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A switch to family centered practice

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Research has been done to explore the development and advantages of family based practices. However, not enough research has been done to evaluate how to switch from a medically oriented approach to a more family based format in report writing. This study evaluates the importance of family oriented clinical early intervention reports (CARs) through comparison of the comprehension of non-professionals to speech and language evaluations. In this paper, the author will discuss the history of client - clinician relationships, importance of family oriented reports, and strategies for developing a family oriented CAR..

Traditionally, the client-professional relationship has been dominated by the concept of the "sick-role" developed by Talcott Parsons in 1951 (Weaver &Wilson, 1994). This traditional problem oriented approach is based on the medical model in which the professional controls clinical interaction and the patient passively accepts what the professional says without questioning his expertise. The patient is exempt from responsibility of his own health in that, he is expected to trust the professional knows what is best for him (Brody, 1980). The only responsibilities of the patient are to comply with the professionals recommendations and seek the appropriate help (Brody, 1980; Bronson, Rubin, & Tufo, 1978; Weaver & Wilson, 1994). This philosophy is reflected in the field of Speech Language Pathology with the use of medically oriented clinical early intervention assessment reports (CARs). There exists an interest to shift away from this imbalance of power in order to develop a more family based practice. As the view changes from a medically oriented to a family oriented philosophy, there will exist an increase in the need and demand for information by the client (Cameron, Corbett, Duncan, Hegyi, Maxwell, & Burton, 1994). This switch in philosophy can be aided in the field of Speech Language Pathology with the use of a family oriented approach in the report writing of

the CAR..

Throughout time the CAR has been used to summarize relevant information obtained during an evaluation and describe how the information was obtained (Alvares, 1997). The CAR serves many functions which can aid in the development of increased family involvement in the diagnosis and treatment of a communication disorder. One function of the CAR is to provide a guide for services to the client.. Involving the family at this level will help the clinician increase his understanding of the clients' level of functioning at the time of the evaluation and aid in determining what, if any, changes have occurred prior to the evaluation. After all, the clinicians may be experts when it comes to a communicative disorders, but, the families are experts when it comes to their child (Luterman, 1996). The use of combined clinician-family information will result in a more complete representation of the childs' language ability. The family should be made aware that their expertise are just as desirable as the clinicians. This can be done by using family observations and interpretations in the development of the CAR.. Family participation at this level will empower the family as mutual partners in the assessment process (Andrews & Andrews, 1990; Brody, 1980; Bronson et aI., 1978; Luterman, 1996; Pannbacker, 1975; Weaver & Wilson, 1994).

In order to increase family cooperation and participation in the assessment and intervention process, it is important to acknowledge the family as valuable resources for change. A family centered CAR should be tailored to the individual and family, addressing the needs and goals of the client and family. The extent to which the CAR acknowledges the family's personal goals and expertise will influence the family'S opinion of the effectiveness of treatment (Weaver & Wilson, 1994). This, in turn, will determine their motivation to follow recommendations and

treatment plans. As stated by Bronson et al. (1978)

> The patient's participation in establishing goals for his own health care is essential, because he is then more apt to understand the reasons for medical actions. (p. 3)

By making the family equal partners in the assessment process, they become more responsible in managing their child's health care. This will become helpful in developing the initiative in the family to increase their involvement in the decision making process (Bronson et aI., 1978). In order to actively participate in the decision making process the family must become educated about the communicative disorder at hand. With regards to client participation in decision making, in her article, "Teaching patients to speak up: Past and future trends", Barbara Sharf (1988) comments that, " people do not act or express such a desire because they do not know how to." (p.100) By integrating a family oriented approach in the assessment procedures the clinician is granted the opportunity to educate the family "how to" actively participate in the decision making process.

