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Using Coaching Strategies to Build Caregiver Capacity

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Using Coaching Strategies to Build Caregiver Capacity

A Project Presented to
The Graduate Faculty of
Minnesota State University Moorhead

By
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Requirements for the Degree of
Master of Science in
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Abstract

This research study investigated the use of coaching strategies to foster engagement and build the capacity of caregivers of very young children receiving early intervention services. This study was conducted as a result of concerns regarding low caregiver engagement and unanswered questions about acquisition of caregivers' skills. Four participants were included in this study. The researcher collected qualitative and quantitative data to examine the impact of using a coaching model with caregiver-participants. Interview data, engagement ratings and a research journal were used to collect engagement and caregiver capacity data. As a result of data collection and analysis, the author reported that participants demonstrated an average engagement rating of 4.75 out of 5 by the end of the research period. Related to caregiver capacity, interview data evidenced skills indicative of improved self-efficacy. Finally, interview data evidenced circumstances in which caregivers, who like themselves were caring for very young children with special needs, were not connected to other caregivers.

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Chapter One

General Problem/Issue

In the first three years of life, brains are being built at lightning speed (Brain Architecture, 2017). Caregivers are responsible for meeting not only a child's basic needs for food, clothing, and shelter but also for providing the experiences necessary to create connections in her brain. A prerequisite for meeting developmental milestones is a responsive caregiver. However, some children are born with conditions affecting their development and not all caregivers are entirely responsive and even with this condition met, it sometimes happens that a child is not meeting milestones. Once evaluated and identified, a very young child experiencing a developmental delay can expect to receive early intervention services through Part C of the Individuals with Disabilities Education Act (IDEA), which was designed to ameliorate developmental delays experienced by infants and toddlers. Employing a multidisciplinary approach, early childhood special education (ECSE) teachers and practitioners from separate disciplines provide home visits in order to help the child meet milestones and change the trajectory of their development.

This school year marks year five that I've had the opportunity to work alongside the families of young children with special needs. My time working in the field has allowed me to do some self-reflection and make some observations about the variety of ways providers approach service delivery. Joint visits, teaming, and weekly child study meetings have made me more fully aware of the spectrum of interactions that take place during home visits. Currently, the early interventionist chooses the service delivery model; interactions with caregivers and young children vary widely from one provider to the next. Using a family guided model is considered best practice, according to most experts in the field, as it focuses on the family's concerns and

priorities identified in the Individualized Family Service Plan. However, when I came on the scene this approach was new to the district and was still not fully embraced.

Choosing a service delivery model can be difficult and is often based on the interventionist's training and comfort level in interacting with adults. In special education, individualizing instruction is a necessity and identifying the strengths and needs of the student is critical to designing an Individualized Education Plan (IEP). In early intervention, it is equally important to recognize the very young child's strengths and needs in order to write and Individualized Family Service Plan (IFSP). Further, it is important to differentiate between these two documents, as an IFSP addresses more than just the child's delays. The IFSP is driven by the family's concerns and priorities and it often addresses the child and family's daily functioning. Pinpointing what the caregiver prioritizes is at the heart of each unique document.

Subjects and Setting

Description of subjects. Participants in this study will be chosen from the families that I am serving in a home-based early intervention program. The families providing care for a child that is affected by an identified disability or developmental delay. Children were previously qualified for early intervention using a standardized instrument or diagnosed condition with a high probability of resulting in developmental delays. Once eligibility is determined children and families will receive services until the child is three, and as long as the child continues to demonstrate educational needs. The families being served are residing in Beltrami County and the majority of families being served are living below the poverty line. Currently, I am serving 20 infants and toddlers and their families. Approximately, 50% of the caregivers are identified as Caucasian and 50% as Native American. Households are made up of 30% single parent households, 30% two-parent homes, and 40% live in out-of-home placements such as foster care.

Selection criteria. The population is anticipated to contain approximately five caregivers that will be selected using random purposive sampling. Caregivers will be included based on their willingness to speak openly and honestly about their experiences in being the caregiver of a young child with special needs. Additionally, it is my intention to include equal at least two Native American caregivers, one or more single parents, and at least one foster parent.

