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Patricia W. Wesley, Virginia Buysse and Lynette Keyes  
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# ***Comfort Zone Revisited: Child Characteristics and Professional Comfort with Consultation***

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**PATRICIA W. WESLEY, VIRGINIA BUYSSE, & LYNETTE KEYES**  
*University of North Carolina at Chapel Hill*

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*This study examined professional comfort of 84 early intervention professionals in providing consultation about children with varying types, severity levels, and combinations of disabilities. A replication of an earlier study with classroom teachers, the study involved a structured interview using the ABILITIES Index to assess professional comfort on the basis of child characteristics. Preliminary analyses suggested that discomfort was consistent with reported disability (behavioral, orthopedic, sensory, cognitive, or multiple disabilities). Significantly more discomfort was reported if the child had severe disabilities or difficulties in communication and behavior. Additionally, training in consultation and experience in early intervention predicted professional comfort in providing consultation. Findings have implications for professional development aimed at improving consultation practice to support early childhood inclusion.*

The shift away from segregated special educational programming for children with disabilities has stimulated numerous studies of adult attitudes related to inclusion. These include examinations of family and professional perceptions toward disabilities (Antonak & Livneh, 1988; Stoneman, 1993) and toward inclusive philosophy, policies, and practices (Buysse, Wesley, & Keyes, 1998; Buysse, Wesley, Keyes, & Bailey, 1996; Giangreco, Edelman, Macfarland, & Luiselli, 1997; Ryndak, Downing, Jacqueline, & Morrison, 1995; Scruggs & Mastropieri, 1996; Peck, Hayden, Wandschneider, Peterson, & Richarz, 1989; Stoneman, 1993; Werts, Wolery, Snyder, & Caldwell, 1996).

Some researchers have approached the study of attitudes with the recognition that a person's attitude toward inclusion in general may be positive, but that individual child characteristics could influence specific experiences and perceptions of inclusion which, in turn, could affect attitudes. Such studies have investigated the relationship between child characteristics and attitudes toward inclusion

among parents (Green & Stoneman, 1989; Guralnick, 1994) and among general early childhood staff (Buysse et al., 1996; Eiserman, Shisler, & Healey, 1995; Ward & Center, 1987). Consistent with findings reported by Eiserman et al. (1995) and with Green and Stoneman's (1989) findings for parents, Buysse and her colleagues (1996) found that teachers' views toward serving children with disabilities varied as a function of the severity of the child's disability, with severe disability in areas of limb functioning and behavior creating the most discomfort. Although a few researchers have identified relationships between child care provider characteristics and attitudes (Buysse et al., 1996; Dinnebeil, McInerney, Fox, & Juchartz-Pendry, 1998), we are not aware of any studies that have examined factors affecting attitudes among early intervention professionals providing consultation to teachers and child care providers who serve children with disabilities.

Successful implementation of inclusion requires that special and general educators collaborate to serve children and families. Con-

sultation is one approach that has been advocated to support such collaboration for the purpose of increasing staff knowledge and skills and improving quality in early childhood classrooms (Buysse, Schulte, Pierce, & Terry, 1994; Buysse & Wesley, in press; File & Kontos, 1992; Hanson & Widerstrom, 1993; Palsha & Wesley, 1998; Wesley, 1994). Implementing new strategies such as consultation involves interactions between the perceived competence of a professional to make the changes, their values with respect to the task, and the concerns they have about implementing the change (Bailey, Palsha, & Simeonsson, 1991). Information about the comfort and attitudes of consultants in relation to providing consultation to support inclusion should be an essential component of a comprehensive professional development system in early intervention. In light of this, we were interested in identifying consultants' comfort zones and the variables affecting them. Understanding the areas of consultant discomfort can provide us with information about the guidance and support needed to extend both professional comfort and professional confidence.

