MEASURING LEADERSHIP DEVELOPMENT IN THE DISABILITIES

FIELD: PERCEPTIONS OF VALUES, SKILLS AND KNOWLEDGE-BASED

AUTHENTIC LEADERSHIP

by

Caitlin E. Bailey

A thesis submitted to the Faculty of the University of Delaware in partial fulfillment of the requirements for the degree of Master of Science in Human Development and Family Studies

Fall 2012

MEASURING LEADERSHIP DEVELOPMENT IN THE DISABILITIES

FIELD: PERCEPTIONS OF VALUES, SKILLS AND KNOWLEDGE-BASED

AUTHENTIC LEADERSHIP

By

Caitlin E. Bailey

Approved: _____
           Steven Eidelman, MSW, MBA
           Professor in charge of thesis on behalf of the Advisory Committee

Approved: _____
           Donald G. Unger, Ph.D.
           Chair of the Department of Human Development and Family Studies

Approved: _____
           Lynn R. Okagaki, Ph.D.
           Dean of the College of Education and Human Development

Approved: _____
           Charles G. Riordan, Ph.D.
           Vice Provost for Graduate and Professional Education

ACKNOWLEDGEMENTS

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

ABSTRACT

Changes over time have expanded and improved the services and supports available to people with intellectual and developmental disabilities and their families (Silverstein, 2000). Quality of supports depends largely upon the leadership within an organization. Strong leadership promoting person centered vision and actions, motivates quality supports and interactions between organizations and families (Avolio & Gardner, 2005).

This thesis presents an analysis of the relationship between four measures of authentic leadership as well as an analysis of the development in perceptions of leadership for emerging leaders who have participated in a week long intensive training, at the time of the training and several months after. Results indicate that the measures are generally related over time, and that perceptions do increase over the week. Findings and analysis from this study provide suggestions for future researchers to measure aspects of leadership development in the future.

Chapter 1

INTRODUCTION AND THEORETICAL FRAMEWORK

In his discourse on the power of voice, Adams (2008) argues that voice is a privilege, not a fundamental right shared by all. In fact, he argues that many groups are systematically silenced, because the privilege of voice implies power; having the opportunity to be heard means having someone to listen. "Acknowledgement of narrative privilege motivates us to discern who we might hurt or silence in telling stories as well as whose stories we do not (and may not ever) hear (Adams, 2008, p.181)." Clouser (1997) adds, "Cultural forces influence what sorts of stories get told, basically who gets a life (p. 77)."

The stories and voices of people with Intellectual and Developmental Disabilities (IDD) have gone generally unheard or un-listened-to due to the historical devaluation and segregation of people with disabilities (Carey, 2009; Noll & Trent, 2004). However, even as inclusion and integration have become enshrined in law in the Americans with Disabilities Act (ADA)(P.L. 101-336, 1990), and similar legislation, parents of children and adults with IDD often feel unheard, or un-listened-to in their interactions with practitioners, educators and other professionals (Neely-Barnes et al, 2010). Additionally, the voices of people with disabilities are largely ignored due to the assumptions that a disability somehow inhibits a person's capacity

to formulate and express desires, needs and opinions (Carey, 2009). People with disabilities and their families need a voice that is not only heard, but also respected; in order to receive the services they have been promised.

In the disabilities field, ideally, a "person centered" vision drives the mission and values of an organization, and therefore esteems the voice of people with IDD and their families (Smull, Bourne & Sanderson, 2010, Clouser, 1997). Person centered practices are those that value, first and foremost, the person receiving the services, give choice and control to the person in all aspects of his or her life, while also ensuring the immediate health and safety of the person (Smull, Bourne & Sanderson, 2010). Ultimately, these values are driven by law and funding, and must meet the four basic policy goals of equal opportunity, full participation, independent living and self-sufficiency (Silverstein, 2000).

According to Smull, Bourne and Sanderson, (2010) the vision and operationalization of person centered practice has progressed over time as these policy goals have been adopted. "While it began with "people are safe and healthy", it then changed to "people are healthy, safe and independent"; and now has evolved to "people live a self-directed life in the community with a balance between staying healthy, safe and happy". (Smull, Bourne & Sanderson, 2010, p. 1)" In order to effectively advance this vision, there needs to not only be buy-in from leaders, but also consistency of vision between leaders and their organizations, whether they be service

provision or government, and the field of disability; most importantly, there must be alignment between vision and actions.

The following project seeks information on how leadership can affect the quality of services and support available to people with IDD and their families. Furthermore, it addresses issues of leadership development within the field to ultimately understand whether and how leader's self perceptions of their leadership skills, knowledge values and behaviors change and/or sustain over time when they experience week-long intensive leadership training. Strong values-based leadership is needed to promote quality and inclusive services (Thompson Brady, Fong, Wanninger & Eidelman, 2009), and leaders who perceive themselves as such lead more effectively (Day & Sinn, 2011). Knowledge about self-perceptions of leadership abilities will give insight into authentic leadership development within the disabilities field, in order to promote and support emerging leaders to impart change to improve the quality of services and supports available to people with disabilities and their families.

Theoretical Framework

People are complex and live their lives within multiple and intersecting individual, relational, organizational, environmental, social and temporal contexts. It is not possible to understand the behaviors and motivations of a person in one arena without recognizing the driving forces in other areas of his or her life

(Bronfenbrenner, 2005). That being said, as people develop they adopt different roles depending on the context in which they are operating. Those roles overlap and interact within a person's environments.

Using a systems theory framework, we can explore the contexts in which people with IDD and their families experience roles and barriers to those roles. Additionally, a systems model allows us to negotiate the multiple contexts that leaders in organizations serving people with disabilities encounter (Allen, Stelzner & Wielkeiwicz, 1999); this project will specifically focus on that population.

A systems theoretical approach assumes that individuals interact with other individuals and their surrounding environments, and that those interactions shape experiences and subsequent behaviors. Hall and Fagan (1956) define a system as "a set of objects and relations between these objects and their attributes (White & Klein, 2008, p. 157). Essentially a system is a context; it includes the individuals, environment and their inter- and intra-systemic experience of interaction.

White and Klein (2008) outline four basic assumptions of systems theory that frame how we will approach leadership in context. They posit, " [1] all parts of a system are interconnected… [2] understanding is only possible by viewing the whole… [3] a system's behavior affects its environment, and in turn the environment affects the system… and [4] systems are heuristics, not real things (p. 156 -157).

With these assumptions, we understand that leaders in the disabilities field exist in multiple relationships and environments that interact, and together, affect how they operate. Using this model, we also presume that there is a reciprocal effect between the leader and his or her systems; from the individuals and families served, to the organization in which he or she works, to their respective state policies and practices to the general disabilities field itself. Additionally, because systems are not concrete and "must not be taken to be a picture of objective reality but rather as a particular way of organizing experience (White & Klein, 2008, p.)" the way that leaders interpret their interconnected systems, as well as their role within those systems also shapes their leadership (Allen, Stelzner & Wielkiewicz, 1999).

Chapter 2

INDIVIDUAL AND FAMILY EXPERIENCES: SOCIAL AND POLITICAL

INTERACTIONS

In the United States, people with intellectual and developmental disabilities

(IDD) regularly encounter "attitudinal" and "institutional" barriers characterizing

"people with disabilities as "defective" and "in need of fixing" (Silverstein, 2000, p.

1695)." Attitudinal barriers include "beliefs and sentiments held by nondisabled

persons about persons with disabilities (p.1695)" while institutional barriers "include

policies, practices and procedures adopted by entities such as employers, businesses

and public agencies (p. 1695)."

The overall treatment of people with intellectual and developmental disabilities

has improved over time, in large part, due to the values, actions and civil rights

advocacy that predicated, created and passed legislation that address the rights of

people with IDD. Legislation includes the Americans with Disabilities Act (P.L 101-

336, 1990), the Developmental Disabilities (DD) Assistance and Bill of Rights Act

(P.L. 106-402, 2000), The Individuals with Intellectual Disabilities Act (IDEA) (20

U.S.C. Secs. 1400 et seq.), and the Social Security Act (42 U.S.C. Secs 301, et seq.),

which includes the Social Security Act's Medicaid program; a Federal/State program

6

that reimburses programs providing supports, or, sometimes people with disabilities

and their families themselves, for community based or institutional services as well as

medical care and expenses (Turnbull, Stowe, Agosta, Turnbull, Schrandt & Muller,

2007) . This paper focuses mainly on the original (1990) and revised (2008)

Americans with Disabilities Act, which explicitly addresses social justice issues of

inclusion, choice and the socio-cultural perceptions and treatment of people with IDD

and their families.

Although it passed in 1990, attitudinal changes occurred, in large part, prior to

the ADA, due to advocacy by family members, friends and self-advocates themselves.

These attitudinal changes lead to the creation and passion of legislation that broke

down institutional barriers, such as traditional policies and practices that maintained

the control and segregation of people with disabilities. Local policies and practices

adapted over time as social values evolved; however drastic mandated changes were

largely inspired by legislation, such as the ADA (Silverstein, 2000, Turnbull et al.,

2007).

With an overarching vision of inclusion and acceptance, the ADA framed

American governments,' businesses' and organizations' treatment of people with

disabilities. The act calls for nondiscrimination and best practice in supports

implementation to ensure that people with developmental disabilities have the most

control over their lives and services possible. Best practice is operationalized by

services that provide the most individualized and community inclusive supports (Schalock, 1996; Lakin & Stancliffe, 2007) that give choice and control to the person with a disability (Whemeyer & Bolding, 2001). However, although best practice is the ideal, disparities between written and implemented policy continue to exist (Silverstein, 2000).

People with IDD, by law, may not be segregated from society against their (or their family's) will, and medical diagnoses may not solely determine their opportunities for physical, social and emotional development and participation in society. Intrinsic to the law are value laden ideals regarding community inclusion, quality of life and choice and control for people with disabilities.

Recently, there has been greater recognition and focus on best practice in the disabilities field leading to quality supports that promote choice and control (Schalock, Gardner & Bradley, 2007). attributes this increased emphasis on quality of life to; "(1) the shift in belief that improvements in life outcomes for persons with disabilities will come from better personal relationships and community involvement and not from medical and technological advances alone, (2) the evolution of the normalization movement that stressed the importance of community life and services as measures of outcomes for individuals within those communities and receiving those services; in other words a movement that supported people with disabilities to live "normal" integrated lives within their communities (3) the emergence and growing strength of

the disability rights movement demanding person centered-planning and empowerment of those who use support services (Schalock, Gardner & Bradley, 2007)."

However, widespread attitudinal changes that contributed to creating and passing the ADA have not been operationalized by all of the organizations and programs providing supports and services for people with disabilities. There are still disparities between written policy and implemented supports causing a wide range of type and quality of services available to people with disabilities. These discrepancies address the disconnect between the legally mandated and socially experienced values and attitudes towards disabilities.

Historical Contexts

Where We Were

Traditionally, people with a disability were characterized as "other" and were segregated from society due to that "otherness" (Kudlick, 2005). American ideals, valuing a strong work ethic, earning one's success, physical beauty (defined by specific cultural standards) and normalcy supported persistent attitudinal and institutional barriers to the inclusion of people with IDD (Gerber, 2005; Trent, 1994; Kudlick, 2005).

Historically, for example, immigrants were denied access into the United States if they were believed to have any kind of disability. Any "abnormal" physical

characteristic or facial feature that presumably indicated decreased cognitive ability, which was perceived as a hindrance to a person's ability to work, was grounds for immediate rejection (Gerber, 2005).

Segregation and further exclusion were marked by institutionalization and physical separation of persons with IDD from their families and communities (Baynton, 2001). Families were encouraged to institutionalize their children with varying types and degrees of IDD, and were made to believe that these types of services were best for the child, their family and society; the goal was to forget the child and move on. (The Arc of Western Wayne County, 2009) Many children with IDD, however, did grow up in their family setting, but were often hidden and isolated from the community and did not have opportunities to experience social integration (Carrey, 2009).

Additionally, a "medical model of disability" defined by "seeing disability as the isolated experience of an afflicted individual (Kudlick, 2005, p. 59)" characterized the "attitudinal" and "institutional" treatment, services and barriers that people with IDD received prior to the 1970's. The medical model perpetuated dehumanization of people with disabilities by categorizing them by their "afflictions" and ignoring their "human qualities" such as emotions and personal values. They were viewed as an "illness" to be treated, or as "incomplete" rather than as whole people (Kudlick, 2005); "disability was on par with illness, and perpetuated similar expectations of

dependence, inactivity and exclusion from participation in community life typically associated with poor health (Krahn, 2003, as cited by Krahn, Hammond & Turner, 2006, p. 71). Even worse, people with IDD were of minimal interest to the medical community, as they could not be "cured" (Krahn, Hammond & Turner, 2006).

<div align="center">Paradigm Shift</div>

Kuhn (1970) characterizes a paradigm shift as not only a change in knowing and understanding, but also a complete change in culture, practice and way of life. From his perspective, a new paradigm, or way of knowing and doing must completely replace the old way because the knowledge and theories intrinsic to the new paradigm are incompatible to those of the old. The shift from segregated congregate care and supports that characterized people as hopeless medical cases to be excluded to integrated inclusive community supports that value people with disabilities humanity represent a paradigm shift in which one way of thinking and supporting people with IDD is completely incompatible with the other.

In the Early in the 1970's, advocates for people with disabilities and their families began a paradigm shift by starting to transform "attitudinal" and "institutional" beliefs and recognizing the detrimental and "debilitating effect of these barriers on persons with disabilities (Silverstein, 2000, p. 1695)". Families, advocates and policy makers questioned practices of forced institutionalization and segregation, as well as commonly accepted assumptions about the needs, wants and actual abilities

of people classified as "disabled". Acceptable and appropriate practices of service implementation began to change. Over the next 20 years, many people moved out of institutions into residential and community facilities or even their own homes; between 1977 and 1987 alone, the number of people living in institutional facilities dropped from approximately 250,000 to 176,000 (Lakin & Stancliffe, 2007). Additionally, service providers began to shift from a medical model to a more person-centered model of implementation, focusing more on individualized supports based on the holistic needs specific to a person with IDD (Lakin & Stancliffe, 2007).

In 1990, the Americans with Disabilities Act marked a "new paradigm" in the attitudinal and institutional treatment of people with disabilities (Silverstein, 2000). According to Silverstein, (2000) the "new paradigm of disability... considers disability as a natural and normal part of the human experience (p. 1695)

"There is a major shift in values and practices, so that rather than focusing on "fixing" the individual, the new paradigm focuses on taking effective and meaningful actions to "fix" or modify the natural, constructed, cultural and social environment... [and] eliminating the attitudinal and institutional barriers that preclude persons with disabilities from participating fully in society's mainstream (p. 1695)."

Silverstein's (2000) legal framework, based on the motivating purposes driving,

primarily, the Americans with Disabilities Act (ADA) and the Individuals with

Disabilities Education Act (IDEA, P.L. 101-476), as well as other legislation

addressing issues experienced by people with IDD and their families, outlines four

core polices and 14 methods of administering those core polices to help professionals

in any arena in the IDD field to effectively support families, in compliance with

federally mandated polices. The core policies include: equality of opportunity; full

participation and empowerment; the most independent living possible; and economic

self-sufficiency for people with IDD in all domains of life, with necessary supports to

ensure the effective enactment of those policies (Silverstein, 2000). Additionally, the

methods of administration proposed include enactment on the federal, state, local

community, organizational and individual level that, if adhered to, not only eliminate

discrimination, but ensure that services are implemented as effectively as possible for

individuals with IDD and their families.