Another function of the CAR is to facilitate communication to the client's family and other professionals. Making communication as open as possible through record sharing gives the family the opportunity to change, add, correct, or clarify information (Bronson et aI. 1978). This can aid in educating the client and his family. The use of the CAR as an educational tool has many benefits for treatment outcome. Through patient education the family possesses an increased ability to attend to, interpret, organize, and respond to the information provided in the CARs (Joan Lavine, 1986). This increased awareness will empower the family independence in the intervention process. As stated by David Luterman (1996) in his book, Counseling Persons with Communicative Disorders & Their Families, family involvement in the assessment process,

".. let's them see the extent of the disability and enables them to effectively participate in the habilitation process." (p.57) The family will be more motivated and willing to follow recommendations if they understand why they need to follow them.

Patient education through the use of open communication in developing CARs also aids in increasing the family's perception of quality of care and respect for the clinician. Prior studies show increased levels of client satisfaction as a result of receiving written and verbal information and support. Levinson, Roter, Mullooly, Dull, and Frankel performed a study which evaluated the relationship between patient-physician communication and patient perception of the quality of care (1997). This study measured patient dissatisfaction by comparing the communication behaviors of physicians with malpractice claims versus those with no malpractice claims. Results showed the physicians without prior malpractice claims provided more orientation and facilitation to their patients through increased communication and patient education. Speech Language Pathologists can use this data as a reasoning for the development of a family oriented CAR.

One way to incorporate the family's perspective into the diagnostic process is through a shift in thinking from treatment based on a linear model to one based on a systemic model (Andrews & Andrews, 1990). This can be done by using a polyocular approach in the diagnostic process. Supporting the importance of the acceptance of a polyocular view in family based early intervention practice, Andrews & Andrews acknowledge that

> Each of the people who interact with the individual having a speech language disorder has a view of the problem that is influenced by the particular perspective of that person as well as by the way in which hislher observations/interactions affect the phenomenon

under consideration. (p. 7)

Therefore, by accepting truth in the various perspectives of the problem the clinician is discovering more options for treatment, as well as, enhancing the precision of the CAR.. Also, acknowledging family observations and interpretations empowers the family as central members in the health care team (Greenfield, 1985).

When the clinician holds a polyoccular view, the emphasis of treatment shifts from a problem based approach to a solution based approach. Since the largest communicative context exists within the family, in order to switch to a solution based approach, the interactive patterns of the communication disorder need to be identified. This will allow the clinician to identify aspects of family behavior which impede or aid positive change in their child's communication disorder (Andrews & Andrews, 1990). Through patient education the family can learn to view a communication disorder in different ways. This may lead the family to change factors in their behavior which impede treatment goals. Using family strategies in the CAR can aid in the development of possible solutions. Making use of the family's strengths in a solution based approach will result in more effective recommendations and increased carryover (Luterman, 1996).

A switch to a family based practice requires a change in the writing style of the CAR. Mary Moore (1969) states in her article, "Pathological writing", " report writing is defective when it is unintelligible, conspicuous, or causes the reader to be confused." (p. 535) Even if the family is heavily involved in the assessment process, their involvement becomes less effective if they cannot understand the findings in the CAR due to the medically oriented writing style (Jerger, 1962). In order to use the CAR as an educational tool the information contained in the

report must be accurately transmitted tho the reader. Students trained in the field of SLP acquire a professional writing style which reflects the medically based training they receive (Alvares,1997). Readers compare new information to preexisting information stored in memory. This information is called schemata (Byler, 1994 & Duin, 1989). Readers learn when they can link new information to schemata. Therefore, this medically based writing style may be fine when the reader is another professional in the field of Communicative Disorders, but, when the reader is the family or other service providers comprehension may be lost.. In writing CARs, the clinician must elicit the prior knowledge the reader brings to text. This will aid in the ability to use the CAR to empower and educate the family.

