
1. Increase of husband/father's time away from family.
2. Increase of wife/mother's time away from family.
3. A member appears to have emotional problems.
4. A member appears to depend on alcohol or drugs.
5. Increase in conflict between husband and wife.
6. Increase in arguments between parent(s) and child(ren).
7. Increase in conflict among children in the family.
8. Increased difficulty in managing teenage child(ren).
9. Increased difficulty in managing school age child(ren) (6-12 yrs.).
10. Increased difficulty in managing preschool age child(ren) (2 1/2-6 yrs.).
11. Increased difficulty in managing toddler(s) (1-2 1/2 yrs.).
12. Increased difficulty in managing infant(s) (0-1 yrs.).
13. Increase in the amount of "outside activities" which the child(ren) are involved in.
14. Increased disagreement about a member's friends or activities.
15. Increase in the number of problems or issues which don't get resolved.
16. Increase in the number of tasks or chores which don't get done.
17. Increased conflict with in-laws or relatives.

II. Marital Status
18. Spouse/parent was separated or divorced.
19. Spouse/parent has an "affair."
20. Increased difficulty in resolving issues with a "former" or separated spouse.
21. Increased difficulty with sexual relationsnip between husband and wife.

III. Pregnancy and Childbearing Strains
22. Family member experiencing menopause.
23. Spouse had unwanted or difficult pregnancy.
24. An unmarried member became pregnant.
25. A member had an abortion.
26. A member gave birth to or adopted a child.

IV. Finance and Business Strains
27. Took out a loan or refinanced a loan to cover increased expenses.
28. Went on welfare.
29. Change in conditions (economic, political, weather) which hurts family investments and/or income.
30. Change in Agriculture Market, Stock Market, or Land Values which hurts family investments and/or income.
31. A member started a new business.
32. Purchased or built a home.
33. A member purchased a car or other major item.
34. Increasing financial debts due to over-use of credit cards.
35. Increased strain on family "money" for medical/dental expenses.

*Item #22 was added to FILE for the AAL Study.

Family Social Science
University of Minnesota
297 McNeal Hall
St. Paul, Minnesota 551(

36. Increased strain on family "money" for food, clothing, energy, home care.
37. Increased strain on family "money" for child(ren)'s education.
38. Delay in receiving child support or alimony payments.

V. Work-Family Transitions and Strains
39. A member changed to a new job/career.
40. A member lost or quit a job.
41. A member retired from work.
42. A member started or returned to work.
43. A member stopped working for extended period (e.g., laid off, leave of absence, strike).
44. Decrease in satisfaction with job/career.
45. A member had increased difficulty with people at work.
46. A member was promoted at work or given more responsibilities.
47. Family moved to a new home/apartment.
48. A child/adolescent member changed to a new school.

VI. Illness and Family "Care" Strains
49. Parent/spouse became seriously ill or injured.
50. Child became seriously ill or injured.
51. Close relative or friend of the family became seriously ill.
52. A member became physically disabled or chronically ill.
53. Increased difficulty in managing a chronically ill or disabled member.
54. Member or close relative was committed to an institution or nursing home.
55. Increased responsibility to provide direct care or financial help to husband's and/or wife's parent(s).
56. Experienced difficulty in arranging for satisfactory child care.

VII. Losses
57. A parent/spouse died.
58. A child member died.
59. Death of husband's or wife's parent or close relative.
60. Close friend of the family died.
61. Married son or daughter was separated or divorced.
62. A member "broke up" a relationsnip with a close friend.

VII. Transitions "In and Out"
63. A member was married.
64. Young adult member left home.
65. A young adult member began college (or post high school training)
66. A member moved back home or a new person moved into the household.
67. A parent/spouse started school (or training program) after being away from school for a long time.

IX. Family Legal Violations
68. A member went to jail or juvenile detention.
69. A member was picked up by police or arrested.
70. Physical or sexual abuse or violence in the home.
71. A member ran away from home.
72. A member dropped out of school or was suspended from school.

Your name _____ Subject No. _____

Address _____

_____

Date _____

Phone No. _____

Date of your birth _____

UNIVERSITY OF WASHINGTON
School of Nursing
INFANT & FAMILY FOCUS

LIFE EXPERIENCES SURVEY

The following is a list of common events in the lives of most people that require some adjustments in their lives. Please think back over the last year and decide whether each of these happened to you. If it did, please place a check mark by that item.

For each item that you check, we'd like to know whether the event was a positive one for you or a negative one. If it had no impact on you, circle the 0. If it was a negative impact, circle one of the negative numbers: -3 for extremely negative, -2 for moderately negative, and -1 for somewhat negative. If it had a positive impact, circle one of the positive numbers: +3 for extremely positive, +2 for moderately positive, and +1 for slightly positive.

Section I. Personal events	extremely negative	moderately negative	somewhat negative	no impact	slightly positive	moderately positive	extremely positive
___ a. Major change in sleeping habits (much more or much less sleep)	-3	-2	-1	0	+1	+2	+3
___ b. Major change in eating habits (much more or much less food intake)	-3	-2	-1	0	+1	+2	+3
___ c. Pregnancy	-3	-2	-1	0	+1	+2	+3
___ d. Abortion	-3	-2	-1	0	+1	+2	+3
___ e. Major personal illness or injury	-3	-2	-1	0	+1	+2	+3
___ f. Outstanding personal achievement	-3	-2	-1	0	+1	+2	+3

Subject No. _____

Date _____

	extremely negative	moderately negative	somewhat negative	no impact	slightly positive	moderately positive	extremely positive
Section II. Changes in the makeup of your household							
___ a. Change in residence	-3	-2	-1	0	+1	+2	+3
___ b. Major change in living conditions (new home, remodeling, etc.)	-3	-2	-1	0	+1	+2	+3
___ c. Detention in jail or other institution	-3	-2	-1	0	+1	+2	+3
___ d. Partner in jail or other institution	-3	-2	-1	0	+1	+2	+3
Section III. Financial Changes							
___ a. Major change in financial status (a lot better off or a lot worse off)	-3	-2	-1	0	+1	+2	+3
___ b. Foreclosure on mortgage or loan	-3	-2	-1	0	+1	+2	+3
___ c. Borrowing more than $10,000 (buying a home, business, etc.)	-3	-2	-1	0	+1	+2	+3
___ d. Borrowing less than $10,000 (buying a car, TV, school loan)	-3	-2	-1	0	+1	+2	+3
Section IV. Changes in Work							
___ a. New job	-3	-2	-1	0	+1	+2	+3
___ b. Changed work situation (different responsibilities, working conditions, hours, etc.)	-3	-2	-1	0	+1	+2	+3
___ c. Trouble with employer	-3	-2	-1	0	+1	+2	+3
___ d. Being fired from job	-3	-2	-1	0	+1	+2	+3
___ e. Retirement from work	-3	-2	-1	0	+1	+2	+3

Subject No. _____

Date _____

	extremely negative	moderately negative	somewhat negative	no impact	slightly positive	moderately positive	extremely positive
Section V. Changes in your partner and your relationship							
___ a. Engagement	-3	-2	-1	0	+1	+2	+3
___ b. Marriage	-3	-2	-1	0	+1	+2	+3
___ c. Sexual difficulties	-3	-2	-1	0	+1	+2	+3
___ d. Major change in number of arguments (many more or many fewer)	-3	-2	-1	0	+1	+2	+3
___ e. Breaking up with boyfriend	-3	-2	-1	0	+1	+2	+3
___ f. Separation from spouse (due to work, travel, etc.)	-3	-2	-1	0	+1	+2	+3
___ g. Separation from spouse (due to conflict)	-3	-2	-1	0	+1	+2	+3
___ h. Reconciliation with boyfriend	-3	-2	-1	0	+1	+2	+3
___ i. Reconciliation with husband	-3	-2	-1	0	+1	+2	+3
___ j. Change in husband/partner's work (new job, new hours, etc.)	-3	-2	-1	0	+1	+2	+3
___ k. Divorce	-3	-2	-1	0	+1	+2	+3
___ l. Death of husband	-3	-2	-1	0	+1	+2	+3
Section VI. Changes in your family							
___ a. Major change in closeness of family	-3	-2	-1	0	+1	+2	+3
___ b. Trouble with in-laws	-3	-2	-1	0	+1	+2	+3
___ c. Gaining a new family member (through birth, adoption, moving in, etc.)	-3	-2	-1	0	+1	+2	+3
___ d. Son or daughter leaving home (school, marriage, own apartment)	-3	-2	-1	0	+1	+2	+3

