CHAPTER THIRTEEN

Family Assessment Within Early Intervention Programs

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This chapter explores the context and processes of family assessment within early intervention programs for children with disabilities or developmental delays. Family assessments are now a routine, indeed mandated, practice in early intervention programs. Three primary reasons can be advanced for the value of family assessment for children with disabilities. First, family assessment recognizes explicitly the need to examine children’s development within their most powerful context, that of the family. This requirement acknowledges that the development of young children is not biologically fixed but is conditioned to a large extent by their environment (Bronfenbrenner, 1992). Second, family assessment is grounded in the belief that parents can benefit from focused attention on their capacities for providing a nurturing, informed, and attentive environment for their children, particularly those with disabilities. Families’ needs for information, guidance, and reassurance in the face of parenting a child with atypical development is presumed to be aided by a structured assessment of their current strengths, resources, and needs. Third, there is increasing recognition that the intensity and specificity of early intervention programs need to be tailored to the characteristics and functioning of the family in light of the child’s disability or risk status (Guralnick, 1998).

Despite the clarity of its rationale, implementation of family assessment reveals deep-seated ambivalence from both parents and early intervention professionals. In its traditional form, family assessment implies a process of fact-finding, evaluation, and professional judgment about the capacities and vulnerabilities of individual families to provide an optimal environment for the growth and development of their children. The goal of such an assessment is to identify specific ways in which external help can be provided that advances the family’s natural or acquired abilities to stimulate, nurture, and support a child’s development, as defined by the parents, the professionals involved in the child’s care, or both. When all parties agree about the optimal conditions for child development, the assessment often proceeds harmoniously and the results reflect a well-negotiated articulation of shared views. When the relevant parties disagree, and express differences in their goals for the child and the means to achieve particular objectives, the family assessment process may constitute a battleground in which deeply held beliefs about family influences and practices produce schisms that must be surfaced, discussed, and reconciled.

For many families, the idea of family assessment as mandated by early intervention programs represents a new phenomenon that they approach skeptically. Others may enter into family assessment quite willingly, explicitly acknowledging that the child’s optimal development requires a frontal approach on all spheres of influence. The need to develop a range of assessment methodologies, strategies, or approaches that achieves the goals of family assessment, that are consistent with the skills of intervention professionals, and that can accommodate varying family preferences constitutes a major challenge for the field.

This chapter reviews current practices in family assessment within early intervention programs. It begins with a discussion of the legal and programmatic
bases for family assessment and describes their current requirements. It then analyzes three perspectives that undergird the choice and focus of family assessment strategies, including ecological theories of human development, stress and coping approaches to parental adaptation, and family empowerment perspectives for human services. The next section focuses on methods of family assessment, including informal nonstandardized strategies and more formal standardized modalities. The chapter concludes with speculations about the future of family assessment within early childhood programs, focusing particularly on the need to capitalize on the legal mandate for family assessment to inform a variety of theoretically and programmatically relevant questions.

LEGAL AND PROGRAMMATIC FRAMEWORKS FOR FAMILY ASSESSMENT

The passage in 1986 of the Education for the Handicapped Act Amendments (P.L. 99-457) marked a watershed for the legal transformation of early childhood intervention from child-oriented to family-oriented programs. Among the law’s provisions was the requirement that plans for children receiving early intervention services be developed within a family context, resulting in the formulation of an Individualized Family Service Plan (IFSP). The IFSP is a written document that an early intervention program must prepare, with family participation; it describes how the program plans to meet the assessed needs of the eligible child and his or her family.

The legacy of increased family involvement in the services provided to young children has been described elsewhere (Krauss & Hauser-Cram, 1992). P.L. 99-457 went much further, however, than previous mandates for parental involvement by redefining the service unit from the child as the primary focus of intervention to the family as the primary focus of services (Krauss, 1990). Legally, services to children in early intervention programs are now required to view the child’s needs within the context of the family’s strengths and areas in need of development, thus mandating as full an assessment of the family’s therapeutic and programmatically relevant issues as was previously provided for the child.

Specific requirements are described for the IFSP’s development and content. The IFSP must be prepared within forty-five calendar days from referral and must contain a description of the child’s current functioning in five domains: physical development, cognitive development, language and speech development, psychosocial development, and self-help skills. It also must contain the results of a family assessment designed to determine the concerns, priorities, and resources of the family related to enhancing the development of the child. All assessments conducted are voluntary on the part of the family. Intervention plans for both the child and the family are included in the IFSP.

Although many early intervention programs conducted formal and informal assessments of families prior to the enactment of P.L. 99-457 (Krauss & Jacobs, 1990), this landmark legislation and its subsequent reauthorizations (e.g., P.L. 102-119) ushered in a new era in which family assessments are required of all programs serving young children with disabilities. Thus, informal practices have been replaced by mandated, explicit expectations for programmatic activity with parents, a change that has produced considerable consternation within the field of early childhood programs (Slentz & Bricker, 1992). Bailey, Bysse, Edmondson, and Smith (1992) noted the difficulties experienced by early intervention programs in implementing the provisions of the IFSP: 1) the change is perceived as significant; 2) professionals in early intervention programs are experts in child development rather than in family systems; 3) resistance to ceding professional decision-making authority to families exists; and 4) many programs are located within larger agencies that do not require an explicit family focus for assessment and service. Thus, the IFSP requirements signal a range of programmatic challenges that cast the purpose and impact of family assessment into bold relief. Interestingly, the response from the field has been pragmatic. Assessment strategies have been designed that rely on families to define their practical and informational needs. Despite the preponderance of pragmatic approaches toward family assessment that have been developed (and are discussed in the next section), the basis of family assessment rests, in part, on a confluence of theoretical developments concerning family-based influences on child development, stress and coping processes in the caregiving context, and family empowerment as a principle for human services.
THEORETICAL BASES FOR FAMILY ASSESSMENT

The intellectual roots of current family assessment practices can be traced to three pivotal contributions. The first contribution was the articulation of theories of human development that acknowledged environmental influences, such as the family, on the development of the child (Bronfenbrenner, 1979). With respect to children with disabilities or developmental delays, the argument was that the phenotypic expression of genetic or constitutional disorders is varied and conditioned by the context in which development occurs (Hodapp, 1997). Guralnick's (1998) synthesis of the empirical literature regarding the effectiveness of early intervention draws upon a theoretical model of child development that integrates the importance of family characteristics, family interaction patterns, and specific stressors experienced by families of children with disabilities.