One way to elicit readers schemata in writing is through the use of familiar terminology. When technical language is dispersed throughout a report, the content of the report becomes difficult to understand. If the family does not comprehend the content of the report they may feel intimidated and will be less likely to ask for clarification (Lavine 1986). If comprehension is lost, so is the equal partnership in the intervention process. The CAR should contain standard English terms which are comprehended at a 12th grade level (Lavine 1986). There are some instances in which the technical term may be required for eligibility or reimbursement purposes (Alvares, 1997). In the case that a label needs to be used Alvares states (19970, " The service provider and family may work together to find terminology with which the family is comfortable." (P.165) If an unfamiliar term is incorporated into the text, the writer can clarify the meaning with a brief definition.

In addition to familiar terminology, examples can be used to activated schemata readers bring to text.. Examples are useful in making families aware of the specific strategies which can

be used to aid in the positive change of a disorder (Alvares, 1997).

There has been some disagreement with the use of first person personal pronouns in report writing. Jerger states that, "...nothing livens up dull material like personal references. Use them often. Especially use personal pronouns like I, me, we, you, she, they, etc. Don't use them to excess - the excessive repetition of anything makes dull reading ..."(1962, p.102) Jerger also believes that using personal pronouns allow a writer to acquire a natural style of writing. Other authors believe that reports should keep too a professional tone by abandoning personal pronouns completely (Pannbacker, 1975). Still others, such as Pannbacker (1975), believe that personal pronouns can be used, but not so much as to create a sense of egocentrism. It is this writers belief that personal pronouns can aid writers in developing a personal, yet professional, style of writing, as well as, aid the client - clinician relationship.

It is important when writing CARS that the clinician does not overwhelm the family with information. As a result, the family may acquire a sense of losing control of their child's treatment process. By using familiar terminology, examples, personal pronouns, and a natural style of writing, the CAR will empower the family and maintain a mutual partnership between the family and the clinician.

Family oriented CARs are critical for the development of family centered practice. While studies have been done to evaluate the relationship between open communication/patient education and patient perceptions of the quality of care, no studies have analyzed this through direct comparison of the effectiveness of medically oriented and family oriented reports.

The purpose of this study was to measure the responses of non-professionals to speech and language evaluation reports. Since the patient education literature suggests that education

materials should be written between a 6th and 9th grade level, this study was directed at high school students. This study was carried out as a preliminary study on clinical report writing. Although more research is needed on this subject, the results are important to professionals seeking the development of family based practice.

Method

Subjects

51 12th grade level high school students enrolled in a communications class at a small private catholic school located in Illinois served as subjects for this test. The average age of the subjects was 17.5 years-old. The subjects had an average Grade Point Average of3.2. 9.8% of the respondents reported having speech and language intervention in the past and 5.9% reported having familiarity with medical terminology. This study was approved by the Institutional Review Board ofDeKalb, Illinois and the Dean of students at Marian Central Catholic High School in Woodstock, Illinois.

Procedures

The subjects received information prior to the study to orientate them as to the purpose of the study. A set of two reports about a fictional character were developed. One report contained medically oriented terminology and content (Form A) and the other a more family based format (Form B) (See Appendix 4 & 5). All other variables were kept constant.. The instructor of the communications course randomly distributed the two forms of the reports with attached surveys to the subjects. Twenty-five students received Form A and twenty-six students received Form B. A questionnaire consisting of four parts was attached to each report.

The first portion of the questionnaire probed the demographic background of the

respondent's in the areas of: sex, age, average GPA, familiarity with medical terminology, and involvement in speech and language intervention. A statement was also presented to determine which form the respondent received.

The second portion of the questionnaire asked the respondents to write down any unfamiliar or confusing terminology they encountered in the report. The students were encouraged to provide their own interpretation of the meaning of the unfamiliar words.

The third portion of the questionnaire consisted of a series of 12 statements regarding the CAR. The statement are listed below in the order in which they appear on the questionnaire:

1. I understood why this child was being referred for testing.
2. I understood the medical information in the Case History Form.
3. I thought the report was too hard to follow.
4. I felt that the style of the report was patronizing.
5. I understood what types of tests were given to the child.
6. I thought the report was written informally.
7. I understood the results of the tests that were given to the child.
8. I felt that the report was written in a professional manner.
9. I thought the report was too long.
10. I understood the recommendations in the report.
11. I liked the style of the report.
12. The report showed respect for the client and client's family.

