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Father Involvement in Early Intervention: Exploring the Gap Between Service Providers' Perceptions and Practices

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Abstract

The purpose of this exploratory study was to examine early intervention (EI) service providers' perceptions of the roles played by fathers in services, as well as their perceptions of the barriers that limit fathers from being engaged in the services provided for families of children with disabilities. A total of 511 EI service providers participated in an online survey. Findings revealed a significant gap between EI providers' perceptions of the impact fathers can have on their children with disabilities and their perceptions of how useful it is to target fathers for involvement in EI services. In addition, several barriers were identified by participants that limit their ability to successfully engage fathers in the services they provide to their children and families. Results are discussed in terms of implications for future training needs of EI providers.

Keywords

father involvement, barriers, early intervention

Introduction

During the past two decades, there has been a growing body of research based on a family systems perspective that explicitly examines the impact of father involvement on child and family outcomes. This literature base has documented the effects of positive father involvement (e.g., responsive caregiving, routine caregiving) on child outcomes across a range of age groups and developmental domains, with the majority of the evidence indicating that positive father involvement is indeed beneficial for typically developing children (Cabrera & Tamis-LeMonda, 2013). For example, research has found that fathers influence their children in a variety of developmental domains and across developmental stages ranging from positive psychological adjustment and lower distress during adolescence (Flouri & Buchanan, 2003); fewer behavioral problems

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during the preschool (Frosch, Cox, & Goldman, 2001), elementary (Aldous & Mulligan, 2002; Mezulis, Hyde, & Clark, 2004), and high school years (Carlson, 2006); improved language and cognitive development during the early childhood years (Roggman, Boyce, Cook, Christiansen, & Jones, 2004; Tamis-LeMonda, Shannon, Cabrera, & Lamb, 2004); and more positive peer relationships during early childhood (Frosch, Cox, & Goldman, 2001) and adolescence (Updegraff, McHale, Crouter, & Kupanoff, 2001).

Although not as fully developed, there is emerging evidence suggesting that father involvement in families of children with disabilities can have similar positive impacts on family and child outcomes (MacDonald & Hastings, 2010; McBride et al., 2014). For example, fathers' positive attitudes (e.g., an emphasis on personal growth in family life) were found to be indicative of lower maternal stress levels in families of children with autism and other disabilities (Simmerman, Blacher, & Baker, 2001). Similarly, paternal support has been found to reduce maternal stress in families of children with disabilities (Saloviita, Itälinna, & Leinonen, 2003), while increased father involvement is positively related to mother marital satisfaction (Simmerman et al., 2001). Fathers' active parenting and family roles have also been identified as a potential buffer of the negative consequences of parenting a child with autism and other related disabilities on mothers' stress, depression, and parenting quality (Keller & Honig, 2004; Laxman et al., 2015). Finally, results from a recent study (McBride et al., 2014) revealed that increased levels of early father involvement in families of children with disabilities can lead to more positive child outcomes when children transition to kindergarten. These studies indicate that fathers can make important contributions to maternal, child, and family well-being in families of children with disabilities. Taken together, these two lines of research indicate that father involvement during the early years can lead to positive child and family outcomes in families of children with and without disabilities. These findings also provide strong justification of the need to explore the roles that fathers may play when their children are receiving early intervention (EI) services.

Father Involvement and EI

Parents play an important role in EI services provided to young children with disabilities in the birth to 3-year-old population. A major premise underlying the Individuals with Disabilities Education Act (IDEA) legislation, especially within Part C, is that parents play a critical role in influencing the early development of children with disabilities (Keilty, 2010), and that parental involvement is a critical ingredient of effective developmental intervention. For example, previous research has suggested that EI tends to be successful at promoting development when it helps parents interact more responsively with their children (Mahoney, Wheeden, & Perales, 2004).

A recent review of the literature suggests that although fathers can have a positive impact on their children with disabilities, they are noticeably absent from EI (birth to 3) services (Braunstein, Peniston, Perelman, & Cassano, 2013; Flippin & Crais, 2011; Mueller & Buckley, 2014). However, when fathers are involved in EI, there is evidence that children have positive outcomes (e.g., Bagner, 2013; Elder et al., 2011; Fletcher, Freeman, & Matthey, 2011). Although researchers, practitioners, and policy makers alike have advocated for father involvement in EI services for children with disabilities, there are several significant barriers that limit their participation; for example, EI services often fail to target fathers, EI services may not take into consideration the unique parenting needs of fathers, and EI service providers may have limited understanding of effective strategies for engaging fathers (Flippin & Crais, 2011; Rivard, Terroux, Parent-Boursier, & Mercier 2014; Salinas, Smith, & Armstrong, 2011). There are examples of models to engage fathers in early childhood programs (e.g., Early Head Start and Head Start); however, these programs have not specifically targeted fathers of children with disabilities and delays in EI services. The procedures employed by these programs may be useful in informing efforts to engage fathers in EI.