The second contribution focuses more specifically on the variability in the most proximate environment inhabited by the developing child, namely, the family. Theories have been advanced to describe and explain those features of the family environment that are most advantageous to the child. This work seeks to explicate the mechanisms that account for individual adaptation to nonnormative events, particularly examining the context of caregiving for dependent family members. Here the subject of study is the caregiver and the processes by which the caregiver adapts to unusual caregiving demands. Among the many theorists who have studied this issue, the work of Pearl and colleagues (Pearlin, Mullan, Semple, & Skaff, 1990) is useful for describing the stress and coping mechanisms families invoke in the face of challenging events.

The third major contribution to current family assessment practices is the articulation of family empowerment principles on which services should be based. These principles assert that how services are provided is as important as what is provided. Family-focused service systems, such as early intervention programs, are fueled by a commitment to family empowerment. Among the earliest developers of the rationale for and strategies to promote family empowerment within family-focused services are Dunst and his colleagues (Dunst & Trivette, 1986; Dunst, Trivette, & Cross, 1986; Dunst, Trivette & Deal, 1988) and Turnbull and Turnbull (1986, 1995). Each of these intellectual roots is discussed in the next section.

Family Influences on Child Development

Family assessment in early childhood programs is based on the conviction that the development of children must be understood within the context of the child's environment. Although some environmental theories suggest that a child's development is affected by the characteristics and contingencies of the immediate context (Sameroff & Feil, 1985), Bronfenbrenner's theory of human ecology advances the idea of reciprocal interactions between the child and the multiple environments in which he or she develops, ranging from proximal to distal influences (Bronfenbrenner, 1992). In addition to asserting the importance of understanding the environmental contexts in which a child develops, Bronfenbrenner focuses on the nature of the interactions between the child and the various environments, noting that different features of the child's behavior instigate or provoke different responses (Sontag, 1996). The reciprocity in the interactions between a child and the environment is perhaps the most compelling aspect of this theory and provides a fundamental rationale for assessing both the child and the family, as the most proximal influence affecting the child.

Guralnick (1998) advanced a developmental theory of child outcomes that incorporates three sets of family patterns of interaction: the quality of the parent–child transactions, family-orchestrated child experiences, and health and safety provided by the family. These patterns are themselves influenced by such family characteristics as parental attitudes and beliefs, psychological functioning, coping styles, social supports, and resources. Guralnick noted that when family characteristics are within normative levels, child development outcomes are generally achieved in an expected manner. Adverse characteristics—such as maternal depression, inadequate support, and so forth—negatively affect familial patterns of interaction, resulting in compromised child development. Guralnick's model of family influences on child outcomes provides an important...
framework for identifying the qualities and characteristics of the family that warrant assessment within early intervention programs.

**Stress and Coping Theories of Parental Adaptation**

The second major contribution to the theoretical basis for family assessment comes from the renewed interest over the past twenty years in factors affecting the adaptation of parents to the task of rearing a child with disabilities or developmental delays (Cnnc, Friedrich, & Greenberg, 1983; Ramey, Krauss & Simeonsson, 1989; Seltzer & Krauss, 1994). An impressive amount of theoretical and empirical work has been reported that focuses on the mechanisms by which individuals adapt successfully or unsuccessfully to stressors or demands that are unusual, unwanted, or novel (Blacher, 1984; Dunst, Trivette, & Jodry, 1997; Olson & Lavee, 1989; Ryff & Seltzer, 1996). In the context of Bronfenbrenner’s theory of human development, this work explores aspects of the microsystem, consisting of the primary caregivers of the child, and the mesosystem, consisting of other systems in which the family lives, and the influences of these systems on familial caregiving practices, which, in turn, affect the child’s development.

A comprehensive theoretical and empirical investigation of stress and coping among caregivers was conducted by Pearlin and colleagues (Pearlin, Mullan, Semple, & Skaff, 1990; Pearlin & Schooler, 1978; Pearlin, Lieberman, Menaghan, & Mullan, 1981). Their research focuses on understanding the experiences of family caregivers of persons with Alzheimer’s disease. It incorporates many issues resulting from the gradual transformation of the relationship between caregiver and care recipient that characterizes this progressive disease. With Alzheimer’s, the requirements of caregiving eventually supersede and dominate all or most aspects of the predisease relationship. Despite the differences in context between their research and studies of parental adaptation to a child with a disability, this conceptual model has general applicability to the study of family experiences during the early childhood period in which the atypical development of a child may challenge anticipated or preexisting parental and familial routines.

Pearlin’s model bears resemblance to the Double ABCX Model of McCubbin and colleagues (McCubbin & Patterson, 1981) in its identification of three primary components of the stress and coping paradigm: 1) characteristics of the stressor (the A component); 2) the meaning of the stressor as perceived by the caregiver (the B component); and 3) the resources available to manage the stressful event (the C component). The outcomes in both McCubbin’s and Pearlin’s conceptualization are the qualities of the adaptations (psychological and behavioral) made by the caregiver.

Pearlin’s model provides a map of the process by which caregiving becomes stressful (Pearlin et al., 1990). Specifically, he and his colleagues suggested that the unfolding of the stress process is conditioned initially and pervasively by the background of the caregiver and the context in which caregiving occurs, including the demographic and social characteristics of the caregiver, history of caregiving within the particular family, family and network composition, and availability of services and other resources to aid in caregiving. They noted that “virtually everything we are interested in learning about caregiving and its consequences is potentially influenced by key characteristics of the caregiver. The effects of ascribed statuses, such as age, gender, and ethnicity, along with educational, occupational, and economic attainments are expected to be threaded throughout the entire stress process” (Pearlin et al., 1990, p. 585).

Pearlin’s work distinguishes between primary and secondary stressors. Primary stressors include objective indicators of the degree of impairment in the care recipient (i.e., cognitive status, adaptive behavior, and problematic behaviors) and subjective indicators of burden of care in the care provider (i.e., sense of caregiving overload, and relational deprivation). Secondary stressors are those that arise from the caregiving requirements but that are not directly related to the care recipient’s need for assistance or the care provider’s direct burden of care. Such stressors include family tensions arising from the demands of caregiving, job caregiving conflicts, economic problems created or exacerbated by caregiving, and constriction of the caregiver’s social life. Pearlin also conceptualizes secondary intrapsychic strains that arise in the caregiver as a result of primary and secondary stressors. These intrapsychic
stressors include those related specifically to the caregiving situation (i.e., loss of self, role captivity, competence, and gain), and more global psychological resources that may be challenged by the duration and intensity of caregiving (i.e., self-esteem and mastery). Finally, the outcomes of the stress process include consideration of the mental and physical health of the caregiver (i.e., depression, anxiety, irascibility, cognitive disturbance, physical health, and yielding of role).

