Research

Preparation Students to Understand and Honor Families as Partners

Melissa C. Bruce
University of Vermont, Burlington
Nancy DiVenere
Cathy Bergeron
Parent to Parent of Vermont, Winooski

As service providers, speech-language pathologists are in the midst of a transition from the “expert” model of intervention to forming partnerships with families and serving as resources. Although the shift from client-centered to family-centered service delivery is underway, little information has been made available on steps being taken at the pre-service training level to accomplish this change and the success of such efforts. This paper describes an innovative approach to preparing speech-language pathology students to be family-centered in their professional interactions and service delivery. Over a 4-year period, 41 students embarking on their first semester of clinical training were paired with families of children with special needs for a family visit of 2 to 4 hours in length. The components of the training included pre-visit classroom exercises focused on personal values clarification and language sensitivity, visit orientation for the students and families, a family visit, journal writing by students about the visit experience, and post-visit class discussion of the visit experiences and learning outcomes. Pre- and post-measurement of students’ attitudes regarding a family’s role in intervention reflected a statistically significant change in students’ responses to questionnaire items. The students’ responses indicated an increase in family-centered attitudes and demonstrated the effectiveness of this approach in shaping those attitudes.

With the passage of Public Law 99-457 in 1986 (Education of…, 1988), a legal mandate was introduced for professionals to recognize and honor the primary role of families in decision making and in the planning of services for their children with special needs. This mandate has continued with the subsequent amendments appearing in the Individuals with Disabilities Education Act of 1990 (P.L. 101-476) and the 1997 reauthorization of IDEA (P.L. 105-17). The growing emphasis on developing meaningful working relationships with families is represented in the focus of a recent feature article in ASHA (Cleminshaw et al., 1996), in which the authors bring families into the mainstream of service delivery by stressing the importance of family involvement. Historically, service providers have been the purveyors of information, engaging in a one-way direction of information sharing with families. In family-focused intervention, “the paternalistic role is replaced with a true partnership model where parents and professionals facilitate one another’s efforts and make decisions jointly” (Able-Boone, Sandall, & Loughry, 1989, p. 98). Professionals are in the early evolutionary stages of developing and nurturing this bidirectional communication and need to continue to strive for that which constitutes and promotes a truly equal partnership (E. Crais, personal communication, January 28, 1998).

The professions will make further headway in being family centered in service delivery when practitioners clearly recognize and believe that the inherent importance of developing meaningful working relationships with families resides in the valuable information we can learn from families, in contrast to a focal mission of teaching them. Inviting and respecting the input families have to offer is essential in forming effective partnerships with families and working collaboratively to create optimally successful intervention strategies. Establishing collaborative relationships with families is not a means to an end, but a crucial beginning in the quest to be valuable resources to families. In a family-centered approach, professionals recognize the primary role of the family and share decision-making with the caregivers (Crais, 1993; Dunst, Trivette, & Deal, 1988; Hanft, 1989; Humphry & Geissinger, 1993; Stewart, 1990; Winton & Bailey, 1990). Several authors (Bailey, 1987; Dunst et al., 1988) have
stressed that the family-centered professional respects and honors family-identified priorities and intervention preferences, though they may differ from the professional’s values and priorities.

It has become apparent that the value of family-centered service delivery is no longer restricted to the preschool population where it had its origins, but extends across the life span. Hooper (1996) emphasized the importance of family-centered service in improving outcomes for older adults involved in rehabilitation. Thus, professional preparation couched within a philosophy and practice of family-centered service delivery is indicated for all speech-language pathology students, regardless of anticipated area of clinical specialization or scope of practice.

Donahue-Kilburg (1992) succinctly describes the traditional model of service as one “in which professionals make most or all of the decisions about treatment and accept total responsibility for planning and carrying out treatment activities” (p. 80). It has become apparent that reorienting to a family-centered model is essential to providing services in an optimal manner that enables the family system to support and maximize the process of intervention (Donahue-Kilburg, 1992). As professionals undertake the transition from the “expert” model of intervention to forming partnerships with families, students in training programs are also encountering this shift, often having been drawn to the career by the traditional “expert” model of service delivery. Although becoming truly family-centered is an ever-evolving process for professionals who knew only the traditional model for many years, opportunities exist to invest incoming students with a more family-centered philosophy that will serve as the foundation of their clinical and professional thinking from the very beginning of their careers.