Chapter 3

IMPLEMENTATION: POLICY VERSUS PRACTICE

Even though legislation mandates quality services that promote inclusion, empowerment and independence, there is a disparity between the ideals outlined in the ADA and the services that most people with IDD receive today. Recognizing the attitudinal and institutional barriers acknowledged by Silverstein (2000) I see that disparity occurring on two fronts, there are; 1) *social justice issues* addressing the slow-to-change values of some people towards disabilities, which cause; 2) *practice and implementation* disparities that affect the types and quality of services that are available to individuals and families. A *social justice* perspective recognizes the beliefs, attitudes and values about people with disabilities that occur on an individual, societal and cultural level (Nussbaum, 2006, Kudlick, 2003, Carey, 2009, Noll & Trent, 2004), while a *practice and implementation* perspective acknowledges the influence that services and supports have on the daily interactions and experiences for people with IDD and their families, based on those values (Summers, Marquis, Turnbull, Flemming, Poston, Wang & Kupzyk, 2007; Poston, Turnbull, Park, Mannan, Marquis & Wang, 2003; Krahn, 2003). These experiences include interactions with

other individuals, service providers and their organizations, and the surrounding community.

Values

Outdated and discriminatory treatment persists, in large part, due to the attitudes held towards and about people with disabilities. In her essay on disability identity, Samuels (2002) applies Judith Butler's (1997) body theory to people with disabilities. Butler's (1997) addressing the societal attitudes about and treatment of "bodies" that, historically in society, do and do not culturally "matter." For example, women and people who do not practice heterosexuality, traditionally, have been discriminated against, and have not been afforded the same rights and opportunities of men and people who identify as straight. Samuels (2002) contends that the way that Butler describes the devaluation of certain groups deemed socially inferior especially applies to people with disabilities who are routinely rejected, segregated and treated as less than human.

"Mainstream connections between handicap, deformity, sexuality, femininity, monstrosity and racial inferiority have a long history… thus… these terms… come into use among a wide range of minority groups (Kudlick, 2005, p. 559)." Disability status has been devalued to the point that labels have been used to further discriminate against traditionally marginalized groups as well as by marginalized groups to discriminate amongst themselves or separate themselves from additional

discriminatory labels. For example, "gay rights activists sometimes speak of themselves as "freaks" (p. 559)." Furthermore, Baynton (2001), in his essay *Disability and the Justification of Inequality in American History*, "shows how in the United States opponents of suffrage, abolition and immigration all used disability to discredit undesirable groups' claims to citizenship. Meanwhile, women, African Americans and immigrants denigrated disability by using their distance from it to create a positive sense of identity (Kudlick, 2005, p. 559)."

Kudlick (2005) also points out that the movement focusing on disability rights is fairly young compared to other social movements. She argues that "the field has gone straight from intellectual infancy to adulthood without sharing the theoretical and methodological adolescence of other marginalized groups. This has created an awkward rupture between what disability historians have discovered and what the American public is willing to learn (Kudlick, 2005, p. 558)."

Others would argue that, in many arenas, social discourse regarding people with disabilities has improved; it is no longer acceptable to publicly discriminate against, mistreat or devalue a person with a disability (Daruwalla, 1996). This trend has helped major social and policy changes to occur, however, Daruwalla (1996) found that "the public verbalizes favorable attitudes towards people with disabilities but actually possesses deeper unverbalized feelings which are frequently rejecting (Daruwalla, 1996 in Daruwalla & Darcy, 2004, p. 549)." These findings point to

reasons for discrepancies between social policies and actual treatment of people with disabilities on an individual level.

Most people with developmental disabilities rely, in some way, on the care of others to support them. In order for a provider to ensure quality, choice and control for an adult with a disability, he or she must value that person's independence, autonomy, social role, citizenship and humanity (Wehmeyer & Schwartz, 1998). Lipsky (1980) contends that "policy implementation, in the end, comes down to the people who actually implement it (p. 8)." For example, The Learning Community for Person Centered Practices, a North Carolina initiative working to improve the quality of supports and services to people with disabilities through individualized person-centered planning and supports implementation, recognizes that the quality of planning and implementation of supports relies on the values and skills of the person doing the planning and supporting.

Recognizing the discrepancies between written and implemented policy and between social discourse and actual day to day experiences, people with disabilities, their family members and leading professionals in the field have, more recently, begun to frame disability rights within a social justice movement (Rich, 2012). "Like all Others, disabled people are emerging as deeply political (and increasingly politicized) historical subjects that help articulate the important line that theorists such as Foucault

and George Canguilhem have drawn between the normal and the pathological

(Kudlick, 2005, p. 558).

Policy

Within the last two decades advocates have demanded that legal attention be

paid to discrepancies between policy and practice. In 1999, the seminal Supreme

Court decision, Olmstead vs. LC (527 U.S. 581, 119 S.Ct. 2176, No. 98–536),

involved two women with intellectual disability who were constrained to an

institutional setting even though they requested access to community based services.

The state of Georgia argued that providing immediate release from the state hospital

and subsequent services would "fundamentally alter the state's programs" thus

rendering the community-based services "unreasonable provisions" (Olmstead vs. LC,

1999 as discussed in Zimring et al., 2008, p. 2). The court sided with the two women,

dismissed the state's claim and mandated immediate transfer of the women to

community residences. Following this case, President George W. Bush issued

Executive Order 13217: Community Based Alternatives for Individuals with

Disabilities. The executive order "calls upon the government to assist states and

localities to swiftly implement (US Department of Housing and Urban Development)"

the Supreme Court decision of Olmstead v. LC (No 98-536) to all Americans with

disabilities. Olmstead inspired advocates to insist that their rights be recognized.

In 2005, Illinois residents with disabilities filed a lawsuit against state officials, and won, due to the "failure to provide the plaintiffs with long term care in the most integrated, community setting appropriate for their needs (Ligas et al., vs. Maram, et al., 2005, p. 1)." The Plaintiffs argued that these types of services and supports were not available to people with disabilities; thus, the State was not in compliance with the ADA. Many people living in institutions, who wished to receive more community-based care, could not, due to the segregated nature of procurable services available. (Ligas, et al., & Maram, et al., 2005).

More recently, in October of 2010, in The United States v. Georgia (Civil No. 1:10-CV-249-CAP, 2010) Georgia was ordered to cease admission into institutional settings by July 1, 2011, and to transition all persons with IDD out of State Psychiatric Hospitals to community settings by July 1, 2015. These lawsuits exemplify social justice issues that encourage devaluation of the rights of people with disabilities, and practice and implementation issues directly impact the quality of daily services accessible to people with IDD.

Justice and Social Implications

Social justice issues impact policies, programs and service implementation on a national, state, community and organizational level. However, they not only impact individuals and families receiving supports, but Kudlick (2003) argues that "just as gender and race have had an impact well beyond women and people of color…" so

has disability also because it "is so vast in its economic, social, political, cultural, religious, legal, philosophical, artistic, moral and medical import (p. 767)." "Disability cuts across all races, classes, genders, nationalities, and generations because it can potentially happen to anyone at any time… (Kudlick, 2003, 768)."

Kudlick (2003) posits that understanding the perceptions of disability over time helps us to,

" answer the overarching questions central to our mission… in a humanistic discipline: what does it mean to be human? How can we respond ethically to difference? What is the value of human life? Who decides these questions, and what do the answers reveal? (p. 764)."

These questions are central to the social attitudes, values and beliefs about people with disabilities. Understanding those attitudes sheds light on "mainstream" social expectations that categorize people as "normal" and "other" (Kudlick, 2005). Kudlick (2005) and Baynton (2001) argue that this categorization of "other" perpetuates discrimination and community dis-inclusion of people with IDD. Gerber (2005) contends that "disability is a social construction, varying in time and place with cultural, social, political and economic circumstance (p. 50)." Thus treatment of

people with a disability is based on the conceptualization and expectation of ability in a specific context or environment.

Although, as mentioned previously, there has been progress in the attitudes about and treatment of people with IDD due to effective advocacy efforts, many individuals and families still experience regular discrimination and stigmatization, due to the perceived meaning of their disability. Often this discrimination comes in the form of ableism (Fougeyrollas & Beauregard, 2001) which is defined by Linton (1998) as "...overt discrimination against people with disabilities, the notion that people with disabilities are inferior to nondisabled people, and the idea that a person's disability is a defining character flaw (as cited by Neely-Barnes et al, 2010, p. 245)."

Practice and Implementation: Services and Supports for People with IDD and their Families

How policy is practiced and implemented on an organizational level has evolved due to shifting social values. Lakin and Stancliffe (2007) outline four relatively recent trends and the impacts that they have had on people with IDD and their families, specifically in terms of residency and community integration. Service trends include; 1) shifting from institutional to community services; 2) decreasing the size of community settings; 3) decreasing dependence on agency owned or controlled housing and increasing the prevalence of homes owned or controlled by individuals with disabilities themselves, and; 4) decreasing out- of- home placements of children

and youth. In general, these trends have improved the lives of families and individuals with disabilities by increasing involvement and belonging in their communities, enabling individuals and families to actively make choices based on their own needs and goals, and creating overall, higher reports of wellbeing.

However, for many families, increased autonomy has resulted in inadequate funding, supports and information, due to long waiting lists and funding models that still monetarily promote institutionalization (Lakin & Stancliffe, 2007). Additionally, as more and more people with disabilities are entering adulthood and desire independent living and occupations, sufficient and adequate services need to adjust accordingly; yet they have not (Stancliffe, 2001).

As families are increasingly central to the care provision of individuals with IDD, they need support systems that promote family centered models of service. When family members have control over services, families report higher satisfaction and overall wellbeing; however, many families do not have control (Neely-Barnes et al., 2008). After conducting focus groups with 45 parents who had at least one child with one or more of the following disabilities: autism, cerebral palsy, Down syndrome or sickle cell disease, Neely-Barnes et al., (2008) found that many parents felt undervalued and excluded by family members, community members and professionals in the field. Specifically, negative interactions with professionals included "limited

information given, lack of empathy or validation of the parents' concerns, and limited knowledge of the child's diagnosis or needs related to the diagnosis (p. 251)."

Written into Supposition II of the ADA and IDEA are policies recognizing that people working in the disabilities field need the necessary knowledge, skills and values in order to provide quality and effective services. According to Silverstein (2000) program supports, in order to "ensure that initiatives conform to the best practices… [and] support systemic change, research training, and technical assistance (p. 1744)," can include the programs aimed at supporting individuals with IDD and their families in the following ways:

A)   "Systemic Change

B)   Training of persons with disabilities and their families

C)   Personnel preparation and training

D)   Research, demonstration, technical assistance and dissemination of
       information (p. 1745)."

Additionally, the Developmental Disabilities Assistance and Bill of Rights Act (D.D. Act), (P.L. 106-402, 2000), last re-authorized in 2000, provides federal assistance to states and public nonprofit agencies to "support community-based delivery of services to persons with developmental disabilities to create and enhance opportunities for independence, productivity, and self-determination (The Arc, AAIDD, AUCD, UCP, NACDD & SABE, 2010, p. 1)." Each state has one Council on

Developmental Disabilities, comprised of volunteers and professionals, all gubernatorial appointees. Each state, under the DD Act, must provide services and regulate systems that ensure the following: Protection and Advocacy systems, University Centers for Excellence in Developmental Disabilities (UCEDDs) and may compete for Projects of National Significance. Ultimately, it is the goal and responsibility of organizations providing residential, occupational and community integration supports to meet the individual needs of people with IDD, as they define them, and are enabled to make their own life choices.

Practice and Implementation: Implications for Service Providers

Organizations providing supports for individuals with disabilities and their families must recognize social justice disparities and intentionally align their practices with their values, beliefs and attitudes. Silverstein (2000) outlines standards that organizations must follow in order to provide services that are in line with the ADA and the four core policies previously mention. Organizations must provide services that:

1. Support quality of opportunity in terms of
   a. Individualization
   b. Genuine, effective and meaningful opportunities
   c. Inclusion and integration

2.   Support full participation

3.   Support independent living

4.   Support economic self sufficiency (p. 1748)

Martha Nussbaum's (2006) capabilities approach to understanding and supporting people with disabilities "values the dignity, autonomy, and potential of all individuals, and views each as his or her own end (Stein, 2007, p. 77);" she outlines "ten functional abilities as a prerequisite to being "truly human," (p. 77)," Stein (2007) argues that some people with IDD may not meet all of the criteria outlined in Nussbaum's approach, and he expands the model to include,

"a more inclusive approach..., which maintains as a moral imperative that every person is entitled to the means necessary to develop and express his or her own individual talent… [and] values all persons based on inherent human worth, rather than basing value on an individual's measured functional ability to contribute to society (p. 77)."

Nussbaum (2006) and Stein's (2007) respective approaches connect broad social issues with practice and implementation issues related to services. The attitudes,

beliefs and values about people with IDD shape the services and supports that individuals and families will receive.

Returning to Silverstein's (2000) four core policy focuses, full participation; empowerment; independent living; and economic self-sufficiency for people with IDD, organizations must recognize the discrepancies that many people and families encounter in order to promote inclusion and wellbeing of individuals and families. Self-Advocates from the Autistic Self Advocacy Network, The National Youth Leadership Network and Self Advocates Becoming Empowered (SABE) produced a report, *Keeping the Promise*, citing current legislation and challenging services to meet the standards outlined in those policies. They contend that,

" over the last half century, the United States has made many important promises to its citizens with intellectual and developmental disabilities… [and that] those of us on the "receiving end" of the promises have taken our Nation's commitments seriously. We expect that when our country guarantees "access to needed community services, individualized supports and other forms of assistance that promote self-determination, independence, productivity, and integration and inclusion in all facets of community life" the promises will be kept (Barrows et al, 2010, p. 2-3)

Chapter 4

RATIONALE: THE NEED FOR LEADERSHIP

Despite progress, people with IDD and their families still face attitudinal and institutional barriers. While legislation, such as the ADA, mandates supports and opportunities for individuals with IDD that promote inclusion into society (Silverstein, 2000) as well as part of the diversity of humanity (Eidelman, 2011), there is still a discrepancy between policy and practices regarding service implementation for many individuals and families (Epley, Summers, & Turnbull, 2010). Conversely, there are individuals and families who receive exceptional supports and services and do not experience all of the same barriers. These experiences, in large part, depend on the quality of supports available and the context in which individuals and families interact with organizations and persons who provide supports. Quality of supports depends largely on the quality of leadership within an organization; leaders shape the way that services and supports are provided (Parish, 2005; Thompson-Brady et al., 2009).

For example, Parish (2005), in her qualitative case study comparison of deinstitutionalization practices in Michigan and Illinois, found that successful transition to community based residential services, and implementation supports within the community were predicated upon effective leadership driven by values of inclusion. Thus, not only is it important to understand the contexts that benefit

27

individuals and families, but it is also important to know about the contexts that promote leaders in the disabilities field to successfully assure the availability of quality supports and to support those families. Contextual influences consist of the attitudes, behaviors and interactions exhibited and experienced on multiple levels of an organization, (including direct support, management and directors) and society (including political and cultural interactions at the community, state, national levels).

Leadership has become a widely studied phenomenon in political, professional and organizational arenas, often studied on an individual basis, asking the question, "What makes a good leader?" However, as Bennis (2007) argues that although we "still tend to see leadership as an individual phenomenon… in fact, the only person who practices leadership alone in a room is the psychotic (3)." He argues that "leaders do not exist in a vacuum (3)" and that leadership must be viewed contextually, and include the leader and/or leaders, followers and the common goal they want to achieve.

Justification in the Disabilities Field

People with IDD and their families interact directly with support providers and professionals on multiple levels of an organization; the quality of the supports received depends largely on the quality of those interactions. Strong leadership that promotes a person centered vision and actions, motivates quality supports and interactions between organizations and families (Avolio & Gardner, 2005).

Leaders in the IDD field in the United States return to legislation such as the ADA, IDEA and DD Act for context and focus. Internationally, the UN Convention on the Rights of Persons with Disabilities and Optional Protocol (United Nations, 2006), cites the Charter of the United Nations, "which recognize[s] the inherent dignity and worth and the equal and inalienable rights of all members of the human family as the foundation of freedom, justice and peace in the world, (p. 2)" calls on world leaders to emphasize "the importance of mainstreaming disability issues as an integral part of relevant strategies of sustainable development (p. 2)." Leaders everywhere must operate on the values of inclusion and the belief that people with intellectual and developmental disabilities can and should have the opportunity and support to develop as individuals with the capacity for self directed lives (Silverstein, 2000, Barrows et al., 2010).