The purpose of this study was to examine how comfortable early childhood professionals are in providing consultation about children with different types, levels of severity, and combinations of disabilities. The study assessed comfort levels, (not attitudes about inclusion) and replicated a structured interview method used by Buysse et al. (1996) to assess the comfort zone of general early childhood *teachers* serving children with disabilities in inclusive settings. This study was part of a larger study that also conducted focus groups with consultants to explore additional dimensions of professional comfort other than child characteristics.

## **METHOD**

### ***Participants***

The participants were 84 early intervention professionals in North Carolina who served children birth through 5 years of age and families who were eligible for special services un-

der the Infant-Toddler or Preschool components of the Individuals with Disabilities Education Act of 1997. The primary role of these professionals was to provide consultation about children with special needs to child care providers and families. Consultation services included at least one visit each week to the child's home or child care program to collaborate with other adults in the child's life about effective strategies to meet the child's needs. Consultants engaged in a range of activities such as making recommendations for environmental modifications, facilitating problem solving, and assisting consultees in assessing their need for additional skills and knowledge. All participants but one were women. More than half (54%) of the participants were employed by early intervention programs operated by mental health agencies, 23% were employed by the public schools, and 23% worked for public or private non-profit contractual agencies. Two percent held doctorate degrees, 44% held masters degrees, and 54% bachelor's degrees. Of the total sample, 89% were Caucasian, 10% were African American, and 1% was Asian. Participants had a mean of 6.04 years (range 6 months to 21 years) of experience providing consultation and a mean of 8.71 years (range 6 months to 25 years) working in the early intervention or early childhood field. The majority (77%) of the participants reported they had received some continuing education related to consultation.

### ***Instrumentation***

To describe children's functional abilities and assess consultants' comfort levels, we used The ABILITIES Index (Simeonsson & Bailey, 1988). This instrument provides a subjective measure of a child's ability level in nine domains: audition, behavior, intellectual functioning, limbs, intentional communication, tonicity, integrity of physical health, eyes, and structural status (shape, body form, and structure). Each domain is rated on an ordinal scale ranging from 1 (*normal functioning*) to 6 (*profound disability*). Previous research has demonstrated the reliability of the ABILITIES Index among raters who differed considerably with respect to discipline and relationship to

the child (Bailey, Simeonsson, Buysse, & Smith, 1993). Weighted kappa coefficients for multiple raters are reported to range from .24 to .90 with a mean of .60. Parents, teachers, and therapists who have used the index report it to be acceptable and useful for describing infants and preschoolers with disabilities (Buysse, Smith, Bailey, & Simeonsson, 1993) and for developing consensus ratings among professionals with different backgrounds (Bailey, Buysse, Simeonsson, Smith, & Keyes, 1995).

### **Procedure**

We recruited participants by presenting an overview of the study at three regional meetings of early intervention consultants serving in both early childhood programs and children's homes. We asked consultants to consider participating in the study and informed them they would receive a follow-up telephone call to determine their interest. Of the 125 meeting attendees, 85 (68%) expressed interest in participating in the study and were sent information packets containing a letter describing the study, a consent form, a demographic form, and a copy of the ABILITIES Index. After participants received their packets, we called them to answer any questions about the study and to schedule a group interview.

Before the group interview, participants were asked to select five children with disabilities from their current or previous 2-year caseload. We requested they select, if possible, one child from each of the following categories: behavioral disorder, orthopedic disability, sensory impairment, cognitive disability, and multiple disabilities. For consultants with more than one child in a category, we provided a method for random selection.

During the group interview, participants completed a demographic form for each selected child. In addition to age, sex, and race information, we also collected information on the child's primary service setting (i.e., early childhood program or home), and whether the child was on their current caseload or the caseload from a previous year. We then followed a scripted protocol to guide consultants

in completing the ABILITIES Index profile for each selected child. Consultants charted a profile of each child's abilities, across the nine domains, by indicating the child's level of functioning on a 1–6 scale (i.e., normal, suspected, mild, moderate, severe, profound).