Description of setting. This study will take place in homes of families living within Bemidji Area Schools, ISD 31. The district is situated in Beltrami County and is located in North Central Minnesota but does not include the Red Lake American Indian Reservation. Demographically, the district population is composed of 74.5% White, 20.9% Native American, 2.3% African American, 1.2% Asian, and 1.1% Hispanic. The district poverty rate is 48.9% and rate of poverty affecting pre-kindergarten students is 64.1%.

Informed consent. Permission will be obtained from the Institutional Review Board (IRB) at Minnesota State University Moorhead and from the school district in which the study will take place. The school district's IRB procedure will be followed to obtain permission to conduct research. Additionally, I will obtain verbal and written permission by all guardians and caregivers in order to videotape early intervention sessions.

Confidentiality will be maintained throughout the study in any written reports, journal entries, and video recordings. Caregivers/guardians will be able to withdraw their consent at any point; they will be made aware of this through verbal and written notification.

Review of Literature

Research topic. Maximizing the efficacy of early intervention has been an ongoing topic of discussion among leaders in the field (Wagner et al, 2003). A promising approach, coaching has the potential to be effective in helping infants and toddlers by enabling them to more fully participate in everyday activities. Delivering special education to very young children in the home looks decidedly different from special education provided in the classroom, and there is still not widespread agreement about who the learner is during home visits. The focus of this study is to examine how using principles of andragogy and coaching strategies can help caregivers build the skills required to help young children with developmental delays and address their special needs.

Service delivery. Although, coaching caregivers is considered a best practice some providers are not readily embracing this approach. Branson (2015) cited the following reasons that some early interventionists may not consistently use coaching strategies: 1) inadequate pre-service preparation, 2) lack of meaningful professional development related to working with adults, 3) the caregiver's expectations regarding the early interventionist's. McBride and Peterson's (1997) examination of service delivery revealed the following: considering the family systems framework attention to both family and child needs was expected, as well as emphasis on parent-child interactions (McBride and Peterson, 1997). Observational findings indicate that the majority of interactions during home visits, involved interventionists and children, though often in conjunction with the parent or another adult (McBride and Peterson, 1997). Further, the descriptive data reflecting the content of home visits and behaviors of the interventionists do not clearly reflect the family systems framework we assumed would be guiding interventionists' interactions with children and families in their homes; the content of these interactions focused

almost exclusively on the child's development or care-taking needs, and home interventionists spent over half the time directly teaching the child (McBride & Peterson, 1997).

One of the major benefits to home visiting programs, is that the intervention can be individualized to meet the needs of each child and family. McBride & Petersen (1997) suggest that tailoring intervention activities to the needs and interests of children and families will enhance their participation and involvement in the intervention maximizing the effect. The degree to which home intervention efforts related to child and family characteristics are individualized has not been examined (McBride & Petersen, 1997). Further, the diversity of services offered, as well as the potential individualized nature of the service delivery, challenge efforts to evaluate the efficacy of home-based early intervention services (McBride & Petersen, 1997).

Coaching. As defined by Branson (2015), “coaching refers to an ongoing process that includes modeling of the desired behavior, opportunities for practice by the learner followed by evaluative feedback from the coach that helps scaffold learning” (p. 44). Some definitions do not utilize evaluative feedback by the coach and employ reflective practices in their place. Rush and Sheldon (2001) define coaching in the following way: “An adult learning strategy in which the coach promotes the learner’s (coachee’s) ability to reflect on his or her actions as a means to determine the effectiveness of an action or practice and develop a plan for refinement and use of the action in immediate and future situations” (p. 8). Employing reflective practices generally allows the caregiver an opportunity to self-evaluate, and in theory, it gives the caregiver an opportunity to make modifications by building self-awareness. Still, questions remain about the use of coaching as a help-giving strategy. Further examination of coaching practices is deemed

necessary through the caregiver's perspective. Also, missing in the literature is culturally responsive coaching practices (Kemp & Turnbull, 2014).