Subject No. _____

Date _____

Section VI. (continued)

	extremely negative	moderately negative	somewhat negative	no impact	slightly positive	moderately positive	extremely positive
___ e. Leaving home for the first time yourself	-3	-2	-1	0	+1	+2	+3
___ f. Serious illness or injury of close family member:							
___ Father	-3	-2	-1	0	+1	+2	+3
___ Mother	-3	-2	-1	0	+1	+2	+3
___ Sister	-3	-2	-1	0	+1	+2	+3
___ Brother	-3	-2	-1	0	+1	+2	+3
___ Grandfather	-3	-2	-1	0	+1	+2	+3
___ Grandmother	-3	-2	-1	0	+1	+2	+3
___ Husband	-3	-2	-1	0	+1	+2	+3
___ Other	-3	-2	-1	0	+1	+2	+3
___ g. Death of a family member:							
___ Mother	-3	-2	-1	0	+1	+2	+3
___ Father	-3	-2	-1	0	+1	+2	+3
___ Brother	-3	-2	-1	0	+1	+2	+3
___ Sister	-3	-2	-1	0	+1	+2	+3
___ Grandmother	-3	-2	-1	0	+1	+2	+3
___ Grandfather	-3	-2	-1	0	+1	+2	+3
___ Other (sepcify _____)	-3	-2	-1	0	+1	+2	+3

Subject No. _____

Date _____

	extremely negative	moderately negative	somewhat negative	no impact	slightly positive	moderately positive	extremely positive
Section VII. Changes in Friends and Social Events							
___ a. Serious injury or illness of close friend	-3	-2	-1	0	+1	+2	+3
___ b. Death of a close friend	-3	-2	-1	0	+1	+2	+3
___ c. Minor law violations (like traffic tickets)	-3	-2	-1	0	+1	+2	+3
___ d. Major change in usual type and/or amount of recreation	-3	-2	-1	0	+1	+2	+3
___ e. Major change in social activities (kind or amount of participation)	-3	-2	-1	0	+1	+2	+3
___ f. Major change in church activities (increased or decreased attendance)	-3	-2	-1	0	+1	+2	+3
___ g. End of formal schooling	-3	-2	-1	0	+1	+2	+3
___ h. Other experiences which have had an impact on your life. List and rate:							
_____	-3	-2	-1	0	+1	+2	+3
_____	-3	-2	-1	0	+1	+2	+3
_____	-3	-2	-1	0	+1	+2	+3

Appendix F.

Quality of the Caregiving Environment Scales

Home Observation for Measurement of the Environment
Nursing Child Assessment Feeding Scale
Nursing Child Assessment Teaching Scale

UNIVERSITY OF WASHINGTON
SCHOOL OF NURSING
NURSING CHILD ASSESSMENT TRAINING

HOME OBSERVATION FOR MEASUREMENT OF THE ENVIRONMENT
(BIRTH TO THREE YEARS)

[redacted] PERSON OBSERVED (CIRCLE)
MOTHER FATHER OTHER

[redacted] MAJOR CAREGIVER (CIRCLE)
YES NO

[redacted] MOTHER'S EDUCATION (CIRCLE)
6 YRS OR LESS 7-8-9-10-11-12-13-14
15-16-17-18-19-20+

[redacted] MARITAL STATUS (CIRCLE)
MARRIED NOT MARRIED

CHILD'S FIRST NAME _____
CHILD'S AGE (IN MONTHS) _____
CHILD'S SEX _____
CHILD'S RACE _____
PARITY _____
MOTHER'S AGE (AT BIRTH OF CHILD) _____

		YES	NO
I	EMOTIONAL AND VERBAL RESPONSIVITY OF MOTHER		
[redacted]	MOTHER SPONTANEOUSLY VOCALIZES TO CHILD AT LEAST TWICE DURING VISIT (EXCLUDING SCOLDING)		
[redacted]	MOTHER RESPONDS TO CHILD'S VOCALIZATIONS WITH VERBAL RESPONSE		
[redacted]	MOTHER TELLS CHILD THE NAME OF SOME OBJECT DURING VISIT OR SAYS NAME OF PERSON OR OBJECT IN A TEACHING STYLE		
[redacted]	MOTHER'S SPEECH IS DISTINCT CLEAR AND AUDIBLE		
[redacted]	MOTHER INITIATES VERBAL INTERCHANGES WITH OBSERVER—ASKS QUESTIONS MAKES SPONTANEOUS COMMENTS		
[redacted]	MOTHER EXPRESSES IDEAS FREELY AND EASILY AND USES STATEMENTS OF APPROPRIATE LENGTH FOR CONVERSATIONS (E.G. GIVES MORE THAN BRIEF ANSWERS)		
07	MOTHER PERMITS CHILD OCCASIONALLY TO ENGAGE IN "MESSY" TYPES OF PLAY		
[redacted]	MOTHER SPONTANEOUSLY PRAISES THE CHILD'S QUALITIES OR BEHAVIOR TWICE DURING VISIT		
[redacted]	WHEN SPEAKING OF OR TO CHILD MOTHER'S VOICE CONVEYS POSITIVE FEELING		
10	MOTHER CARESSES OR KISSES CHILD AT LEAST ONCE DURING VISIT		
[redacted]	MOTHER SHOWS SOME POSITIVE EMOTIONAL RESPONSES TO PRAISE OF CHILD OFFERED BY VISITOR		
	SUBSCALE TOTAL (NO. OF YES ANSWERS)		
II	AVOIDANCE OF RESTRICTION AND PUNISHMENT		
[redacted]	MOTHER DOES NOT SHOUT AT CHILD DURING VISIT		
13	MOTHER DOES NOT EXPRESS OVERT ANNOYANCE WITH OR HOSTILITY TOWARD CHILD		
[redacted]	MOTHER NEITHER SLAPS NOR SPANKS CHILD DURING VISIT		
[redacted]	MOTHER REPORTS THAT NO MORE THAN ONE INSTANCE OF PHYSICAL PUNISHMENT OCCURRED DURING THE PAST WEEK		
[redacted]	MOTHER DOES NOT SCOLD OR DEROGATE CHILD DURING VISIT		
[redacted]	MOTHER DOES NOT INTERFERE WITH CHILD'S ACTIONS OR RESTRICT CHILD'S MOVEMENTS MORE THAN 3 TIMES DURING MY VISIT		
[redacted]	AT LEAST TEN BOOKS ARE PRESENT AND VISIBLE		
[redacted]	FAMILY HAS A PET		
	SUBSCALE TOTAL (NO. OF YES ANSWERS)		
III	ORGANIZATION OF ENVIRONMENT		
[redacted]	WHEN MOTHER IS AWAY CARE IS PROVIDED BY ONE OF THREE REGULAR SUBSTITUTES		
21	SOMEONE TAKES CHILD TO GROCERY STORE AT LEAST ONCE A WEEK		
[redacted]	CHILD GETS OUT OF HOUSE AT LEAST FOUR TIMES A WEEK		
[redacted]	CHILD IS TAKEN REGULARLY TO DOCTOR'S OFFICE OR CLINIC		
[redacted]	CHILD HAS A SPECIAL PLACE IN WHICH TO KEEP HIS TOYS AND "TREASURES"		

[redacted] ITEMS WHICH MAY REQUIRE DIRECT QUESTIONS

		YES	NO
25	CHILD'S PLAY ENVIRONMENT APPEARS SAFE AND FREE OF HAZARDS		
	SUBSCALE TOTAL (NO. OF YES ANSWERS)		
IV	PROVISION OF APPROPRIATE PLAY MATERIAL		
26	CHILD HAS SOME MUSCLE ACTIVITY TOYS OR EQUIPMENT		
27	CHILD HAS PUSH OR PULL TOY		
28	CHILD HAS STROLLER OR WALKER RIDDE CAR SCOOTER OR TRICYCLE		
29	MOTHER PROVIDES TOYS OR INTERESTING ACTIVITIES FOR CHILD DURING INTERVIEW		
30	PROVIDES LEARNING EQUIPMENT APPROPRIATE TO AGE—CUDDLY TOY OR ROLE PLAYING TOYS		
31	PROVIDES LEARNING EQUIPMENT APPROPRIATE TO AGE—MOBILE TABLE AND CHAIRS HIGH CHAIR PLAY PEN		
32	PROVIDES EYE-HAND COORDINATION TOYS—ITEMS TO GO IN AND OUT OF RECEPTACLE FIT TOGETHER TOYS BEADS		
33	PROVIDES EYE-HAND COORDINATION TOYS THAT PERMIT COMBINATIONS—STACKING OR NESTING TOYS BLOCKS OR BUILDING TOYS		
34	PROVIDES TOYS FOR LITERATURE AND MUSIC		
	SUBSCALE TOTAL (NO. OF YES ANSWERS)		
V	MATERNAL INVOLVEMENT WITH CHILD		
35	MOTHER TENDS TO KEEP CHILD WITHIN VISUAL RANGE AND TO LOOK AT HIM OFTEN		
36	MOTHER TALKS TO CHILD WHILE DOING HER WORK		
37	MOTHER CONSCIOUSLY ENCOURAGES DEVELOPMENTAL ADVANCE		
38	MOTHER INVESTS MATURING TOYS WITH VALUE VIA HER ATTENTION		
39	MOTHER STRUCTURES CHILD'S PLAY PERIODS		
40	MOTHER PROVIDES TOYS THAT CHALLENGE CHILD TO DEVELOP NEW SKILLS		
	SUBSCALE TOTAL (NO. OF YES ANSWERS)		
VI	OPPORTUNITIES FOR VARIETY IN DAILY STIMULATION		
41	FATHER PROVIDES SOME CARETAKING EVERY DAY		
42	MOTHER READS STORIES AT LEAST THREE TIMES WEEKLY		
43	CHILD EATS AT LEAST ONE MEAL PER DAY WITH MOTHER AND FATHER		
44	FAMILY VISITS OR RECEIVES VISITS FROM RELATIVES (APPROX ONCE A MONTH)		
45	CHILD HAS THREE OR MORE BOOKS OF HIS OWN		
	SUBSCALE TOTAL (NO. OF YES ANSWERS)		