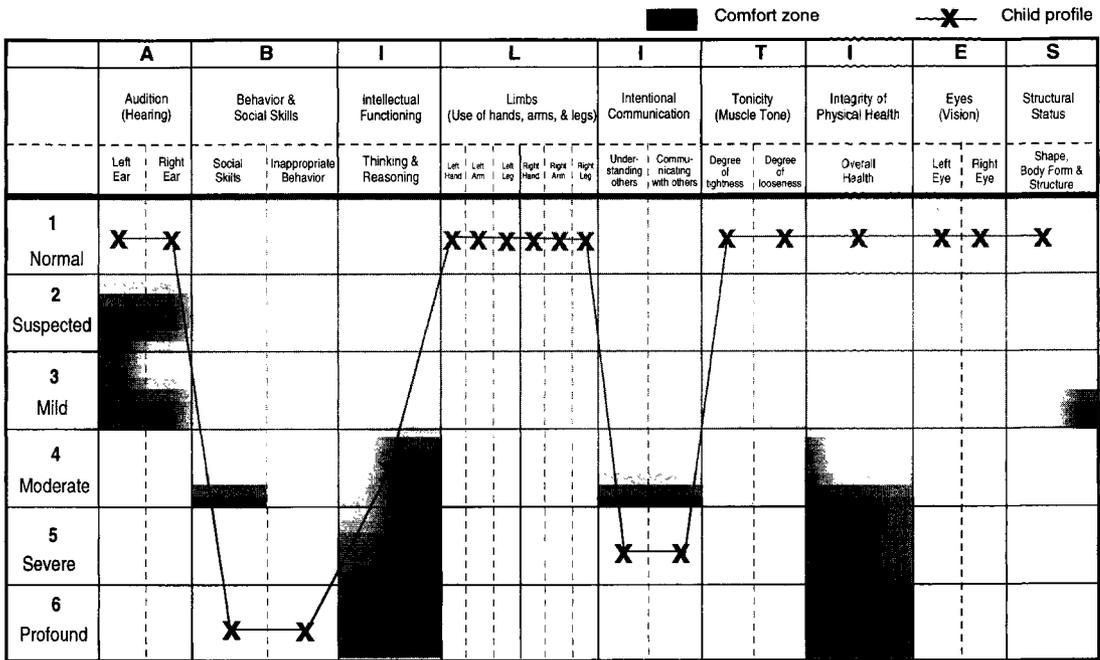
Next, using the completed ABILITIES Index profiles, consultants completed a second profile indicating the point on each 1–6 scale at which they no longer felt comfortable providing consultation. For example, on the first domain, audition, consultants were asked if they would be comfortable providing consultation about their selected child to early childhood professionals or the child's family if the child had normal hearing (i.e., Level 1 on the 1–6 scale). If the consultant indicated they *would be comfortable* providing consultation at this level, no mark was made on the profile, and we proceeded with the same question at Level 2 (suspected disability). Project staff continued the questioning until the consultant indicated no longer being comfortable providing consultation. At that point, the consultant was instructed to mark the profile, and the comfort zone was established. If the consultant was comfortable across all levels, a mark was placed at the bottom of the scale. This process was repeated for each child on each of the nine domains.

By having consultants first complete the ABILITIES Index profile for a child they were serving (or had served), they could consider actual domains of functioning with a familiar child prior to making judgments about a hypothetical case. This allowed us to determine indirectly if there was a discrepancy between a child's ability level in a particular domain and a consultant's comfort level in providing consultation about that child. Figures 1 and 2 show completed profiles from two consultants.