Family Guided Routines-Based Early Intervention (FGRBI). Coaching in combination with the use of routines-based intervention is a recommended practice by the Division for Early Childhood at the Council for Exceptional Children (Branson, 2015). Interviewing families to get an accurate portrayal of the families' routines is crucial to planning for interventions. Brown and Woods (2016) further refine the coaching practice and align it with adult learning strategies by suggesting families embed teaching and learning into their preferred routines and support their capacity. Authors Brown & Woods (2016) go on to advocate for coaching across family-identified routines, as opposed to in a single routine or in varied prescribed activities, stating it may be a key component in achieving increased intervention dosage and dispersed frequent learning opportunities. Author McWilliam (2012) emphasizes a family-centered approach that utilizes naturally occurring learning opportunities. Further, Brown & Woods (2016) fully embrace using the existing family routines as opportunities to plug-in interventions and cite the need to move beyond play as the only intervention context. McWilliam (2012) goes on to state, "The intervention the child receives is not really the home visit time (e.g., 1 hr a week, if the family is lucky) but all the time between home visits. Understanding this distinction between service and intervention and capturing the dosage of intervention are vital" (p. 227).

Engagement. As the shift continues to take place toward working with the whole family, the child is no longer the sole focus of intervention efforts and recommended practices are reflecting this change. The Wagner et al. study (2003), takes a closer look at engagement and further examines its many facets. Consider the following: "Understanding the relationship

between parent and home visitor and how it develops over time also may advance our understanding of successful engagement” (Wagner et al., 2003, p. 179). Further, meeting the individual needs of each family can be a challenging task for early interventionist and building a relationship with the caregiver is at the core of fostering engagement. According to Wagner et al. (2003), it is typically the families that are most at risk that are the least engaged. When it comes to keeping families engaged and learning, it can best be described as a balancing act it requires a good deal of flexibility and skill (Wagner et al., 2003).

Caregiver capacity. Rush and Sheldon (2001), focus on building the adult’s skill set and within the chapters of their book delineate a process intended to build the caregiver’s capacity. More specifically: “The coach’s ultimate goal is sustained performance in which the caregiver has the competence and confidence to engage in self-reflection, self-correction, and the generalization of new skills and strategies to other situations as appropriate” (Rush and Sheldon, 2001 p. 75). A similar sentiment as stated by McWilliam (2012): “The key to child progress through home-based services is for professional support to be aimed at family competence and confidence” (p. 148). Still, coaching as a help giving strategy is entirely dependent upon the ability of the interventionist to forge a relationship with the caregiver. Kemp & Turnbull (2014) posed the following question as it relates to caregivers parenting young children with developmental delays and disabilities, “How do we support them in this part of their lives and pass on intervention skills?” (p. 319). Kemp & Turnbull (2014) suggest that coaching with parents is often used to increase children’s developmental outcomes but also increases adult outcomes; such as: an increase in the following skills: stronger sense of self-efficacy, direction, and support. Specific to language development, authors Brown and Woods (2016) promote the

use of responsive strategies to develop communication skills, especially for early communicators.

After examining several studies, Kemp & Turnbull stated the following: “The synthesis cannot yet provide a confirming answer as to how intensive coaching with parents must be implemented to show positive impact on child and family outcomes” (2014, p. 319). Questions surrounding coaching to build caregiver capacity remain and further research is in order. Brown and Woods (2016) leave us with a series of topics that are in need of exploration and research, specifically they suggest, “Additional studies could separate high and low implementers and examine the coaching strategies used in each group to determine if there was a relationship between a particular pattern of coaching strategies and parent implementation” (p. 123).

Wagner et al. (2003) referenced a five-point scale to measure engagement during home visits. The following engagement scale was used to quantify data:

1. “say yes” engagement,
2. “be there” engagement,
3. “be involved” engagement,
4. “do the homework” engagement, and
5. “look for more” engagement.

A more thorough explanation is as follows:

“Say Yes” Engagement. This dimension is exhibited by parents when they are sufficiently attracted by the program and motivated to learn more about parenting and about their children that they “say yes” to the invitation to enroll and agree to an initial home visit.

“Be There” Engagement. The second dimension of engagement involves the motivation to keep home visit appointments consistently over time.

“Be Involved” Engagement. The third dimension of engagement refers to the active involvement of families during their home visits.

“Do the Homework” Engagement. The fourth dimension of engagement relates to the use by families of PAT Program information, ideas, and materials between home visits.

“Look for More” Engagement. The final dimension of engagement refers to parents’ going beyond the home visits in seeking information about and support for parenting issues.