A 7-point rating scale was used to measure the subjects response. The subjects were directed to circle the number that best represented hislher opinion, with 1 representing strongly agree and 7

representing strongly disagree. Statements (1-3,5, 7, & 10) dealt with the comprehension of the report; statements (4, 6, 8, & 9) addressed the style of the report; statement (11) determined the respondents preference for the report; statement (12) acknowledged the respect the report had toward the family.

The fourth portion of the questionnaire asked the subject to present hislher interpretation of the report in hislher own words.

Analysis

Preliminary analysis involved the grouping of the reports according to the form. Methods of statistical analysis were used for computing the mean and standard deviation of each of the 12 questionnaire statement responses across the two reports. The sum of the unfamiliar words were also calculated across the two reports.

Responses from the fourth portion of the questionnaire were categorized as intelligible, unintelligible, or neutral.. Standards for intelligible responses included: statements referring to phonological errors, recommendations for speech and language intervention, and correct description of receptive and expressive language abilities (e.g. "Margaret is unable to pronounce certain phonemes correctly. Because of this, she is not able to express herself in her language.") Unintelligible responses included statements which indicated the respondent did not retain or comprehend the report (e.g. "The results showed that the machine had made an error in assessing Margaret's condition ...") Forms containing no responses were classed as neutral.

Results and Discussion

A list of the unfamiliar words and number of respondent's classifying the word as unfamiliar across the two reports is presented in Table 1 (See Appendix 1). The most common

word recorded was 'otitis media'. The sum of the unfamiliar words for Form A was 42 words. The sum for Form B was 11 words. These results show us that there were almost four times as many words in Form A then there were in Form B. These results agree with the prediction ofthe author.

The responses on the fourth portion of the questionnaire are shown in Table 2 (See Appendix 2). These results show more intelligible summaries written by those respondents that received Form B. Compared to 15 respondents presenting intelligible summaries for Form B, only 9 respondents presented intelligible summaries for Form A. These results are consistent with the results from Table 1. The lower number of intelligible summaries from Form A respondents may be due to the excess amount of unfamiliar terms in the report. A high number of Form A respondents discussed the Oral Motor aspect of the report. Also, Form A respondents included statements of confusion, as well as, word for word interpretations in their summaries. The subjects did not fully comprehend the information presented in Form A. It should be noted that the author classified the summaries as unintelligible. Form B summaries contained references to the presence of phonological errors and receptive and expressive speech abilities. Respondents from Form B commented that the report was, "poorly organized" and, "difficult to follow."

Calculated means and standard deviations for the responses on the 12 questionnaire statements across the two reports are shown in Table 3 (See Appendix 3). When the average and standard deviation of the 12 questionnaire statements were compared, the largest difference between Form A and Form B was observed in statement 2, with a difference of 1.17 (Form A=3.88, Form B=2.71). This statement dealt with the comprehension of the report. This result

is consistent with the results from both Table 1 and Table 2. The results for the statements pertaining to the comprehension of the report favored Form B as being more intelligible and easier to follow. An interesting observation is made when looking at the results from statements 6 & 8. More respondent's receiving Form A classified their report as written informally and having a less professional writing style. The subjects received information about the purpose and procedure of the report prior to filling out the questionnaire. Since both forms of the report contained medical terminology, this may have influenced the subjects response. Statement 11 also showed unexpected results. This statement dealt with the amount of respect the respondent thought the report had for the client and the client's family. There existed a difference of only .13 in the response averages across the two reports, with Form A having a higher response average. This author assumed the difference would be higher with Form B receiving the higher rating. The subjects responses showed that Form A showed more respect than Form B. Again, the subjects may have responded with a bias towards what they thought favored the studies purpose.