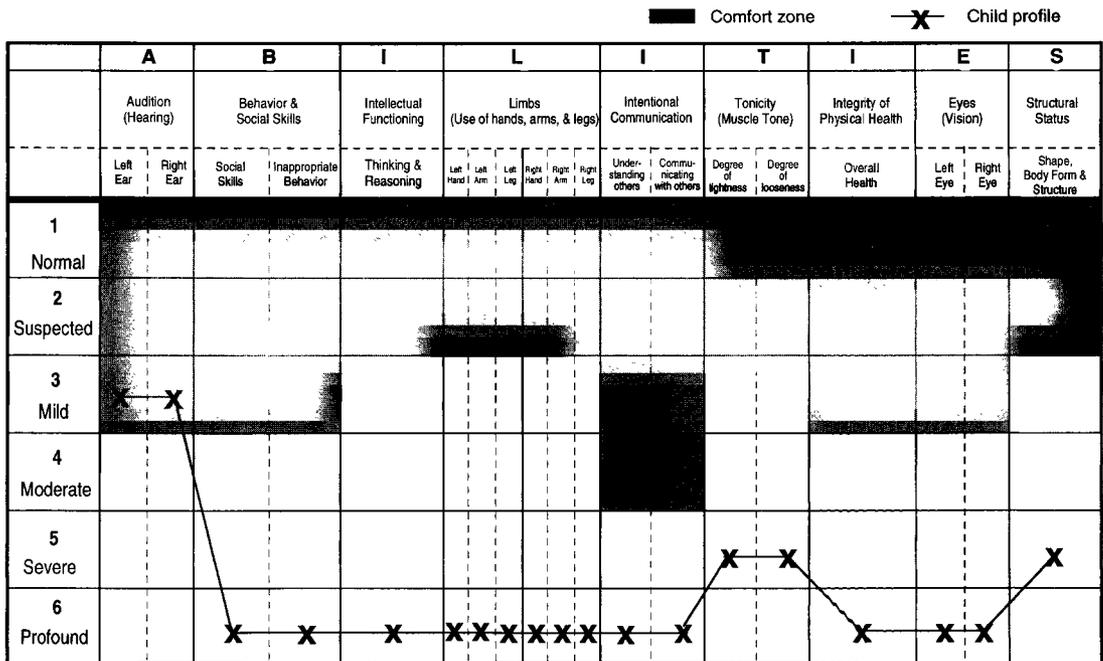
## **RESULTS**

### **Descriptive Analyses**

*ABILITIES Index ratings.* Table 1 displays the ABILITIES Index mean ratings and standard deviations for each of the five disability groups. Because not every consultant served



**Figure 1.**  
One consultant's comfort zone based on the ABILITIES Index for a child with behavioral disorders



**Figure 2.**  
One consultant's comfort zone based on the ABILITIES Index for a child with multiple disabilities

**Table 1.**  
*Mean Ratings on the ABILITIES Index Across Disability Groups*

Category and Domain	Behavior (N = 68)		Cognitive (N = 84)		Orthopedic (N = 74)		Sensory (N = 62)		Multiple (N = 68)	
	M	SD	M	SD	M	SD	M	SD	M	SD
Audition	1.2	0.5	1.3	0.7	1.2	0.5	2.6	1.8	1.8	1.2
Behavior and Social Skills	4.3	1.0	3.2	1.2	2.2	1.3	3.1	1.6	4.2	1.5
Intelligence	2.7	1.4	3.9	1.0	2.4	1.3	3.1	1.5	4.7	1.4
Limbs	1.3	0.8	1.9	1.3	4.3	1.1	2.2	1.7	4.5	1.4
Communication	3.1	1.4	3.8	1.1	2.8	1.6	3.6	1.7	5.1	1.1
Tone	1.4	1.0	2.1	1.4	3.9	1.3	2.3	1.5	4.3	1.4
Health	1.6	1.1	2.0	1.3	2.3	1.4	2.1	1.4	3.8	1.6
Vision	1.1	0.6	1.6	1.1	1.9	1.2	3.1	2.0	2.7	1.9
Structural Status	1.3	0.7	1.5	1.0	2.6	1.7	1.8	1.5	3.2	1.7

children from each of the five disability categories, and because we deleted profiles with missing ratings, the sample size across the groups is not equal. Not surprisingly, children with multiple disabilities had the highest mean ratings (indicating a more significant disability) on the ABILITIES Index. In four of the five groups, communication, and behavior and social skills were the two areas receiving the highest mean ratings..