The work of Fondiller, Rosage, and Neuhaus (1990) offers a relevant conceptual framework that can be applied when considering the impact of early training experiences on the philosophy of service delivery adopted by students. These authors proposed the existence of a dynamic working model of the clinician based on clinical knowledge, experience, and personal values. Indeed, the mental model the clinician constructs of the consumer is derived from the clinician’s values, attitudes, opinions, views, and the model to which the clinician has been exposed, both implicitly and explicitly, during his or her professional education. In relation to the family-centered perspective of intervention, what attitudes are being established as a product of professionals’ training experiences that are congruent or incongruent with this perspective? In a study reported in 1993, Humphry and Geissinger highlighted the impact on service delivery of attitudes of occupational therapists toward families and identified influencing factors. This research effort measured clinicians’ attitudes about family-centered service delivery and, in turn, developed an instrument that could be used to measure the outcome of family-focused professional education efforts. The extent to which a family-centered approach was endorsed by the clinician’s employer/agency and colleagues was identified as an important factor that influenced attitudes toward family-centered service delivery. In addition, professional background (e.g., amount of education and professional experience) proved to have more influence than personal experience (e.g., parental status, having a family member with special needs) on the participants’ score on a family-centered attitude measure. Thus, it can be concluded that educational and professional experiences can influence the degree to which the clinician’s mental model is compatible with family-centered care. Furthermore, the existing mental model will dictate the clinician’s likelihood of implementing such an approach effectively.

Although several authors have stressed the need to shift service delivery from client-centered to family-centered (Bailey, 1987; Crais, 1991; Crais & Leonard, 1990; Donahue-Kilburg, 1992; Winton, 1988; Winton & Bailey, 1990), only limited information is available on the steps being taken to accomplish this change and even less on the success with which this shift is being accomplished at the pre-service level. It is instructive to examine the research of Eichinger, Rizzo, and Sirotnik (1991), who investigated changes in students’ attitudes toward persons with disabilities. The students were exposed to information and persuasive messages regarding persons with disabilities delivered in an introductory special education course. The experimental group was provided contact with individuals with disabilities in addition to this classroom material, whereas a control group of students taking a general foundations of education course was not. The authors reported that students in the experimental group had significantly greater improvement in attitudes than did students in the control group. Furthermore, the students in the experimental group reported that contact was significantly more influential in changing their attitudes than either information or persuasive messages.

Kerns (1992) reported a pioneering effort to examine students’ attitude change on completion of an academic course titled “Supporting Parents of Children with Special Needs.” Through the use of open-ended questions, the author examined changes in attitudes and behaviors described by students before and after the course. Thirty-two students responded to the questions that were posed immediately following the course, and 9 responded to the 1-year follow-up questions. The author reported student outcomes of greater empathy, increased respect, and significantly more parent collaboration and communication based on the students’ responses. The factors identified as influential in increasing positive interaction with parents were readings, interviews with families, and provision of respite care, though the method applied to yield this finding was not clearly described. Furthermore, it is not known whether these factors would have a similar effect independent of each other.

Two programmatic efforts designed to increase the family focus of service delivery have been documented recently. Winton and DiVenere (1995) discussed roles families have begun to play in personnel preparation and strategies that have been implemented to foster family-professional partnerships during personnel preparation in the fields of education, medicine, and some health-related professions. More recently, Capone and DiVenere (1996)
described family-centered training for practitioners in the field of early childhood special education. An earlier effort by DiVenere (1994) reported implementation of a medical education project in which physicians in training were paired with the family of a child with disabilities for a home visit to foster development of a family-centered perspective of medical practice.

It was the medical education project described by DiVenere (1994) that inspired the approach detailed in this article. The current project was undertaken to provide speech-language pathology students with experiences early in their professional preparation that would foster an understanding and commitment to establishing partnerships with families. To determine whether the approach positively affected the students’ perspectives, the Humphry and Geissinger (1993) instrument was employed as a pre and post measure.

In an attempt to influence students’ development of a family-centered philosophy of service delivery, this article may serve as a guide to training programs in (a) combining classroom activities with family interactions as a means of establishing a family-centered philosophy of service delivery as the foundation of clinical training in speech-language pathology and (b) in measuring the effectiveness of such training efforts.

**Method**

**Participants**

Over a 4-year period, 41 students studying to become speech-language pathologists participated in this project. Thirty-six first-semester graduate students and 5 senior undergraduates were each paired with a family recruited through Parent to Parent of Vermont, an organization that offers resources and support to families of children with special needs. Parent to Parent has been active in developing partnerships between professionals in Vermont and the families they serve. Each student arranged a visit of 2 to 4 hours with a participating family at the family’s convenience. These were families of children with special needs, though the special need was not necessarily a communication disorder.