Hypothesis. Caregivers of infants and toddlers receiving early intervention, in the form of coaching, will be engaged during sessions and will report an increase in skills associated with caregiver capacity.

Chapter Two

Research Questions

1. How does coaching affect caregiver engagement?
2. In what ways will caregiver's skills related to capacity change?

Research Plan

Methods and rationale. The five-point scale referenced above will be used to quantify engagement data throughout the research period. A total of five consecutive visits will be recorded and charted for each caregiver. A combination of methods will be used to collect qualitative data surrounding the phenomenon of what it means to build caregiver capacity. A research journal will be kept to record observations related to engagement and caregiver-child interactions throughout the research period. At the beginning of the research period, each participant will be interviewed using a semi-structured individual interview about their attitudes and opinions of their own ability to parent their child and their confidence in doing so. The Minnesota Department of Education (MDE) designed the Family Outcomes Survey (FOS) to address the following caregiver objectives: know their rights, effectively communicate their children's needs, and help their children develop and learn. The interview questions will be drafted specific to this qualitative study and based on the Family Outcome Survey (FOS), typically given to the families at the conclusion of the intervention period (Family Outcomes Survey, 2010). Throughout the intervention period the caregiver will be interviewed monthly. Additionally, the researcher will use guided observation to look for appropriate parent-child engagement and positive guidance. Video will be used to capture positive parenting moments and replayed for the family as appropriate. Using reflective questioning, the video will be

analyzed by the researcher and caregiver seeking to reinforce the caregiver's confidence and competence.

Schedule. Intervention will be provided as per the IFSP. A journal entry will be completed after each home visit during the research period. Anecdotal data, caregiver engagement ratings, and basic impressions will be recorded with regard to interactions during sessions, as well as the overall productivity of the home visit as a whole. Additionally, caregivers will be interviewed after a period of intervention of two or more months. The interviews will likely be added on to the end of an already scheduled weekly home visit. Interviews will be conducted at the end of the visit at the parent's convenience. Video recording sessions will take place monthly and will be done during a regularly scheduled session, mutually agreed upon by the caregiver and researcher.

Ethical issues. No ethical issues were encountered throughout this study.

Chapter Three

This study examined the impact of using coaching strategies to determine how caregivers' engagement and skills to build their capacity were affected. The study was prompted by the researcher's desire to foster consistent meaningful interaction, while building the confidence and competence of caregivers. Therefore, it was the researcher's priority to study how her use of coaching strategies positively impacted engagement and transformed the capacity of caregivers.

Table 1

Caregiver Characteristics

Caregiver A	Caregiver B	Caregiver C	Caregiver D
30	22	32	32
Female	Female	Female	Female
Native American	Native American	Caucasian	Native American
Single parent	Single parent	Two-parent household	Single parent
Completed some college	Withdrew from high school prior to graduation	High school graduate	Withdrew from high school prior to graduation

Research Questions

How did coaching affect caregiver engagement?

After analyzing the data logs specific to caregiver engagement common themes became evident. Common themes included the following: caregiver engagement often followed an upward trajectory and then leveled off, higher levels of engagement by caregivers did not remain

constant, and caregiver engagement declined in the face of family hardship. Further, data logs revealed that although I used coaching strategies with fidelity caregiver engagement fluctuated from one home visit to the next. While engagement was inconstant, the relationships I established with caregivers created opportunities to adapt to themes based the concerns of families in times of distress.