*Professional comfort with consultation.* For each of the five children who were rated on the ABILITIES Index, comfort scores were derived for an individual consultant by calculating, for each domain, the difference between the consultant's comfort rating (i.e., the point at which the consultant indicated no longer being comfortable providing consultation) and the child's level of functioning for each domain. A consultant was considered uncomfortable providing consultation in a particular area of child functioning if the comfort scores were less than zero. As presented in Table 2, discomfort in general was consistent with the type of disability. For example, 33% of the consultants reported discomfort in the area of behavior and social skills for children with behavior disorders. Likewise, behavior and social skills represented an area of discomfort for 34% of the consultants who served children with multiple disabilities and 16% of consultants who served children with sensory problems. Consultants also reported increased discomfort in the area of multiple disabilities.

Another pattern was the report of low discomfort for audition across all disability types. For 79% of the consultants, children's ratings fell outside of their comfort zone in at least one area of functioning.

### ***Modeling Professional Discomfort as a Function of Child, Program, and Consultant Characteristics***

We used a two-stage modeling procedure to identify child, program, and consultant characteristics associated with consultants' discomfort. In the first-stage model, the probability of consultant discomfort was modeled as a linear logistic function of predictors associated with the child, including setting (i.e., home or center-based), child demographic variables (i.e., chronological age, race, gender), disability category (i.e., behavior, cognitive, orthopedic, sensory, and multiple disabilities), severity of disability (see Buysse et al., 1998, for a description of how the severity index is derived), domain (i.e., nine domains of interest from the ABILITIES Index), and all 2-way interactions with disability category. Because discomfort was assessed multiple times for each child (i.e., once for each of nine domains of the ABILITIES Index), the logistic models were fit using the method of generalized estimating equation (GEE) assuming an exchangeable within-child correlation structure (Liang & Zeger, 1986). Insignificant interaction terms were eliminated from the final model.

**Table 2.***Percentage of Consultants Reporting Professional Discomfort Across Disability*

Category and Domain	Behavior (N = 68)	Cognitive (N = 84)	Orthopedic (N = 74)	Sensory (N = 62)	Multiple (N = 68)
Audition	0%	1.2%	1.4%	14.5%	7.4%
Behavior and Social Skills	32.8%	13.1%	9.5%	16.1%	34.3%
Intelligence	9.0%	13.4%	1.4%	8.1%	32.4%
Limbs	1.5%	2.4%	28.4%	12.9%	32.4%
Communication	11.8%	20.2%	5.4%	27.4%	38.8%
Tone	1.5%	8.4%	20.5%	11.3%	33.8%
Health	4.5%	8.4%	5.6%	11.3%	29.9%
Vision	1.5%	4.8%	10.8%	22.6%	19.4%
Structural Status	1.5%	4.8%	16.2%	13.3%	27.9%

Wald chi-square tests identified a statistically significant main effect for the overall severity of the disability (Wald Chi Square = 30.9,  $df = 1$ ,  $p < 0.0001$ ). Odds of consultant discomfort increased with increasing severity of disability (Odds Ratio for 1 point increase = 1.04). For example, with a 10-point increase in severity score, odds of consultant discomfort are predicted to increase by 53% after accounting for differences in other child characteristics.

The model also revealed a statistically significant interaction effect between disability category and domain (Wald Chi Square = 123.8,  $df = 31$ ,  $p < 0.0001$ ). Further investigation demonstrated that the relationship between discomfort and disability category varied as a function of ABILITIES domain. Table 3 gives the predicted probabilities of discomfort

by domain and category (after accounting for differences in other child characteristics), as well as p-values for Wald tests of the effect of disability category within each domain. Tests revealed no statistically significant differences among categories for the health and structural integrity domains. For all other domains, differences among categories were statistically significant with high probabilities of discomfort generally associated with the disability category most directly related to the domain. For example, within the behavioral domain, the probability of discomfort is highest among children with behavioral disabilities. With the exception of the audition domain, the probability of discomfort also was generally high across domains for children in the multiple disability category. Pooled over all disability categories, behavioral and com-