Conclusion

The many advantages to switching to a family based practice through use of CARs have been stated throughout this report. The CAR serves as an excellent educational tool which can be used to empower families as mutual partners in their child's intervention process. The results from this study are consistent with the theory for the need of family centered CARs. By a more family based format in writing the CAR, the clinician can improve comprehension. Although the results ofthis study need further testing and analysis, they are important to professionals who seek to empower their clients, improve their client - clinician relationship, and develop a family

based intervention process.

Table 1		
Unfamilar word	Form B	FormA
jaundice	5	7
bili lights	10	10
PE tubes	3	13
immittance	5	2
clinician	1	
gestation	4	
audiological	1	1
phonological	2	2
phonemes	2	9
C.A..	1	
swallowing	1	
Hz		2
otitis media		24
siblings		1
Bactrum		1
milestones		1
spnotaneous		1
utterances		1
morphological		12
integrity		1
gradation		4
pudding		1
lip seal		1
MLU		5
Dysarthria		14
DAS		12
fronting		5
GA		10
mastication		5
bilaterally		4
phonology		7
bolus		8
Cluster reduction		5
pragmatic skills		4
deletion		1
fidelity		4
rotary		1
posterior		1
laryngeal		2
anterior		1
expressive speech		1

		Table 2	
Form	Intelligible	Unintelligible	Neutral
A	9	14	2
B	15	7	4

		Table 3		
Statement	Form A Avg.	Form B Avg.	Form A Std. Dev.	Form B Std. Oev.
1	3.88	2.75	1.71	1.72
2	3.88	2.71	1.65	1.68
3	4	4.65	1,43	1.42
4	4.1	4.92	2.14	1.57
5	3.76	2.71	2.11	1.79
6	3.84	4.31	1.50	1.49
7	3.6	2.65	1.77	1.84
8	3.68	2.62	1.76	1.70
9	4.52	5.06	1.94	1.64
10	3.32	2.23	1.55	2.01
11	3.36	3.23	1.20	1.31
12	3.48	2.5	1.94	2.10

Appendix 4

A

SPEECH-LANGUAGE DIAGNOSTIC REPORT

Date of Diagnostic: March 10, 1996

Child's Name: [redacted]

C.A: 2"7

Parents: [redacted]

Clinician: Anne Atwater, M.S., CCC-SLP

BACKGROUND HISTORY

[redacted], a 2 year. 7 month-old female, was referred to Northern Illinois Speech and Hearing Clinic for a speech and language evaluation by Dr. Herbert Goleas. Dr. Goleas was concerned about [redacted] delayed speech development which may have resulted from a history of otitis media. [redacted] also reported concerns about [redacted] expressive speech.

[redacted] was born at 36 weeks G.A. and was treated for jaundice at birth using bili lights. Developmental history is unremarkable except for recurring episodes of otitis media. Until [redacted] was 24 months, the otitis media was managed using antibiotics (Bactrum). At 25 months, PE tubes were inserted. Developmental milestones, except for speech milestones, were reported by the [redacted] to be achieved within normal limits.

[redacted] an audiological evaluation at NIU Speech and Hearing Clinic on *1129/96.* Results showed normal hearing sensitivity at 500 Hz, 1000 HZ and 2000 Hz bilaterally. Immittance revealed PE tubes were functioning and clear.

[redacted]t is the youngest of three children. She has siblings aged 6 years and 10 years. Mr. [redacted] is employed as a carpenter, and [redacted] provides day care in her home for 4 children, including [redacted] have expressed concern about [redacted] language development.

DIAGNOSTIC EVALUATION

The evaluation was conducted by the speech-pathologist at NIU Speech and Hearing Clinic with the child's parents present. [redacted] was alert and cooperative during the evaluation. The results of the evaluation were judged to have good reliability.