Values Based Leadership

According to Smull, Bourne and Sanderson (2010) professionals and leaders who practice a person-centered vision and work so that "people live self-directed lives in the community" must value the voices of the people and families they serve. These leaders not only hear what is important to the persons and families, but the priorities of the people receiving services are central to their professional lives. Again, the connection between personal values and action is essential; authenticity is necessary.

Additionally, recognizing the element of power that is associated with leadership, authenticity, marked by alignment between internal values, vision beliefs and knowledge and the behaviors and skills demonstrated, can be adopted as an appropriate model of leadership; an authentic professional in the IDD field would not be motivated by the power associated with the leader's position, but rather by recognition that the power belongs to the people who are receiving the services. Shamir and Elaim (2005) posit that "leadership is based on personally held values and convictions rather than on mere conventions of an appointed office or the desire for personal power, status or other benefits, and that the leader's behaviors are consistent with his or her beliefs, values and convictions. (p. 408)."

Chapter 5

AUTHENTIC LEADERSHIP

Justification in the Disabilities Field

An authentic framework of leadership requires that leaders are motivated by internal values and convictions and have the skills and knowledge to promote person centered services and supports within their organizations. Person centered values must exist at the core of an authentic leader so that individuals and families are confident that services and supports will truly regard their needs and priorities, and provide services accordingly. Ultimately then, it is important to develop and foster authentic leadership for professionals in the Intellectual and Developmental Disability field in order to effectively support people with IDD and their families.

Thompson Brady et al., (2009) assert that an authentic leadership model "is particularly salient for leadership within organizations serving people with disabilities, because the field is driven by values of equality and human rights… Future leaders must lead in the direction of disability policy goals…" (p. 3). In their interviews of leaders and emerging leaders within various disability organizations they found that leadership was overwhelmingly reported as an essential factor, necessary to promote

and sustain values in order to effectively support individuals with IDD and their families in line with ADA values and policy goals (Thompson Brady, et al., 2009).

Defining an Authentic Leader

In order to promote Authentic Leadership within disability organizations, an operationalized model and definition of leadership is necessary. Avolio, Luthans and Walumbwa (2004) defined authentic leaders as,

"those who are deeply aware of how they think and behave and are perceived by others as being aware of their own and others' values/moral perspectives, knowledge, and strengths; aware of the context in which they operate; and who are confident, hopeful, optimistic, resilient and of high moral character (p. 4)"

Additionally, Avolio and Gardner (2005) suggest that authenticity is achieved when a leader is able to own his or her thoughts, has a deep understanding of self: "self knowledge" and acts in accordance with that knowledge. The distinguishing characteristic of Authentic Leadership that sets it apart from other leadership models is authenticity. Authenticity, rooted in the colloquialism "to thine own self be true" is a trait encompassed by persons "who are "in tune" with their basic nature and clearly

and accurately see themselves and their lives..." and behave accordingly (Avolio & Gardner, 2005, p. 319)."

Similarly, Shamir and Elaim (2005) posit that authentic leaders are able to express, through behavior, their self-concept. Self-concept is comprised of "self knowledge, self-concept clarity, self- concordance and role person merger (p. 395)." Essentially, authentic leaders not only know themselves, but also have a strong belief in their values and knowledge and are able to effectively express their self-concept; they perceive themselves as authentic leaders and behave accordingly. Shamir and Elaim (2005) offer the following qualifications that define an authentic leader,

> "(1) rather than faking their leadership, authentic leaders are true to
> themselves (rather than conforming to expectations of others); (2)
> authentic leaders are motivated by personal convictions, rather than to
> attain status, honors or other personal benefits; (3) "authentic leaders
> are originals, not copies" (pp. 321); that is, they lead from their own
> personal view; and (4) the actions of authentic leaders are based on
> their personal values and convictions. (Avolio & Gardner, 2005 p. 321
> on Shamir and Elaim, 2005)."

The definition of an authentic leader must recognize the complexity of the individual within the context of his or her organization (Avolio & Gardner, 2005). A definition that is realistically multidimensional and multilevel, however, makes operationalization and measurement of leadership difficult. There are not necessarily prescribed tools or skills that make an authentic leader, nevertheless leadership based in values, knowledge and skills that drive action and behavior are the defining characteristics being observed in this project. Additionally, we will continue to recognize that an individual's experiences contribute to his or her leadership style and ability greatly.

Identity and Leadership

Personal identity contributes to leadership identity, and is an important aspect of the lived experience of a leader. Personal identity speaks to a person's perceptions of him or herself, while leadership identity speaks to how one perceives oneself as a leader. Reicher, Haslam and Hopkins, (2005) argue that social identity, which predicates personal identity, also contributes to the leadership experience. Social identity not only establishes a person's individual conceptualization of self, but it also establishes social power and status for a leader. Social power and its' resulting influence on leadership identity is especially salient for people who have been traditionally categorized as a minority. Meyer (2003) explains in his definition of minority complex, that people who identify with or belong to groups that have been

traditionally oppressed, understand their "minority status" and are thus affected by the implications of it. The effects are often negative and affect either psychological or emotional health due to discrimination, even if they are not explicitly oppressed. People are aware of their status in society and decrease of power due to their "other" affiliation. Conversely, a person who is in a position of leadership power, is also aware of that role, and is aware of how his or her social identities contribute to that power.

Reicher, Haslam and Hopkins, (2005) suggest that social identity has the following influences:

"1. Social identities provide parameters of mass mobilization;

2. Who is included within a social category determines who will be mobilized;

3. The content ascribed to social category will determine what they will be mobilized for;

4. The prototypes of the category will determine who will be in a position to direct the mobilization (p. 556)."

People's social identities, therefore, not only influence their own understanding of themselves as a leader, but it also positions them within an organization and society, and effects the type and scope of power and influence that they may have.

Authentic Leadership In Context

The question that emerges then, how does one promote and foster authentic leadership within an organization? Researchers, (Thompson-Brady et al., 2009) asked executive directors and emerging leaders about effective leadership within their organizations that support people with disabilities. They identified skills and characteristics of authentic leaders, as well as some of the necessary tools to help develop those leaders. Among their findings, they identified a need for leadership training regarding skills, knowledge and values, and concluded that authentic leadership can be taught and enriched. At the same time, many of the executive directors and emerging leaders recognized that a supportive organizational culture was a necessary environmental factor to foster authentic leadership. Individual skills alone are not enough; the context in which the leaders exist matters. (Thompson Brady et al, 2009).

Leadership must be understood from a multidisciplinary, practical lens. Bennis (2007) called for looking at the adaptive capacity and resiliency of leaders, and said that leadership is often inspired by "a hunger to understand why the world [has] gone mad" and is led by "scholars who [feel] empowered by… tools… and a willingness to collaborate across traditional disciplinary lines (3)" This framework must be placed within the leader's interacting contexts. These contexts include individual and family lives, organizational environment, community, and the larger

social and political environment as well.   How a leader experiences, conceptualizes, values, and is supported in his or her role, in his or her intersecting environments, will affect the perceptions, characteristics and quality of his or her leadership.

It is important, to understand how to promote and support effective leadership in order to impact positive change on an organizational and social level. Effective leadership is dependent on the context in which that leadership is implemented. Anita Roddick, founder of the Body Shop cited "wholeness of values and virtues; wholeness in the sense of being part of something larger than the person… and wholeness as a person in the sense of aligning thinking, feeling and acting (Pless, 2007, p. 451)" as factors that made her a conscientious leader who contributed not only to the success of her company, but also to a sustainable and responsible society as a whole.

From Pless (2007), we see that the individual experience of a leader must be placed in the context of the organization in which he or she is working, as well as the multiple, intersecting contexts that are pertinent to the leader. Pierro, Cicero, Bonauto, Knippenberg and Kruzlanski, (2005) discussed the need for organizational support and clarity in order to promote leadership, successful relationships between leaders and followers, and effective behaviors. Additionally, Epitropaki and Martin (2005), after interviewing 502 employees found that transformational leadership (causing change in individuals and systems) and transitional leadership (supporting successful transitions as leadership roles change) were supported by perceptions of organizational identity,

or feeling a strong sense of connection between one's personal self and an organization's values and actions. How a leader perceives support from his or her organization will greatly affect the ability to lead effectively and authentically.

An authentic leadership framework is a gateway to understanding the lived experiences of leaders that exhibit congruence between their personal beliefs and actions. It is a model that combines values, knowledge, skills and behaviors that inspire and give emerging leaders the tools to enact change, and is an effective model to apply to leadership within the disabilities field (Thompson Brady et al, 2009).

In order to understand the decisions and actions that contribute to leadership, we must first understand the way that the role is perceived and how those perceptions influence resulting behaviors. Understanding this may improve future leadership development strategies (Thompson Brady et al, 2009).

Chapter 6

DEVELOPING AUTHENTIC LEADERSHIP IN THE DISABILITIES FIELD

Developing Leadership

Knowing how to promote and support effective leadership is necessary to
impact positive change within organizations that will better the lives of individuals
with IDD and their families. However, we must first establish that leadership can be
developed and that leadership training can benefit leadership performance. Although
researchers have found that people believe that leadership training can effectively
impart positive organizational change (eg. Thompson-Brady et al., 2009) and that
leadership can indeed be developed and fostered (eg. Bennis, 2007) few studies have
shown the effective outcomes of leadership trainings, and virtually none have done so
in the field of disability.

An example from the business world includes Barling, Weber and Kelloway's,
(1996) small study of transformational leadership training. The researchers assigned 9
bank managers to a one-day intensive training group and four follow up training
sessions, and assigned 11 bank managers to a control group. They conducted pre and
posttest surveys of subordinates' perceptions of their managers' leadership skills.

Researchers also analyzed pre and post financial success of their respective banks. They found that subordinates rated the managers who had gone through the training significantly higher in the post test than those who hadn't, and found that the financial success of the banks with the trained leaders increased, although not significantly (however they recognized that due to their small sample size, further larger-scale studies were necessary).

Recognizing the lack of available research in this area, Day and Sin (2011) began to explore the benefits of understanding leadership development over time, and mapped the perceived identity of leaders over time. They found that fostering leadership, specifically achievement goals, learning and facilitation of leadership skills and personal perceptions over time relates to positive leadership trajectories. Riggio and Mumford (2011) support this claim in their overview of longitudinal research on leadership development, and argue that more research over time would benefit trainers, leaders and the organizations that employ them.

Additionally, Avolio, Avey and Quisenberry (2010) measured return on investment in leadership training and found that, depending on the training, the value of leadership development was well worth the cost and that the return on investment often well exceeded the cost of the training. Their study highlights the necessity for quality training, but shows how training and development can quantifiably benefit an organization.

Developing Leadership In Context

Leadership can be trained and fostered; nevertheless effective leadership is dependent on the context in which that leadership is implemented. In a human services organization, effective leadership enables a person to promote the wellbeing of others, and motivate followers to do so as well (Thompson Brady, et al., 2009). The overall vision of an organization, constructed from the vision and values of the leaders within an organization, is contextually embedded within the community and social problems driving the mission.

Specifically, within the intellectual and developmental disabilities field, outstanding leadership has promoted positive social changes regarding the way that we, as a society, see and treat people with disabilities and their families. However, a model of leadership that helps us understand and support leaders to promote community inclusion, independence and self-directed lives for people with IDD and their families is needed. This model, based on the definition of authentic leadership, includes the interaction of self-perceived skills, values and knowledge that is contextually bound. In this model, leadership is displayed, based on self-perceptions, through actions and behaviors displayed within a professional or organizational context in the field of disabilities. (Figure 1)

Figure 1

Conceptual Model of Authentic Leadership
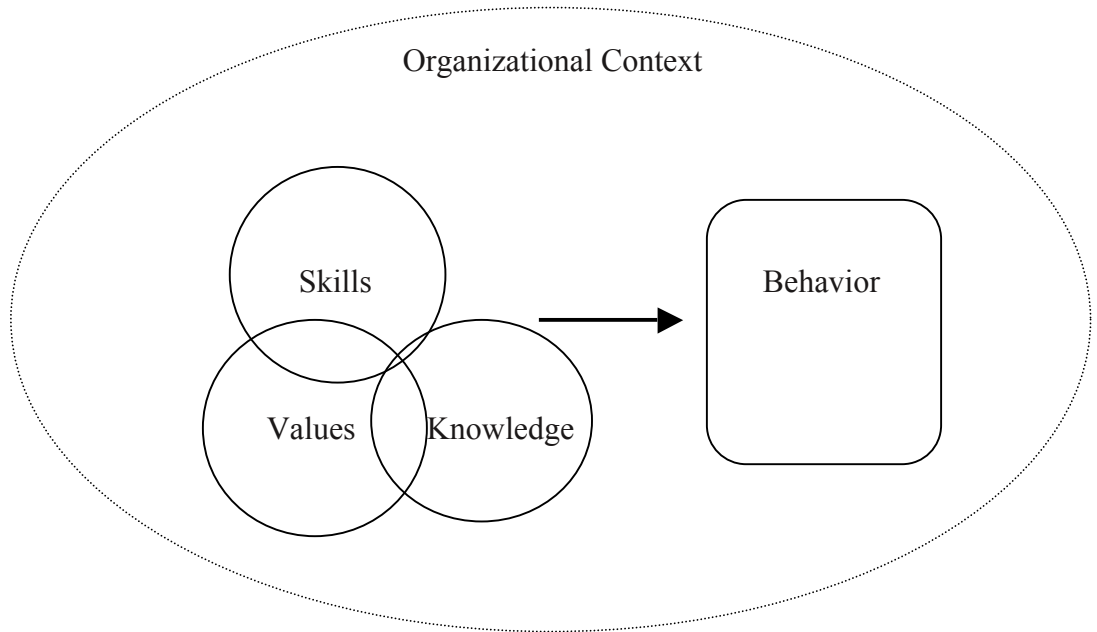
Core values of inclusion and equality are important to individuals and their

families and are now mandated by federal policies enacted in recent years (Silverstein,

2000). The leadership framework outlined above recognizes the individual

experiences of professional leaders in the IDD field who are attempting to implement

these core values on an organizational level. While their perceptions of leadership will

be explored in depth in order to understand their leadership attitudes and roles within

their organizations, it is important to remember that, ultimately, their leadership

abilities and strengths are affecting the policies and programs on all systems levels.

Chapter 7

AUTHENTIC LEADERSHIP AND FAMILY EXPERIENCES

Current federal policy promotes individual, family and community-centered models of supports for individuals with IDD. Independence and self-directed lives are critical to persons with disabilities. People with ID /DD and their families need supports that promote these values, not only as an idea, but in practice in order to successfully care for and support independence of a person with IDD (Poston, et al., 2003, Wehmeyer & Bolding, 2001). Turnbull et al., (2007) argued that there are two major justifications for supporting family centered models,

"First, the family is the core unit of society; its decisions are entitled to great but not unlimited deference. Second, there is a limited role for the state, namely, to protect the life and health of the member when the family endangers it; the state may not decide how families should raise their members (p. 118)."

These justifications give power to families to demand individualized supports and services for members with IDD. They also place responsibility on leaders in

44

organizations that serve people with disabilities to focus specifically on individualized person and family directed supports.

Historically, the conceptualization of person and family centered supports has evolved,

"though the key elements of family centeredness (i.e., family as the unit of attention, family choice, family strengths, family-professional relationship, and individualized family services) have remained consistent, the emphasis has shifted from the family as the unit of attention to family-professional relationship and family choice (Epley, Summers & Turnbull, 2010, p. 269)."

Individuals with disabilities themselves and, in many cases with the help of families, should direct the type and scope of supports and services needed to live the lives of their choosing. Leadership in organizations that support people with disabilities can ensure these services not only in policy, but also in practice through authentic values, knowledge and skill based modeling (Thompson Brady et al., 2009).