The structural elements of the stress process are conditioned, according to Pearlin and colleagues, by two primary mediators: coping and social support. “It is the mediators that are usually called upon to provide the explanation for outcome variability” (Pearlin et al., 1990, p. 589). For example, individuals whose coping strategies are effective in dealing with stressful events (Turnbull et al., 1993) or who have strong social support networks to assist emotionally and instrumentally (Dunst, Trivette, & Jody, 1997) are more likely to weather the ups and downs of caregiving than individuals whose coping strategies are ineffective or who have unhelpful or negative support networks. According to the model, under conditions of high stress in the caregiving situation, effective coping and satisfying social support can blunt the impact of the stressors and reduce the occurrence of secondary stressors.

Pearlin and colleagues’ theoretical framework has been operationalized with a variety of newly constructed instruments and measures (Pearlin et al., 1990). Other standardized, psychometrically sound measures exist that can also be applied to the model (Bailey & Simeonsson, 1988a, 1988b; Krauss & Jacobs, 1990). Although most early childhood programs are not intended or expected to test theories of family adaptation, the elements of Pearlin’s theory have strong applicability in identifying specific attributes or resources of families and parents that warrant consideration in the development of intervention programs. Indeed, the powerful mediating influences of coping strategies and social support were among the most common issues investigated in research conducted within early intervention programs during the 1980s and 1990s (Bromwich & Parmelee, 1979; Crnic, Greenberg, Ragozin, Robinson, & Basham, 1983; Krauss, 1997).

Family Empowerment in the Human Services

The third major contribution to the development of current family assessment strategies is the family empowerment model, particularly as articulated by Dunst and colleagues (Dunst, Trivette, & Deal, 1988) and Turnbull and Turnbull (1995). The empowerment model focuses on strategies by which families use assistance to identify and achieve self-defined goals. Its premise is that the most effective interventions are those that are responsive to what the “consumer” of the services deems important. Family empowerment models assert that allowing and assisting families to inventory their own resources, strengths, and needs provides the only valid basis for service delivery. And, most importantly, these models effectively redistribute power from professionals to family members (Turnbull, Turbiville, & Turnbull, this volume).

Drawing on the work of Bronfenbrenner (1975, 1979), Rappaport (1981), Hobbs et al. (1984), and Gottlieb (1983), Dunst and colleagues present a model of parent–professional relationships within early intervention programs that was designed to enhance family functioning through an empowerment process. They identified three conditions that form the core of that process (Dunst et al., 1988, p. 4): 1) a proactive stance in helping relationships, in which it is assumed that people are already competent or have the capacity to become competent; 2) creation of enabling experiences in which competent behavior may be displayed; and 3) recognition that to feel empowered, the help-seeker must attribute behavior change to his or her own actions.

The crux of the empowerment model is a re-drafting of the ways in which professionals interact with families (Turnbull, Turbiville, & Turnbull, this volume). A basic tenet is that the most important needs of the family are those that are identified by the family, not by the professional. Furthermore, the empowerment model is based on a goal of the acquisition of self-sustaining and adaptive behaviors that emphasize growth among all family members. In contrast to intervention practices that promote dependencies of the family members on the professional help-givers, the family empowerment model seeks to activate the intrinsic competencies assumed to exist in all families and to utilize natural
and formal resources in the many environments of the family to support and sustain their identified goals and capabilities. As noted by Garshells and McConnell (1993), “By focusing on those needs that are of direct concern to families, interventionists can develop a trusting and collaborative relationship with families, assist families in achieving functional goals, and ultimately enhance the integration of the child with handicaps and other family members” (p. 37).

The empowerment model in human services meshes neatly with the requirement that early intervention programs be family focused. As McBride, Brotherson, Joanning, Whiddon, and Demmitt (1993) noted, family-focused programs establish the family as the unit of services, support and respect family decision making, and provide services designed to strengthen family functioning. This model has also challenged the utility of family assessment strategies that rely on standardized, norm-referenced assessments of various aspects of family functioning, many of which were developed originally for research purposes rather than for service delivery planning (Bailey & Henderson, 1993).

Bailey et al. (1998) offer a framework for assessing family outcomes in early intervention that is based on the empowerment model. They suggested that eight questions be answered to determine whether early intervention has accomplished the goals inherent in a family-centered approach. Three of the outcome questions focus on the family’s perceptions of their experiences in early intervention, specifically, 1) Does the family see early intervention as appropriate in making a difference in their child’s life? 2) Does the family see early intervention making a difference in their family’s life? and 3) Does the family have a positive view of professionals and the service system? The second set of questions focuses on the impact of early intervention on various domains of family life, namely, did early intervention 1) enable the family to help their child grow, learn, and develop? 2) enhance the family’s perceived ability to work with professionals and advocate for services? 3) assist the family in building a strong support system? 4) enhance an optimistic view of the future? and 5) enhance the family’s perceived quality of life? Although Bailey et al. (1998) acknowledged the need for psychometrically sound instruments to measure the proposed family outcomes, they noted that “the attainment of most family outcomes is a personal experience that can only be reported by family members themselves... A better understanding can be attained through interviews or direct observation, but these methods are time-consuming to administer and interpret” (pp. 315-6).

Summary

Bronfenbrenner’s enumeration of the hierarchy of environments influencing child development is particularly instructive and illustrates the fact that many of the environments that impinge on a family include those in which the family is not even physically present. For early interventionists, Bronfenbrenner’s work has given particular weight to efforts to view the child in the context of the family and to see the family in the context of their social conditions. Guralnick’s model of child development illustrates the pivotal role of specific family interaction patterns and characteristics on child outcomes. Thus, one purpose of family assessment within early intervention programs is to identify risk and protective factors within the child’s most proximal environment.

Pearlin’s articulation of the mechanisms by which caregiving becomes stressful to individuals over time has been helpful in explaining why such resources as social support networks and coping strategies are so crucial among caregivers. Many early intervention programs focus on enhancing parental support networks and on helping parents become skilled advocates for their children; these goals reflect the buffers to caregiving stress posited by Pearlin. The emphasis on coping and social support within the stress process model also fits neatly with the family empowerment model that spotlights the salutary effects of strong social support networks and adaptive coping.

The family empowerment model now has strong roots in early intervention programs. Its emphasis on families as decision makers regarding their family’s services and the belief that service providers should elicit and support objectives determined by families is consistent with the general trend toward family-focused services. The family empowerment model, particularly as articulated by Dunst and his colleagues (Dunst, Trivette, & Deal, 1988), focuses on the nature and manner of interactions between families and service providers. In light of the lack
of formal training of most early interventionists for working with families, the empowerment model provides useful practice guidelines.