Table 2

Caregiver Engagement

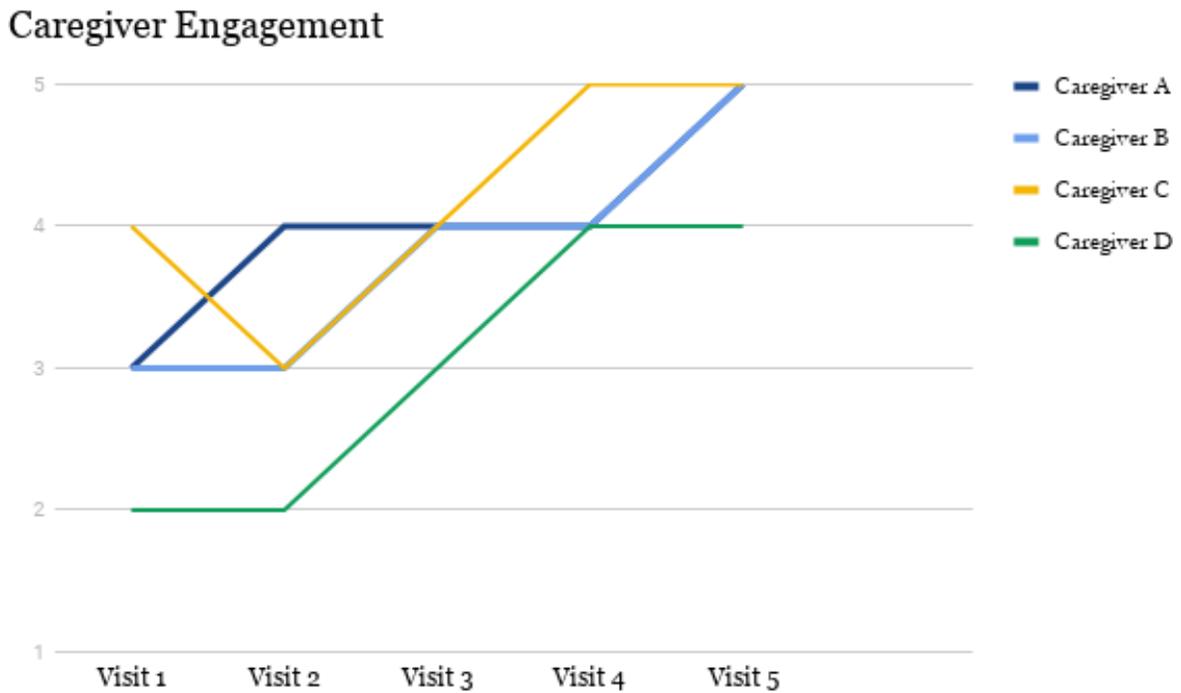


Table 3

Caregiver Engagement Ratings by Session

	CAREGIVER A	CAREGIVER B	CAREGIVER C	CAREGIVER D
Visit 1	3	3	4	2
Visit 2	4	3	3	2
Visit 3	4	4	4	3
Visit 4	4	4	5	4
Visit 5	5	5	5	4

The first common theme that was evidenced through my data was the eventual plateau of caregiver engagement. Caregivers that had prior experiences with early intervention, in which an outdated model had been applied, were harder to get engaged in sessions initially. However, once caregivers had time to process and become accustomed to the new model they engaged at high levels. Caregivers that had no prior experience with early intervention had a somewhat different trajectory of engagement. With no prior experience to draw on, caregivers that had only experienced the coaching model seemed to make rapid gains only to plateau earlier into the intervention period.

In order to gain a better understanding of how caregiver engagement was impacted, an in depth examination of how the elements of coaching impacted caregiver engagement is essential. Regardless of prior experience, the use of joint planning was a pivotal step in creating a focus for individual early intervention sessions. By having the caregivers select a focus for each session, the buy-in necessary to keep them involved and invested was established. Caregivers that were

slow to engage initially responded well and engaged more fully once they felt heard. When the priorities of caregivers' were kept at the forefront of sessions caregivers responded with openness and creativity. Caregivers became open to the idea of intervention taking place in a variety of routines and some even planned for sessions at a grocery store and playground, in addition to their homes.

Making reference to the joint plan created opportunities to focus and at times refocus a session. Together with the caregiver, I used approximately the last ten minutes of each session to draft a joint plan. The joint plan included a plan for what routine would be worked through on the following visit and would the caregiver would like to focus on in between the current visit and the next visit. It added accountability and allowed the caregiver assigned their own homework. Planning for intervention delivered by the caregiver draws directly upon McWilliam's (2010), premise that what happens between visits is of the utmost importance.