**Table 3.***Predicted Probabilities of Discomfort (adjusted for differences in child demographics)*

Category and Domain	Behavior	Cognitive	Orthopedic	Sensory	Multiple	Pooled	Wald Test p value
Audition	*	0.014	0.016	0.13	0.041	0.034	0.04
Behavior and social skills	0.38	0.14	0.11	0.11	0.22	0.18	0.001
Intelligence	0.11	0.15	0.016	0.045	0.21	0.079	0.01
Limbs	0.018	0.029	0.31	0.094	0.21	0.085	<0.0001
Communication	0.15	0.25	0.048	0.26	0.22	0.16	0.03
Tone	0.018	0.10	0.21	0.094	0.22	0.10	0.02
Health	0.056	0.094	0.064	0.094	0.17	0.089	0.3
Vision	0.018	0.045	0.11	0.22	0.11	0.076	0.02
Structural status	0.018	0.061	0.18	0.12	0.16	0.085	0.07

\*No observed discomfort in this cell.

munication were the ABILITIES domains associated with the highest predicted probabilities of discomfort. Audition had the lowest probability of discomfort.

In the second stage model, predictors associated with consultant characteristics were added to the model. These included level of education (i.e., highest degree attained), discipline (i.e., specialist, educator, other), agency (mental health, public school, private non-profit), training in consultation (yes or no), direct classroom teaching experience (yes or no), years in job's primary role, years of professional experience in the early intervention/early childhood field, and years of consulting experience.

Wald tests identified statistically significant main effects for training in consultation (Wald Chi Square = 5.8,  $df = 1$ ,  $p = .01$ ) and years of professional experience (Wald Chi Square = 5.5,  $df = 1$ ,  $p = 0.02$ ) after accounting for differences among child characteristics. Predicted odds of discomfort are 76% higher among untrained consultants compared to trained consultants (Odds Ratio = 1.76). In addition, predicted odds of discomfort increase with decreasing years of experience (Odds Ratio for increase of 1 year = 0.94). For example, the predicted odds of discomfort are 30% higher when experience is decreased by 5 years.

## DISCUSSION

In this study we examined early intervention professionals' comfort with providing consultation about children with different types, levels of severity, and combinations of disabilities. By focusing on the views of consultants, the findings extend our knowledge about adult attitudes related to serving young children in inclusive community-based programs and provide a more informed perspective about consultation as an approach to support inclusion. This study also has implications for the preparation and training of individuals who work as consultants in inclusive settings.

As a replication of an earlier study with teachers, this study involved consultants who participated in a structured interview using the

ABILITIES Index to assess professional comfort in providing consultation about individual children who were currently or formerly included as part of their caseloads. In general, consultants reported high comfort in the area of audition. Given that overall mean ratings of audition for the study sample were in the normal range, the most likely explanation for the high comfort with audition is that consultants had little exposure to children who were deaf or who had a hearing loss. Consultants reported greatest discomfort in the areas of behavior and communication, followed by limb functioning and muscle tone. The finding that the behavior and social skills domain produced discomfort is not surprising, given the interest in this topic at training events and its prevalence in professional discourse in the early intervention and early childhood fields.

Similar to previous findings, considerable overall discomfort with multiple disabilities was reported. The finding that consultants' views varied as a function of the severity of the child's disability is consistent with findings of previous studies of teachers' views (Buysse et al., 1996; Eiserman et al., 1995). Although these results underscore what many administrators, parents, teachers, and preservice and inservice educators may intuit, the finding could explain one reason why fewer children with severe disabilities are placed in inclusive programs (Buysse et al., 1994).