TOTALS FOR EACH CATEGORY	
TIONAL AND VERBAL RESPONSIVITY OF MOTHER	
VOIDANCE OF RESTRICTION AND PUNISHMENT	
GANIZATION OF ENVIRONMENT	
VISION OF APPROPRIATE PLAY MATERIAL	
ATERNAL INVOLVEMENT WITH CHILD	
PORTUNITIES FOR VARIETY IN DAILY STIMULATION	
TOTAL SCORE END OF YES ANSWERS	

AMPLES OF SELECTED QUESTIONS FOR THE HOME (BIRTH-3 YEARS)

SECTION I EMOTIONAL AND VERBAL RESPONSIVITY OF MOTHER

ITEM 7 MESSINESS "DOES HE SOMETIMES WANT TO PLAY IN HIS FOOD OR IN HIS BATH? OR DO YOU SOMETIMES LET HIM PLAY AND BE MESSY?

SECTION II AVOIDANCE OF RESTRICTION AND PUNISHMENT

ITEM 15 DISCIPLINE HOW DO YOU MANAGE HIS DISCIPLINE AT THIS AGE—WHAT WORKS THE BEST? IN GENERAL DOES HE MIND PRETTY WELL OR DO YOU HAVE TO OCCASIONALLY SLAP HIS HANDS OR PHYSICALLY PUNISH HIM IN SOME WAY?
IF YES PROBE FOR NUMBER OF TIMES IN THE PAST WEEK

SECTION III ORGANIZATION OF ENVIRONMENT

ITEM 20 "NOW ABOUT YOUR TIME OUTSIDE THE HOME AND AWAY FROM YOUR CHILD DO YOU HAVE A REGULAR SITTER THAT YOU CAN COUNT ON OR DO YOU HAVE TO GET SOMEONE DIFFERENT EACH TIME?
PROBE FOR GROCERY STORE (ONCE A WEEK
RELATIVES (MONTHLY)

ITEM 21 & 22 "NOW ABOUT HIS TIME OUT OF THE HOME WHERE ARE SOME OF THE PLACES YOU TAKE HIM AND ABOUT HOW OFTEN DOES HE GET OUT OF THE HOUSE EACH WEEK?
PROBE FOR GROCERY STORE (ONCE PER WEEK
RELATIVES (MONTHLY)

ITEM 24 SPECIAL PLACE FOR TOYS (SMALL)
ASK THIS AT THE END OF THE INTERVIEW SAYING "I'M INTERESTED IN SEEING SOME OF YOUR CHILD'S TOYS WHERE HE KEEPS THEM AND SOME OF HIS FAVORITE THINGS TO PLAY WITH

SECTION V MATERNAL INVOLVEMENT WITH CHILD
(CAN ASK WHILE LOOKING AT CHILD'S TOYS)

ITEM 36 "DO YOU SOMETIMES FIND YOURSELF MAKING CONVERSATION WITH HIM WHILE YOU'RE WORKING AROUND THE HOUSE OR IS HE USUALLY ASLEEP WHILE YOU'RE DOING YOUR HOUSEWORK?

ITEM 37 "WHAT ARE SOME OF THE THINGS YOU'RE HELPING YOUR CHILD TO LEARN AT THIS AGE?
PROBE FOR DEVELOPMENTALLY APPROPRIATE THINGS (E.G. SELF-FEEDING, WALKING, ETC.)

ITEM 38 "HOW DOES HE USUALLY GET STARTED PLAYING WITH A NEW TOY—DO YOU SHOW HIM HOW TO WORK IT AND TRY TO GET HIM INVOLVED WITH IT OR DOES HE USUALLY FIGURE IT OUT FOR HIMSELF?"

ITEM 39 "ON A DAY TO DAY BASIS HOW DOES HE GET STARTED PLAYING WITH HIS TOYS? DO YOU SOMETIMES SIT AND PLAY WITH HIM OR DOES HE USUALLY GET STARTED BY HIMSELF AND PLAY ALONE?

ITEM 40 "HOW DO YOU USUALLY DECIDE WHAT KINDS OF TOYS TO SELECT AND OFFER YOUR CHILD TO PLAY WITH AT THIS AGE—WHAT ARE SOME OF YOUR GUIDELINES?

LISTEN FOR TOYS THAT WILL CHALLENGE CHILD TO DEVELOP NEW SKILLS

SECTION VI OPPORTUNITIES FOR VARIETY IN DAILY STIMULATION

ITEM 41 & 42 HOW ABOUT BOOKS DOES HE HAVE SOME OF HIS OWN YET?
PROBE FOR NUMBER OF HIS OWN BOOKS

"DOES HE SOMETIMES LIKE FOR YOU TO READ TO HIM?
IF YES HOW MANY TIMES A WEEK DO YOU HAVE TIME TO DO THAT?

ITEM 43 "WHAT DOES HE DO WHILE YOU AND YOUR HUSBAND EAT YOUR MEALS? DOES HE USUALLY EAT WITH YOU OR DOES HE EAT AT ANOTHER TIME?

[redacted] (CIRCLE)
[redacted] YES NO

[redacted] OBSERVED IN INTERACTION (CIRCLE)
[redacted] MOTHER FATHER OTHER

[redacted] OR CAREGIVER (CIRCLE)
[redacted] YES NO

[redacted] OF FEEDING (CIRCLE)
[redacted] BREAST BOTTLE SOLID

[redacted] OF FEEDING (CIRCLE)
10 OR LESS 10-20 20-30 30 OR MORE

[redacted] (CIRCLE)
[redacted] HOME CLINIC OTHER

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FEEDING SCALE
(BIRTH TO ONE YEAR)