It is important to note that sometimes there is a disconnect between the services and choices that individuals with IDD desire and the choices that family members wish to make for those individuals, which sometimes threatens the rights of persons with disabilities. Turnbull et al. (2007) recognized that courts often look to

families to make final decisions for persons with IDD, and that they have "not always been so sensitive to the interests of the family member with a disability, especially where those interests, if acknowledged, might subject the state to various obligations and liabilities (p. 118)." For example, in 1981 parents in New Jersey were permitted to sterilize their minor daughter with ID against her will, on the grounds that "she might live in the community without risking pregnancy (p. 177)"

Additionally, as the population of adults with IDD /DD is growing rapidly (Seltzer & Luchterhand, 1994; Zigman et al., 1994; Callacot & Cooper, 1997) leaders must recognize rights of autonomy and independence that many adults with disabilities seek. Family centered models of practice are essential; however those models must maintain focus on the individual with IDD These values are necessary for effective leaders to promote person-centered supports.

Organizations, lead by leaders who value person centered and inclusive practice, not only protect the rights of individuals with IDD according to the ADA and similar legislation (Silverstein, 2000), but they also promote better quality of life for families (Poston, et al., 2003). Poston, et al., (2003) after interviewing 187 individuals including persons with IDD, family members of persons with and without a disability, direct service providers and administrators in organizations that support people with IDD, found that most who interviewed "spoke about family in an ideal sense as a place of love, acceptance, harmony and nurturance (p. 324)," but that family members

of an individual with IDD discussed the need for more and better supports in order to foster that ideal environment.

Summers, et al., (2007) also "found that service adequacy ratings were a significant predictor of family quality of life (p. 319)." Lakin and Stancliffe (2007) and Wehmeyer and Bolding (2001), noted that, as residential trends have become more community based and independent, there has been an increase in personal freedom, self determination and personal choice and a decrease in staff control and loneliness for people with IDD. Families, as a whole, are healthier and happier when they experience supportive contexts that promote independence. And, family members of persons with IDD report higher personal wellbeing and individuals with a disability have a higher quality of life when they are happy with the services and supports provided (Summers et al., 2007).

However, people with IDD, particularly adults, and their families who do not receive adequate supports sometimes actually fare worse than families who use more congregate care models, specifically in terms of preventative healthcare. For example, based on medical health records and medical examinations (including physical, dental, psychiatric and reproductive- for women only) of 353 adults with IDD living in community care facilities in Los Angeles California, Lewis, Lewis, Leake, King and Lindemann (2002) described the inadequate access to medical and dental health care that the adults experienced due to lack of knowledge and availability of accessible

services and supports. Additionally a study through the Special Olympics Healthy Athletes initiative, found that athletes with disabilities who were screened, had a 39% rate of tooth decay and limited access to oral health services.

Similarly, Bershadsky and Kane (2010) in accordance with Freedman and Chassler's (2004) findings, based on a sample of 15,000 Minnesota residents with IDD over the age of 18 who were eligible for Medicaid in 2001-2002, found that people who lived in institutional settings, such as ICF/MRs ("Intermediate Care Facilities for the Mentally Retarded") and group homes were most likely to have received dental services within the past 12 months, followed by people living in their own homes, with individuals living with their families least likely to have received dental services in the past year.

These discrepancies in quality of services available exemplify the disparities between policy goals and implemented services and supports and support the need for authentic leaders in organizations that support people with disabilities. Family wellbeing depends, in part, on the services that are available (Poston et al., 2003, Summers et al., 2007). For example, self-determination (Wehmeyer & Bolding, 2001) and adaptive behaviors, defined as displaying ability to adapt to multiple social and daily settings and includes gaining independent living skills and increasing positive social behavior (Felce & Emerson, 2001) increase when adults received adequate supports from service providers**.** Services that are person and family centered, and that

effectively support individuals to lead self-directed lives promote health, happiness

and overall quality of life (Summers et al., 2007, Epley, Summers & Turnbull, 2010).

The availability and effectiveness of those services depend on the structure of the

organization (Beatty & Perry,1998, Anderson, 2006), which is modeled by the values,

knowledge, and practices of the leaders within the organization (Avolio & Gardner,

2005, Thompson Brady et al., 2009).

Chapter 8

THEORY OF CHANGE: JUSTIFICATION FOR AUTHENTIC LEADERSHIP
DEVELOPMENT

As a culmination of the literature review above, a theory of change model, based on an example developed by the Annie E. Casey Foundation (2004), was created. The theory of change framework uses information gained from the literature and current knowledge of the field as well as a list of assumptions about change to develop a logic model that "offers a picture of important destinations" and acts as a guide to "ensure you are on the right pathway (p.1)." Evidence based assumptions to support the model include:

1) There is such thing as "best practice." Community based, individualized (Lakin & Stancliffe, 2007), person and family centered supports (Gardner & Carran, 2005, Smull & Bourne, 2011) that give choice and control to families (Stancliffe et al., 2009) lead to better quality of life outcomes for individuals (Lakin & Stancliffe) and their families (Neely-Barnes et al.,2008, Neely-Barnes et al., 2010).

2) Effective leadership is a necessary element to promote effective organizational services (Avolio & Gardner, 2005).

3) Leadership can inspire change and vision (Avolio & Gardner, 2005)

4) Authentic Leadership is an appropriate and effective model of leadership in the disability field (Thompson Brady et al., 2009). Authentic leadership can be operationalized by the alignment of internal values, skills, knowledge and external behavior and action within a context (Avolio & Gardner, 2005, Thompson Brady et al., 2009, Pierro et al., 2005).

5) Self perceptions of leadership affect leadership behavior (Day & Sin, 2011).

6) Leadership can be developed (Bennis, 2007)

7) Leadership occurs in the context of an organization, community and larger social, economic and political society (Bennis, 2007, Shamir & Elaim, 2005).

"As Alice observed in Wonderland, "If you don't know where you are going, any road will take you there"… communities and their partners have too much at stake to be aimless, amorphous or random in their actions (p. 1)." Leadership development ought to be intentional and directional, as leaders affect the types and quality of supports and services available to families (Avolio & Gardner, 2005, Thompson Brady et al., 2009).

 A model of change was developed, recognizing that the current research study addresses only the first steps in the pathway towards understanding how leadership development can impact the experiences of people with disabilities and their families,

in regards to the quality of services and supports that they receive. The outcome map (Figure 2), based on the assumptions above, provides direction; how to get from A (training emerging leaders) to Z (better quality lives for people with IDD and their families). At this time, the map can be separated into three categories: what we know and currently have, what this project seeks to understand, and what, based on the results of this project, we will want to know in the future (Figure 3).

Figure 2

Outcome Map: Justification for Authentic Leadership Development

*Train emerging authentic leaders based on person and family-centered skills,
knowledge and values*
SO THAT
*Emerging leaders develop person and family-centered skills, knowledge and values of
emerging leaders*
IN ORDER TO
Influence their self-perceptions of leadership
SO THAT
Leaders return to organizations with self-perceived skills, knowledge and values
SO THAT
Organizations have better leadership within the organization
IN ORDER TO
Affect organizational change
SO THAT
Better quality, more person and family centered services are available
SO THAT
Individuals and Families have access to and choice of quality services and supports
SO THAT
Quality of life for individuals with ID/DD and their families increases

The current project addresses the first four items in the model. Through the National Leadership Consortium on Developmental Disabilities, faculty at the Leadership Institute, who are esteemed and respected leaders within the disabilities field in provider, advocacy, academic, state and federal government and training and consulting agencies, train emerging authentic leaders, based on person and family centered skills, knowledge and values *so that* emerging leaders develop those person and family centered skills *in order to* influence self-perceptions of leadership *so that* leaders return to their organizations with self perceived skills, knowledge and values.

The next steps in the map focus on leadership within the organization: organizations will have better leadership *in order to* affect organizational change *so that* better quality, more person and family centered services are available. In order to understand how leaders affect organizational change, we first need to know if leaders can be trained in the areas of skills knowledge and values, and if self perceptions of leadership can develop and sustain over time.

Figure 3

Outcome Map: Justification for Authentic Leadership Development With Knowledge

Timeline

"Know" "Want to know now" "Want to know in the future"

Train emerging authentic leaders based on person and family-centered skills, knowledge and values

SO THAT

Emerging leaders develop person and family-centered skills, knowledge and values of emerging leaders

IN ORDER TO

Influence their self-perceptions of leadership

SO THAT

Leaders return to organizations with self-perceived skills, knowledge and values

SO THAT

Organizations have better leadership within the organization

IN ORDER TO

Affect organizational change

SO THAT

Better quality, more person and family centered services are available

SO THAT

Individuals and Families have access to and choice of quality services and supports

SO THAT

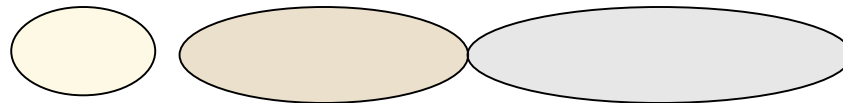*Quality of life for individuals with ID/DD and their families increases*

Developing and Sustaining Authentic Leadership

Family wellbeing depends on the effectiveness of the services and supports from the organizations that serve them (Summers, et al. 2007, Poston et al., 2003, Lakin & Stancliffe, 2007). An organization's effectiveness, in part, depends on the values, knowledge, behavior and skills promoted by the leaders within their organizations (Thompson Brady et al., 2009). Leaders can promote change, given the personal and organizational resources, including a supportive context (Pierro et al., 2005).

Authentic leadership, based on person and family centered values of inclusion and self-direction, in the disabilities field is crucial to ensuring effective supports in order to promote the wellbeing of individuals with IDD and their families. According to Bennis (2007), leaders can be trained and developed. Specifically, authentic leaders can develop based on acquiring and growing values, skills and knowledge (Avolio & Gardner, 2005, Thompson Brady et al., 2009).

Organizations that support individuals with IDD and their families need strong leadership, and those leaders can benefit from authentic leadership training (Thompson Brady et al., 2009). The question becomes though, after leaders are trained, do they implement and sustain the values, skills and knowledge acquired and or fostered within their organizations to support people with disabilities and their

families? Do those values sustain over time? And if so, do they truly encourage change that is more person and family centered?

It is important to note that while this final question may address the critical issue central to organizational systematic change, due to the scope of this project, it will not be answered here. However, describing and examining leaders' perceptions over time, will allow future researchers to address how authentic leadership is implemented within organizations and the field.

To date, authentic leadership has not been empirically operationalized as a measurable construct in the way that has been outlined in this project, thus a measure of authentic leadership has not been previously created or tested in relation to leaders in the disabilities field. For this project, a theoretical model, based on a review of literature regarding authentic leadership has been identified and developed; the model includes five factors: values, knowledge, skills and behavior (Avolio & Gardner, 2005) in context (Pierro et al., 2005; Pless, 2007) (see figure 1). Based on this model, a survey was created using questions drawn from existing measures that addressed one or more of each of the five factors outlined above. These measures include, the Aptitude for Becoming a Mentor Survey (ABM) (Karp, 2000), the Role Efficacy Scale (RES) (Pareek, 1980) the Leadership Dimensions Survey (LDS) (Miller, 1999) and the Community Living Attitudes Scale towards Mental Retardation (CLAS) (Henry, Keys, Jopp & Balcazar, 1996) and are described in depth, below.

This project seeks to evaluate the appropriateness of these measures and to understand the relationship among and between these measures over time in order to understand how leaders in the disabilities field's self-rated perceptions of leadership, regarding these five factors change or sustain over time. Thus, the following research questions were addressed:

Research Questions

I. How do the measures of skills, knowledge, behaviors, values and context relate to each other and themselves over time?

1. Were there differences in scores on the measures from Time 1 to Time 2 and across Time 1, Time 2 and Time 3 on four constructs the ABM, RES, LDS and CLAS?

2. Were there differences in scores on the four constructs, the ABM, RES, LDS and CLAS at Time 3 for people who were followed up with before and after 1 year?

Chapter 9

METHODS

Participants

This project uses longitudinal data from the National Leadership Consortium on Developmental Disabilities Leadership Institutes. These are weeklong leadership trainings that teach and promote authentic leadership based on person and family centered values, skills, knowledge and behaviors that challenge leaders to impart changes in their own organizations to ensure the most inclusive and self directed services possible.

This project uses data collected through a survey administered before, directly after and following up at various times after the leadership training. This study is part of a larger longitudinal research project that began in July 2008. A Leadership Institute has been held twice a year (once in July and once in January) since 2006. Participants are selected by directors of the leadership training based on applications that include occupational information as well as open-ended responses about perceptions of leadership role within one's organization, current structure and future vision and mission of the leader within an organization and the field of disabilities. Applicants must work in the field of intellectual and developmental disabilities and are

selected based on their perceived leadership potential within their organizations and in the future, and based on their willingness to participate in the research project.

<center>Participants at the Time of Training</center>

Because very little is known about leadership development, particularly in the disabilities field (Thompson-Brady et al., 2009), it is important to describe the group of emerging leaders that have participated in the trainings and responded to the surveys. Information about the participants will provide knowledge about the types of leaders who have participated in the leadership training and reflected on their self-perceptions of leadership over time.

To date, 223 leaders have completed surveys; mean age at time of participation was 43.8 years (SD, 9.1) (with a range of 23-66 years old). The sample consisted of 32.3% (N=61) males and 67.7% (N=128) females. Most of the participants identified as white (78.6%, N=143) or black or African American (9.3%, N=17). Additionally, most participants had earned a bachelor's degree and above. The actual distribution of frequencies related to race and highest level of education are in Tables 1 and 2 below.

Time employed in the field ranged from 0 to 540 months, with an average of 186.72 months (SD, 114.09). Table 3 displays the distribution of the type of role in the field that participants held at the time of the Leadership Institute, and Table 4 shows the distribution of the types of organizations that participants worked in at the time of the Leadership Institute. Participants could choose more than one role and type of

<center>60</center>

organization in the field, thus we are unable to compare groups based on type of role or organization.

Table 1

Frequency Distribution of Race

Race	Frequency (%) (N=187)
White	78.6 (N=143)
Black or African American	9.3 (N=17)
Hispanic	1.1 (N=2)
Asian or Pacific Islander	2.7 (N=5)
Multiracial	1.6 (N=3)
Did not Identify	6.6 (N=12)

Table 2

Frequency Distribution of Highest Level of Education at the Time of the Leadership

Training

Level of Education	Frequency (%) (N=175)
High School Diploma or GED	1.1 (N=2)
Associate's Degree	5.8 (N=11)
Bachelor's Degree	48.1 (N=93)
Master's Degree	26.3 (N=50)
Doctoral Degree	8.4 (N=16)
Undergraduate or Graduate Certificate	1.6 (N=3)

Missing Data

Participants in the Leadership Institute have been surveyed before and directly following an intensive week of leadership training since July 2008. Follow-up surveys have also been sent via online survey, to participants from July 2008 (7 months and 2 years and 10 months later), January 2009 (9 months and one year and 9 months later), July 2009 (1 year and 9 months later), January 2010 (1 year and 9 months later), July 2010 (10 months later), and January 2011 (9 months later).

It is important to note that there is a substantial amount of missing data in various sections of the questionnaires. Missing data are a common occurrence in the social sciences where subjects fail to provide responses as they become tired, bored, do not understand certain queries, and/or become embarrassed (Jelic̆ ić´, Phelps, & Lerner, 2009). Attrition is also common in longitudinal studies, "It is not uncommon for a small number of cases to be present at one wave, missing at a later wave, and then give data at still a later wave (Graham, 2009, p. 552)."

The past 2 follow-up surveys of all July and January participants have yielded a 57% and 60% response rate respectively. Some responses were not able to be used for three reasons: some respondents had attended the Leadership Institute before July 2008 when data collection began: they indicated the incorrect year that they had attended and were, therefore, unidentifiable: or they had participated in 2 follow up surveys and only the responses from the first follow up were used for this paper. When these responses were eliminated, the response rate of usable data for the first follow up was 37.6%.

While published studies generally ignore the problem (Jelic̆ ić´ et al., 2009), the most common method for handling missing data is to employ listwise (deleting the entire case from all analyses) deletion (Peugh & Enders, 2004), which is known to produce biased parameter estimates and standard errors (Allison, 2001). In this project, missing data was excluded from analysis using pairwise deletion (deleting the

case only in the relevant analyses), causing the number of cases analyzed to vary.