The second common theme that emerged was that higher levels of engagement did not remain constant. Unfortunately, even with a joint plan in place and a solid plan of action, occasionally caregivers did not give a visit their full attention. Revisiting the joint plan to draw a caregiver's attention back to task at hand worked, at times. However, I found it necessary to adapt to their current circumstances and meet them where they were at by addressing their concerns before expecting them to move on. The responsibilities that caregivers were facing weighed heavily on them and made it challenging, if not impossible for them to constantly be focused on intervention. There wasn't always an explanation for the behavior but the decline was obvious. Often, the caregivers had a sort of candor that allowed them to express a variety of concerns including: transportation issues, drug addiction, and custody disputes. Consider the following,

After knocking, the door of the family home was opened for me by the toddler I had been visiting for just a few months. I stood in the door of the caregiver and found her talking on her mobile phone. This was not typical of her and I was surprised that she did not greet me in her usual manner with a hello and big smile. She motioned for me to come in and I did. She stayed on the phone for several minutes discussing problems with her van and her limited finances. After a total of approximately ten minutes, she hung up the phone and explained that she hit a deer earlier in the week and she no longer had reliable transportation. She explained the repercussions of the family vehicle being out of commission and how it was affected her anxiety. Approximately twenty minutes into the session, I made some observations about the progress I saw her son making in the communication domain. We spent the next forty minutes focused on a sensory activity that she had planned for the week before. I am convinced that the quality of the relationship and the use of coaching strategies saved the session.

The significance that observation played in my coaching practice during the intervention period cannot be overstated. Even in the face of challenging circumstances and fluctuating engagement each session proved to be an opportunity to observe caregivers with their children during daily routines and provided opportunities analyze the situation, behaviors and interactions. The opportunity to assess situations within context was key to providing opportunities for caregiver reflection and growth. The vast majority of sessions were scheduled at a time that a caregiver-selected activity was to take place. Scheduling an action-based sessions provided ample opportunities for practice. I discovered that sessions focused on a preselected routine never failed to produce high levels of engagement, as supported by data logs. Action-based session allowed me to do some modeling and direct teaching. While modeling allowed caregivers to get a first hand look at techniques for fostering language development and providing choices to very young children, I used this strategy and the direct teaching of the child minimally. I also followed up with opportunities for reflection and an opportunity for the caregiver to try the techniques. Feedback was provided to caregivers primarily through the use of reflective questions. I became intentional about helping caregivers to draw their own conclusions

about the productivity of their behaviors and interactions with their children. Overwhelmingly, the caregivers that participated in my study were able to, with minimal guidance determine what behaviors and caregivers on their part would help their child develop the skills were being targeted.

The third distinct theme involved the decline of caregiver engagement in the face of family hardship. Within my data logs, I found evidence of the hardships faced by the caregivers that I worked with throughout the research period. These challenges affected their engagement in very real ways. Nonetheless, by choosing the relationship over my agenda, it was possible to reach the caregiver even during family crisis. Hardships affected not only the caregivers' interactions during the home visit but their follow through after the visit had concluded. According to Wagner et al. (2003), it is typically the families that are most at risk that are the least engaged. Caregivers that experienced significant financial problems, deep emotional pain, or the loss of a relationship were less likely to take something away from the visit and seek out more on their own, a telltale indicator of high-level engagement. It should be noted that the caregivers were able to move forward after they had had time to process and deal with the hardships they faced. For example,

One morning I walked into a home and found the caregiver at the kitchen table with her eyes wet from crying. She shared with me that it was the anniversary month of the death of her brother and her infant daughter's twin sister. After a few moments of talking about her grief the caregiver was ready to follow the joint plan drafted the week prior. While the child's mother followed through with feeding her infant daughter baby food, it was obvious that she was not quite herself. She asked few questions and answered my questions with short answers in low tones. I also noticed that she was not as responsive to her daughter's communication attempts. However, it should be noted that eight days later I received a text from the caregiver stating that her daughter was eating like a champ.

What skills will caregivers report an increase in at the end of the research period?

This study examined to what extent caregivers would report an increase in skills at the conclusion of the research period. The study of caregiver skill acquisition was motivated by my desire to ascertain whether or not coaching was an effective model of developing caregiver capacity. Themes that emerged throughout the research period included the following: caregivers were readily able to identify their child's strengths and needs, readily able to find services available to them, parents were confident in their understanding of parent rights and could succinctly summarize them, and in general felt confident in their ability to help their child learn and grow. However, the caregivers reported that they had not connected with other families that have a child with special needs and did not report feeling supported by other caregivers in similar situations.