Although a major emphasis in the IDEA legislation is on family-centered programming, the majority of EI services provided focus on mothers. As argued by Flippin and Crais (2011) and

Meadan, Parette, and Doubet (2013), mothers continue to be the primary and often exclusive participants in EI service delivery. In addition, very little empirical evidence is available that documents the level of involvement exhibited by fathers in EI services, as well as the barriers (both real and perceived) that limit their participation in such activities. For example, a potential barrier is a lack of residential fathers as, according to data from the National Early Intervention Longitudinal Study (NEILS), only 63% of children entering EI live with their biological father (Hebbeler et al., 2007). Although this is less than the general population (73%), this statistic does not take into account that the majority of children do live with their biological father or other men who may step into a father role. Similarly, work may be a barrier. The majority of fathers (85.3%) of young children (below 6) work full-time (Bureau of Labor Statistics, 2012), whereas only 41.8% of mothers of children the same age work full-time (Bureau of Labor Statistics, 2012). This gap may be even wider for parents of children with disabilities and delays as there is some evidence that a child's disability status has a negative impact on maternal employment but not paternal employment (Parish & Cloud, 2006). Again, these statistics cannot account for within-group variations in EI providers' perceptions of father involvement in EI, nor is it clear how work and residential status play a role in perceptions of involvement. Finally, although there is growing evidence suggesting that family members (including fathers) have favorable perceptions of the roles of fathers in families of children with disabilities (e.g., Flippin & Crais, 2011; Fox, Nordquist, Billen, & Savoca, 2015; Gavidia-Payne & Stoneman, 2004; Meadan, Stoner, & Angell, 2015), little data exist that explore EI service providers' perception of the importance of father involvement in such families or in the receipt of EI services. More knowledge regarding the barriers outlined above, including EI providers' perceptions of the role of fathers, will be critical in supporting the efforts of EI service providers as they seek to develop and implement initiatives to expand the support services available for families of children with disabilities. Such information will be critical in enabling EI providers to meet the needs of fathers more effectively who might be struggling in this parenting context.

The purpose of this exploratory study was to take initial steps in addressing this gap in the research and program development literature. Data were gathered from EI service providers to address the following questions:

Research Question 1 (RQ1): How do EI service providers view the role of fathers in influencing the development of their children with disabilities?
Research Question 2 (RQ2): How do EI service providers perceive fathers as being effective targets for EI services?
Research Question 3 (RQ3): At what levels do EI service providers engage fathers in the services being provided?
Research Question 4 (RQ4): What are the major barriers confronting EI service providers to getting fathers more involved in the services provided?

Information gained from the data collected may provide valuable new insight on potential reasons why fathers may play minimal roles in EI services for their children with disabilities. Such information will be critical to inform efforts designed to encourage greater levels of fathers' participation in the receipt of EI services.

Method

Participants

Data for this project were drawn from an online needs assessment conducted with EI service providers who were part of a state-level training network for EI personnel located in the Midwest.

This network provides activities for both preservice and inservice EI professionals, and serves as a clearinghouse for training and online resources and information for more than 6,000 EI professionals throughout the state. As part of this network, a listserv is maintained to notify members of upcoming training opportunities, as well as to maintain a registry of professional development activities for providers within the network. After receiving Institutional Review Board approval, as well as approval from administrators within the agency hosting the EI training network, an email was sent to all members on the network listserv describing the study and providing a link to the survey. A total of 3,073 EI service providers on the listserv opened the email in which the needs assessment survey was sent, of which 582 clicked on the link to the survey, with 511 answering at least the first question. Because this was an online survey there were missing data, especially as the survey progressed; the entire survey took approximately 20 min to complete. To account for this, we have reported the number of responses used to analyze each individual measure.

The largest categories of participants ($N = 511$) were female (94.3%), between the ages of 30 and 39 (31.5%), Caucasian (83.8%), had achieved a master's degree (62.2%), had been working in EI for 2 to 5 years (27.0%), and worked at an agency (45.8%). EI professionals represented in the data include speech and language pathologists (35.4%); developmental therapists/special instructors (18.1%); physical therapists (11.5%); occupational therapists (10.5%); mental, behavioral, or physical health professionals (9.3%); and advocates, administrators, and coordinators (e.g., service coordinator, parent liaison, program director; 15.3%). Although some members of this last group do not work directly with families, they affect the professional climate and thus their responses are included, except where they are unable to answer the question (e.g., Of the children on your caseload, how many have a father involved in their life that you are aware of?). Table 1 provides demographic details on the complete sample.

Measures

The survey used in this investigation was developed through an iterative process involving researchers, stakeholders, and practitioners (McBride et al., 2015). The research team initially identified selected scales and adapted measures focused on the topic for possible use, and also developed items based on previous research. The survey was then revised based on feedback from stakeholders involved at the state level for EI technical support and training. The survey was further revised based on cognitive interviews with practitioners (Ryan, Gannon-Slater, & Culbertson, 2012). These interviews involved sitting with practitioners ($n = 2$) as they completed the survey and also answered questions such as "What were you thinking when you read that question?" "Why did you answer the question that way?" and "What did you think that meant?" The final survey had four main sections that were presented as separate sections with different methods of response: demographics, perceptions of father involvement in EI, fathers' relative involvement in EI, and perceptions of barriers to father involvement in EI. Each will be discussed in more detail.

Demographics. Participant demographic characteristics were gathered with 11 items included in the survey that assessed participants' gender, age, ethnicity, education, years working in their profession, years working in EI, profession, working situation (e.g., at an agency or as an independent provider), community size, and the number of children on caseloads.