Pairwise deletion assumes that data is missing completely at random (MCAR), or that

there is no pattern or condition that leads to a missing response (Graham, 2009).

A Missing Value Analysis (MVA) was conducted using SPSS. MVA

"describes the pattern of missing data (SPSS Inc, 2007 p. 1)." It identifies where the

missing values are located, how extensive the missing-ness is, whether or not pairs of

variables have missing values in multiple cases, and whether or not they are missing at

random. Descriptive variables including gender, race, education level, role in the field,

type of organization and cohort were selected for the analysis. Results show that data

was missing completely at random, indicating that people who identify with a certain

gender or race, have obtained a certain level of education, work in a certain position or

type of organization or who have attended the leadership at one time or another are not

more or less likely to have responded to the follow up survey.

<div align="center">Participants at the Time of the Follow Up</div>

Participants were asked, at the follow up, about their role in the field, type of

organization that they worked for, and if there were any changes in employment,

including position, role and organization. Frequency distributions of reported roles in

the field and type of organization are below in Tables 3 and 4. Again, participants

could select more than one role and type of organization. Additionally, of the

approximately 60 people who responded, 16% had changed their employment. Of

those, 2.6% worked in a different organization, 7.7% worked in a different position and 5.1% in a different role.

Finally, participants were asked about change in level of education earned. Of the people who responded, 6 had earned a masters degree, 2 had earned an honorary graduate certificate and 2 had earned other types of degrees.

Table 3

Frequency Distribution of Role in the Field at the Time of the Leadership Training and Follow Up

Position	Time of Leadership Training (%) (N=190)	Time of Follow Up (%) (N=95)
Self Advocate	2.6 (N=5)	0 (N=0)
Direct Support Professional	4.7 (N=9)	0 (N=0)
Parent/ Family Member	8.9 (N=17)	10.5 (N=10)
Educator	7.9 (N=15)	1 (N=1)
Consultant	4.7 (N=9)	3.2 (N=3)
Executive Director (CEO)	20 (N=38)	22.1 (N=21)
Financial Manager (CFO)	2.1 (N=4)	2.1 (N=2)
Advocate	14.7 (N=28)	8.4 (N=8)
Director	42.1 (N=80)	36.8 (N=35)
Trainer	12.6 (N=24)	6.3 (N=6)
Human Resources Personnel	4.2 (N=8)	2.1 (N=2)
Program Manager	3.2 (N=6)	15.8 (N=15)
Other	24.7 (N=47)	26.3 (N=25)

Table 4

Frequency Distribution of Type of Organization at the time of the Leadership Training and Follow Up

Type of Organization	Time of Leadership Training (%) (N=187)	Time of Follow Up (%) (Total N=96)
Provider	68.4 (N=128)	61.1 (N=58)
City/ County Government	3.2 (N=6)	2.1 (N=2)
State Agency/ Department	7.5 (N=14)	9.4 (N=9)
Federal Agency/ Government	.53 (N=1)	1 (N=1)
Advocacy Association	6.4 (N=12)	6.3 (N=6)
Developmental Disabilities Council	2.1 (N=4)	2.1 (N=2)
University Center for Excellence in Developmental Disabilities Education	5.3 (N=10)	5.2 (N=5)
Not Employed	.53 (N=1)	0 (N=0)
Other	9.1 (N=17)	13.5 (N=13)

This section provided a general description of the personal and professional characteristics of emerging leaders who participate in the weeklong training. Although national data about the demographic characteristics of people working on all levels of organizations in the disabilities field have as not been collected, to date, (Hewitt, Larson, Edelstein, Seavey, Hoge & Morris, 2008), available data show that direct support workers are usually women and are more likely to identify with a racial group

67

that is not white. However, in higher-level positions, as the position increases in status, the person holding that position is increasingly male and white. It is clear, then, that the group of leaders attending the leadership training is fairly diverse in comparison to national trends.

Measures

Four subscales, included in the survey, were analyzed to measure perceptions
of leadership, based on an authentic leadership model and operationalized by
individual perceptions of values, skills, knowledge, organizational role and
consistency of internal beliefs with resulting actions. Figure 4 provides a model of
authentic leadership as it is measured in this study. Questions from three of the four
measures are included in Pfeiffer's Classic Inventories, a collection of questionnaires
and surveys that address training and development of leaders. These three include the
Aptitude for Becoming a Mentor Survey (ABM) (Karp, 2000), the Role Efficacy Scale
(RES) (Pareek, 1980), and the Leadership Dimensions Survey (LDS) (Miller, 1999).
The fourth measure used, the Community Living Attitudes Scale towards Mental
Retardation (CLAS-MR) (Henry, Keys, Jopp & Balcazar, 1996) was published in the
Journal of Mental Retardation as a measure to be used to understand attitudes of
different samples about the ability of people with ID/DD to participate in the
community.

The internal consistency for the means given at the beginning of the week, the
end of the week and the follow up of were tested using Cronbach's Alpha (1951).
Klein (1999) notes that although .7 is generally the cutoff for acceptable reliability,
when dealing with some psychological constructs not well understood, in this case

leadership perceptions, an α of less than .7 might be expected due to the diversity of constructs measured.

The ABM (Karp, 2000) specifically measures coaching, counseling, providing political guidance and providing social and emotional support, generally measuring a person's perceived skills and ability to demonstrate leadership and behavior in context. Questions are asked using a 5-item likert scale, ranging from "Strongly disagree" to "Strongly agree". The survey uses 5 of the 20 original questions. Cronbach's α =.670, .850 and .104 for the pre (beginning of the week), post (end of the week) and follow up surveys, respectively.

The RES (Pareek, 1980) measures "the integration of individuals and their roles (p. 207)" in order to address efficacy of authentic leadership in the context, and the ability of a leader to lead within his or her organization. The RES addresses, mainly, the contextual aspect of authentic leadership, as well as skills and behaviors demonstrated. Questions are asked using a 3 item scale, to which participants can select a, b or c for each question. Items were originally scored on a -1, +1 and +2 scale, and included 10 dimensions of role efficacy, measured by two items each. This survey includes 5 of the 10 dimensions for a total of 10 questions. The dimensions include "centrality vs. peripherality, creativity vs. routinism, superordination vs. deprivation, influence vs. powerlessness and growth vs. stagnation." The original dimensions were scored together for a total efficacy score. Reliability (α =.68) and

validity (.80) of the total measure have been previously tested, and the measure has been used in a number of articles published in the <u>Indian Journal of Industrial Relations</u> (eg. Pethe & Chaudhari, 2000; Chauhan & Chauhan, 2007). In this study, the RES had a Cronbach's α = .700, .753, and .741 at the pre, post and follow up respectively.

The LDS (Miller, 1999) measures four dimensions of self-perceived frequency of demonstrating leadership: constancy of purpose, congruity of activity, competency of outcome and compatibility of values. This scale addresses the knowledge and behavioral aspects of authentic leadership. Questions are asked using a 4-item likert scale, ranging from "Almost always" to "Almost never". The survey in this study uses 31 of the 32 original questions, omitting one question relating to competency of outcome. Cronbach's α =.887, .892 and .886 for the pre, post and follow up.

Finally, the CLAS-MR (Henry et al., 1995) measures the attitudes and values of people toward the community living rights and abilities of people with IDD and specifically addresses the values piece of our definition of authentic leadership. The original measure (40 questions in total) included subscales regarding values of empowerment (13 items), exclusion (8 items), sheltering (7 items) and similarity (12 items). The measure had a retest reliability, using Cronbach's alpha of over .7 and correlations between scales of r=.57. Our survey includes 8 items from the empowerment (5 items) and sheltering (3 items) subscales. The measure had a retest

71

reliability, using Cronbach's α of over .7 and correlations between scales of r=.57. Cronbach's α for the pre, post and follow up = .636, .605 and .803 respectively

Questions were updated slightly from their original format to ask about people with "Intellectual and developmental disabilities" rather than "for people with mental retardation." Historically, people with intellectual disabilities have been described using the pejorative term "retard", however this word perpetuates stigmatization and exclusion of people with any kind of intellectual disabilities and has been used to discriminate against people with any kind of disability for many decades. Recently, there has been a movement and campaign to change the language used to describe people with intellectual disabilities and has lead to the signing of Rosa's law (S.2781, 2010) which changed the phrase "mental retardation" to "intellectual disability in all federal statutes. Additionally, the American Association on Mental Retardation, a more than 100-year-old interdisciplinary professional society, changed its name to the American Association on Intellectual and Developmental Disabilities in 2006.

Table 5

Measures and Abbreviations

Measure	Characteristics Measured	Abbreviation
Aptitude for Becoming a Mentor	Skills and Behaviors	ABM
Role Efficacy Scale	Context	RES
Leadership Dimensions Survey	Knowledge and Behaviors	LDS
Community Living Attitudes Scale towards Mental Retardation	Values	CLAS

Figure 4

Conceptual Model of Authentic Leadership in Relation to the Measures
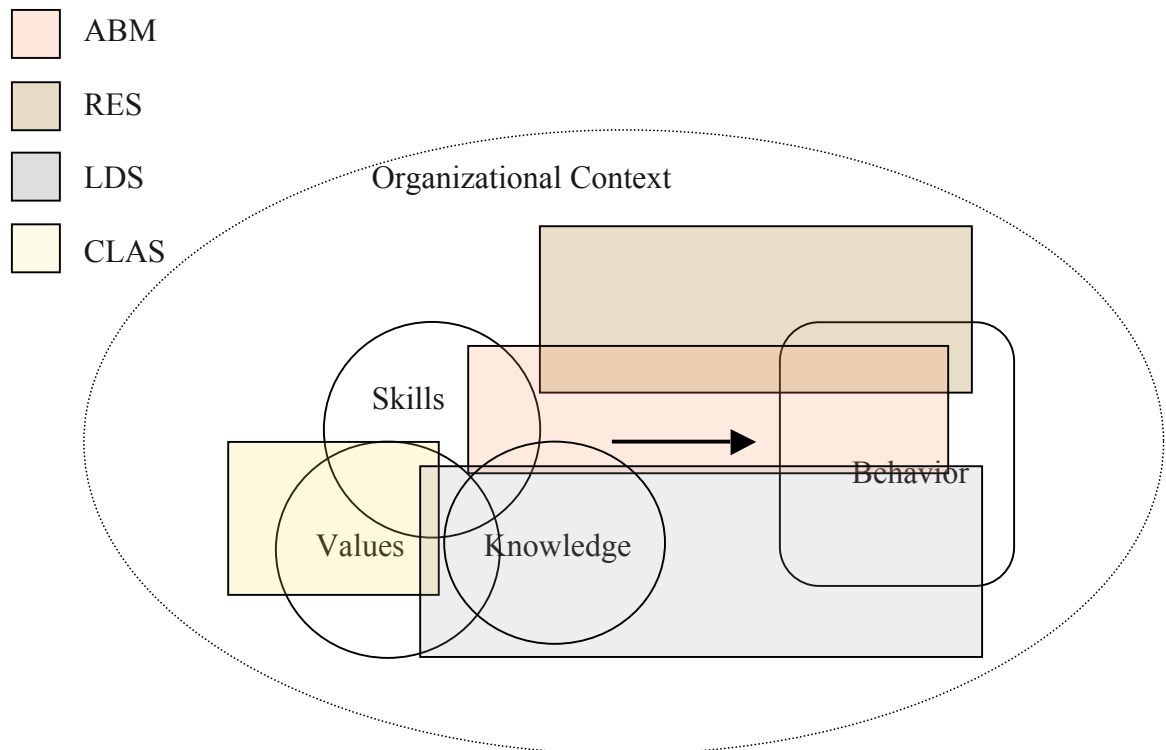
Chapter 10

ANALYSIS AND FINDINGS

Analysis and Results

Relationships Between the Measures

In order to answer research question I, addressing the relationship between and within the measures at each time, multiple Pearsons correlations were conducted using data from Time 1, Time 2 and Time 3

Correlations

Correlations were conducted between the measures at each time; results indicate whether the measures relate to one another, according to the theoretical model. Next, correlations were conducted within each measure to analyze whether each measure relates to itself over time, indicating the consistency in responses for individuals over time.

An a priori power analysis was run to determine an adequate sample size for correlation analysis. It was determined that this study would need 29 participants to have power = .80, using a two-tailed correlation analysis, and assuming a large effect size.

First, the relationships between the variables measuring perceived capacity (ABM, RES, LDS and CLAS) were examined at each point in time (pre, post and

follow-up). Significant correlations between the measures indicate a relationship to each other based on the theoretical model of leadership that has been proposed.

The relationship between each measure at the pre, post and first follow up survey are represented in Tables 6, 7 and 8. At the beginning of the week [Time 1], there was a significant positive relationship between four of the six possible combinations ABM to RES (r=.330, p<.001) ABM to LDS (r=.207, p<.001), RES to LDS (r=.174, p<.001) and LDS to CLAS (r=.306, p <.001) reflecting a medium to large, small to medium and medium to large effect size respectively. The association was significant between the same variables at the end of the week [Time 2], reflecting a small to medium effect size. However, at the follow up, the only significant correlation was between LDS and CLAS (r=.326, p<.001).

Table 6

Correlations Between the Measures at Time 1

Measure	ABM	RES	LDS	CLAS
ABM				
RES	.330**			
LDS	.207**	.174**		
CLAS	.006	.047	.306**	

Note: * p<.01, **p<.001

Table 7

Correlations Between the Measures at Time 2

Measure	ABM	RES	LDS	CLAS
ABM				
RES	.236**			
LDS	.186**	.305**		
CLAS	.129	.064	.286**	

Note: * p<.01, **p<.001

Table 8

Correlations Between the Measures at Time 3

Measure	ABM	RES	LDS	CLAS
ABM				
RES	.039			
LDS	.048	.167		
CLAS	-.035	-.013	.326**	

Note: * p<.01, **p<.001

Next, correlations were conducted for each measure using summed scores from the pre, post and follow up to understand how each measure relates to itself over time

and to indicate whether the scores changed or sustained consistently for participants as they work in the field.

Tables 9, 10, 11 and 12 show the significant positive correlation between each measure at Time 1 and Time 2. These correlations indicate that perceptions of leadership, on all of the measures remained consistent among the sample. The correlations reflected a medium to large effect size.

Results for the follow up [Time 3] (Tables 9-12) however, were not as consistently correlated. For the ABM, there was not a significant correlation between the Time 3 and the Time 1 and Time 2 results. For the LDS, there was no significant correlation between the Time 1 and Time 3. However, for the CLAS and the RES, there were correlations within each measures at each time.

Table 9

Correlations Across Time on the ABM

Time	Time 1	Time 2	Time 3
Time 1			
Time 2	.239**		
Time 3	.148	.215	

Note: * p<.01, **p<.001

Table 10

Correlations Across Time on the RES

Time	Time 1	Time 2	Time 3
Time 1			
Time 2	.551**		
Time 3	.375**	.272**	

Note: * p<.01, **p<.001

Table 11

Correlations Across Time on the LDS

Time	Time 1	Time 2	Time 3
Time 1			
Time 2	.378**		
Time 3	.157	.656**	

Note: * p<.01, **p<.001

Table 12

Correlations Across Time on the CLAS

Time	Time 1	Time 2	Time 3
Time 1			
Time 2	.434**		
Time 3	.430*	.458**	

Note: *p<.01, **p<.001

The relationships between the measures will be discussed further in the discussion section, however, it is important to note that scores on the ABM were not consistently related to the other measures and were only significantly related to themselves between Time 1 and Time 2, indicating that scores on this measure do not

hold up over time. These results show that people did not respond consistently to the questions related to this measure, demonstrating that the ABM weakly measures perceptions of skills and ability over time. Additionally, the Chronbach's α, measuring internal consistency, were .670, .850 and .104 at Times 1, 2 and 3, respectively. The very low α at Time 3 shows that there is very low internal consistency in the measure, also signifying, that the measure does not adequately address people's perceptions of skills and ability over time. Due to the weakness of the measure, the ABM was dropped from further analyses, and only relationships between and within the other three measures (the RES, LDS and CLAS) were analyzed. Dropping the measure suggests that, in the future, researchers should find a stronger measure of perceived leadership skills.