CHILD'S FIRST NAME _____

CHILD'S AGE (IN MONTHS) _____

CHILD'S SEX _____

CHILD'S RACE _____

PARITY _____

MOTHER'S EDUCATION (CIRCLE)
6 YRS OR LESS 7-8-9-10-11-12-13-14-15-16-17-18-19-20+

MARITAL STATUS (CIRCLE)
MARRIED NOT MARRIED

MOTHER'S AGE (AT BIRTH OF CHILD) _____

		YES	NO
	SENSITIVITY TO CUES		
1	[redacted] PARENT POSITIONS CHILD SO THAT CHILD IS SAFE BUT CAN MOVE HIS [redacted] ARMS		
2	PARENT POSITIONS CHILD SO THAT THE CHILD'S HEAD IS HIGHER THAN [redacted]		
3	[redacted] PARENT POSITIONS CHILD SO THAT TRUNK-TO-TRUNK CONTACT IS [redacted] MAINTAINED DURING MORE THAN HALF OF THE BREAST OR BOTTLE FEEDING (50%)		
4	PARENT POSITIONS CHILD SO THAT EYE-TO-EYE CONTACT IS POSSIBLE		
5	[redacted] PARENT'S FACE IS AT LEAST 7-8 INCHES OR MORE FROM THE CHILD'S [redacted] FACE DURING FEEDING EXCEPT WHEN KISSING / CARESSING HUGGING OR BURPING THE CHILD		
6	[redacted] PARENT SMILES VERBALIZES OR MAKES EYE CONTACT WITH CHILD [redacted] WHEN CHILD IS IN OPEN-FACE-GAZE POSITION		
7	[redacted] PARENT COMMENTS VERBALLY ON CHILD'S HUNGER CUES PRIOR TO FEEDING		
8	[redacted] PARENT COMMENTS VERBALLY ON CHILD'S SATIATION CUES BEFORE [redacted] TERMINATING FEEDING		
9	PARENT VARIES THE INTENSITY OF VERBAL STIMULATION DURING FEEDING		
10	[redacted] PARENT VARIES INTENSITY OF ROCKING OR MOVING THE CHILD DURING [redacted] THE FEEDING		
11	PARENT VARIES THE INTENSITY OF TOUCH DURING THE FEEDING		
12	[redacted] PARENT ALLOWS PAUSES IN FEEDING WHEN THE CHILD INDICATES BY [redacted] TURNS FACE AWAY HAND BACK ARCHING PULLING AWAY PUSHING FOOD AWAY TRAY POUNDING TURNING HEAD SHAKING HEAD NO OR SAYING NO OR FALLING ASLEEP OR WHEN CHILD IS IN PAUSE PHASE OF THE BURST-PAUSE SEQUENCE OF SUCKING (75% OF THE TIME)		
13	[redacted] PARENT SLOWS PACE OF FEEDING OR PAUSES WHEN CHILD AVERTS [redacted] GAZE PLACES HAND-TO-EAR HAND-TO-MOUTH HAND-BEHIND-HEAD HAND-BACK-OF-NECK HANDS OVER STOMACH YAWNS RUBS EYE OR DISPLAYS FEET MOVEMENT (75% OF THE TIME)		
14	[redacted] PARENT TERMINATES THE FEEDING WHEN THE CHILD TURNS HEAD [redacted] FALLS ASLEEP COMPRESSES LIPS PUSHES FOOD AWAY SHAKES HEAD NO OR SAYS NO ONCE OR MORE OR AFTER OTHER METHODS [redacted] REPOSITIONING BURPING OR WAITING) HAVE PROVED UNSUCCESSFUL		
15	PARENT DOES NOT INTERRUPT CHILD'S SUCKING OR CHEWING BY [redacted] REMOVING THE NIPPLE JIGGLING THE NIPPLE OR OFFERING THE CHILD MORE OR OTHER KINDS OF FOOD WHILE CHILD IS EATING		
16	[redacted] PARENT DOES NOT OFFER FOOD WHEN THE CHILD LOOKS AWAY LOOKS [redacted] DOWN TURNS AWAY OR TURNS AROUND		
	[redacted] SUBSCALE TOTAL (NO OF YES ANSWERS)		
	RESPONSE TO DISTRESS (INDICATE IN BOX WHETHER OCCURRED OR NOT IF NO DISTRESS MARK EACH BOX YES)		
	[redacted] CHILD SHOWS DISTRESS DURING THE FEEDING DOES THE PARENT		
17	[redacted] STOP OR START FEEDING IN RESPONSE TO THE CHILD'S DISTRESS		
18	CHANGE THE CHILD'S POSITION IN RESPONSE TO CHILD'S DISTRESS		
19	[redacted] MAKE POSITIVE OR SYMPATHETIC VERBALIZATION IN RESPONSE TO [redacted] CHILD'S DISTRESS		
20	CHANGES VOICE VOLUME TO SOFTER OR HIGHER PITCH IN RESPONSE TO CHILD'S DISTRESS		
21	[redacted] MAKES SOOTHING NON-VERBAL EFFORTS IN RESPONSE TO CHILD'S [redacted] DISTRESS		
22	DIVERTS CHILD'S ATTENTION BY PLAYING GAMES INTRODUCING A TOY [redacted] OR MAKING FACES IN RESPONSE TO CHILD'S DISTRESS		
23	[redacted] PARENT DOES NOT MAKE NEGATIVE VERBAL RESPONSE IN RESPONSE TO [redacted] CHILD'S DISTRESS		
24	[redacted] PARENT DOES NOT MAKE NEGATIVE COMMENTS TO HOME VISITOR [redacted] ABOUT CHILD IN RESPONSE TO CHILD'S DISTRESS		
	[redacted] MAY OCCUR ONCE TO SCORE YES		
25	PARENT DOES NOT YELL AT THE CHILD IN RESPONSE TO HIS DISTRESS		
26	PARENT DOES NOT USE ABRUPT MOVEMENTS OR ROUGH HANDLING IN RESPONSE TO CHILD'S DISTRESS		
27	PARENT DOES NOT SLAP HIT OR SPANK CHILD IN RESPONSE TO DISTRESS		
	SUBSCALE TOTAL (NO OF YES ANSWERS)		
III	SOCIAL-EMOTIONAL GROWTH FOSTERING		
28	PARENT PAYS MORE ATTENTION TO CHILD DURING FEEDING THAN TO OTHER PEOPLE OR THINGS IN ENVIRONMENT		
29	PARENT IS IN EN FACE POSITION FOR MORE THAN HALF OF THE FEEDING (50%)		
30	PARENT SUCCEEDS IN MAKING EYE CONTACT WITH CHILD ONCE DURING FEEDING		
31	PARENT'S FACIAL EXPRESSION CHANGES AT LEAST TWICE DURING FEEDING		
32	PARENT ENGAGES IN SOCIAL FORMS OF INTERACTION (PLAYS GAMES WITH CHILD AT LEAST ONCE DURING THE FEEDING		
33	PARENT USES POSITIVE STATEMENTS IN TALKING TO CHILD DURING THE FEEDING		
34	PARENT PRAISES CHILD OR SOME QUALITY OF THE CHILD'S BEHAVIOR DURING THE FEEDING		
35	PARENT HUMS CROONS SINGS OR CHANGES THE PITCH OF HIS/HER VOICE DURING THE FEEDING		
36	PARENT LAUGHS OR SMILES DURING THE FEEDING		
37	PARENT USES GENTLE FORMS OF TOUCHING DURING THE FEEDING		
38	PARENT SMILES VERBALIZES OR TOUCHES CHILD WITHIN 5 SECONDS OF CHILD SMILING OR VOCALIZING AT PARENT		
39	PARENT DOES NOT COMPRESS LIPS GRIMACE OR FROWN WHEN MAKING EYE CONTACT WITH CHILD		
40	PARENT DOES NOT SLAP HIT SHAKE OR GRAB CHILD OR CHILD'S EXTREMITIES DURING THE FEEDING		
41	PARENT DOES NOT MAKE NEGATIVE OR UNCOMPLIMENTARY REMARKS TO THE CHILD OR HOME VISITOR ABOUT THE CHILD OR CHILD'S BEHAVIOR		
	SUBSCALE TOTAL (NO OF YES ANSWERS		
IV	COGNITIVE GROWTH FOSTERING		
42	PARENT PROVIDES CHILD WITH OBJECTS FINGER FOODS TOYS AND OR UTENSILS		
43	PARENT ENCOURAGES AND/OR ALLOWS THE CHILD TO EXPLORE THE BREAST BOTTLE FOOD CUP BOWL OR THE PARENT DURING FEEDING		
44	PARENT TALKS TO THE CHILD USING TWO WORDS AT LEAST THREE TIMES DURING THE FEEDING		
45	PARENT VERBALLY DESCRIBES SOME ASPECT OF THE FOOD OR FEEDING SITUATION TO CHILD DURING FEEDING		
46	PARENT TALKS TO CHILD ABOUT THINGS OTHER THAN FOOD EATING OR THINGS RELATED TO THE FEEDING		
47	PARENT USES STATEMENTS THAT DESCRIBE ASK QUESTIONS OR EXPLAINS CONSEQUENCES OF BEHAVIOR MORE THAN COMMANDS IN TALKING TO THE CHILD		
48	PARENT VERBALIZES TO CHILD WITHIN FIVE SECONDS AFTER CHILD HAS VOCALIZED		
49	PARENT VERBALIZES TO CHILD WITHIN FIVE SECONDS AFTER CHILD'S MOVEMENT OF ARMS LEGS HANDS HEAD TRUNK		
50	PARENT DOES NOT TALK BABY TALK		
	SUBSCALE TOTAL (NO OF YES ANSWERS		

	YES	NO
[illegible]RITY OF CUES CHILD SIGNALS READINESS TO EAT		
CHILD DISPLAYS A BUILD-UP OF TENSION AT THE BEGINNING OF FEEDING		
CHILD DEMONSTRATES A DECREASE IN TENSION WITHIN A FEW MINUTES AFTER FEEDING HAS BEGUN		
CHILD HAS PERIODS OF ALERTNESS DURING THE FEEDING		
CHILD DISPLAYS AT LEAST TWO DIFFERENT EMOTIONS DURING THE FEEDING		
[illegible] AND INACTIVITY DURING THE FEEDING		
CHILD'S MOVEMENTS ARE SMOOTH AND COORDINATED DURING THE FEEDING		
CHILD'S ARM AND LEG MOVEMENTS ARE GENERALLY DIRECTED TOWARD PARENT DURING FEEDING (NOT DIFFUSE)		
CHILD MAKES CONTACT WITH PARENT'S FACE OR EYES AT LEAST ONCE DURING FEEDING		
CHILD VOCALIZES DURING FEEDING		
CHILD SMILES OR LAUGHS DURING FEEDING		
CHILD AVERTS GAZE LOOKS DOWN OR TURNS AWAY DURING FEEDING		
CHILD ACTIVELY RESISTS FOOD OFFERED		
CHILD DEMONSTRATES SATISFACTION AT END OF FEEDING THROUGH SLEEP FACIAL EXPRESSIONS DECREASED MUSCLE TONE ARMS EXTENDED ALONG SIDE VOCALIZATIONS OR CHANGE IN ACTIVITY LEVEL OR MOOD		
CHILD DOES NOT HAVE MORE THAN TWO RAPID STATE CHANGES DURING FEEDING		
SUBSCALE TOTAL (NO OF YES ANSWERS)		