These three major contributions to family assessment strategies— theories of child development, the stress and coping model of caregiving, and the family empowerment model of services—constitute a rich foundation on which the legal mandates for family-focused services rests. However, it has been noted that the dominant question within the early intervention community has shifted over the past twenty years. In its rapid period of expansion during the 1980s, the field of early intervention tried to address the question: What impact does program participation have on families? The methods for investigating family impacts were drawn heavily from the theoretical literature on family processes, family systems, and parental adaptation to unusual caregiving demands. Currently, the dominant question is: To what extent are family goals achieved? (Krauss, 1997). The shift from professionally defined outcomes to family-defined goals may seem subtle, but the implications for assessment strategies are significant. The next section discusses how early intervention programs now approach the task and challenge of family assessment.

CHALLENGES OF FAMILY ASSESSMENT

Prior to the passage of P.L. 99-457 in 1986, family assessment within early intervention programs was not a legally mandated activity. To be sure, many programs conducted informal and formal family assessments as part of the evolution toward family-focused services. However, few programs were guided by theories of family development or behavior. This resulted in an atheoretical approach to family assessment (Krauss & Jacobs, 1990). Many programs avowed a diffuse commitment to family involvement and family-focused services but lacked a clear understanding of why certain services should or could lead to specific outcomes. As Harbin (1993) noted, there is a need for a conceptual framework that translates the results of family research into a comprehensive and systematic view of family intervention. Early interventionists still struggle with developing more ecologically based individualized assessment and intervention programs for families (Beckman, 1996).

With the advent of mandated family assessment in early intervention programs, intensive and extensive activity has resulted in the development of guidelines for the conduct of meaningful family evaluations (Bailey & Simeonsson, 1988a, 1988b; Beckman, 1996). The primary tasks of these guidelines are to develop strategies that both assess family needs and provide practical information for early intervention professionals. Because of the legal requirement to include an explicit statement in the IFSP about the family’s needs, resources, and strengths, programs struggle with identifying mechanisms that comply with the legal mandate, are acceptable to families who may be unaccustomed to the requirements of family assessment, yield information of practical value for the program, and conform to the training and capacities of program staff who are often untrained in family processes.

A basic issue faced by early intervention programs has been whether to access the knowledge, methods, and expertise of family therapists, psychologists, and social workers in conducting family evaluations or to develop different approaches and goals for family assessment that are consistent with the essential goals of early intervention programs. Most early intervention programs have chosen the latter approach. The result has been an emphasis on family-focused assessment strategies that allow families to conduct their own evaluations of their strengths, resources, and needs, rather than on professionally driven assessment strategies that are based on theories of child development, family development, and models of caregiver adaptation (Simeonsson, Edmondson, Smith, Carnahan, & Bucy, 1995). One reason for this trend is the absence of appropriately trained professionals within the early intervention system to conduct formalized family evaluations (Krauss & Jacobs, 1990). A more compelling reason, however, is the desire to close the gap between assessment procedures and programmatic utility. As Bailey and Henderson (1993) noted, many of the most sophisticated and well-developed methods of family assessment are ill-suited for early intervention programs, either because the methods were developed primarily for research purposes or because they were designed to be used in therapeutic interventions in family systems. Furthermore, it has been noted that formal family assessment strategies typically focus on uncovering problem areas of family functioning
and thus send a deficit message to families in early intervention programs instead of a message that emphasizes family strengths and capabilities (Slenz & Bricker, 1992). Given the context in which family assessment occurs within early intervention programs, the field needs assessment tools and strategies that can be utilized in a straightforward, nonjudgmental fashion, that can be employed by professionals with little or no specific training in family assessment, and that yield readily interpretable and programmatically useful information.

Bailey and Simeonsson (1988a, 1988b) enumerated three primary issues in the development of useful family evaluation procedures for early intervention. The first issue is the articulation of essential domains of family assessment. Based on previous research, the list could be extensive, including psychological attributes (e.g., attitudes, beliefs, and personal traits), patterns of relationships within the family, the ecology of the family, specific family needs, family resources, existing and potential sources of support, current manifestations of family stress, and so forth. Honing in on those family domains that have the most salience for interventionists and that respect family privacy and tolerance for assessment constitutes a major area of program challenge.

The second issue concerns how to conduct family assessments. In contrast to the tradition of formalized, standardized, and norm-referenced assessments of children entering early intervention programs, the guidelines for family assessment are far less fixed. Many options are available, ranging from highly informal conversations about family needs, to direct observation of family practices and interactions, and to formalized rating scales completed by family members. The time requirements, degree of intrusiveness, and quality of information collected vary considerably across the available methods. Furthermore, the methods chosen must match the expertise and skills of the professionals involved in the evaluation, most of whom have had no specialized training in family assessment or family work.

The third issue is to ensure that, whatever methods are chosen, they yield information that has prescriptive utility (Bailey et al., 1998). Because the goal is to link family assessment to family services, strategies that might be useful theoretically in the study of family development but have only vague connections to clinical applications are unlikely to be adopted. Rather, the challenge is to develop methods that identify specific areas of family need and priorities in the areas in which early intervention programs have something to offer.

Although the dominant emphasis in family assessment has been on empowering families to identify their own needs and to match those needs with specific services, concern has also been expressed about the lack of congruence between professionals’ assessment of family needs and the family’s assessment of those needs (Blackard & Barsh, 1982; Simeonsson et al., 1995; Turnbull & Turnbull, 1985; Wilker, Wasow & Hatfield, 1981). Indeed, this lack of congruence has been cited as a compelling rationale for family-focused assessments. Rather than act on what professionals assume to be the family’s needs, it is far better and more effective to let the “consumer” direct the assessment and service provision process. An interesting test of this hypothesis was reported by Garshelis and McConnell (1993), who compared ratings of family needs (using the Family Needs Survey, described later) on a set of families in early intervention programs from three sources of ratings: mothers, individual professionals serving on interdisciplinary intervention teams, and the interdisciplinary teams as a group. They found that both individual professionals and interdisciplinary teams as a whole attributed more needs to mothers than the mothers actually identified. They also found that although interdisciplinary teams as a whole were more consistent with the mothers’ identification of needs than were individual professionals, the level of agreement between the teams and the mothers on family needs was less than 60%. The authors recommended that professionals use maternal responses to survey instruments as a guide during subsequent personal interviews regarding service planning. In a related report, Bailey and Blasco (1990) reported that half of the fathers and 40% of the mothers preferred sharing information with early intervention professionals through the use of written surveys instead of parent interviews.