Perceptions of father involvement in EI. A version of a previous instrument focused on early childhood teachers' perceptions of father involvement in classrooms (McBride, Rane, & Bae, 2001) was adapted and used to assess EI providers' perceptions of fathers' involvement in EI services. For example, an item such as "Fathers should be encouraged to participate in early childhood

Table 1. Participant Demographics.

Variable	Category	% (*n* = 511)
Gender	Female	94.3
	Male	5.1
Age	29 or below	12.2
	30-39	31.5
	40-49	23.7
	50-59	22.7
	60 or older	9.4
Ethnicity	Caucasian	83.8
	African American	5.9
	Latino or Latina	4.1
	Asian or Pacific Islander	2.3
	Multiethnic	2.7
Highest level of education achieved	GED or high school	2.2
	Associates or certificate	3.1
	Bachelor's degree	26.6
	Master's degree	62.2
	Doctorate	5.7
Years in EI	1 or less	8.6
	2-5	27.0
	6-10	24.7
	11-15	22.3
	16-20	9.4
	More than 20	6.1
Setting	At an agency or organization	45.8
	As an independent provider	42.3
	Both	11.0
	Not currently working in EI	0.4

Note. Some percentages may not add up to 100% due to missing data. EI = early intervention; GED = general education diploma.

classrooms" was changed to "Fathers should be encouraged to participate in early intervention services." Participants were asked to respond to 12 items on a 5-point scale from 1 (*strongly disagree*) to 5 (*strongly agree*). As many of the items changed from the original measure and the current measure was being used with a different population, we examined the internal validity. To look for potential subscales, we conducted an exploratory factor analysis using principal components extraction with varimax rotation on each of the 12 items. This orthogonal approach for rotation was selected based on the correlation matrix not warranting an oblique rotation approach, as well as the desire to achieve as simple a factor structure as possible (e.g., Brown, 2009). Missing data were eliminated listwise. The Kaiser–Meyer–Olkin (KMO) measure of sampling adequacy was .86, Bartlett's test of sphericity was significant ($p < .001$), and the correlation matrix (see Table 2) had many coefficients greater than .3. Each of these tests indicates that the results of the factor analysis (see Table 3) were appropriate for interpretation. Consistent with previous use of the original measure, only two factors were extracted, which explained 55% of the total variance. One of the 12 items failed to adequately load on either factor and was subsequently dropped from further analyses (*EI services should not spend time developing initiatives for fathers*). To further evaluate the factor structure of the subscales identified, we performed a confirmatory factor analysis using SPSS AMOS with full-information maximum likelihood (Akaike, 1998). Full-information maximum

Table 2. Correlation Table of Perceptions of Father Involvement Items.

	1	2	3	4	5	6	7	8	9	10	11	12
1.		.62**	.08	.58**	.55**	.60**	.04	.10*	−.13*	.08	.02	.51**
2.			.12**	.71**	.61**	.68**	.05	.10*	−.16**	.04	−.01	.60**
3.				.09	.02	.05	.14**	.23**	.04	.08	.07	.02
4.					.67**	.79**	.05	.07	−.17**	.01	−.04	.58**
5.						.70**	.17**	.20**	−.01	.14**	.11*	.57**
6.							.08	.12**	−.12**	.04	.01	.65**
7.								.53**	.21**	.22**	.21**	.09*
8.									.29**	.35**	.32**	.15**
9.										.21**	.35**	.01
10.											.42**	.16**
11.												.14**
12.												

*Correlation is significant at the .05 level.
**Correlation is significant at the .01 level.

likelihood was used due to the presence of missing data (Little, Jorgensen, Lang, & Moore, 2014). We inspected root mean square error of approximation (RMSEA), nonnormed fit index (TLI), and comparative fit index (CFI) for the two-factor model with the items that loaded onto one of the two factors. We considered the model fit to be acceptable if RMSEA < .08, TLI > .95, CFI > .95 (Hu & Bentler, 1999). The two-factor model of the 11 items approached criteria for acceptable fit (RMSEA = .082, TLI = .899, CFI = .934). Examination of eigenvalues and a scree plot provided support for this two-factor solution. Factor loadings ranged from 0.62 to 0.89.

Fathers' influence on development. The first factor to emerge from these analyses consisted of six items, all with factor loadings greater than 0.7 (n = 465, 91.0% of respondents answering). These items assessed EI providers' perceptions of the potential of fathers for having a positive influence on their children's development (e.g., "Every father has some strengths that could be tapped to increase child success"). Cronbach's alpha for items on this subscale was high (α = .91).

Fathers as targets for EI. The second factor to emerge from these analyses consisted of five items, all with factor loadings greater than 0.6 (n = 466, 91.2% of respondents answering). These items assessed the extent to which EI providers perceived fathers to be effective targets for intervention services (e.g., "It is best not to approach a father if you need to find out information about a child for intervention purposes"). Items comprising this subscale were reverse coded to indicate that a higher score would correspond with fathers being effective intervention targets. Cronbach's alpha for items on this subscale was moderate (α = .69).