Preliminary analyses suggested that consultants' discomfort was consistent with the type of disability a child was represented to have. In order to investigate this further, we created a model to isolate other variables that might influence professional comfort after accounting for differences attributed to disability type. Perhaps the most significant finding was that professionals who had received training in consultation were more likely to report increased comfort. This finding suggests the need to examine carefully professional development programs to ensure that practitioners can acquire the technical knowledge underpinning effective practices that support inclusion. In general, more research is needed in the field of early intervention on the effectiveness of various training approaches on practitioners'

knowledge and skills, attitudes, and their ability to address situations of uncertainty or conflict. The finding that years of experience in early education and intervention also predicted professional comfort likely indicates that professionals also learn consultation knowledge and skills by practicing them on the job and determining through trial and error which consultation styles and approaches work best for them. Employing reflective practice techniques used in mentorship and supervision (Fenichel, 1991; Gallacher, 1997) to support the consulting role seems particularly important for practitioners who are new to the field and lack an experiential base for consultative practice. It is worth noting that consultants' comfort was not affected by whether the service setting was home- or center-based. This finding is encouraging, given the increasing numbers of children enrolled in community early childhood programs.

This study was subject to several limitations. First, we recruited consultants through quarterly meetings of early intervention professionals serving as consultants in early childhood programs and in children's homes. The meetings were organized by a statewide technical assistance project to provide opportunities for discussion of consultation issues and to facilitate peer support and mentoring. Because the process for recruiting consultants did not involve random selection, and because the participants self-selected from the initial group, the generalizability of study findings may be limited to consultants with similar characteristics. Second, our findings are limited by the fact that consultants were asked to assess their comfort in serving children with disabilities in five predetermined categories (behavioral disorder, orthopedic disability, sensory impairment, cognitive disability, severe and multiple disabilities). As a result, we have no information about consultants' comfort in serving children who do not fit these categories.

Study findings have several implications for practice. First, it is important to recognize that learning how to work as a consultant is a relatively new role for early intervention professionals (Buysse & Wesley, 1993). Although

recommended consultation practices are still emerging, there is general agreement that effective consultation should stress both content (i.e., direct help-giving in the form of offering specific strategies to parents and care providers) as well as process (e.g., building relationships, conflict resolution, communication; Buysse, Schulte, Pierce, & Terry, 1994; Coleman, Buysse, Scalise-Smith, & Schulte, 1991; File & Kontos, 1992). One approach that has been shown to be effective to help professionals work collaboratively with general early childhood staff to improve global program quality is the on-site consultation model (Palsha & Wesley, 1998; Wesley, 1994).

In addition to these general considerations for establishing effective consultation practice, study findings regarding practitioners' comfort in providing consultation suggest the need for additional content expertise in two areas of child functioning (communication and behavior) as well as additional preparation in consulting about young children with severe disabilities. It is disturbing that some of these areas of professional discomfort (behavior and severe disabilities) among consultants are the same as those reported for early childhood teachers, who are the recipients of consultation services in early intervention (Buysse et al., 1996). The overlap in areas of professional discomfort among providers and recipients of consultation also raises questions about the potential of the consultation process to be an effective support for some children and families and lends a sense of urgency to the need for more effective training. Since general early educators and the consultants who serve them appear to have similar concerns about serving particular children in inclusive settings, it may be most effective to offer training to consultants and consultees together and to tailor content and follow-up to their specific needs.

Given that not all consultants and teachers are equally comfortable or skilled, it is in the best interest of children and families to gain as much information as we can about professionals' needs for support and training as we strive to improve inclusive opportunities for

all children. An examination of professional comfort is an important part of the picture and a method of self-reflection using the process described in this study offers one option for gathering this type of information. Results could be used by supervisors, staff development experts, and practitioners to plan technical assistance activities and as a springboard for dialogue between consultants and consultees. Extending our inquiries about inclusion to descriptions of professional comfort sets the stage for more in-depth exchange about challenges and effective practices supporting early childhood inclusion.

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Address correspondence to **Patricia Wesley**, Frank Porter Graham Child Development Center, Sheryl Mar Suite 100, 521 S. Greensboro St., Carrboro, NC 27510. Email: [pat.wesley@unc.edu](mailto:pat.wesley@unc.edu).