The field of early intervention has focused more on the “how” of family assessment rather than on the “why.” The development of methods that are comfortable for families and useful to programs remains a major challenge. The “what” that should be assessed seems to have centered primarily on
concrete needs families avow regarding their child’s development and their own needs for providing as healthy an environment for the child as possible.

STRATEGIES FOR FAMILY ASSESSMENT: INFORMAL APPROACHES

There is no standard or uniform approach for conducting family assessments in early intervention programs. Three issues tend to dominate, however: 1) developing a “stance” toward family assessment; 2) determining the content of the assessment; and 3) translating the results with respect to service provision. The first issue has received considerable discussion in the literature, particularly with respect to the need to develop a respectful, nonjudgmental, and open attitude toward the diversity of family experiences. The second issue addresses the need to focus the content of family assessment activities on specific concerns that are appropriate for early intervention programs and that are consistent with the families’ appraisals of current matters with which they contend. The third issue addresses the need for relevance of family assessment processes to the offerings of intervention programs.

With respect to the stance taken in the conduct of family assessment, guidelines recommend that practitioners preserve a degree of informality in the process and are clear about the purpose, scope, and outcome of the assessment. Assessment is not something to be done “to” or “on” the family; it is something that takes place with the family. Assessment is not a process for exposing the family’s deficiencies; it is a process of identifying the family’s goals. Assessment is not intended to yield a prescription for remediation of the family’s problems; it helps to create an understanding between early interventionists and the family about what types of assistance are desired (if any), as determined by the family. Indeed, family assessment more accurately may be called “family information gathering.” Berman and Shaw (1996) noted that “early intervention professionals are not being asked to intrude upon the privacy of families, but are charged with providing opportunities for families to choose to share the challenges for which they want help and support” (p. 365).

Guidelines for the way in which service providers approach families have been enumerated. Beckman, Frank, and Newcomb (1996) suggested six specific skills needed for establishing a relationship with families, including 1) join the family (i.e., listening without judging); 2) use active listening (i.e., listening for both what is said and how it is said); 3) use questions effectively (i.e., balancing between questions that require factual answers and those that are open ended); 4) reflect and clarify (i.e., rephrasing and expanding parent comments); 5) provide information (i.e., offering concrete assistance); and 6) reframe (i.e., redefining problems or information in a positive way). Others have suggested a strategy of “tuning in” to families, in which professionals suspend assumptions about what a family needs or how a family feels about an assessment process (Stepanek, Newcomb, & Kettler, 1996). Because many families feel uncomfortable discussing personal and family issues with professionals, the emphasis on professionals’ stance toward families has received considerable attention (S intentz, Walker, & Bricker, 1989).

These strategies can be understood as building blocks for the emerging relationship between service providers and family members. Beckman (1996) identified three cardinal issues: 1) having genuine respect for the family; 2) adopting a nonjudgmental attitude; and 3) conveying empathy for the family’s issues. Because family assessment activities typically occur at the beginning of what may well be a long-term relationship between the family and the service provider, the establishment of a collaborative relationship is paramount. Indeed, a major concern among early interventionists is ensuring that parents are equal participants in the development of the IFSP. As Campbell, Strickland, and LaForme (1992) noted, “A quality IFSP is one that uses an individualized family service planning process to produce a written plan that exceeds minimal legal requirements and responds to family concerns, resources, and priorities about their children. Only when parents are involved equally with professionals in the planning and writing of the IFSP can a truly quality plan be written” (p. 113).

For example, Hutchins and Cole (1992) suggested that questions such as Why were you upset by that meeting? may provoke defensiveness, whereas a simple rephrasing to What happened at that meeting that upset you? provides an easier context to provide the requested information. In part, the focus on how information is gathered reflects the belief that families will be more at ease, more responsive,
and more forthcoming if they are assured that they will be treated with respect and understanding. It also reflects the need to give service providers, most of whom are untrained in conducting family assessments, some ground rules and guidelines for their work.

The second issue that dominates the literature is the content of family assessment. Beyond the gathering of basic sociodemographic information that is often part of intake procedures, the issue of what to focus upon in family assessment activities remains unresolved. In part, this reflects the atheoretical context in which contemporary family assessment is conducted. In part, the determination of content reflects a carefully balanced appraisal of what should matter for families and what families are willing or able to discuss at the tender juncture of entry into an intervention program.

Two approaches are discussed in the literature with respect to the content of family assessment. One relies on the family revealing its daily routines and concerns through direct questions about patterns of family activities and parenting styles. This approach is based on a belief that family "storytelling" will illuminate specific areas in which interventions may be effective in ameliorating problematic interactions, unsatisfactory routines, or arenas of parental concern. The second approach relies on the interventionist to structure the information gathering according to predetermined areas of probable concerns among families of children with disabilities. For example, Bailey (1987) suggested that service providers organize discussions about resources and concerns by focusing on such specific categories as financial, physical, social, emotional, medical, developmental, and informational issues. These are not mutually exclusive strategies; both may be employed effectively in early intervention programs.

Informal or nonstandardized family assessments usually start with open-ended conversations that focus on family strengths, resources, and needs (Beckman & Bristol, 1991; Winton & Bailey, 1988). Practice guidelines suggest that this conversation should follow the lead of the parent; focus initially on the child and on questions the parent(s) may have about development, management, and prognosis; and then turn to issues affecting the family (Stepanek, Newcomb, & Kettler, 1996). For example, interventionists may ask about the daily routines in the family, the allocation of caretaking tasks among family members, the times of day most difficult to manage, or the ways that families relax together, as a means of eliciting a general understanding of how a particular family functions, as well as its values and needs. By describing the child in the context of the family, the discussions maintain a child-oriented focus but allow family concerns to surface. These concerns can then be explored with respect to how the early intervention program might assist the family or what other sources of support may be useful.