[illegible]PONSIVENESS TO PARENT CHILD RESPONDS TO FEEDING ATTEMPTS BY PARENT DURING FEEDING		
CHILD RESPONDS TO GAMES SOCIAL PLAY OR SOCIAL CUES OF PARENT DURING FEEDING		
CHILD LOOKS IN THE DIRECTION OF THE PARENT'S FACE AFTER PARENT HAS ATTEMPTED TO ALERT THE CHILD VERBALLY OR NON-VERBALLY DURING FEEDING		
CHILD VOCALIZES TO PARENT DURING FEEDING		
CHILD VOCALIZES OR SMILES WITHIN 5 SECONDS OF PARENT'S VOCALIZATION		
CHILD SMILES AT PARENT DURING FEEDING		
CHILD EXPLORES PARENT OR REACHES OUT TO TOUCH PARENT DURING FEEDING		
CHILD SHOWS A CHANGE IN LEVEL OF MOTOR ACTIVITY WITHIN 5 SECONDS OF BEING HANDLED OR REPOSITIONED BY PARENT		
CHILD SHOWS POTENT NEGATIVE CUES DURING LAST HALF OF FEEDING		
CHILD SHOWS POTENT NEGATIVE CUES WITHIN 5 SECONDS AFTER PARENT MOVES CLOSER THAN 7 TO 8 INCHES FROM CHILD'S FACE		
CHILD DOES NOT TURN AWAY OR AVERT GAZE FROM PARENT DURING FIRST HALF OF FEEDING		
SUBSCALE TOTAL (NO OF YES ANSWERS)		

ENTER TOTALS FOR EACH CATEGORY	
SENSITIVITY TO CUES	
RESPONSE TO DISTRESS	
SOCIAL-EMOTIONAL GROWTH FOSTERING	
COGNITIVE GROWTH FOSTERING	
CLARITY OF CUES	
RESPONSIVENESS TO PARENT	
TOTAL (NO OF YES ANSWERS)	

HOME VISIT QUESTIONS

1 WOULD YOU SAY THIS WAS A TYPICAL FEEDING?
A YES B NO
IF NO, WHY NOT?

2 WERE YOU UNCOMFORTABLE DURING ANY PART OF THE FEEDING DUE TO MY PRESENCE?
A YES B NO
IF YES WHY?

3 DO YOU HAVE A[illegible]TIONS ABOUT THE FEEDING OR YOUR CHILD'S EATING?
A YES B
IF YES SPECIFY

4 OBSERVER'S COMMENTS

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TEACHING SCALE
(BIRTH TO THREE YEARS)

[redacted] OBSERVED IN INTERACTION (CIRCLE)
MOTHER FATHER OTHER

MAJOR CAREGIVER (CIRCLE)
YES NO

[redacted] TASK _____

[redacted] OF TEACHING (CIRCLE) MIN
1 or LESS 2 3 4 5 6 OR MORE

SETTING (CIRCLE)
HOME CLINIC OTHER

CHILD'S FIRST NAME _____
CHILD'S AGE (IN MONTHS) _____
CHILD'S SEX _____
CHILD'S RACE _____
PARITY _____
MOTHER'S EDUCATION (CIRCLE)
8 YRS OR LESS 7-8-9-10-11-12-13 14
15-16-17-18-19-20+
MARITAL STATUS (CIRCLE)
MARRIED NOT MARRIED
MOTHER'S AGE (AT BIRTH OF CHILD) _____

		YES	NO
	SENSITIVITY TO CUES		
1	PARENT POSITIONS CHILD SO CHILD IS SAFELY SUPPORTED		
	PARENT POSITIONS CHILD SO THAT CHILD CAN REACH AND MANIPULATE MATERIALS		
3	PARENT GETS THE CHILD'S ATTENTION BEFORE BEGINNING THE TASK AT THE OUTSET OF THE TEACHING INTERACTION		
	IN NEARLY ALL CASES PARENT GIVES INSTRUCTIONS ONLY WHEN THE CHILD IS ATTENTIVE (80%+)		
5	PARENT ALLOWS CHILD TO EXPLORE THE TASK MATERIALS FOR AT LEAST 5 SECONDS BEFORE GIVING THE FIRST TASK RELATED INSTRUCTION		
	PARENT POSITIONS CHILD SO THAT IT IS POSSIBLE FOR THEM TO HAVE EYE-TO-EYE CONTACT WITH ONE ANOTHER DURING THE TEACHING EPISODE		
	PARENT PAUSES WHEN CHILD INITIATES BEHAVIORS DURING THE TEACHING EPISODE		
8	PARENT PRAISES CHILD'S SUCCESSES OR PARTIAL SUCCESSES		
	PARENT ASKS FOR NO MORE THAN THREE PERFORMANCES WHEN CHILD IS SUCCESSFUL AT COMPLETING THE TASK		
10	PARENT CHANGES POSITION OF CHILD AND OR MATERIALS AFTER UNSUCCESSFUL ATTEMPT BY THE CHILD TO DO THE TASK		
	PARENT DOES NOT PHYSICALLY FORCE THE CHILD TO COMPLETE THE TASK		
	SUBSCALE TOTAL (NO OF YES ANSWERS)		
	RESPONSE TO DISTRESS (INDICATE WHETHER DISTRESS OCCURRED OR NO)		
	STOPS THE TEACHING EPISODE		
	MAKES POSITIVE SYMPATHETIC OR SOOTHING VERBALIZATION		
14	CHANGES VOICE VOLUME TO SOFTER OR HIGHER PITCH (DOES NOT YELL)		
	REARRANGES THE CHILD'S POSITION AND OR TASK MATERIALS		
	MAKES SOOTHING NON VERBAL RESPONSE E G PAT TOUCH ROCK CARESS KISS		
	DIVERTS CHILD'S ATTENTION BY PLAYING GAMES INTRODUCES NEW TOY		
	DOES NOT MAKE NEGATIVE COMMENTS TO THE CHILD		
	DOES NOT YELL AT THE CHILD		
	DOES NOT USE ABRUPT MOVEMENTS OR ROUGH HANDLING		
	DOES NOT SLAP HIT OR SPANK		
22	DOES NOT MAKE NEGATIVE COMMENTS TO HOME VISITOR ABOUT THE CHILD		
	SUBSCALE TOTAL (NO OF YES ANSWERS)		
	SOCIAL-EMOTIONAL GROWTH FOSTERING		
	PARENT'S BODY POSTURE IS RELAXED DURING THE TEACHING EPISODE (AT LEAST HALF THE TIME)		
	PARENT IS IN THE FACE-TO-FACE POSITION WITH THE CHILD DURING THE TEACHING INTERACTION (AT LEAST HALF THE TIME)		
	[illegible] LAUGHS OR SMILES AT CHILD DURING THE TEACHING		
	[illegible] GENTLY PATS CARESSES STROKES HUGS OR KISSES CHILD DURING EPISODE		