Change in Scores of Perceived Leadership Over Time

In order to answer Research Question I Sub question 1, addressing the differences in scores on each measure at Time 1 and Time 2, a paired samples t-test was conducted using data from Time 1 and Time 2.

Furthermore, to address differences in scores across Time 1, Time 2 and Time 3 on each measure, a time series analysis was conducted using data from Time 1, Time 2 and Time 3.

Paired Samples T Test

The paired samples t-test and the within subjects repeated measures ANOVA were both run due to attrition, resulting in a smaller sample size at Time 3 than at Times 1 and 2. A larger sample provides more robust information about a greater number of people and is likely to be more characteristic of the population than a smaller sample (McMillan, 2008). The first analysis, the paired samples t-test, provides information about change over the week from Time 1 to Time 2, with sample sizes ranging from 160 to 182 respondents (depending on the measure). The time series analysis, however, provides information about change over Time 1, Time 2 and Time 3, with sample sizes ranging from 45-70 participants who responded to the follow up survey at Times 1, 2 and 3.

For both the paired samples t-test and the time series analysis, scores on each measure of perceived leadership at Time 1, 2 and 3 were summed, and the means of those sums were used. Results from these analyses indicate whether scores on each individual measure of leadership perceptions change significantly from the beginning of the training [Time 1] to the end [Time 2], and several months after [Time 3].

Paired Sample T-Tests

Means scores were compared at Time 1 and Time 2 on three of the leadership dimensions, (the RES, LDS and CLAS) to determine whether there was significant

change in the participant's perceptions of knowledge, skills, values, behavior and contextual support immediately following the Leadership Training.

Effect size was determined, using Cohen's d (1988) and the sample size (n). N ranged from 160 to 182 respondents, leading to effect sizes ranging from .186 to .457, indicating a small to medium effect size for all significant differences. Therefore, as well as being statistically significant, the mean differences will represent a substantive finding.

Table 13 presents means and standard deviations for each paired measure of leadership. Participants showed significantly higher scores at Time 2 than at Time 1 on 2 of the 3 measures of perceived leadership: measures relating to skills, knowledge, values and behaviors including the LDS (t=-2.987, df [159], p=.003) and CLAS (t= -6.465, df [161], p=.000).

Table 13

Changes in Mean Perceptions of Leadership

Measure (n)	Mean at Time 1 (sd)	Mean at Time 2 (sd)	T-test	P	df
RES (166)	16.51 (2.91)	16.68	-.762	.447	165
LDS (160)	**99.71 (12.25)**	**102.71 (10.40)**	**-2.987**	**.003**	**159**
CLAS (162)	**40.64 (4.65)**	**42.96 (3.85)**	**-6.465**	**.000**	**161**

Note: Bold indicates significant change
n: number of respondents, sd: standard deviation

Time Series Analysis

A time series analysis was conducted for each measure in addition to the
Paired T-Tests. These results show the trajectory in scores of perceptions of leadership
over time. Scores on three measures of perceptions of leadership (RES, LDS and
CLAS) were collected at three time periods, thus time is the within-subject factor that
was examined across each measure. A time series analysis is useful in a quasi-
experimental design when there is no control group (such as this one) as it has the
added benefit of only requiring one group (Bloomfield, 1976).

Because 3 separate Time Series analyses were run, the results did not tell us
anything about the relationship between the measures over time, but did provide
information about people's mean perceptions before, directly after and following the
week-long training on each measure (Bloomfield, 1976; Box, George, Jenkins &
Gwilym, 1976).

A priori power was estimated for repeated–measures ANOVA (Faul,
Erdfelder, Lang, & Buchner, 2007), which can be used to find the necessary sample
size in a time series analysis as well. Because we are using a time series analysis, only
a within-subjects power analysis was run to indicate the sample size needed to observe
the mean scores for each group with a main effect for time on the mean. The proposed
analysis will use a two-tailed alpha level set to .05. Overall power was set to .80,

meaning the study will have an 80% probability of finding a significant difference if such a difference exists in the population. Equal sample sizes at each time were assumed for each group. A medium effect size was anticipated (Cohen's [1988] f = .25). Results showed an overall sample size of 56 would be required. One of the measures, The CLAS, did not meet this requirement (45 respondents completed this survey at each time). Analysis was still run, recognizing that this inadequate sample size is a limitation to the study.

Table 14 presents means and standard deviations for the four groups on the dependent variable and it does so separately by time period. Mauchly's test indicated that the assumption of sphericity was not violated for the CLAS ($\chi^2 = 4.98$, df = 2, p =.083). However, the assumption of sphericity was violated for the RES ($\chi^2 =19.41$, df = 2, p =.000) and LDS ($\chi^2 =15.61$, df = 2, p =.000).

Consequently, degrees of freedom were corrected using the Huynh-Feldt estimates of sphericity ($\varepsilon = .75$ for the ABM, $\varepsilon = .811$ for the RES and $\varepsilon = .804$ for the LDS). Wickens and Keppel (2004) suggest that if the assumptions of sphericity are violated, the Huynh-Feldt or Greenhouse-Geisser significance tests, which adjust for the violation of the assumption, may be used. When epsilon is less than .75, the Greenhouse-Geisser epsilon should be utilized, however, when the epsilon is greater than .75, the Huynh-Feldt epsilon may be more appropriate.

Within subjects contrasts were run using Difference, Helmert and finally Polynomial contrasts to thoroughly observe change over time. Difference contrasts compare each level of the factor, except the first, to the mean of the previous levels, thus comparing Time 1 to Time 2 and Time 3 to the combined means of Times 1 and 2. Helmert contrasts, however, compare each level of the factor, except the last, to the mean of the subsequent levels, thus comparing Time 1 to the combined means of Times 2 and 3 and Time 2 to Time 3. Finally, Polynomial contrasts test for linear or quadratic trends in the within subjects factor, thus revealing the shape of the trajectory.

Results for the LDS reveal the main effect for time was significant ($F = 5.08$, df [1.61, 78.78], $p = .013$] however difference and Helmert post hoc comparisons reveal that differences were significant between Time 1 and 2 *(F=7.55, [1, 49], p=.008),* but not between Time 2 and 3 *(F= .02, df[1, 49], p=.88)* for the LDS. Additionally, results for the CLAS reveal the main effect for time was significant across Times 1, 2 and 3 (F=10.169, df [2, 88], p=.000). The obtained effect for time represented a medium effect size (i.e., partial eta squared = .094 for the LDS and .188 for the CLAS) (Tabachnik & Fidel, 2006). Polynomial post hoc comparisons for the time effect revealed that the trend was best described by a linear function for the LDS ($F = 5.38$, df [1, 49], $p = .025$), although the increase in scores across time was not significant from Time 2 to Time 3. Polynomial comparisons indicated a quadratic function for the CLAS ($F = 19.38$, df [2,88], $p = .000$), indicating that scores rose

significantly from Time 1 to Time 2 and fell significantly from Time 2 to Time 3, however the difference contrast indicated that there was no significant difference between Time 3 and the combined scores of Times 1 and 2 indicating that people's scores did not change significantly between Times 1 and 3. There was no significant main effect for the RES ($F = .398$, df [2.62, 107.09], $p = .63$).

Table 14

Means and Standard Deviations for scores by Measure and Time

Group	M	SD
RES Pre	16.49	2.56
RES Post	16.84	2.66
RES Follow Up	16.75	3.66
LDS Pre	**99.76**	**12.43**
LDS Post	**104.86**	**10.35**
LDS Follow Up	**105.06**	**12.93**
CLAS Pre	**40.78**	**4.74**
CLAS Post	**43.69**	**3.54**
CLAS Follow Up	**42.31**	**3.91**

Note: *M* = mean, *SD* = standard deviation

Time of Follow Up

In order to answer Research Question I Sub Question 2, an independent samples t-test was conducted to address difference in time of measurement between

Time 2 and Time 3, or the inconsistency in time of follow-up.

Independent Samples T-Test

In order to account for difference in time between the post and follow up test, the sample was split up into those who had been followed up with less than one year after the Leadership Institute (actual response time ranging from 7-10 months after), and those who had been followed with up more than one year after a Leadership Institute (responses from 1 year and 1 month to 2 years and 10 months). Because the differentiation in follow up was done at random (there was no purposeful reason for the differences in time followed up, it was simply an oversight on the part of the researcher at the time), the group can be split this way.

The group was split this way, mainly to allow for equal sample sizes within each group. One of the assumptions of an independent t test is that the sample sizes of the two independent groups will be about the same. Using this breakdown, the size of group 1, those who responded less than one year after the Leadership Institute (n=35) and the size of group 2, those who responded more than one year after the Leadership Institute (n=33) are relatively equal. This breakdown shows whether or not perceptions change or sustain differently when evaluated closer to or further from the actual training. Although we are not able to make solid inferences on the effect of difference in time of follow up, the following analysis addresses the issue.

The mean follow up scores for each dependent variable, ABM, RES, LDS and

CLAS were compared using an independent samples t-tests and were separated by groups that were followed up with before and after 1 year.

Table 15 presents means and standard deviations for the dependent variable of each leadership perception score and it does so separately for the two groups, those who were followed up with before and after one year. Results showed a statistically insignificant difference in scores on each measure between the two follow up groups: ABM (t= .243, df[63], p=.809), RES (t=-.1435, df [60], p=.156), LDS (t=-.746, df [58], p=.459), CLAS (t= .228, df [59], p=.820). Results indicate that the time in follow up did not account for significant differences in reported leadership perceptions. The effect sizes range from very small for the ABM (Cohen's, 1988, d=.06) and CLAS (d=.058) to small for the LDS (d =.193) to medium for the RES (d=.365) and represents no substantive differences between the two groups on any of the variables .

Table 15

Means, Standard Deviations, and Distributional Statistics for Time at Follow Up

Scores

| Measure | Follow Up | |
| | Before 1 Year | After 1 Year |
	Mean (Standard Deviation)	Mean (Standard Deviation)
ABM	23.12 (9.48)	22.68 (3.58)
RES	16.41 (2.53)	17.60 (3.92)
LDS	103.83 (13.31)	106.26 (11.92)
CLAS	42.39 (4.02)	42.17 (3.48)

Chapter 11:

DISCUSSION

The results will be discussed in three parts, according to the layout of the research questions above.

Relationships Between the Measures

Aside from the ABM, which was dropped, relationships between the measures were generally significantly positively correlated. Specifically, the RES (measuring perceptions of context) and the LDS (measuring knowledge and behavior in context) were significantly related at both Times 1 and 2, indicating that, over the training, there was a significant relationship between measured perceptions of knowledge and behaviors and the context in which they are enacted. This relationship is expected and desired based on the theoretical construct of authentic leadership and earlier literature. Avolio and Gardner (2005) understood that the concept and display of leadership was complex and dependent on the context in which it occurred. Congruently, Bennis (2007) argued that leadership behaviors and abilities are related to the support that a person receives to enact them.

Although the RES and LDS were significantly related at Time 1 and 2, only the LDS and the CLAS (measuring values) were significantly correlated at Times 1, 2 and 3. These results suggest that there is a strong relationship between these two

measures across time such that there is a consistency between people's perceived values towards people with disabilities and their perceived leadership knowledge and behaviors within the context of their organization. Again, this relationship is desirable and supports Shamir and Elaim's (2005) claim that how a person displays authentic leadership is based on personally held convictions. Authentic leadership assumes an alignment between values and behavior (Shamir & Elaim, 2005; Avolio, Luthans & Walumbwa, 2004) and requires that a leader understand his or her values and act accordingly (Avolio & Gardner, 2005).

Ideally, each measure would be significantly positively correlated at each time to support the theoretical model of authentic leadership over time. However, because that is not the case, these results suggest that further analysis is necessary to determine how the factors contributing to the operationalization of authentic leadership actually relate quantitatively. In particular, more knowledge is needed regarding the relationship between peoples' perceived values and the amount and quality of support they receive within contexts in which they are leading.

According to the literature, contextual supports enable or hinder a person to lead effectively. Specifically, within human services organizations, effective leadership involves the alignment between values and behaviors (Thompson Brady et al., 2009; Avolio & Gardner, 2005) thus leaders need the support to make positive

organizational changes that promote the values of people with disabilities and their families.

Relationships Within the Measures

Each measure was correlated at Time 1 and Time 2, indicating that people's perceptions developed consistently over the week, i.e. those who had lower than average perceptions of their leadership abilities at the beginning of the week, even if they did improve, generally had lower than average scores at the end of the week as well. The same was true at Time 3 for the RES (measuring perceptions of support to lead in context), and the CLAS (measuring values). However, the scores at Time 1 for the LDS (measuring knowledge and behavior) did not relate significantly to the Time 3 results. This lack of correlation across time indicates that results at Time 1 and Time 3 were significantly different such that people's scores in perceptions of their leadership knowledge and behaviors were not significantly similar at beginning of the training (Time 1) and several months after (Time 3).

Development of Reported Perceptions of Leadership

Because there is virtually no prior data, but a great deal of theoretical and practical support for leadership development within the disability field (Thompson Brady et al., 2009,); this study provides initial evidence.

First, the scores reported on all measures, except the RES (measuring perceptions of contextual support) improved significantly from Time 1 to Time 2.

These results indicate that scores on individual perceptions of leadership related to the leaders' themselves did improve, however, their perceptions of contextual support did not.

These results are logical, suggesting that leaders who do not feel supported coming into the training (Time 1) generally do not feel supported directly after the training (Time 2) because, although they were at a weeklong training, their organization has still been operating in the same way over the week. However, because contextual support is, theoretically, important to foster effective leadership (Pless, 2007; Thompson-Brady et al., 2009) future researchers should address the influence of organizational context over time.

Furthermore, there was significant change over time for scores on the LDS (measuring knowledge and behaviors) and the CLAS (measuring perceptions of values), however scores changed differently for each measure. Scores on the LDS changed significantly over the week (from Time 1 to Time 2) but that change did not improve, significantly, over time (to Time 3). Change in scores on the CLAS, were significantly negative from Time 2 to Time 3, such that people's perceived values decreased significantly after the training so that their scores were statistically similar at Time 3 (the follow up) to Time 1 (before the training occurred).

These results indicate that scores on perceptions of values and context decreased, and only scores on perceptions of knowledge and behaviors increased over

time. Because these two measures are significantly correlated at Times 1, 2 and 3,

showing an alignment between perceived behaviors, knowledge and values, it is not

expected that scores on one measure would increase (LDS) while the other would

decrease (CLAS) from Time 2 to Time 3.

The findings in this study show that leadership training can be a beneficial

experience for many emerging leaders in the disabilities field. Although causal

inferences cannot be drawn, results indicate that, at least from the beginning of the

week to the end, participants increase their scores on leadership knowledge, behaviors

and values. These results support current theoretical literature arguing that leaders

need skills, knowledge and values to promote changes within their organizations in

order to improve the quality of services and lives of people with disabilities and their

families (Thompson Brady et al., 2009; Avolio & Gardner, 2005; Bennis, 2007).

Why scores on these measures changed in the ways that they did are not

addressed in the scope of this study. One possibility might relate to the findings of

Buchanan, Fitzgerald, Ketley, Gollop, Jones, Lamont, Neath and Witby's (2005)

literature review on sustained organizational change, In their review, the authors

describe Lewin's (1951) concept of freezing; "A change toward a higher level of

group performance is frequently short lived… group life soon returns to the previous

level (p. 228)." At the same time, the Buchanan et al., (2005) address temporal issues

to sustaining change within an organization and posit that change needs to be viewed

94

close to an intervention, to see that it is occurring, and later to see if it has had enough time to become part of the culture of an organization, causing lasting effects.

Because perceptions of behaviors, knowledge and values do not sustain over time in this study, the results indicate that leaders may need further support after the training in order to sustain their increased leadership abilities. Leaders may need continued guidance and mentorship after the training has occurred. A one-time training may need to be supplemented with additional follow up supports in order for changes, motivated by the training, to last.