Father's relative involvement in EI. *The Who Does What in EI* (WDW-EI) questionnaire was developed for use in this study. It was derived from the *Who Does What* (WDW) questionnaire (Cowan & Cowan, 1990), which measures the division of household labor and childcare tasks in families. Higher scores indicate greater fathers' involvement relative to mothers'. The WDW-EI differs from the original WDW, in that the WDW-EI focuses on how parents' participation in EI is divided (as opposed to their participation in household labor and non-EI childcare tasks). For example, one item asked how parents divided "making decisions regarding the EI services the child receives?" The seven items of the WDW-EI were developed in consultation with researchers and practitioners familiar with EI services. EI providers were asked to report the division of

Table 3. Factor Loadings of Exploratory Analysis of Father Involvement in Early Intervention on Two Varimax Rotated Principal Components and Confirmatory Analysis Using Full-Information Maximum Likelihood.

Item	EFA			CFA	
	I	II	h^2	I	II
1. Father involvement is important for a good service climate.	0.77	−0.13	0.60	0.71	
2. Every father has some strengths that could be tapped to increase child success.	0.84	−0.15	0.72	0.80	
3. Early intervention services should not spend time developing initiatives for fathers.	0.12	.28	0.09		
4. All fathers could learn ways to assist their children to help them achieve success.	0.86	−0.20	0.78	0.86	
5. Fathers play just as important a role as mothers in influencing their children's development.	0.82	0.03	0.68	0.78	
6. Fathers should be encouraged to participate in early intervention services.	0.89	−0.13	0.81	0.89	
7. Early intervention services should target mothers as they are primarily responsible for childrearing tasks.	0.20	0.62	0.43		0.60
8. Because fathers are less involved with high-risk children, parent involvement initiatives should be targeted primarily at mothers.	0.27	0.73	0.60		0.77
9. Mothers are more likely to respond favorably to parent involvement initiatives than fathers.	−0.10	0.62	0.39		0.41
10. It is best not to approach a father if you need to find out information about a child for intervention purposes.	0.16	0.63	0.42		0.49
11. Most fathers in the lives of children receiving early intervention services are not that interested in parent involvement activities.	0.12	0.67	0.46		0.49
12. Fathers can provide valuable insight on issues regarding children to early intervention providers.	0.78	0.03	0.61	0.72	
% of variance	35.63	19.37	55.00		

Note. EFA = exploratory factor analysis; CFA = confirmatory factor analysis.

EI participation for the family with whom they had most recently interacted *in which both a mother and a father lived at home with the child.* Using online survey features, only respondents who reported working directly with families were asked this question (n = 376-387 of respondents answering for each item). For each item, EI providers were first asked to indicate if at least one of the parents participated in the EI activity. If this was true, then the EI providers reported the division of participation in EI services among families in their caseload using a 9-point scale ranging from 1 (*Mom does it all*) to 9 (*Dad does it all*) with 5 (*They both do it equally*). As with the WDW, higher scores on the WDW-EI indicate greater relative father involvement. Because not all families engaged in every EI activity, an average score was not explored. Instead, for each item, we calculated the mean and standard deviation of fathers' relative involvement for families in which at least one parent participated in the activity.

Barriers to father involvement in EI. Four open-ended questions that probed EI providers' perspectives on father involvement were included in the online survey completed by participants, one of which is directly relevant to the current set of analyses (i.e., "What are the barriers to involvement of fathers in early intervention services?"). This item was designed to tap into EI providers'

experiences with fathers, and was meant to tease out providers' perceptions of the different sources of these barriers (e.g., workplace, family dynamics, fathers' personality).

Data Analytic Plan

Descriptive statistics and correlational analyses were conducted with the demographic measures, as well as the three measures of father involvement. The scales developed from the *Father Involvement in EI* measure were used to address RQ1 and RQ2. To answer these questions more fully, we conducted one-way between-groups ANOVA to explore differences based on demographic characteristics. The responses from the WDW-EI questionnaire were analyzed descriptively to answer RQ3.

A thematic analysis approach was used to analyze responses to the open-ended question regarding EI providers' perceived barriers to involving fathers in EI services and, in doing so, answer RQ4. Six steps were used in this thematic analysis following guidelines outlined by Braun and Clarke (2006): (a) read the data, (b) generate initial codes, (c) search for themes, (d) review themes, (e) define and name themes, and (f) produce a report. With such an approach, a theme "captures something important about the data in relation to the research question, and represents some level of patterned response," whereas codes "identify a feature of the data that appears interesting." We took several steps to establish the credibility of the qualitative interpretations as suggested by Brantlinger, Jimenez, Klingner, Pugach, and Richardson (2005): *researcher reflexivity* (self-reflection regarding assumptions, beliefs, and values), *disconfirming evidence* (looking for evidence that is inconsistent with themes), *collaboration* (multiple researchers concurring about conclusions), *peer debriefing* (colleagues providing critical feedback on interpretations), *external auditors* (confirming results outside the coding team that the inferences are logical), and *detailed description* (reporting sufficient quotes to provide evidence). Two members of the research team were responsible for coding data and generating themes collaboratively. These two researchers would bring the themes to the larger team (i.e., coauthors for the current manuscript) for feedback and then revise coding until results were confirmed by the group.

Results

The results of the analyses are presented as answers to the four research questions.