		YES	NO
27	PARENT SMILES OR TOUCHES CHILD WITHIN 5 SECONDS WHEN CHILD SMILES OR VOCALIZES		
28	PARENT PRAISES CHILD'S EFFORTS OR BEHAVIORS BROADLY (IN GENERAL) AT LEAST ONCE DURING THE EPISODE		
29	PARENT MAKES CONSTRUCTIVE OR ENCOURAGING STATEMENT TO THE CHILD DURING THE TEACHING INTERACTION		
30	PARENT DOES NOT VOCALIZE TO THE CHILD AT THE SAME TIME THE CHILD IS VOCALIZING		
31	PARENT DOES NOT MAKE GENERAL NEGATIVE OR UNCOMPLIMENTARY REMARKS ABOUT THE CHILD		
32	PARENT DOES NOT YELL AT THE CHILD DURING THE EPISODE		
33	PARENT DOES NOT MAKE CRITICAL NEGATIVE COMMENTS ABOUT THE CHILD'S TASK PERFORMANCE		
	SUBSCALE TOTAL (NO OF YES ANSWERS)		
IV	COGNITIVE GROWTH FOSTERING		
34	PARENT PROVIDES AN IMMEDIATE ENVIRONMENT WHICH IS FREE FROM DISTRACTIONS FROM ANIMATE SOURCES (SIBS PETS ETC)		
35	PARENT FOCUSES ATTENTION ON CHILD'S ATTENTION ON THE TASK DURING MOST OF THE TEACHING (60% OF THE TIME)		
36	AFTER PARENT GIVES INSTRUCTIONS AT LEAST 5 SECONDS IS ALLOWED FOR THE CHILD TO ATTEMPT THE TASK BEFORE PARENT INTERVENES AGAIN		
37	PARENT ALLOWS NON TASK MANIPULATION OF THE TASK MATERIALS AFTER THE ORIGINAL PRESENTATION		
38	PARENT DESCRIBES PERCEPTUAL QUALITIES OF THE TASK MATERIALS TO THE CHILD		
39	PARENT USES AT LEAST TWO DIFFERENT SENTENCES OR PHRASES TO DESCRIBE THE TASK TO THE CHILD		
40	PARENT USES EXPLANATORY VERBAL STYLE MORE THAN IMPERATIVE STYLE IN TEACHING THE CHILD		
41	PARENT'S DIRECTIONS ARE STATED IN CLEAR UNAMBIGUOUS LANGUAGE (AMBIGUOUS = TURN REACH UNAMBIGUOUS = TURN THE KNOB TOWARD ME)		
42	PARENT USES BOTH VERBAL DESCRIPTION AND MODELING SIMULTANEOUSLY IN TEACHING ANY PART OF THE TASK		
43	PARENT ENCOURAGES AND OR ALLOWS THE CHILD TO PERFORM THE TASK BEFORE INTRUDING IN ON THE USE OF TASK MATERIALS		
44	PARENT VERBALLY PRAISES CHILD AFTER CHILD HAS PERFORMED BETTER OR MORE SUCCESSFULLY THAN THE LAST ATTEMPT		
45	PARENT SMILES AND/OR NODS AFTER CHILD PERFORMS BETTER OR MORE SUCCESSFULLY THAN THE LAST ATTEMPT		
46	PARENT RESPONDS TO THE CHILD'S VOCALIZATIONS WITH VERBAL RESPONSE		
47	PARENT USES BOTH VERBAL AND NONVERBAL INSTRUCTIONS IN TEACHING THE CHILD		
48	PARENT USES TEACHING LOOPS IN INSTRUCTING CHILD (75% OF THE TIME)		
49	PARENT SIGNALS COMPLETION OF TASK TO CHILD VERBALLY OR NONVERBALLY		
50	PARENT SPENDS NOT MORE THAN 5 MINUTES AND NOT LESS THAN ONE MINUTE IN TEACHING THE CHILD THE TASK		
	SUBSCALE TOTAL (NO OF YES ANSWERS)		

	YES	NO
[redacted]TY OF CUES CHILD IS AWAKE		
[redacted]CHILD WIDENS EYES AND/OR SHOWS POSTURAL ATTENTION TO TASK SITUATION		
[redacted]CHILD CHANGES INTENSITY OR AMOUNT OF MOTOR ACTIVITY WHEN TASK MATERIAL IS PRESENTED		
[redacted]C..LD'S MOVEMENTS ARE CLEARLY DIRECTED TOWARD THE TASK MATERIALS OR AWAY FROM THE TASK OR TASK MATERIALS (NOT DIFFUSE)		
[redacted]CHILD MAKES CLEARLY RECOGNIZABLE ARM MOVEMENTS DURING THE TEACHING EPISODE (CLAPPING REACHING WAVING POUNDING POINTING PUSHING AWAY)		
[redacted]CHILD VOCALIZES WHILE LOOKING AT TASK MATERIALS		
[redacted]CHILD SMILES OR LAUGHS DURING THE EPISODE		
[redacted]CHILD GRIMACES OR FROWNS DURING THE TEACHING EPISODE		
[redacted]CHILD DISPLAYS POTENT DISENGAGEMENT CUES DURING THE TEACHING INTERACTION		
[redacted]CHILD DISPLAYS SUBTLE DISENGAGEMENT CUES DURING THE TEACHING INTERACTION		
[redacted]SUBSCALE TOTAL (NO OF YES ANSWERS		

RESPONSIVENESS TO PARENT		
[redacted]CHILD GAZES AT PARENT'S FACE OR TASK MATERIALS AFTER PARENT HAS SHOWN VERBAL OR NONVERBAL ALERTING BEHAVIOR		
62 CHILD ATTEMPTS TO ENGAGE PARENT IN EYE-TO-EYE CONTACT		
[redacted]THE CHILD LOOKS AT THE PARENT'S FACE OR EYES WHEN PARENT ATTEMPTS TO ESTABLISH EYE-TO-EYE CONTACT		
64 CHILD VOCALIZES OR BABBLES WITHIN 5 SECONDS AFTER PARENT'S VERBALIZATION		
[redacted]CHILD VOCALIZES OR BABBLES WITHIN 5 SECONDS AFTER PARENT'S GESTURES TOUCHING OR CHANGING FACIAL EXPRESSION		
66 CHILD SMILES AT PARENT WITHIN 5 SECONDS AFTER PARENT'S VERBALIZATION		
[redacted]CHILD SMILES AT PARENT WITHIN 5 SECONDS AFTER PARENT'S GESTURE TOUCH OR FACIAL EXPRESSION CHANGES		
[redacted]WHEN PARENT MOVES CLOSER THAN 8 INCHES FROM THE CHILD'S FACE—THE CHILD SHOWS SUBTLE AND OR POTENT DISENGAGEMENT CUES		
69 CHILD SHOWS SUBTLE AND OR POTENT DISENGAGEMENT CUES WITHIN 5 SECONDS AFTER PARENT CHANGES FACIAL EXPRESSION OR BODY MOVEMENTS		
[redacted]CHILD SHOWS SUBTLE AND OR POTENT DISENGAGEMENT CUES WITHIN 5 SECONDS AFTER PARENT'S VERBALIZATION		
71 THE CHILD SHOWS SUBTLE AND/OR POTENT DISENGAGEMENT CUES WHEN PARENT ATTEMPTS TO INTRUDE PHYSICALLY IN THE CHILD'S USE OF THE TASK MATERIAL		
72 CHILD PHYSICALLY RESISTS OR RESPONDS AGGRESSIVELY WHEN PARENT ATTEMPTS TO INTRUDE PHYSICALLY IN CHILD'S USE OF THE TASK MATERIAL		
[redacted]THE CHILD STOPS DISPLAYING DISTRESS CUES WITHIN 15 SECONDS AFTER PARENT'S SOOTHING ATTEMPTS		
[redacted]SUBSCALE TOTAL (NO OF YES ANSWERS)		

ENTER TOTALS FOR EACH CATEGORY	
SENSITIVITY TO CUES	
RESPONSE TO DISTRESS	
SOCIAL-EMOTIONAL GROWTH FOSTERING	
COGNITIVE GROWTH FOSTERING	
CLARITY OF CUES	
RESPONSIVENESS TO PARENT	
TOTAL (NO OF YES ANSWERS)	

1 WERE YOU UNCOMFORTABLE DURING ANY PART OF THE TEACHING DUE TO MY PRESENCE?

A YES B NO

IF YES WHY?

2 OBSERVER'S COMMENTS

Appendix G.

References

Affleck, G., Tennen, H., Allen, D.A., & Gershman, K. (1986). Perceived social support and maternal adaptation during the transition from hospital to home care of high risk infants. Infant Mental Health Journal, 7, 6-18.

Bailey, D. (In press). Management in early intervention. Journal of the Division for Early Childhood.

Bailey, D. (1987). Collaborative goal setting with families: Resolving differences in values and priorities for services. Topics in Early Childhood Special Education, 7, 59-71.

Bailey, D. and Simeonsson, R. (1985) Survey of family needs. Chapel Hill: University of North Carolina.

Barnard, K.B. (1978). Nursing child assessment feeding scale. Seattle: University of Washington School of Nursing.

Barnard, K.B. (1978). Nursing child assessment teaching scale. Seattle: University of Washington School of Nursing.

Barnard, K.B. (1985). Life experiences survey. Seattle: University of Washington.

Barnard, K.E., & Bee, H.L. (1985). The assessment of parent-infant interaction by observation of feeding and teaching. Unpublished paper, University of Washington, School of Nursing and the Child Development and Mental Retardation Center, Seattle.

Bee, H.L., Barnard, K.E., Eyres, S.J., Gray, C.A., Hammond, M.A., Spietz, A.L., Snyder, C., & Clark, B. (1982). Prediction of IQ and language skill from perinatal status, child performance, family characteristics, and mother-infant interaction. Child Development, 53, 1134-1156.