Limitations

This project has several limitations, which have been discussed throughout the entire paper but will be further addressed here. First, the construct of authentic leadership development over time has not been previously measured, so there are no prior standardized tests of authentic leadership. "Standardization refers to the guidelines established in the administration and scoring of an instrument or other assessment method, and also encompasses the psychometric concepts of reliability and validity (Kaufman & Kaufman, 2005, p. 164)." Furthermore "instruments that are standardized and psychometrically sound are least susceptible to instrumentation effects, while other types of assessment methods (e.g., independent raters, clinical impressions, "home-made" instruments) dramatically increase the possibility of instrumentation effects. (p. 164)." Although the measures used are not "home-made"

95

and have drawn questions from previously developed surveys, this particular measure has not been piloted before this study.

Tests for internal consistency for each measure showed, in general, adequate reliability, however Klein (1999) suggests that generally accepted reliability cutoffs may not be applicable for psychological constructs that are not as well understood, such as leadership.

Specific threats to the analyses were evident in the results revealing the correlations between the measures. Although the measures generally are correlated across time, the r's or strength of the relationship are relatively small indicating that, although they are significantly related, the scope of the relationship is not particularly strong.

Furthermore, The results are limited, because there is no control group to provide a baseline and indicate actual effects of the intervention. Additionally, these analyses do not simultaneously provide information and about the relationship between the measures, or their relationship to the overall construct of authentic leadership, but they do describe the change on scores for each measure (as they are related to the individual factors that define authentic leadership).

Because the concept of authentic leadership has not been previously measured, threats to construct validity, or "the congruence between the study's results and the theoretical underpinnings guiding the research (Kazdin, 2003 in Kaufman & Kaufman,

2005, p. 188)," may occur. All of these threats relate to the newness and lack of standardization of the measurement. Future studies, utilizing these measurements will help researchers to know whether or not their results are in fact valid and reliable. Follow up studies with the participants could ask about the accuracy of the findings to their actual perceived leadership experiences. Factorial analyses to see how each measure relates to the latent construct of authentic leadership are also suggested.

Additional limitations relate to the sampling process and the effects of the training on responses. In this study, there was no control or baseline group that has not gone through the training to compare to, so no causal inferences about the actual effectiveness of the training itself could be drawn. Furthermore, participants were purposefully selected based on their perceived capacity to develop effective leadership skills, knowledge, values and behaviors to impact change in the contexts in which they work. Participants were not randomly selected, thus there is most likely sample selection, which poses an external threat to validity. The resulting development of leadership perceptions observed in this group may not generalize to other leaders in the field who were either not selected or have not applied to participate in the training.

Finally, novelty effects, or "threats to external validity... that... may be due in part to the uniqueness or novelty of the stimulus or situation and not to the intervention itself (Kaufman & Kaufman, p. 183) may influence leader's self perceptions during and after the week. Again, Lewin (1951) describes this issue and

discusses how people go through training and are motivated and feel empowered, however whenever they return to their normal work routine, that motivation and empowerment, which was stimulated by the setting of the training, is lost. This limitation reiterates the possible need for follow up assistance and mentorship after the training so that people continue to feel empowered.

Implications for Future Research

Expanding the Types of Leaders

Although people could select more than one role and type of organization, leaders attending this training were disproportionately from provider organizations and held positions as directors or above within their organizations. It is important to note that although these participants were specifically selected based on their perceived potential to effectively develop as leaders and impart change within their organizations and the field, this project has a distinct focus on leaders in higher positions within, for the most part, organizations that provide some kind of supports to people with IDD. Future research could focus on leaders who hold a certain position or are from a particular type of organization to understand more about the development of certain types of leaders in the disabilities field.

For instance, people in direct support positions who serve people IDD and their families may be a particularly important group to focus on in order to address the disparities between written and implemented policy (Silverstein, 2000). Lipsky

(1980), in his book *Street Level Bureaucracy,* argues "policy implementation, in the end, comes down to the people who actually implement it (p. 8)." From this point of view, the development of skills, knowledge, values and behaviors for direct support providers may be particularly pertinent to the quality of services available to people with IDD and their families.

<div align="center">Enhancing Understanding of the Measures</div>

Because the relationships between and within the measures were not significantly correlated at each time and over time, future researchers could perform more in depth analyses on and across the measures.

For instance, researchers could perform an exploratory factor analysis to determine which measures load significantly onto the latent construct of authentic leadership. These methods would be beneficial when there is a larger sample size to adequately perform the analyses.

Finally, researchers should examine the influence of context on a leader's capacity to lead and effect change within his or her organization. Future projects should address how context relates to skills, knowledge, values and behaviors and its empirical importance to promote successful and effective authentic leadership development. Furthermore, researchers could further explore and develop the construct of context, and what factors within the organization, community and field of disabilities contribute to contextual support.

Understanding Change and Development Over Time

The results of this study are preliminary, thus no conclusions regarding whether and how perceptions of leadership sustain over time can be drawn as of now. However the results do point to a potentially discouraging trend and/ or potential issues with the measurement to effectively address perceptions of authentic leadership over time. Future researchers should follow up with participants to see if they actually feel that their leadership skills, knowledge, values behaviors and contexts in which they work have declined.

Finally, perceived values did decline from the end of the training (Time 2) to the follow up (Time 3), which may indicate that leaders do not feel the support that they need in the long run to effectively maintain their perceived values towards people with disabilities. There may be a need for follow up support after the leadership training is completed, which researchers in the future could address.

Conclusion

This project addressed the development of perceived leadership skills, knowledge, values and behaviors in context by surveying leaders using measures that, collectively, addressed each of these factors before, directly after and at least 7 months following a week-long training.

Patterns have emerged, particularly at Time 1 and Time 2, including significant changes in scores on the LDS and CLAS from the beginning of the week to the end and significant correlations between and within the RES, LDS and CLAS at both times. However, from the results, it is clear that less is known about how leaders report self-perceptions of leadership over time, and how their contexts affect their perceived ability to lead.

Ultimately, because the construct of authentic leadership has not yet been empirically measured in this way, the process and results of this project have further implications beyond the findings. It is clear that authentic leadership is a complex construct that, theoretically, influences a person's ability to effectively and successfully lead within an organization. However, measuring this construct quantitatively has shown to be a challenging feat. Reflections on the project, thus far, have brought to question the methods that we have used in an attempt to empirically measure authentic leadership. Shackle (1972), writes that,

"There is a natural disposition and temptation to think that we can do for politics and economics, and even for art, literature and music, and history in the most inclusive sense, what we hope to do for physics and chemistry and perhaps for genetics and the evolution of life-forms, namely to present an incontestably self-contained and self-sufficient picture of inevitable necessity; to demonstrate that things could not be other than they are… (p. 7)"

Byrne (1980) contends that if we look for order, if we look for one, or a certain set of empirical methods by which to measure something, we will find that order, but it begs the question, what are we really finding? And if we are finding order, do we want to? He argues that if we can formulaically describe and predict a phenomenon/ behavior/ action/ reaction, we have indeed found order; but he questions whether order limits the possibility for creativity, flexibility and even change. Furthermore, Wolin (1969) in his essay, *Political Theory as Vocation*, cautioned that a dominance of one type of empirical methodism will provide a lot of description about how the world is now, but does not tell us anything about how the world could be/ should be/ would be if we knew it differently.

Currently, very little is known about authentic leadership development in the disabilities field, however, there is a clear vision of how the world could be/should be and would be for people with disabilities if the organizations that support them had the values and capacity to provide quality, community inclusive, person centered services that gave people choice and control over their lives. There is also evidence (Parish, 2005) and support in the field (Thompson Brady et al., 2009) that strong leadership may be one way to increase capacity and shift values within organizations. Thus, the justification for promoting, training fostering and developing leadership is there, but the means by which to understand that development and its impacts are in their infancy, and have proven challenging due to the complexity of the experience of leadership in the context of the disabilities field.

Recognizing the complexity of the issue, however, should not cause us to throw up our hands and declare the issue unresearchable. Shackle (1972) continues:

"Yet order and reason are indispensable to understanding. If the cosmos provides men with a field of purposeful and sometimes successful action, offering a game partly of skill as well as of chance, there must be discernible regularities of repetitive patterns in the sequence of states (p. 7)"

From the beginning of this project, we have recognized that authentic

leadership cannot be conceptualized by a single measure that provides a "self-

contained and self-sufficient picture" of the construct. This recognition has lead to the

multifactor theoretical model and the multi-phase model of change. And after

preliminary analyses, the results of this study have indicated that it is necessary for us

to explore, further, and in different ways, the concept and implications of authentic

leadership. Furthermore, new and different research is necessary to understand how

leadership skills, knowledge and values are demonstrated effectively while

recognizing the complex interaction of contextual supports.

At a time when people talk rhetorically about the need for good leadership to

impact necessary changes, and about the need to understand how to foster leadership

on a large scale, so that we can successfully develop and support emerging leaders, the

stage for empirical research is set. Now, we need to improve and expand our

methodologies. Wolin (1968) and Frederichs (1970) provide suggestions for future

researchers in their books *Paradigms and Political Theories* and *Sociology of

Sociology*. The authors both conclude that a diversity of knowledge, rather than a

single way of knowing something, may be a strength. It may foster creativity and keep

open the possibilities for new ways of knowing and understanding in the future.

Nancy Weiss (2012), Director of the National Leadership Consortium on

Developmental Disabilities often says that people who are providing quality services

today now cringe at the way in which they defined and implemented quality 15 years ago, and she fully expects that 15 years from now, we will, again, look back and cringe. Along the same lines, Drimmer, (1993) argues that over time, disability rights have gone through many models of interpretation, starting with a medical model and evolving into a civil rights movement. As these models have developed, how we, as a society, know and support people with disabilities has also evolved so that what used to be bedrock assumptions about the rights and needs of people with disabilities have since become discriminatory and obsolete (Drimmer, 1993). Furthermore, Drimmer (1993) posits that, as policies and legislation continue to progress, today's assumptions will also become outdated as new and improved models of interpretation are adopted. If, in 15 years leaders need to cringe at the way they conceptualized quality services today, they need to have the flexibility to do so.

Researchers need to have the flexibility and diversity in methods to understand how leadership development occurs in the context of an ever-changing field. This project offers theoretical justification, a model of change and a preliminary analysis of one aspect of an overall vision of leadership development as a means to impact needed changes in the disabilities field so that people with disabilities and their families will have more independent, community based and quality lives of their choosing.

REFERENCES

Adams, T. E. (2008). A review of narrative ethics. *Qualitative Inquiry, 14*, 175-194.
DOI: 10.1177/1077800407304417.

Allen, K., Stelzner, S.P., & Wielkiewicz, R. M. (1999). The ecology of leadership:
Adapting to the challenges of a changing world. *Journal of Leadership and
Organizational Studies, 5.* DOI: 10.1177/107179199900599207.

Allison, P. D. (2001). *Missing data*. Thousand Oaks, CA: Sage Publications.

Americans with Disabilities Act of 1990, Pub. L. 101–336, 42 U.S.C. 12101 et seq.

Americans with Disabilities Amendments Act of 2008, Public Law 110–325, 122 Stat.
3553 (2008).

Anderson W. L., Wiener J. M., & Khatutsky G. (2006). Workforce issues and
consumer satisfaction in Medicaid Personal Assistance Services. *Health Care
Finance Review, 28*, 87–10. 1

Arc, AAIDD, AUCD, UCP, NACDD & SABE. (2010). Developmental disabilities
assistance and bill of rights act (D.D. Act): Fact sheet. *2010 Disability Policy
Seminar*.

Arc of Western Wayne County (2009*)* About us: History. *Arc of Western Wayne
County Homepage*. http://www.thearcww.org/about-us/.

Avolio, B. J., Avey, J. B., & Quisenberry, D. (2010). Estimating return on leadership development investment. *The Leadership Quarterly, 21*, 6330644. DOI: 10.1016/j.leaqua.2010.06.006.

Avolio, B. J., & Gardner, B. L. (2005). Authentic leadership development: Getting to the root of positive forms of leadership. *The Leadership Quarterly, 16,* 315-338.

Avolio, B. J., Luthans, F., & Walumba, F. O. (2004). Authentic leadership: Theory building for veritable sustained performance. *Working paper: Gallup Leadership Institute*, University of Nebraska-Lincoln.

Barling, J., Weber, T., & Kelloway, K. E. (1996). Effects of transformational leadership training on attitudinal and financial outcomes: A field experiment. *Journal of Applied Psychology, 81*(6) 827-832.

Barrows, M., Braddock, G., Durbin-Westby, P. C., Kirk, S., Lakin, C., Milbern, S., Ne'eman, A., Robertson, S. M., Thaler, N., Topper, K., Valnes, B., Ward, N., & Williams, B. (2010). Keeping the promises: Self advocates defining the meaning of community living. *CMS Summit on Community Living.*

Baynton, D. C. (2001). Disability and the justification of inequality in American history," in *The New Disability History: American Perspectives*, (eds). Longmore, P. K., & Umansky, L., 33-57. New York: New York University Press.

Beaty J., & Perry N. (1998). *Good staff, bad staff, no staff at all: advice from two consumers.* In: Hewitt A., & Larson S. A. (Eds). Impact: feature issue on direct support workforce development, 10(1).

Bennis, W. (2007). The challenges of leadership in the modern world: Introduction to the special issue*. American Psychologist, 62* (1), 2-5. DOI: 10.1037/0003-066W.62.1.2

Bershadsky, J., & Kane, R. (2010). Place of residence affects routine dental care in the intellectually and developmentally disabled adult population on Medicaid. Health Research and Educational Trust, 45 (5). DOI: 10.1111/j/1475-6773.2010.01131.x

Bloomfield, P. (1976). *Fourier analysis of time series: In introduction.* New York: Wiley

Box, G. Jenkis, & Gwilym. (1976). *Time series analysis: Forecasting and control, rev. ed.* Oakland, California: Holden-Day

Braddock, D. (2007). Washington rises: Public financial support for intellectual disability in the United States, 1955-2004, *Mental Retardation and Developmental Disabilities Research Review, 13;* 169-177.

Bronfenbrenner, U. (2005). *Making human beings human: Bioecological perspectives on human development,* Thousand Oaks, CA: Sage.

Buchanan, D., Fitzgerald, L., Ketley, D., Gollop, R., Jones, J. L., Lamont, S. S.,

Neath, A., & Whitby, E. (2005). No going back: A review of the literature on sustaining organizational change. *International Journal of Management Reviews, 7,* 189-205.

Bush, G. W. (2001). Executive Order 13217: Community Based Alternatives for Individuals with Disabilities.

Butler, J. (1993). *Bodies That Matter: On the Discursive Limits of "Sex."* New York: Routledge.

Byrne, J. (1980). Social Knowledge in an Orderly World in *The Problem of Order in Social Theory.* Newark: University of Delaware

Callacott R.A., & Cooper S.A. (1997). A five-year follow up study of adaptive behaviour in adults with Down syndrome. *Journal of Intellectual and Developmental Disabilities, 22*, 187–197.

Carey, C. A. (2009). *On the margins of citizenship: Intellectual disability and civil rights in twentieth-century America.* Philadelphia, PA: Temple University Press.

Chauhan, S. P., & Chauhan, D. (2007). Emotional intelligence: Does it influence decision making and role efficacy? *Indian Journal of Industrial Relations, 43,* 217-238.

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Hillsdale, NJ: Lawrence Erlbaum Associates, Inc.

Corrigan, W. P., &Watson, A. (2002). Understanding the impact of stigma on people

  with mental illness. *World Psychology 1*, 16-20

Couser, G. T. (1997). *Recovering bodies: Illness, disability, and life writing*. Madison:

University of Wisconsin Press.

Cronbach, L. J (1951). Coefficient alpha and the internal structure of tests.

  Psychometrika, 16, 297-334.

Daruwalla, P. (1999). The trouble with travel: People with disabilities and tourism.

  Social Alternatives, 18, 41-46.

Daruwalla, P., Darcy, S. (2005). Personal and societal attitudes to disability. *Annals of*

  Tourism Research, 32, p. 549-570. DOI: 10.1016/j.annals.2004.10.008

Day, D. V., & Sin, H. (2011). Longitudinal tests on an integrative model of leader

  development: Charting and understanding developmental trajectories. *The*

  Leadership Quarterly, 22, 545-560. DOI: 10.1016/j.leaqua.2011.04.011.