EI Providers' Perceptions of the Influence of Father Involvement on Child Development

Perceptions of *Fathers' Influence on Development* were highly endorsed by respondents (M = 4.32, SD = 0.77). These responses refer to the subscale of *Perceptions of Father Involvement in EI* regarding the potential of fathers for having a positive influence on their children's development generally. To explore these results in more detail, we conducted an ANOVA with post hoc comparisons using the Tukey test to look for differences between groups by profession: speech and language pathologists, developmental/special instructor therapists, physical therapists, occupational therapists, mental, behavioral, or physical health professionals, and advocates, administrators, and coordinators. There was a statistically significant difference in perceptions of *Fathers' Influence on Development* among the six groups, $F(5, 448) = 2.3$, $p = .04$; however, post hoc analyses revealed a difference only between the mental, behavioral, and physical health professionals group (M = 4.63, SD = 0.37) and the advocates, administrators, and coordinators group (M = 4.20, SD = 0.92). Data violated the assumption of homogeneity of variance, so we

Table 4. *Who Does What* in Early Intervention.[a]

Item	*M*[b]	*SD*	%Neither[c]
Responding to contacts from provider	3.12	2.07	10.9
Receiving training on activities to do with child	3.64	1.83	7.0
Developing the IFSP (Individualized Family Service Plan)	3.58	1.72	9.6
Making EI service decisions	3.85	1.62	7.8
Being present during services	3.58	2.08	9.4
Taking child to special activities related to disability/delay	3.83	1.90	53.5
Participating in parent training or support group programs	3.74	1.86	73.7

Note. EI = early intervention.
[a]*n* = 511.
[b]Higher scores indicate greater father relative involvement.
[c]%Neither = percentage of families in which neither the mothers nor the fathers participate in the EI activity.

conducted the robust test of equality of means (the Welsch and Brown-Forsythe), and both were significant. Although there was a statistically significant effect, the actual difference in mean scores between the groups was small; the effect size, calculated using eta squared, was .025.

EI Providers' Perceptions of Fathers as Effective Targets for EI Services

Although perceptions of *Fathers' Influence on Development* were fairly high, there was less endorsement of statements related to *Fathers as Targets for EI* ($M = 3.72$, $SD = 0.62$). This indicates that although providers viewed fathers as having a positive influence on child development, they are less likely to view them as good targets for getting involved in EI services. In addition, the relationship between these factors was weak ($r = .05$). Again, to explore these results in more detail, we conducted an ANOVA, but there were no statistically significant differences at the $p < .05$ level in perceptions of *Fathers as Effective Targets for EI* for the six professional groups: $F(5, 450) = 1.04$, $p = .40$.

Level of Engagement by Fathers in EI Level of Engagement by Fathers in EI Services

Given that we surveyed providers and they serve a diverse array of families, it was difficult to assess the degree to which fathers were involved in EI. We did have one measure to give an indication of the degree to which fathers were involved in various tasks related to EI as a snapshot of the providers' caseloads (see Table 4). For each task, there was substantial proportion for which neither the mother nor the father of the last child they interacted with participated in the task. For example, in 9.6% of the families neither the mother nor the father participated in developing the IFSP in spite of both parents living in the home with the child. For each task, for those families in which either the mother or the father was involved, on average mothers were more involved, but not the only ones involved, as indicated by means less than 0 but greater than −4. The means ranged from 3.85 regarding *making service decisions* as the most egalitarian distributed task to 3.12 regarding *responding to contacts* as the least egalitarian distributed task. There was also a great deal of variation between families as indicated by the relatively large standard deviations. Standard deviations ranged from 1.62 (for *making service decisions*) to 2.08 (for *being present during services*). Although fathers were rated to be much less involved compared with mothers, when looking at any involvement (score of 2 or greater), fathers were involved in tasks related to EI ranging from 68.1% for responding to contacts to 86.3% for making decisions regarding services.

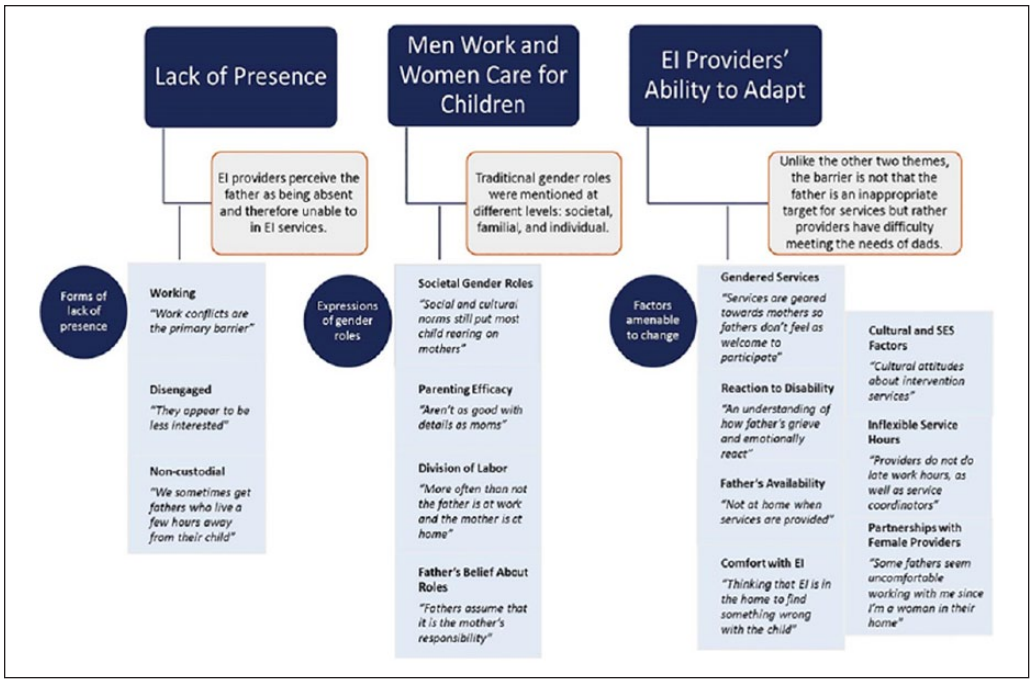

Figure 1. Summary of qualitative results reflecting barriers to father involvement in EI as indicated by providers.
Note. EI = early intervention; SES = socioeconomic status.