Belsky, J. (1985). Experimenting with the family in the newborn period. Child Development, 56, 407-414.

Belsky, J. and Steinberg, L.D. (1979). The effects of day care: A critical review. Annual Progress in Child Psychiatry and Child Development, 576-611.

Bennett, F.C. (1987). The effectiveness of early intervention of infants at increased biologic risk. In M.J. Guralnick and Forrest C. Bennett (Eds.), The effectiveness of early intervention for at risk and handicapped children (pp.33-78). Orlando: Academic Press, Inc.

Berrueter-Clement, J. (1984). Changed lives. The effects of the Perry Preschool Program on youths through age 19. Monographs of the High/Scope Educational Research Foundation, 8.

Bradley, R., & Caldwell, B. (1976). The relationship of infant's home environment to mental test performance at 54 months: A follow up study. Child Development, 47, 1172-1174.

Bristol, M.M. (1983). Carolina Parent Support Scale. Chapel Hill: University of North Carolina.

Bristol, M.M. and Gallagher, J.J. (1982). A family focus for intervention. In C.T. Ramey & P.L. Trohanis (Eds.). Finding and educating high risk and handicapped infants. Baltimore: University Park Press.

Broman, S. (1979). Perinatal anoxia and cognitive development in early childhood. In T.M. Field, M. Sostek, S. Goldberg, and H. Shuman (Eds.), Infants born at risk. New York: Spectrum Publications.

Broman, S., Bien, E., and Shaughnessy, P. (1985). Low achieving children: The first seven years. Hillsdale, NJ: Erlbaum.

Bronfenbrenner, V. (1975). Is early intervention effective? In B. Friedlander, G. Stenit, and G. Kirk (Eds.) Exceptional infant: Vol. 3. Assessment and intervention. New York: Brunner/Mazel.

Bryant, D.M. & Ramey, C.T. (1987). An analysis of the effectiveness of early intervention programs for environmentally at risk children. In M.J. Guralnick and Forrest C. Bennett (Eds.), The effectiveness of early intervention for at risk and handicapped children (pp.33-78). Orlando: Academic Press, Inc.

Campbell, D.T. & Stanley, J.C. (1966). Experimental and quasi-experimental designs for research. Chicago: Rand McNally.

Carolina Institute for Research in Early Education for the Handicapped (1985). Frank Porter Graham Child Development Center, University of North Carolina (Chapel Hill).

Chandler, L.K., Fowler, S.A., Lubeck, R.C. (1986). Assessing family needs: The first step in providing family focused intervention. Diagnostique, 11, 233-245.

Cohen, S. & Syme, S. (1985). Social support and health. New York: Academic Press.

Corah, N., Anthony, E., Painter, P., Stern, J., & Thurston, D. (1965). Effects of perinatal anoxia after seven years. Psychological Monographs, 79 (3, Whole No. 596).

Crnic, K.A., Greenberg, M.T., and Slough, M.M. (1986). Early Stress and social support influences on mothers' and high risk infants' functioning in late infancy. Infant Mental Health Journal, 7, 19-48.

Crockenberg, S.B. (1986). Professional support for adolescent mothers: Who gives it, how adolescent mothers evaluate it, what they would prefer. Infant Mental Health Journal. 7, 49-58.

Darling, R.B. (1983). Parent-professional interaction: The roots of misunderstanding. In M. Seligman (Ed.), The family with a handicapped child. Miami: Grune and Stratton, Inc.

Denhoff, E., Hainsworth, P.K., & Hainsworth, M.L. (1972). The child at risk for learning disorder. Clinical Pediatrics, 11, 164-170.

Dunst, C. (1988). Supporting and strengthening families: New visions, new directions. Family Resource Coalition Report, 7, 2, 4-6.

Dunst, C.J. & Trivette, C.M. (In press). An enablement and empowerment perspective of case management. Topics in Early Childhood Special Education.

Dunst, C.J. & Trivette, C.M. (1985). A guide to measures of social support and family behaviors. Chapel Hill: Technical Assistance Development System, Monograph Number 1.

Dunst, C.J., Trivette, C.M., and Deal, A.G. (1987). Enabling and empowering families: Principles and guidelines for practice. Cambridge: Brookline Books.

Dunst, C.J., Trivette, C.M., McWilliam, R.A., & Galant, K. (1987). Toward experimental evaluation of the family, infant, & preschool program. In H. Weiss and F. Jacobs (Eds.), Evaluating family programs. New York: Aldine Publishing Company.

Dunst, C., Vance, S. & Cooper, C. (1986). A social systems perspective of adolescent pregnancy: Determinants of parent and parent-child behavior. Infant Mental Health Journal, 7, 34-48.

Epstein, N.B., Bishop, D.S., & Baldwin, L.M. (1982). McMaster model of family functioning: A view of the normal family. In F. Walsh (Ed.) Normal family processes. New York: Guilford Press.

Friedman, D.H. & Friedman, S. (1982). Day care as a setting for intervention in family systems. Social Casework: The Journal for Contemporary Social Work, 291-295.

Friedman, S., Reiss, J. & Pierce, P. (1988). Focus and functions of family centered case management. A working paper. Institute for Child Health Policy. Gainesville: Florida State University.

Friedrich, W.N., Greenberg, M.T., and Crnic, K. (1983). A short form of the questionnaire on resources and stress. American Journal of Mental Deficiency, 88, 41-48.

Field, T.M. (1982). Infants born at risk: early compensatory experiences. In L.A. Bond & J.M. Joffe (Eds.) Facilitating infant and early childhood development. Hanover: University Press of New England.

Garbarino, J. (1982). Children and families in the social environment. Hawthorne, N.Y.: Aldine Publishing Co.

Garbarino, J. (1986). The abuse and neglect of special children: An introduction to the issues. In J. Garbarino and K. Authier (Eds.), Safe environments for handicapped children. New York: Aldine Publishing Co.

Garber, H.L. (1988). The Milwaukee Project. Preventing mental retardation in children at risk. Washington, D.C.: American Association on Mental Retardation.

Garland, C. (1981). Early intervention for children with special needs and their families: Findings and recommendations (WESTAR Series Paper No. 11). Seattle, WA: University of Washington.

Garland, C., Woodruff, G. & Buck, D. (1988). Case management. Division for Early Childhood, Council for Exceptional Children White Paper.

Guralnick, M. and Bennett, F. (1987). The effectiveness of early intervention for at risk and handicapped children. Orlando: Academic Press, Inc.

Guralnick, M.J. & Bricker, D. (1987). The effectiveness of early intervention for children with cognitive and general developmental delays. In M.J. Guralnick and Forrest C. Bennett (Eds.), The effectiveness of early intervention for at risk and handicapped children (pp.33-78). Orlando: Academic Press, Inc.

Harbin, G.L. (1988). Issues in the assessment of infants and toddlers with handicaps. Chapel Hill: University of North Carolina.

Hanson, M.J. & Schwarz, R.H. (1978). Results of a longitudinal intervention program for Down Syndrome infants and their families. Education & Training of the Mentally Retarded, 13, 403-407.

Herzog, L.P., Cherniss, D.S. & Menzel, B.J. (1986). Issues in engaging high-risk adolescent mothers in supportive work. Infant Mental Health Journal, 7, 59-68.

Hobbs, N. (1979). Helping disturbed children: Psychological and ecological strategies, II: Project Re-ed, twenty years later. Center for the Study of Families and Children, Vanderbilt Institute for Public Policy Studies, Vanderbilt University.

Hobbs, N., Dokecki, P.R., Hoover-Dempsey, K., Moroney, R.M., Shayne, M.W., and Weeks, K.H. (1984). Strengthening families. San Francisco: Jossey-Bass, Inc.

Imber-Black, E. (1988). Families and larger systems: A family therapist's guide through the labyrinth. New York: Guilford Press, Inc.

Iris, M.A. (1988). The parent/professional relationship: Complex connections, intricate bonds. Family Resource Coalition Report, 7, 9.

Jeppson, E.S. (1988). Parents take priority in family-centered care. Family Resource Coalition Report, 7, 1-2.

Kochanek, T.T. (1980). Early detection programs for preschool handicapped children: Some procedural recommendations. Journal of Special Education, 14, 347-353.

Kochanek, T.T. (1987). Preschool early detection and infant classification technique and service. Handicapped Children's Early Education Project (Grant No. G008730278), U.S. Department of Education. Providence: Rhode Island College.

Kochanek, T.T., Kabacoff, R.I., & Lipsitt, L.P. (1987). Early detection of handicapping conditions in infancy and early childhood: Toward a multivariate model. Journal of Applied Developmental Psychology, 8, 411-420.