The first common theme indicated that caregivers are readily able to identify their child's strengths and needs. All of the caregivers included in this study knew their children very well and had confidence in their estimation of their child's abilities. Data logs suggested that caregivers became more aware of their children's unique strengths and needs at the culmination of the research period. Throughout the research period, caregivers eagerly answered questions related to their children's unique skills, interests and challenges. At the conclusion of the research period, final interviews included the following responses to the questions below:

Do you feel you have a solid understanding of his delays and/or needs?

"I think so. We understand her developmental delay a little bit."

"Yeah, what I think is going on with him is survival mode. Mental. His dad wasn't taking care of him. He is so independent because he has to be. He needs a lot of help with mental health. There was a lot of abuse and neglect."

“His needs and delays can change but bonding and making meaningful connections give him security consistency and other connections- which is what we grow towards.”

How do you feel about your understanding of your child’s strengths and abilities?

“Good. I feel confident.”

“That kid is smart. He is independent. He is determined and motivated. If he wants something he finds a way to get it. He is a very strong little boy. He can be very caring. When I see him, I see me.”

The caregivers’ statements were open, honest and insightful. Overwhelmingly, data reflected that caregivers did know their children’s strengths and needs quite well. Keeping caregivers involved in the ongoing assessment process and the use of reflective questions, allowed them to make solid conclusions about the foundational skills that their child already possessed and those that they needed to reach their outcomes.

The second common theme indicated that caregivers were readily able to find services available to them. However, this theme was actually two-fold. Positive responses to this question indicated that families were readily able to identify their needs, and in a second step, they were able to access desired services, programs, and activities in their community.

How easy or difficult do you find it to find services and programs you available to you?

“ I know how to reach out for help. I’ll keep looking until I figure it out. If I don’t know I reach out and as my worker. Evergreen has been a great resource. They are like my parents. I’m not shy to ask for help.”

“Pretty easy.”

Further, follow up questions indicated that all of the participants commented that their basic needs were met, suggesting that they had successfully accessed resources, as needed.

Further questions related to medical and dental need being met yielded very similar answers.

The caregivers that participated in this study did not express any significant concerns related to basic needs, and were able to navigate systems to keep their sheltered, fed and healthy, at the conclusion of this study. Coaching strategies were utilized when a caregiver of two very young boys shared her concerns with me regarding their mental health and history of neglect, maternal drug abuse, and out of home placement. Based on her observations and her report of their troubling behavior, we had a lengthy conversation in which I used a series of reflective questions with the purpose of helping her choose a therapy model that she believed would be a good fit. Overall, 100% of the caregivers' self-reported strong skills in this area at the study close.

The third common theme revealed that caregivers understood their parental rights and were able to effectively summarize them. Three out of four caregiver's reported a solid understanding of their parent rights and the ability to relay them to someone else. I found this theme the most surprisingly of them all. I have always offered procedural safeguards at the designated times as required by IDEA and encouraged caregivers to read it at their leisure. However, I have not spent a great deal of time on the subject as a whole. Upon, providing the packet of parental rights I have given my own synopsis of the document and encouraged parents to come to me with any concerns. Further, I highlighted the importance of consent, confidentiality, and the existence of a process if a dispute were to arise. At the onset of services, I assured caregivers that I would do my best to draft an IFSP that addressed their concerns and priorities. Caregivers were heavily involved in the drafting of outcomes and referred to as the child's expert. Caregivers engaged in the process without any challenges and I often referred to them as their child's advocate. I was intentional about using them term to describe their actions when it was appropriate.

On one occasion I asked a caregiver what her comfort level was with making a call to the pediatrician for a referral to a specialist, and she responded without hesitation that she could face anything for her child. Consider the following response to the interview question regarding parent rights:

“Yes. Write a complaint or talk to you. When it comes to my kids I’m a loudmouth, I guess.”

I came to very much admire the candor of this particular caregiver. On a separate visit this caregiver shared with me that this was the first time, in the four years since her oldest son was born, that she had parented sober and in the last twelve months she had developed the confidence to voice concerns and act as her sons’ advocate.