Barriers to Father Involvement as Indicated by Providers

The responses to the open-ended question regarding barriers to father involvement were coded and grouped into three themes. The 383 EI providers who answered the question yielded 653 unique responses. Each response was coded utilizing an interpretive process, so there was not an attempt to balance the themes in terms of the quantity of responses corresponding with each theme. Instead, the goal was to represent the nuance of different responses in answer to the question of "What are the barriers to involvement of fathers in early intervention services?" in a cohesive and meaningful way. To that end, the smaller codes that comprise each theme were collapsed or expanded. The three themes we defined were *Lack of Presence*, *Men Work and Women Care for Children*, and *EI Providers' Ability to Adapt*. Each of these themes as well as the codes that comprise these themes will be discussed in more depth (Figure 1). It is important to emphasize that these barriers to father involvement are from the point of view of the providers based on their own perceptions and experiences.

Lack of presence. Many EI providers perceive the father as being absent, and therefore unable to participate or be involved in EI services. *Lack of Presence* took on three forms: *Working*, *Disengaged*, or *Noncustodial*. Many fathers were absent from EI because they were *Working*. As these fathers lacked presence during sessions, at meetings, and during contacts, they were unknown to EI providers. The responses related to *Working* lack context and simply reflect work as a major barrier to father involvement as typified in these responses from a speech and language pathologist and developmental therapist: "They are not present due to work obligations" and "In my case, the main reason why a father is not involved is that he is at work." Like fathers who are *Working*, *Disengaged* fathers are also not present for services; however, the tone of these

responses is much different. *Disengaged* fathers are uninterested or unaware of the services being provided and may not be involved in the child's life at all. For example, a speech and language pathologist said, "I think the major barrier I see is that most dads are not involved at all." A parent liaison simply said, "their lack of interest." Finally, in some cases the father's *Noncustodial* status may preclude involvement. Divorce, custody issues, and the father's residential status may create a situation where the father is not involved in EI services: "We sometime get referrals where fathers live a few hours away from their child and this makes it hard for them to make meetings," said a service coordinator, and "Mothers and fathers who aren't married or living together—this interrupts the consistency of father involvement," said an occupational therapist. Each of the codes in *Lack of Presence* is distinct in its tone and characteristics; however, the commonality is that in each case, providers believed that a barrier to father involvement in EI is his absence.

Men work and women care for children. Traditional gender roles were mentioned by providers as a barrier to father involvement in EI at different levels: societal (Societal Gender Roles), familial (Division of Labor), and individual (Father's Beliefs about Roles and Parenting Efficacy). There was an acknowledgment of *Societal Gender Roles* as cultural expectations of who does what. Because the societal expectation is that men work and women care for children, men are not expected to participate in EI at the societal level. For example, a speech and language pathologist stated, "Social and cultural norms still put most child rearing on mothers," and a physical therapist said, "Societal expectations are of women being better equipped to deal with infants' and small children's needs." At the family level, EI providers reflected that, for many families, the *Division of Labor* falls along traditional lines where the father is the provider and the mom is the caregiver. This was often attributed to being the choice of the family and appropriate for specific families. For example, a speech and language pathologist responded that a barrier to father involvement in EI was the following: "The father is the primary worker outside of the home and the child related responsibilities are primarily on the mother," and an occupational therapist said, "Most of the fathers are the primary breadwinners; therefore, [they] are working while the mothers stay home with the child." At both the societal and family levels, work is an important feature of the data, but unlike fathers who are *Working* from the previous theme, more context is given to suggest the gendered nature of labor divisions. This is evidenced through the words "societal" and "cultural" for *Societal Gender Roles* and "breadwinner," "primary care giver," "supporter," and "provider" for the *Division of Labor*.

In moving from the societal and familial levels to the individual level, work becomes less central and the father as not being a caregiver becomes more prominent. Data coded as *Father's Beliefs About Roles* reflect that EI providers perceived that some of the fathers believed that childrearing tasks or EI tasks were not their responsibility. For example, a speech and language pathologist said, "Dads assume they will leave the developmental issues to someone else," and a developmental therapist said, "Many fathers view EI services as not needed or something that 'Mom should take care of.'" *The Father's Beliefs About Roles* and specifically the belief that caregiving is not his responsibility is a barrier to participation in EI. Often, providers expressed this as their perception of an implicit belief and used the word *assume* to indicate that.