Kysela, G., Hillyard, A., McDonald, L., and Ahlsten-Taylor, J. (1981). Early intervention: Design and evaluation. In R.L. Schiefelbusch & D.D. Bricker (Eds.) Language intervention series: Vol. 6. Early Language: acquisition and intervention. Baltimore: University Park Press.

Lazar, I., Darlington, R. Moray, H., Royce, J., & Snipper, A. (1982). Lasting effects of early education: A report from the Consortium for Longitudinal Studies. Monographs of the Society for Research in Child Development, 47 (2-3, Serial No. 195).

Levine, M.D., Palfrey, J.S., Lamb, G.A., Weisberg, H.H., & Bryk, A.S. (1977). Infants in a public school system: The indicators of early health and educational need. Pediatrics, 60, 579-587.

Lipsitt, L.P. (1986). Learning in infancy: Cognitive development in babies. Journal of Pediatrics, 109, 172-182.

Little, W. On the influence of abnormal parturition, difficult labors, premature birth, and asphyxia neonatorum, on the medical and physical condition of the child, especially in relation to deformities. Transactions of the Obstetrical Society of London, 1861, 3, 293.

May, J. (1988). Special needs children, special needs fathers. Family Resource Coalition Report, 7, 10.

McGoldrick, M., Pearce, J.K. & Giordano, J. (1982). Ethnicity and family therapy. New York: Guilford Press, Inc.

McGonigel, M.J. & Garland, C.W. (1988). The individualized family service plan and the early intervention team: Team and family issues and recommended practices. Infants and Young Children, 1, 10-21.

McNulty, B.A. (1983). Effectiveness of early special education for handicapped children. Report commissioned by the Colorado General Assembly, Denver, CO.

Meier, J. (1985). Assault against children. San Diego: College Hill Press.

Meisels, S.J. & Wasik, B.A. (1988). Who should be served? Identifying children in need of early intervention. In S.J. Meisels & J.P. Shonkoff (Eds.), Handbook of Early Childhood Intervention. New York: Cambridge University Press.

Mitchell, S.K., Bee, H.L., Hammond, M.A., & Barnard, K. E. (1985). Prediction of school and behavior problems in children followed from birth to age eight. In W.K. Frankenburg, R.N. Emde, & J.W. Sullivan (Eds.), Early Identification of children at risk. New York: Plenum.

Mitchell, S.K., Magyary, D., Barnard, K.E., Sumner, G.A., & Booth, C.L. (1985). A comparison of home based prevention programs for families of newborns. Unpublished paper, University of Washington, School of Nursing and the Child Development and Mental Retardation Center, Seattle.

Moos, R.H. & Moos, B.S. (1981). Family environment scale manual. Palo Alto: Consulting Psychologists Press.

Nichols, P.L., & Chen, T. (1981). Minimal brain dysfunction: A prospective study. Hillsdale, NJ: Erlbaum.

O'Connor, G. (1983). Social support of mentally retarded persons. Mental Retardation, 21, 187-186.

O'Grady, D. and Metz, R. (1987). Resilience in children at high risk for psychological disorder. Journal of Pediatric Psychology, 12, 3-23.

Olson, D.H., McCubbin, H.I., Barnes, H., Larsen, A., Muxen, M., and Wilson, M. (1982). Family inventories. St. Paul: University of Minnesota.

Parmelee, A., & Michaelis, R. (1971). Neurological examination of the newborn. In J. Hellmuth (Ed.), Exceptional infants (Vol. 2). New York: Brunner/Mazel.

Patterson, J.M. & McCubbin, H.I. (1983). Chronic illness: Family stress and coping. In C.R. Figley and H.I. McCubbin (Eds.). Stress and the family: Vol. II. Coping with catastrophe. New York: Brunner-Mazel.

Pfeffer, C., Solomon, G., Plutchik, R., Mizruchi, M., and Weiner, A. (1985). Variables that predict assaultiveness in child psychiatric patients. Journal of the American Academy of Child Psychiatry, 26, 775-780.

Rynders, J.E. and Horrobin, J.M. (1980). Educational provisions for young children with Down Syndrome. In J. Gottlieb (Ed.) Educating mentally retarded persons in the mainstream. Baltimore: University Park Press.

Sameroff, A.J. & Chandler, M. (1975). Reproductive risk and the continuum of caretaking casualty. In F.D. Horowitz (Ed.), Review of Child Development Research (Vol. 4). Chicago: University of Chicago Press.

Sameroff, A.J., Seifer, R., Barocas, R., Zax, M., & Greenspan, S. (1987). Intelligence quotient scores of 4 year old children: Social environmental risk factors. Pediatrics, 79, 343-350.

Sarason, I.G., Johnson, J.H., and Siegal, J.M. (1978). Assessing the impact of life changes: Development of the life experiences survey. Journal of Consulting and Clinical Psychology, 46, 932-946.

Schweinhart, L.J. & Weikart, D.B. (1980). Young children grow up: The effects of the Perry Preschool Program on youths through age 15. Ypsilanti, MI: High/Scope Educational Research Foundation.

Scott, K.G. & Masi, W. (1979). The outcome from and utility of registers of risk. In T.M. Field (Ed.) Infants born at risk. New York: Spectrum Publications.

Shonkoff, J. & Hauser-Cram, P. (1987). Early intervention for disabled infants and their families: A quantitative analysis. Pediatrics, 80, 650-658.

Siegel, L.L. (1985). A risk index to predict learning problems in preterm and full term children. In W.K. Frankenburg, R.N. Emde, & J.W. Sullivan (Eds.), Early identification of children at risk. New York: Plenum.

Sigman, M., & Parmelee, A. (1979). Longitudinal evaluation of the pre-term infant. In T.M. Field, M. Sostek, S. Goldberg, & H.H. Shuman (Eds.), Infants born at risk. New York: Spectrum Publications.

Salvia, J. & Ysseldyke, J. (1985). Assessment in special and remedial education. Boston: Houghton Mifflin Co.

Simeonsson, R.J., Cooper, D.H. and Scheiner, A.P. (1982). A review and analysis of the effectiveness of early intervention programs. Pediatrics, 69, 635-641.

Susser, M., Hauser, W.A., & Kelly, J.L. (1985). Quantitative estimates of prenatal and perinatal risk factors for perinatal mortality, cerebral palsy, mental retardation, and epilepsy. In J.M. Friedman (Ed.) Prenatal and perinatal factors associated with brain disorders. Washington, D.C.: National Institutes of Health, Pub. No. 85-1149.

Trivette, C.M. & Dunst, C.J. (1986). Influences of social support on mentally retarded children and their families. Paper presented at the second annual Parent Symposium, Philadelphia, PA.

Trivette, C.M. and Dunst, C.J. (1987). Caregiver styles of interaction: Child, parent, family, and extra family influences. Unpublished manuscript. Family, Infant, and Preschool Program, Western Carolina Center, Morganton, NC.

Tyler, F.B., Pargament, K.J. & Gaty, M. (1983). The resource collaborator role, American Psychologist, 38, 388-398.

University of Connecticut, Pediatric Research and Training Center's Workbook #2 (1988). An introduction to building teams in early childhood special education. University of Connecticut Health Center, the Exchange, Farmington, CT.

University of Connecticut, Pediatric Research and Training Center's Workbook #11 (1988). An introduction to Individual Family Service Plans in early childhood special education. University of Connecticut Health Center, the Exchange, Farmington, CT.

Weick, A. and Pope, L. (1988). Knowing what's best: A new look at self-determination. Social Casework: The Journal of Contemporary Social Work, 10-17.

Werner, E.E., Bierman, J.M., & French, F.E. (1971). The children of Kauai: A longitudinal study from the prenatal to age ten. Honolulu: University Press of Hawaii.

Werner, E.E. & Smith, R.S. (1977). Kauai's children come of age. Honolulu: University Press of Hawaii.

Werner, E.E. and Smith, R.S. (1982). Vulnerable but invincible: A study of resilient children. San Francisco: McGraw Hill.

Wiener, C. (1962). Psychologic correlates of premature birth: A review. Journal of Nervous and Mental Diseases, 134, 129-144.

Winton, P. and Bailey, D. (1988). The family-focused interview: A collaborative mechanism for family assessment and goal-setting. Journal for the Division for Early Childhood, 12, 195-207.

Wise, P., First, L., Lamb, G., Kotelchuck, M., Chen, D., Ewing, A., Hersee, H., Rideout, J. (1988). Infant mortality increase despite high access to tertiary care: An evolving relationship among infant mortality, health care, and socioeconomic change. Pediatrics, 81, 542-548.

Wynne, L.C., McDaniel, S.H. and Weber, T.T. (1987). Professional politics and the concepts of family therapy, family consultation and systems consultation. Family Process, 26, 153-166.

Zeitlin, S. (1985). The coping inventory. Bensenville: Scholastic Testing Service.