Bernheimer and Keogh (1995) described an ecocultural approach to family assessment based on the theory that families actively and proactively respond to their life circumstances through the maintenance of routines that support their goals and priorities. Their approach is rooted in Bronfenbrenner's description of the child embedded within a set of interrelated environments that may be conditioned, but not governed, by specific sociodemographic characteristics. The ecocultural approach focuses on the family's ability to "tell their story" as a way of identifying the values, goals, and family patterns that have meaning for them. On the basis of longitudinal research with a diverse sample, Bernheimer and Keogh (1995) identified ten domains of daily family life that are particularly salient in surfacing patterns and issues that may warrant intervention: family subsistence, services, home/neighborhood safety and convenience, domestic workload, child-care tasks, child peer groups, marital roles, instrumental/emotional support, father/spouse role, and parenting information. They noted that "sustainable" interventions are those that are consistent with the family's daily routines and goals. Two aspects of their work are particularly appealing in the context of early intervention programs. First, the interview methods for eliciting family routines are consistent with the preferences of families for informal discussions, conversations, and storytelling as a mechanism for family information gathering (Beckman & Bristol, 1991; Winton, 1988). Second, the methods are applicable to diverse groups of families who may vary along cultural and demographic dimensions (Barnwell & Day, 1996).

Others have noted that although the intent of family interviews or conversations may be to elicit information that has direct impact on services or
supports, they bear a resemblance to traditional therapeutic interviews designed to focus on family interactions that reveal psychodynamic material regarding parent–child or other intrafamily relationships. Hirshberg (1996) provided an eloquent description of parent interviews that can reveal a wide range of issues affecting the role of a child with disabilities in the family. He categorized the process as “history making” in contrast to “history taking” in light of his view that the goal of such interviews is to construct a scenario for the articulation of aspirations for the future, based on an understanding of interaction patterns in the past. The sophistication of his approach to interviews with families illustrates a critical difference between family interventions led by highly skilled family therapists and those led by well-meaning but improperly trained early interventionists who are thrust into the realm of “family work.”

The third issue is the need for a connection between family assessment and programmatic purposes, namely, the assumption that targeted assistance to families will effect some desired change. As Simeonsson (1988) noted, “The fundamental issue underlying evaluation is clinical and programmatic accountability” (p. 251). Determining the link between assessment and outcomes undoubtedly is complex, insofar as programmatic outcomes for families in early intervention services have never been clearly specified. Most programs rely on measures of satisfaction with services as the most commonly monitored outcome, while acknowledging that satisfaction does not equal effectiveness. The premise is that if the goals identified for and by families are met, the program has achieved some degree of impact or effectiveness. Using informal family-driven modalities for identifying family needs offers excellent possibilities of securing high satisfaction ratings and thus reinforces program practices of individualized assessment and program planning procedures.

In summary, informal assessment procedures constitute the most common method of family assessment in early intervention programs. The literature is more extensively developed on the issues in developing a stance with families, offering many guidelines about how to put families at ease, about good listening and reflecting skills, and about the need to be respectful toward families’ individual histories. There is also considerable discussion about the topic areas that should be covered in family conversations, particularly focused on basic needs of families and on the context in which the child is being reared. The linkage of program activity to outcomes is more tenuous and relies most commonly on general satisfaction measures. The disproportionate concern with how to approach family assessment in an informal way, as compared to what to discuss or to what outcomes assessment should be directed, reflects the field’s concern with process rather than outcome.

Given that family assessment and intervention were imposed on a cadre of early interventionists who were not trained for such work, it is imperative that additional tools be made available to those who are called upon to perform such sensitive and critical tasks. In the spirit of providing adequate tools for these roles, several easy-to-administer and clinically valid assessment techniques are available to assess the needs of families of children with suspected or confirmed developmental delays. A sampling of these is described in the next section.

STRATEGIES FOR FAMILY ASSESSMENT: FORMAL METHODS

Formal methods of family assessment are typically used in conjunction with, rather than in lieu of, more informal interview-based assessment strategies. A variety of standardized instruments measuring various aspects of family functioning (i.e., parenting stress, informal support, coping strategies, family cohesion, marital satisfaction, and so forth) are available, many of which were developed initially for research rather than clinical purposes. The selection of instruments is affected by the programmatic orientation of the service setting; the time, energy, and costs associated with different assessment protocols; and the skills and training of the program’s staff. An additional selection factor is the acceptability of the protocols to the families being assessed. Important concerns have been expressed about the use of many existing psychometrically tested standardized instruments. Some of these instruments are criticized as “deficit-oriented, value-laden, or intrusive, asking personal questions about lifestyle, spouse support, personal values and feelings. Not only are such questions of little use in
program planning, but they may actually be counterproductive by creating resentment and mistrust” (Bailey & Simeonsson, 1988a, p. 7). In response to such concerns, several programmatically relevant instruments have been developed.

Programs that wish to combine standardized structured assessment strategies with more informal methods of information gathering now have the benefit of instruments that have been developed specifically for use in early intervention programs. Other standardized instruments that may have utility in early intervention programs but that were not developed specifically for use in such settings, such as measures of parenting stress, social support, coping strategies, and family environments, have been reviewed elsewhere (Bailey & Simeonsson, 1988a; Clifflin & Meisels, 1992; Krauss & Jacobs, 1990).

Among the more recently developed instruments appropriate for early intervention programs are measures for the assessment of parent-child interaction, family needs and priorities, family functioning, and social support. Illustrative examples of these measures are given here.

Parent-Child Interaction

Comfort and Farren (1994) developed the Parent/Caregiver Involvement Scale (P/CIS) to monitor the development of social behavior and affect and to identify problems that may interfere with daily life and healthy interpersonal relations. This observation strategy also yields information about the caregiver’s interactive style and knowledge of child development. The P/CIS can be used in home visits, laboratory settings, or clinics, and consists of a twenty-minute observation of a free-play interaction between the caregiver and a child between the ages of 3 and 60 months. The observer rates three elements – amount, quality, and appropriateness – for eleven behaviors (physical involvement, verbal involvement, responsiveness of caregiver, playful interaction, teaching behavior, control over child’s activities, directives, relationship among activities, positive statements, negative statements/discipline, and goal setting). The reliability of the P/CIS is reported to range from .77-.87 when the scale is administered in a home setting and from .54-.93 when scored from taped observations. Assessment of the validity of the P/CIS revealed moderate-to-high correlations with behavioral counts of parent-child behaviors and associations with parental and child characteristics (e.g., locus of control, support, and temperament) similar to those presented in the developmental literature (Farren et al., 1987).

The training required for use of the P/CIS includes a four-hour introductory session with a training videotape and workbook. The authors recommend that a consultant be available during the training and that practice sessions be utilized to achieve interrater reliability. They caution that the results of the P/CIS must be interpreted within the context of other relevant information about the family and should be based on multiple observations. Given the reluctance typically experienced by families to be observed or evaluated with respect to their parenting style or skills, it is also urged that the P/CIS (or any other parent-child observational instrument) be used only when a parent or caregiver has expressed concern about the quality of the relationship with the child (Comfort, 1988).