The beliefs of the provider can also be a barrier to father participation in EI. Some providers reflected a belief that fathers lack *Parenting Efficacy*, and are thus not good at childrearing tasks. Similar to *Father's Beliefs About Roles*, the fathers are not perceived as caregivers, but in this case, the providers hold this belief instead of the fathers. For example, a physical therapist stated, "Many fathers do not understand the developmental processes a child goes through, either through lack of experience or education in this area." A mental health professional said, "When fathers are present, they tend to look to the mother to answer any question about the child, as they do not seem very confident in their own answers." The perception of a lack of efficacy is implicit in their descriptions of the fathers' parenting abilities. Each of the codes in this theme, *Societal*

Gender Roles, Division of Labor, Father's Beliefs about Roles, and *Parenting Efficacy*, suggests that the barrier to father involvement is that men are not caregivers but rather that M*en Work and Women Care for Children*.

EI providers adapting. For each of the previous themes, providers reported that they viewed the father as an inappropriate target for services either because of his *Lack of Presence* or because M*en Work and Women Care for Children*. In contrast, the codes in this theme focus on the providers and ways in which they have difficulty adapting to engage fathers in EI. It should be noted that the providers did not always see themselves as having difficulty adapting, but that this theme is the common connection between their responses. The factors related to *EI Providers Adapting* are each amenable to change to some degree and include *Gendered Services, Partnerships With Female Providers, Reaction to Disability, Comfort With EI, Cultural and Socioeconomic Status (SES) Factors, Father's Availability*, and *Inflexible Services Hours*. Each of these codes, if not under the locus of control of the provider directly, suggests an area where the provider could accommodate.

Several respondents suggested that EI services are *Gendered Services*, meaning that providers have difficulty working with fathers, have difficulty working with men, only target mothers, or fail to target fathers. For example, an administrator said, "Most early intervention staff are female and don't understand gender differences," while a developmental therapist said, "Many providers communicate with the mom and refer to mom during therapy. Often fathers don't feel included or part of the team." *Partnerships with Female Providers* is a similar barrier; however, instead of the emphasis being on the provider or the services, the provider puts the emphasis on the father. Here, the term *partnership* refers to the professional relationship between parents and providers consisting of a climate of mutual trust and respect that leads to shared decision making, and the barrier, as reported by providers, is that fathers have a difficult time engaging in this type of relationship with women. These providers perceived a barrier to father involvement in EI is that fathers feel uncomfortable taking female direction or working with female providers. For example, a speech and language pathologist said, "I have some fathers who seem uncomfortable working with me since I'm a woman in their home." An occupational therapist said, "Sometimes there is difficulty with accepting advice or direction from a woman, especially if she is young and/or casually dressed, as we often are when working on the floor with children." Both these codes suggest the tension that can emerge between men and women in intimate settings and when there is differential institutional power; however, impetus shifts from the provider to the father when moving from *Gendered Services* to *Partnerships With Female Providers*. Although the distinction is important, in either case, as part of professional development, providers can learn how to manage and mitigate that tension.

Other factors related to *EI Providers Adapting* did not refer to gender dynamics but the unique needs of fathers, which sometimes go unmet. For example, one such need reported by providers was the unique reactions that fathers have to their child having a disability or delay, which was coded as *Reaction to Disability*. For example, a developmental therapist responded, "Most fathers are in denial that there is even a delay so they may not engage the children in suggested exercises at home," and another said, "Also many fathers do not think there is anything 'wrong' with their child and do not understand the need for EI." When interpreting such responses as a barrier, the ways in which EI providers can adapt to the father's *Reaction to Disability* must be addressed to get them involved in EI. Unfortunately, many EI providers find it difficult to support fathers who hold this perspective. In addition to a father's *Reaction to Disability*, providers reported that a father's *Comfort With EI*, or lack thereof, is a barrier. For example, a speech and language pathologist said, "Some fathers feel uncomfortable getting involved in the therapy process." An occupational therapist said, "Some fathers seem hesitant to speak up and talk or ask questions of the therapist." Fathers' lack of comfort, knowledge, or understanding of EI was a barrier that

providers must address. Some providers listed culture, language, poverty, and lack of education as barriers, which we called *Cultural and SES Factors*. The data in this code were limited (e.g., simply "money" or "culture") but seemed to reflect a need for culturally sensitive services. *Reaction to Disability, Comfort With EI*, and *Cultural and SES Factors* suggest areas in which providers can learn to adapt and target services specifically to meet the unique needs of fathers.

Finally, *Father's Availability* and *Inflexible Service Hours* are actually the same barrier but reflect two different perspectives of the issue. *Father's Availability* refers to the disconnect between when fathers are available and when services are available: "I think one of the largest barriers is work schedules. Many families have a dad (or both parents) that works which makes it difficult to participate actively in sessions," said a speech and language pathologist. The implication is that fathers are not available during the set times that services are provided. *Inflexible Services Hours* refers to providers' unwillingness or inability to provide services when fathers are available: "In my experience, fathers are typically working during the hours that our providers are willing to offer services," said a service coordinator. To further illustrate this contrast, *Father's Availability* was a barrier according to one speech and language pathologist: "The father is not home when services are provided," but *Inflexible Service Hours* were reported as a barrier by a socioemotional consultant: "the hours that we provide services." In both cases, the time when services are provided is the barrier, but the responsibility has shifted. Although providers do not always see it as a factor amenable to change, addressing the availability of fathers is a way EI providers could adapt.