Developmental Disabilities Assistance and Bill of Rights Act of 2000. Pub. L. 106-

  402. USC 15001 *et. seq.*

Eidelman, S. (2011). Personal Communication. University of Delaware

Epitropaki, O., & Martin, R. (2005). The moderating role of individual differences in

  the relation between transformational/transactional leadership perception and

  organizational identification. The Leadership Quarterly, 16, 569-589. DOI:

  10.1016/j.leaqua.2005.06.005.

Epley, P., Summers, J. A., & Turnbull, A. (2010). Characteristics and trends in family-centered conceptualizations. *Journal of Family Social Work, 13* (3), 269-285. DOI: 10.1080/10522150903514017.

Ericsson & Mansell, J. (2006). Deinstitutionalization and community living: Progress, problems and priorities. *Journal of Intellectual and Developmenta Disability, 31*.

Faul, F., Erdfelder, E., Lang, A.-G., & Buchner, A. (2007). G*Power 3: A flexible statistical power analysis program for the social, behavioral, and biomedical sciences. *Behavior Research Methods*, *39*, 175-191.

Felce, D., & Emerson, E. (2001). Living with support in a home in the community: Predictors of behavioral development and household community activity. *Mental Retardation and Developmental Disabilities Research Reviews, 7*, 75-83.

Fougeyrollas, P., & Beauregard, L. (2001). The interactive person-environment in disability in creation. in G. L. Albrecht, K. D. Seelman, & M. Bury (Eds.), *Handbook of disability studies.* (pp. 171-194). Thousand Oaks, CA: Sage.

Freedman, R. I., & Chassler, D. (2004). Physical and behavioral health of adults with mental retardation across residential settings. *Public Health Reports, 119*, 401-408.

Frederichs, R. W. *A Sociology of Sociology,* New York: The Free Press.

Gardner, J.F. & Carran, D. T. (2005) Attainment of personal outcomes by people with developmental disabilities. *Mental Retardation, 43*, 157–174

Gerber, D. A. (2005). Comment: Immigration history and disability history. *Journal of American Ethnic History, 24* (3), 49-53.

Graham, J. W. (2009). Missing data analysis: Making it work in the real world. *Annual Review of Psychology, 60,* 549-576. DOI: 10.1146/annurev.psych.58.110405.085530

Hall, A., & Fagan, R. (1956). Definition of Systems. *General Systems 1*, 18-28.

Henry, D., Keys, C., Jopp, D., & Balcazar, F. (1996). Community living attitudes scale. *Mental Retardation, 34,* 149-158.

Hewitt, A., Larson, S., Edelstein, S., Seavey, D., Hoge, M., & Morris. J. (2008). A synthesis of direct service workforce demographics and challenges across intellectual/ developmental disabilities, aging, physical disabilities and behavioral health. National Direct Service Workforce Resource Center.

Huglin, K. M., & O'Brien, J. (2004). Person-centered services and organizational context: Taking stock of working conditions and their impact, *Journal of Mental Retardation, 42,* 169-180. DOI: 10.1352/0047-6765(2004)<169:PSAOCT>2.0.CO;2.

Individuals with Disabilities Education Act (20 U.S.C. Secs. 1400 *et seq.)*

Jelicˇicˊ, H. Phelps, E., & Lerner, R. M. (2009). Use of Missing Data Methods in

    Longitudinal Studies: The Persistence of Bad Practices in Developmental

    Psychology. Developmental Psychology, 45, 1195-1199. doi:

    10.1037/a0015665.

Karp, H.P. (2000). Aptitude for Becoming a Mentor Scale from Pfeiffer's Annual

    Volume 1 Guide to Training.

Kaufman, A. S, & Kaufman, N. L. (eds.) (2005). *Essentials of Research Design and*

    Methodology., Hoboken, NJ: John Wiley & Sons.

Krahn G. 2003. Changing concepts in health, wellness and disability. In: Consortium,

    editor. *State of the Science Proceedings.* Portland, OR: Oregon Health &

    Science University.

Krahn, G. L., Hammond, L. & Turner, A. (2006). A cascade of disparities: Health and

    health care access for people with intellectual disabilities. *Mental Retardation*

    and Developmental Disabilities Research Reviews, 12, 70-82.

Kudlick, C. J. (2003). Disability history: Why we need another "other.*" The American*

    Historical Review, 108 (3), 763-793.

Kudlick, C. J. (2005). Disability history, power, and rethinking the idea of "the other."

    Modern Language Association, 120 (2), 557-561.

Kuhn, T.S. (1970). *The Structure of Scientific Revolutions*. Chicago: University of

    Chicago.

113

Lakin, C. K., & Stancliffe, R. J. (2007). Residential supports for persons with

intellectual and developmental disabilities. *Mental Retardation and*

Developmental Disabilities, 13, 151-159.

Lewin, K. (ed.) (1951). *Field Theory in Social Science: Selected Theoretical Papers*

by Kurt Lewin, (UK edition published 1952, ed. Dorwin Cartwright). London:

Tavistock.

Lewis, M. A., Lewis, C.E., Leake, B., King, B. H., & Lindemann, R. (2002). The

quality of health care for adults with developmental disabilities. *Public Health*

Report 117, 174–184.

Ligas S., et al., Maram, B. S., et al. (2005). *Legas et al., v. Maram et al.* The United

States District Court for the Northern District of Illinois Eastern Division. No.

05 C 4331.

Linton, S. 1998. Claiming Disability: Knowledge and Identity. New York: New York

University Press.

Lipsky, M. (1980). *Street-Level Bureaucracy: Dilemmas of the Individual in Public*

Services. Russell Sage.

McMillan, J. (2007). Educational Research: Fundamentals for the Consumer. (5th Ed.).

Boston, MA: Allyn and Bacon.

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and

bisexual populations: Conceptual issues and research evidence. *Psychological*

Bulletin, 129 (5), 674-697. DOI: 10.1037/0033-2909.129.5.674.

Miller, G. (1999). *The Leadership Dimension Survey,* in Pfeiffer's Annual Volume 1
    Training Guide.

Neely-Barnes, S. L., Graff, J. C., Marcenko, M., & Weber, L. (2008). Family decision-
    making: Benefits to persons with developmental disabilities and their family
    members. *IDD, 46,* 93-105.

Neely-Barnes, S. L., Graff, J. C., Roberts, R. J., Hall, H. R., & Hankins, J. S. (2010*).
    "It's our job": Qualitative study of family responses to ableism. Journal of
    Intellectual and Developmental Disabilities, 48* (4), 245-258. DOI:
    10.1352/1924-95556-48.4.245.

Noll, S., & Trent, J, Jr. (2004). *Mental retardation in America: A historical reader.*
    New York: New York University Press.

Nussbaum, M. C. (2006). *Frontiers of justice: Disability, nationality, species
    membership.* Belknap Press, Harvard University. Cambridge, MA.

Organizational Research Services (2004). Theory of Change: A practical tool for
    action, results and learning. *Annie E. Casey Foundation.*

Pareek, U. (1980). *Role Efficacy Scale* in Handbook for Facilitators, Trainers and
    Consultants.

Parish, S. L. (2005). Deinstitutionalization in two States: The impact of advocacy,
    policy and other social forces on services for people with developmental

disabilities. *Research & Practice for Persons with Severe Disabilities, 30* (4),
219-231.

Pethe, S., & Chaudhari, S. (2000). Role efficacy dimensions as correlates of
occupational self efficacy and learned helplessness. *Indian Journal of
Industrial Relations, 35,* 507-518.

Peugh, J. L., & Enders, C. K. (2004). Missing data in educational research: A review
of reporting practices and suggestions for improvement. *Review of Educational
Research, 74,* 525–556.

Pierro, A., Cicero, L., Bonaiuto, M., van Knippenberg, D., & Kruglanski, A. W.
(2005). Leader group prototypicality and leadership effectiveness: The
moderating role of need for cognitive closure. *The Leadership Quarterly, 16*,
503-516. DOI: 10.1016/j.leaqua.2005.06.002.

Pless, N, M. (2007). Understanding responsible leadership: Role identity and
motivational drivers. *Journal of Business Ethics, 74* (4), 437-456. DOI:
10.1007/s10551-007-9518-x.

Poston, D., Turnbull, A., Park, J., Mannan, H., Marquis, J., & Wang, M. (2003).
Family quality of life: A qualitative inquiry. *Mental Retardation, 41*(5), 313-
328.

Prouty, R., Smith, G., & Lakin, K.C. (eds). (2004). *Residential services for persons
with developmental disabilities: Status and trends through 2003.* Minneapolis,

MN: university of Minnesota, Research and Training Center on Community
Living.

Raudenbush, S. W., & Bryk, A. S. (2002). *Hierarchical linear models: Applications
and data analysis methods* (2nd. ed.): Thousand Oaks, CA: Sage.

Reicher, S., Haslam, S. A., & Hopkins, N. (2005*).* Social identity and the dynamics of
leadership: Leaders and followers as collaborative agents in the transformation
of social reality. *The Leadership Quarterly, 16,* 547-568. DOI:
10.1016/j.leaqua.2005.06.007.

Riggio, R. E., & Mumford, M. D. (2011). Introduction to the special issue:
Longitudinal studies of leadership development. *The Leadership Quarterly, 22,*
453-456. DOI: 10.1016/j.leaqua.2011.04.002.

Samuels, E. (2002). Critical divides: Judith Butler's body theory and the question of
disability. *NWSA Journal, 14,* p.58-76.

Seltzer G.B., & Luchterhand C. (1994). Health and wellbeing of older persons with
developmental disabilities: A clinical review. In: Seltzer M.M., Krauss M.W.,
& Janicki M.P. (Eds). *Life course perspectives on adulthood and old age.*
Washington, DC: American Association on Mental Retardation, 109–142.

Schalock, R. Gardner, J., & Bradley, V. (2007). *Quality of life for persons with
intellectual and other developmental disabilities: Applications across*

individuals, organizations, communities and systems. Washington, DC:

AAIDD.

Shackle, G.L.S. (1972). *Epistemics and Economics.* Cambridge, England: Cambridge

University Press.

Shamir, B., & Elaim, G. (2005). "What's your story?" A life-stories approach to

authentic leadership development*. The Leadership Quarterly, 16*, 395-417.

DOI: 10.1016/j.leaqua.2005.03.005.

Shumway, D. (1996). *Closing Laconia.* In Mansell & Ericsson (eds.)

Deinstitutionalization and Community Living: Intellectual Disability Services

in Scandinavia, Britain and the USA. London, Chapman and Hall.

Silverstein, R., (2000). Emerging disability policy framework: A guidepost for

analyzing public policy. *Iowa Law Review, 85* (5), 1691-1806.

Smull, M., Bourne M. L., & Sanderson, H. (2010). Best practice, expected practice,

and the challenge of scale*. Report Publication in Association with the National*

Association of State Directors of Developmental Services, Support

Development Associates & Virginia Commonwealth University. Publication for

Grant No.1L0CMS030186.

Social Security Act. Sec. 1900. 42 U.S.C 1396-1.

Stancliffe, R. J. (2001). Living with support in the community: Predictors of choice
and self-determination. *Mental Retardation and Developmental Disabilities
Research Reviews,* 7, 91-98.

Stein, M. A. (2007). Disability human rights. *California Law Review, 95* (1), 75-121.

Summers, J. A., Marquis, J., Mannan, H., Turnbull, A. P., Fleming, K., Poston, D. J.,
Wang, M., & Kupzyk, K. (2007). Relationship of perceived adequacy of
services, family professional partnerships, and family quality of life in early
childhood service programmes. *International Journal of Disability,
Development and Education, 54(*3) 319-338. DOI: 1080/10349120701488848.

Tabachnick, B.G., & Fidell, L. S. (2006). *Using multivariate statistics* (5th ed.).

Thompson Brady, L., Fong, L., Waninger, K. N., & Eidelman, S. (2009). Perspectives
on leadership in organizations providing support to people with disabilities: An
exploratory study. *Intellectual and Developmental Disabilities, 47,* 358-372.

Trent, J. W. (1994). *Inventing the feeble mind. History of mental retardation in the
United States.* Berkeley, CA: University of California Press.

Turnbull, H. R. III., Stowe, M. J., Agosta J., Turnbull A. P., Schrandt, M. S., &
Muller, J. F. (2007). Federal family and disability policy: Special relevance for
developmental disabilities. *Mental Retardation and Developmental
Disabilities, 13*, 114-120. DOI: 10.1002/mrdd.20145.

United Nations (2006). Convention on the rights of persons with disabilities and

optional protocol. *Convention on the Rights of Persons with Disabilities.*

United States v. Georgia (2010). Civil No. 1:10-CV-249-CAP.

Wehmeyer, M. L., & Bolding, N. (2001). Enhanced self-determination of adults with

intellectual disability as an outcome of moving to community based work or

living environments. *Journal of Intellectual Disability Research,* 371-383.

White, J. M., & Klein, D. M. (2008). *Family Theories (3rd ed.)* Sage Publications.

Thousand Oaks, California.

Wickens, T. D., Keppel, G. (2004). *Design and analysis: A researcher's handbook* 4th

ed.). Englewood Cliffs, New Jersey: Prentice-Hall.

Wolon, S. (1968). Paradigms and Political Theories in *Politics and Experience* (King,

P., & Prekh, B. C. ed's). London: Cambridge University Press.

Wolin, S. (1969). Political theory as a vocation. *American Political Science Review.*

World Health Organization. (2011). *2011 World Report on Disability.* World Health

Organization and World Bank. Geneva, Switzerland: WHO Press.

Zigman W. B., Seltzer G. B., & Silverman W.P. (1994). Behavioral and mental health

changes associated with aging in adults with mental retardation. In: Seltzer M.

M., Krauss M. W., & Janicki M.P. (Eds). *Life course perspectives on*

adulthood and old age. Washington, DC: American Association on Mental

Retardation, 67–92.

Zimring et al., (2008). Olmstead v. L.C. No. 98-536. 527 U.S. 581, 119 S. Ct. 2176.

APPENDIX
IRB APPROVAL LETTER

RESEARCH OFFICE 210 Hullihen Hall University of Delaware

Newark, Delaware 19716-1551 *Ph:* 302/831-2136
Fax: 302/831-2828

DATE:

TO: FROM:

STUDY TITLE:

SUBMISSION TYPE:

ACTION: APPROVAL DATE: EXPIRATION DATE: REVIEW TYPE:

REVIEW CATEGORY:

June 21, 2012

Steve Eidelman
University of Delaware IRB

[252757-3] Understanding the Impact of Leadership Training on Emerging Leaders in the Field of Intellectual and Developmental Disability

Continuing Review/Progress Report

APPROVED
June 21, 2012 July 20, 2013 Expedited Review

Expedited review category # 7

Thank you for your submission of Continuing Review/Progress Report materials for this research study. The University of Delaware IRB has APPROVED your submission. This approval is based on an appropriate risk/benefit ratio and a study design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission.

This submission has received Expedited Review based on the applicable federal regulation.

Please remember that informed consent is a process beginning with a description of the study and insurance of participant understanding followed by a signed consent form. Informed consent must continue throughout the study via a dialogue between the researcher and research participant. Federal regulations require each participant receive a copy of the signed consent document.

Please note that any revision to previously approved materials must be approved by this office prior to initiation. Please use the appropriate revision forms for this procedure.

All SERIOUS and UNEXPECTED adverse events must be reported to this office. Please use the appropriate adverse event forms for this procedure. All sponsor reporting requirements should also be followed.

Please report all NON-COMPLIANCE issues or COMPLAINTS regarding this study to this office. Please note that all research records must be retained for a minimum of three years.

Based on the risks, this project requires Continuing Review by this office on an annual basis. Please use the appropriate renewal forms for this procedure.

If you have any questions, please contact Jody-Lynn Berg at (302) 831-1119 or jlberg@udel.edu. Please include your study title and reference number in all correspondence with this office.