Family Needs and Priorities

To compensate for the perceived inappropriateness of existing instruments, new measures have been developed that are tailored specifically to identify family needs and priorities. In this regard, one of the most promising and widely adopted formal assessment tools is the Family Needs Survey (Bailey & Simeonsson, 1988b). This thirty-five-item self-administered scale can be completed by both mothers and fathers (and presumably, other involved family members). The instrument yields information in six categories: 1) needs for information; 2) needs for support; 3) explaining to others; 4) community services; 5) financial needs; and 6) family functioning. Each item begins with the statement, “I need more … [opportunities to meet and talk with other parents of handicapped children]” to which the respondent gives a rating between 1 (definitely do not need) and 3 (definitely need help with this). The advantage of this phrasing is that it proactively states what the individual needs based on his or her own priorities and has direct applicability to service planning. Test-retest correlations over a six-month period for total scores were reported to be .67 for a sample of mothers and .81 for fathers.
Sexton, Burrell, and Thompson (1992) reported the results of a set of reliability analyses and confirmatory factor analyses of the Family Needs Survey. Cronbach’s alpha reliability coefficient was .91 for the total score, with subscale coefficients ranging from .65 to .86. Bailey, Blasco, and Simeonsson (1992) reported that a factor analysis conducted separately for mothers and fathers yielded independent results for both groups. For example, for mothers, the eight social support items loaded onto a single factor, whereas for fathers they loaded onto two factors (differentiating between personal needs for support and family needs for support). They also reported that mothers expressed significantly more needs than did fathers, particularly with respect to the need for help in explaining the child’s condition to others. Other studies have also found that the Family Needs Survey yields different results based on parent gender (Cooper & Allred, 1992).

Turnbull and Turnbull (1986) developed the Family Information Preference Inventory (FIPI), a thirty-seven-item tool that covers five informational areas: 1) teaching the child at home; 2) advocacy and working with professionals; 3) planning for the future; 4) helping the whole family relax and enjoy life more; and 5) finding and using more support. The FIPI requires that the respondent indicate the degree of need related to each item using a four-point scale (ranging from no interest in this information to information is a high priority) and then to identify the desired means of obtaining the information (i.e., a group meeting with other parents, an individual meeting, or written materials). No information on its psychometric properties has been reported. The FIPI was not designed specifically for use in early intervention programs and includes some items regarding sexuality and vocational issues. Its structure, however, is flexible, and additional items geared toward concerns of parents of young children easily could be added.

The Family Resource Scale (FRS; Dunst & Leet, 1987) is intended to measure the adequacy of both physical and human resources, including food, shelter, transportation, time to be with family and friends, health care, money to pay bills, child care, and so forth. The scale consists of thirty-one items ordered from most to least basic. Each item is rated on a five-point scale, ranging from not at all adequate to almost always adequate. The items are conceptualized to reflect a needs hierarchy, from basic nutritional resources to interpersonal growth opportunities. Items rated not at all adequate or seldom adequate can be used clinically as family need identifiers.

Data on the reliability and validity of the scale are based on a study of forty-five mothers of preschool children with special needs in an early intervention program. The alpha reliability coefficient was .92, and the stability of the FRS was .82 based on administration of the scale over a two-to-three-month interval (Dunst & Leet, 1987).

The Family Needs Scale (FNS; Dunst, Cooper, Weeldreyer, Snyder, & Chase, 1985) is formatted similarly to the FRS but focuses specifically on the family’s need for any of forty-one types of resources. The resources are grouped into nine major categories (financial, food and shelter, vocation, child care, transportation, communication, etc.). Each item is rated on a five-point scale, ranging from almost never to almost always a need. The FNS was designed specifically to elicit family-identified needs for intervention purposes. Reliability and validity assessment of the FNS are based on a study of fifty-four parents of preschool children with disabilities in an early intervention program. Coefficient alpha for the scale was .95. The total scale score correlated significantly with measures of locus of control, parental well-being, and decision making (Dunst et al., 1985).

**Family Functioning**

The Family Functioning Style Scale (Dunst, Trivette, & Deal, 1988) is a self-report measure that can be used in intervention programs to elicit discussions about particular qualities in a family, including family strengths, information-sharing patterns, and coping/resource strategies. According to the authors, there are twelve qualities of strong families that were used to derive the specific items. These include 1) a commitment to growth for all family members; 2) appreciation for individual effort; 3) allocation of time for family activities; 4) sense of purpose in good and bad times; 5) congruence within the family for shared goals; 6) communication emphasizing positive interactions; 7) rules and values regarding acceptable behavior; 8) coping strategies that are positive; 9) problem solving to meet collective needs; 10) positivism in the face of problems; 11)
flexibility and adaptability in meeting needs; and 12) balance in using internal and external resources in meeting needs. The scale consists of twenty-six statements rated on a five-point scale, ranging from *not at all like my family to almost always like my family*. It can be completed either by individuals or by the family as a whole. No reliability or validity data are available, although the authors assert that the scale holds promise for clinical utility in its identification of family strengths and resources.

The Family Adaptability and Cohesion Evaluation Scales (FACES I, II, and III; Olson, 1986; Olson, Portner & Bell, 1982) are based on the Circumplex Model of family behavior. The FACES instruments assess the degree of adaptability and cohesiveness within the family system and can be used to identify discrepancies between perceived and idealized qualities in the family. Family cohesion is defined as the emotional bonding that family members have toward one another. Adaptability is defined as the ability of the marital or family system to change its power structure, role relationships, and relationship rules in response to situational and developmental stress (Olson, Portner, & Bell, 1982). According to the Circumplex Model, there are four levels of family cohesion (ranging from disengaged to enmeshed) and four levels of adaptability (ranging from rigid to chaotic). Balanced levels within each dimension are hypothesized to be the most viable for healthy family functioning.

Cohesion is measured with sixteen individual items and adaptability is measured with fourteen individual items, all rated on a five-point scale ranging from *almost never* to *almost always*. Cronbach reliability coefficients were reported as .87 for cohesion, .78 for adaptability, and .90 for the total scale. Test-retest reliability over a 4- to 5-week period was .84 for the total scale (Olson, Portner, & Bell, 1982).

**Social Support**

The Inventory of Social Support (Dunst, Trivette, & Deal, 1988) is designed to determine the types of help and assistance that different individuals, groups, and agencies provide to a person. The inventory maps the frequency during the past month (ranging from *not at all* to *almost every day*) and method of contact (ranging from *in person, in a group, or by telephone*) between the respondent and various sources of support and ascertains which sources of support are most utilized for different purposes. The respondent is also asked to whom he or she turns for support for twelve different types of aid or assistance. Responses are portrayed in a matrix format that provides a graphical display of the person's personal support network with respect to both source and type of support. Psychometric data on the inventory's properties have not been reported.