Discussion

Findings from our exploratory study suggest a disconnect exists in providers' perceptions of fathers' impact on child development compared with their perceptions of fathers as targets for EI services. There were no differences in these perceptions based on the provider's profession, which may indicate that this is indicative of EI service culture rather than a specific professional group. Results from the quantitative data indicate that providers affirmed the potential that fathers have for affecting child development, yet they were much more hesitant to see fathers as effective targets for intervention, as suggested by the differences in the two scales of father involvement. Providers may have a lack of awareness of their perceptions and how they might affect father involvement in EI. Previous research has suggested a lack of father involvement in EI services (Flippin & Crais, 2011), which may be influencing provider perceptions; however, data from the WDW-EI questionnaire suggest a slightly more complicated picture. Data from this scale suggest that in most cases, fathers were involved in specific aspects of EI but to a lesser degree than mothers and with a great deal of variability between families. This finding is consistent with Early Head Start literature, which has found that about half of fathers were involved with at least one program activity (Raikes, Summers, & Roggman, 2005). Findings from the qualitative data shed some insight on potential barriers that could be contributing to why this discrepancy may exist.

Results from our qualitative analyses seem to confirm that providers did not perceive their own perceptions as a barrier to father involvement. This by itself suggests an area for further provider training. The factors identified in the theme we called *EI Providers Adapting* underscore several dimensions related to EI providers' ability to adapt. Many of these themes may serve as additional targets to intervene with providers: gendered services, partnerships with female providers, reaction to disability, comfort with EI, cultural and SES factors, fathers' availability, and inflexible service hours. Each of these factors was identified as a major barrier to getting fathers more involved in the receipt of EI services. Providers can be taught how to provide more gender-sensitive services, help fathers cope with their reactions to disability, help fathers be in partnerships with female providers, support fathers with being more comfortable with EI, provide

culturally sensitive support, and have flexible service hours. Even though each of these factors provides a valuable starting point for changing the nature of services being provided, EI providers receive little professional development or training on these factors. Professional development that focuses on providing gender-sensitive services, helping fathers to cope with their reactions to disability, helping fathers be in partnerships with female providers, and supporting fathers with being more comfortable with EI may better enable them to directly involve fathers in EI services, and thus support the unique needs of fathers. Future research will be needed to explore the potential benefit of such foci in professional development activities for EI providers.

Finally, fathers' work was identified as a factor affecting involvement. Work played a role in each of the three major themes we identified. Providers reported that fathers were not present because they were working and thus it was difficult for providers to begin to build partnerships with fathers if they do not see the father. Work was also reflected in terms of providers' perceptions of gender roles and family values. Similarly, fathers' work was also reported as a barrier because it occurs at the same time as providers' work. As a team, we view the issue of work as being the "elephant in the room" that is difficult to address. Our data suggest that work for both fathers and EI providers is a major contributor to the limited involvement of fathers in EI services being provided for families of children with disabilities. If we truly want to see more fathers involved in EI services, the issue of work will need to be addressed. Financial incentives for providers to provide evening and weekend services as well as stipends for fathers to take time off work could address the mismatch between provider and father availability. In addition, communication technologies (e.g., Skype, FaceTime) can be used to engage fathers in EI who cannot be physically present when services are provided.

Findings from this exploratory study have identified several important factors that may become targets for encouraging fathers to assume more active roles in the EI services being provided to their children with disabilities. Caution is warranted, though, when interpreting the results. This project examined only the perceptions of EI providers in terms of father involvement, while the voices and perceptions of the fathers themselves are not represented in the data. Future research is needed that seeks insights from fathers and their partners as to their perceptions of the barriers that limit father involvement in EI services. In addition, as our data are at the provider level, it is difficult to determine how family- and child-level variables may act as potential barriers to father involvement in EI, including children with noncustodial fathers, gay fathers, or father-figures (e.g., step-father, grandparent). Several of our codes (e.g., custodial status) suggest that these may be important barriers to consider. Future research is needed that explores these factors in more detail. We examined father involvement in terms of direct contact with EI services. Alternatively to engaging fathers directly in EI, providers can support father involvement in the lives of children with disabilities and delays by affirming and facilitating father support of mothers. Future research can take this into consideration when exploring involvement in EI. In addition, future work should explore the role of culture in childrearing and how that affects father involvement in EI. Furthermore, father involvement was defined for service providers as men's participation in the receipt of EI services for their children. Although research consistently underscores the importance of such activities for child and family well-being, such a narrow definition of father involvement does not acknowledge the many other ways in which men are involved in parenting that are critical to healthy child development. Data on the "family centeredness" of the EI providers' practices are also not available. Previous research has suggested that not all EI service providers use a family-centered approach to their practices (Fleming, Sawyer, & Campbell, 2011). Findings from the current data lend support to this contention, and underscore how such practices may be directly related to providers' perceptions of the importance of engaging fathers in the receipt of services. Future research is needed that explores to what degree services provided to children and their families by EI providers would be classified as being family centered. Finally, data were gathered from providers that were part of a state-level training

network for EI personnel located in the Midwest. Additional data are needed that explore how perceptions of the barriers to father involvement in EI services may vary across different regions within the United States. Additional data are also needed to validate the findings, given that we used a nonprobability Internet-based sample.

In spite of these limitations, our findings indicate an acknowledgment on the part of providers of the important role fathers play in the development of children with developmental disabilities and delays. Our results also reveal several significant barriers to fathers being more involved in EI services from the perspective of service providers. The insights provided by this study have important implications for what kind of training and services EI providers might need to help them better support fathers in being more involved in EI.

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