Appendix 5

B

SPEECH-LANGUAGE DIAGNOSTIC REPORT

Date of Diagnostic: March 10, 1996

Child's Name: [redacted]

e.): 2-7

Parents: [redacted]

Clinician: Anne Atwater, M.S., CCC-SLP

BACKGROUND HISTORY

[redacted], a 2 year, 7 month-old girl, was referred to Northern Illinois Speech and Hearing Clinic for a speech and language evaluation by Dr. Herbert Goleas. Dr. Goleas was concerned about [redacted] delayed speech development which may have resulted from recurrent ear infections. [redacted] also reported that they were concerned that [redacted] has difficulty being understood, especially by people who are not familar to her. understand.

[redacted] reported that [redacted] was born preterm at 36 weeks gestation age. She was treated for jaundice at birth using bili lights. [redacted] reported that [redacted] health since birth has been good for recurring ear infections. Until [redacted] t was 24 months, the ear infections were treated using antibiotics (Bactrum). At 25 months, [redacted] received pressure equalization tubes. The [redacted] reported that developmental milestones such as sitting, crawling, walking, and toilet training were achieved at expected ages. However, speech milestones such as [redacted] first word and use of phrases were delayed. [redacted] said her first word at 16 months and began to combine words into phrases at 28 months.

[redacted] had an audiological evaluation at NIU Speech and Hearing Clinic on 1129/96. There were no concerns about her hearing, and results showed normal hearing sensitivity at 500 Hz, 1000 HZ and 2000 Hz in both ears. Immittance testing revealed PE tubes were functioning and clear.

[redacted] is the youngest of three children. She has a 6 year-old sister and a 10 year-old brother. [redacted] enjoys playing with the other children and her siblings. [redacted] is employed as a carpenter, and [redacted] provides day care in her home for 4 children, including [redacted] [redacted] have expressed concern that [redacted] language speech development seems to be behind other children her age. They believe her speech delay

References

Alvares, R.A. (1997). Family-centered report writing in early intervention. *Infant-Toddler Intervention,* 7(3), 161-178.

Andrews, J.R. & Andrews, M.A. (1995). *Family-Based Treatment in Communicative Disorders.* Sandwich, IL: Janelle Publications.

Byler, N.R. (1994). The effect of purpose on professional communication. *Technical Communication, First Quarter, 71-80.*

Brody, D.S. (1980). The patient's role in clinical decision making. *Annals of Internal Medicine,* 93, 718-722.

Cameron, P., Corbett, K., Duncan, C., HegyI, K., Maxwell, H. & Burton, P.F. (1994). Information needs of hospital patients: a survey of satisfaction levels in a large city hospital. *Journal of Documentation,* 50(1), 10-23.

Dunst, C.J., Johanson, C., Trivette, C.M, & Hamby, D. (1991). Family-oriented early intervention policies and practices: family-centered or not? *Exceptional Children, 58(2),* 115-126.

Fahrenfort, M. (1987). Patient emancipation by health education: an impossible goal? *Patient Education and Counseling,* 10,25-37.

Greenfield, S. (1985). Expanding patient involvement in care: Effects on patient outcomes. *Annals 0/Internal Medicine,* 102,520-527.

Lavine, J.S. (1986). De-mystifying professional evaluations. *Academic Therapy,* 21(5),615-617.

Luterman, D.M. (1996). *Counseling Persons with Communication Disorders and Their*

Families. Austin, TX: PRO-ED, Inc.

Pannbacker, M. (1975). Diagnostic report writing. *Journal of Speech and Hearing Disorders,* 40, 367-379.

Sharf, B.F. (1988). Teaching patients to speak up: past and future trends. *Patient education and counseling,* 11,95-108.

Turnbull, A.P. & Turnbull, H.R. (1990). *Families, Professionals and Exceptionality: A Special Partnership.* New York: Merrill.

Weaver, S.K. & Wilson, J.F. (1994). Moving toward patient empowerment. *Nursing and Health Care,* 15(9),480-483.