The Family Support Scale (Dunst, Jenkins, & Trivette, 1984) focuses on the family as a unit and measures the helpfulness of sources of support to families rearing a young child. It includes eighteen potential sources, such as parents, in-laws, spouse/partner, children, parent groups, church, physicians, service programs, and professional agencies. Each source is rated on a five-point scale, ranging from *not at all helpful* to *extremely helpful* with respect to assistance with parenting. Within an intervention program, the Family Support Scale can be used as the basis for discussions about why and how family support network members may be helpful in meeting basic family needs. Analysis of the scale's reliability resulted in a Cronbach's alpha coefficient of .77. Test-retest reliability over a one-month interval was .75.

Although the regulations governing the implementation of the IFSP state that the assessment must include a personal interview with the family (Winton & Bailey, 1990), the relative efficacy of a personal interview alone or in conjunction with other standardized procedures has been explored only minimally. Sexton, Snyder, Rheams, Barron-Sharp, and Perez (1991) compared the opinions of forty-eight mothers of children in early intervention programs and twenty-five service providers regarding preferences for sharing information through personal interviews or written surveys. The surveys included the Family Needs Survey (Bailey & Simeonsson, 1988a, 1988b), the Family Needs Scale (Dunst, Cooper, Weeldreyer, Snyder, & Chase, 1988), and the Family Functioning Style Scale (Deal, Trivette, & Dunst, 1988). Mothers also participated in family-focused interviews with service providers regarding the development of their IFSPs. They found that about half of the mothers preferred the use of written surveys, and the other half preferred a personal interview. Regardless of personal preference for assessment method, the vast majority of the
mothers rated the three written surveys as more useful and user friendly than did service providers. In a related study, Bailey and Blasco (1990) asked almost 230 mothers in ten states to evaluate the utility of the Family Needs Survey. They found that mothers rated the survey highly with respect to its ability to convey their needs to professionals, the utility of the shared information for program planning, and the degree of comfort they experienced in completing the survey. These results were similar for mothers representing different ethnic minorities and those from low-income groups. Bailey and Blasco also found that 60% of the fathers and 40% of the mothers preferred sharing information with early intervention professionals through the use of written surveys in contrast to parent interviews. These results may be attributable to differences in the time required to complete brief surveys as compared to engaging in personal interviews, and the sense of clear boundaries provided by standardized questions versus the potential expansiveness of interview situations, and the lack of anonymity provided by interviewers.

SPECULATIONS ON THE FUTURE OF FAMILY ASSESSMENT

Family assessment practices within early intervention programs have become a very complex endeavor. Multiple and often competing forces affect the strategies used by programs, the preferences voiced by families, and the utility of assessments for program planning and service delivery. On the one hand, the mandate for family assessment stems from a sophisticated view of the child's development. Influenced by Bronfenbrenner's work, particularly as it addresses the role of the family system, there are strong theoretical reasons for assessing the qualities and capabilities of those environments most proximate to the child. Understanding the family as an agent in the child's growth legitimizes professional interest in how the family functions, its potential for the promotion of healthy development, and its accommodations to the tasks of rearing a child with atypical development. Coupled with the deepened understanding now available of how families as units, and parents as individuals, manage the unique stressors of caregiving, one would expect a push toward more formalized theoretically grounded assessment strategies that concentrate on specific aspects of family life that are known to explain variability in family environments. Indeed, much of what is known about the adaptation of families with young children to the demands of parenting a child with a disability was learned in the context of early intervention programs that have been eager participants in comprehensive research programs over the past twenty years.

Despite the promise of early intervention programs as a place for the study of families and of the transactional nature of development, the field has taken a different tack. Family assessment strategies are focused on identifying the needs of families in relation to their child with a disability, aiding families to understand the service delivery system on which many will depend over time, and helping families adjust to what "disability" may mean for their future. The mechanisms for such assessments are typically informal, nonstandardized, and highly flexible. Partnerships with parents are valued and an open and accepting stance permeates the early intervention literature. This approach has been accepted enthusiastically by families who, along with early intervention personnel, are uneasy about formal assessment practices for families.

There are two important shortcomings in the current scenario of family assessment. First, there is insufficient interest in investigating the linkage between assessment strategies and service outcomes for families. The focus has been on mechanisms to elicit families' appraisals of their immediate needs - be it through informal unstructured conversations or more standardized instruments. The goal of operationalizing the mandate of family involvement in the development of the IFSP has spawned a healthy investment in diverse ways to match families' needs with service responses. Whether the services that are provided satisfy families' needs or result in changed family functioning is unknown. As with any human service, the need to demonstrate efficacy and appropriateness of public resources that support such services cannot be avoided. Thus, in the future there may be more professional interest in examining critically what early intervention programs actually do for families, how families leaving programs differ from the way they entered such
programs, and the efficiency of current practices to produce the changes that may occur. A spirit of inquiry may well lead to more variation in how family assessments are conducted and may result in a more empirically based rationale for how early intervention programs involve, support, and assist families.

Second, it is important to acknowledge that current professionals working in early childhood programs are poorly trained to conduct sophisticated family assessments. Early childhood programs tend to attract personnel whose skills derive from a knowledge of child development, not family functioning. The infusion of substantive family content into the curriculum of graduate programs that produce professionals who will staff early childhood programs is inescapable if this situation is to change. Widening the lens on what matters for children to include what matters for the families in which they live is a natural, yet often neglected, focus in graduate education. We cannot expect early childhood personnel to accomplish tasks for which they are not trained. Family assessment, with all its current imprecision in methodology, constitutes a critical topic that should be incorporated in contemporary professional training programs.

In summary, family assessment within early intervention programs has yet to demonstrate a degree of consistency in practice or clarity in purpose that may well have been expected in the years since the passage of P.L. 99-457. Although the commitment to families as the key context for child development remains strong, the translation of that commitment into assessment procedures that link family needs with program capabilities remains tenuous. Efforts to develop family assessment procedures that are acceptable to families, consistent with program capabilities, and useful for service design and delivery have resulted in program-specific strategies rather than in nationally recognized standards of assessment. The lack of consensus regarding reliable and valid methods for family assessment within a service delivery context suggests that careful monitoring of family assessment strategies is critical. Continued experimentation should be viewed as opportunities to enable early intervention programs to contribute to new understandings of how better to serve vulnerable children and their families.

REFERENCES


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