One collective theme that was evidenced through the data was the confidence of caregivers to help their children learn and grow. When the research period and interviews concluded caregivers reported a high level of efficacy related to helping their children learn new skills and achieve outcomes. Journal entries and videotaped sessions evidenced significant growth in the manner that caregivers’ responded to their children. Videotaped sessions created unique opportunities to foster the relationship between the caregiver and child by providing feedback in the form of reflective questioning. Caregivers became more adept at recognizing their children’s communication attempts and better at recognizing when to provide more wait time. Additionally, action-based sessions in which caregivers worked through challenging routines and problem-solved with the help of the interventionist evidenced significant growth on the part of caregivers. Consider the following questions and responses regarding caregiver self-efficacy:

How do you feel about your ability to help your child learn new skills?

How do you feel about your ability to work on their goals during everyday routines?

“I think, we’re doing really good at that. They do learn a lot from me and my actions. I can teach them a lot more than anyone else because they look up to me.”

“When he says something wrong I try to teach him the right way. I taught him his manners. He is loud like me. Trying to teach him to keep it down.”

“I always try to connect with him on a spiritual level and maintain a stable positive environment. He will simultaneously be learning through exploring.”

“I’m working on it.”

“I feel good. We can handle that.”

Overwhelmingly, all of the caregivers reported that they believed in their ability to teach their children and work on goal-specific skills found in their children’s IFSPs. The confidence and competence caregivers reported was based in part on the legitimate growth in their capacity to read their children’s cues, redirect their behaviors, and embed interventions.

After I analyzed the data, one final outlying theme came to my attention it was the circumstance in which caregivers who participated in the study were not connected to caregivers who like themselves were raising a very young child that has experienced a developmental delay or a disability. The reason that this theme jumped out at me relates to the isolation that caregivers sometimes feel when raising a very young child with special needs. Further, the Bemidji area is quite rural and in the dead of winter isolation is real concern. It is my position that this theme could further investigation in the future.

Conclusions

This study was a rare opportunity to analyze how my use of a coaching interaction style affected caregiver outcomes. Data suggested that caregiver engagement fluctuated but could effectively be influenced, and the hardships experienced by caregivers, negatively impacted engagement. Additionally, after receiving early intervention for a period of three or more months, caregivers reported skills associated with capacity. Finally, caregivers do not report having the support of other caregivers that are parenting very young children with special needs.

Week after week, caregivers invited me into their homes with the aspirations to help their children more fully participate in their world and along the way relationships were forged. These caregivers that I had the pleasure to learn and grow with throughout this study had a vast array of talents and aptitudes; still, they had something more valuable, they had passion for helping their children to succeed. I'll leave you with these words by Helen Keller, "Optimism is the faith that leads to achievement. Nothing can be done without hope and confidence." The caregivers I coached and collaborated with had sky-high hopes for their children; it was my pleasure to help guide them on their journey.

Chapter Four

Action Plan

I found the results of my research both interesting and surprising in some ways. Prior to conducting this study, I had some preconceived beliefs that coaching was fairly effective at getting caregivers engaged and learning. However, I was without any real certainty about its level of effectiveness. Through this research project, I acquired data that identified concrete themes surrounding caregiver engagement and their skills and capacity.

Considering the results of this study, it is my intention to continue to prioritize forging relationships with caregivers and use coaching strategies with fidelity. The use of coaching strategies has the potential to benefit the entire family unit. In order to refine my coaching practice and help families to get their needs met effectively, I will continue to choose the relationship over my agenda. It is my top priority to help caregivers develop the necessary tools to provide intervention to their own children.

Chapter Five

Plan for Sharing

Conducting this research was a unique opportunity to discover for myself certain truths about coaching and determine if it was a good fit for my own practice. It offered me insight into why coaching is an evidenced-based practice and perspective about its potential limitations. The common themes that I found positively impacted caregivers' engagement and capacity could be incorporated into any home visiting program. I would be willing to share them with any early interventionist who is interested in thinking about building engagement and capacity through coaching. My study was significant in that, both quantitative and qualitative data suggest that the use of a coaching model was effective in fostering engagement and building the capacity of the caregiver-participants. The study will help inform my decision to use the coaching model with caregivers in the future.

As leader of a Professional Learning Community, I have already shared early impressions of using a coaching interaction style with my colleagues, which consists of home based early intervention teachers and the deaf and hard of hearing specialist. I look forward to sharing the results of this study with them in the near future. Additionally, I plan to share finding these finding with a second year that I am mentor to as she recently adopted the coaching model. I will also share results interventionist new to our district and based on their interest, I will share my study with caregivers.

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