**Description of Instrument**

An instrument titled “Issues in Early Intervention,” authored by Humphry and Geissinger (1993), was used as a pre-post measure of the degree of family-centeredness of each student (see appendix). As mentioned earlier, the instrument was originally developed by Humphry and Geissinger to capture changes in occupational therapists’ attitudes about family-centered services associated with inservice training in family-centered care. The questionnaire includes 23 statements that reflect “attitudes consistent or inconsistent with a family-centered approach” to service delivery. Respondents indicated on a 5-point scale the extent to which they agreed or disagreed with each item. The rating scale is 1 = strongly agree (SA), 2 = agree (A), 3 = uncertain (U), 4 = disagree (D), 5 = strongly disagree (SD). The scoring of items 3, 4, 7, 16, and 20 was reversed; for example, a scale score of 1 was tallied as 5, 2 was 4, and so on. Thus, for scoring purposes, higher scores reflected attitudes that were more family-centered. Furthermore, the first item on the questionnaire was classified by the authors as a neutral item and not intended for inclusion in the analysis, resulting in 23 scored items.

The instrument has a reported test-retest reliability of .78 using a Pearson correlation (Humphry & Geissinger, 1993). Internal consistency was demonstrated by the authors with a Cronbach’s alpha of .84, and content validity was established. A similar level (.80) of internal reliability was reported in relation to a later training application with graduate students (Humphry & Geissinger, 1993).

**Procedures**

The professional preparation described in the paragraphs that follow consisted of two classroom learning activities, a family visit, post-visit journal writing, and post-visit class discussion. To determine the efficacy of this training approach in fostering growth in the family-centered attitudes of students, the students’ attitudes were assessed before and after the training sequence using the previously validated measure of attitudes about family-centered services described earlier (Humphry & Geissinger, 1993) (see appendix).

Thirty-six graduate students and 5 undergraduates completed the pretest questionnaire the first day of a clinical preparation and management course that occurred either in the first semester of their graduate program, or during their senior year in the case of the undergraduates. The topic of family-centered service delivery was introduced by conducting the pre-visit classroom activities described previously, and visits were arranged to occur within the subsequent 3 weeks. Following the completion of all family visits, the questionnaire was re-administered at the end of the class period devoted to sharing experiences and insight gained from the family visits.

**Pre-Visit Activities**

*Family Recruitment and Student Matching.* The families were recruited by Parent to Parent of Vermont, and student-family matches were based largely on their geographical proximity. In addition, care was taken to match students with families who were previously unknown to them. The purpose of the visit was described for each family, both during a recruitment phone call placed by the Parent to Parent Coordinator and in a follow-up letter that preceded the student’s visit.

*Preparatory Classroom Exercises.* Before the students were given information for contacting families to make visit arrangements, two class meetings were devoted to preparatory activities as an orientation to focusing on the perspectives of families. The exercises are briefly summarized below as context for the reader. However, review of the complete activity guidelines (Edelman, 1991) is recommended before implementation. First, a values clarification exercise (Edelman, 1991) was conducted in which students explored their own values and subsequently reflected on and discussed the assumptions we as professionals make.
about the values of families with whom we work. To examine their own values, students were instructed to privately list the five values each held most dear. The group then compiled a list of the various values held by class members. Examples of some of the values identified were family, health, independence, respect, flexibility, having choices, and freedom. During further instruction, students were expected to discard three and retain only two of their five values (e.g., the desire to retain the values of family and health meant giving up one’s other three next most important values of privacy, independence, and choice). The experience of being expected to abandon any of one’s most closely held values can have an emotionally profound impact. Ultimately, the students considered and discussed the similar circumstances we, as service providers, may inadvertently create in our efforts to have families conform to the values we hold as “experts” in the care and management of their family member’s communication needs. Through this experience, students may come to recognize (a) the assumptions clinicians must be cautious about making and the sensitivity needed to serve effectively as a resource person to families and (b) the need to participate collaboratively in developing recommendations in ways that do not violate values held by the families, but rather are sensitive to and respect the families’ values.

The second classroom activity was a language sensitivity exercise (Edelman, 1991) in which students identified words used by professionals to describe families that “reflect negative attitudes and that prevent collaborative relationships from developing” (p. 57). Words they had heard used to characterize family members and their motivation or dedication to treatment or parenting were listed via brainstorming as a group. Some of the characterizations generated were “difficult,” “uninvolved,” “angry,” “overprotective,” “uncaring,” “uncooperative,” and “unmotivated.” Through application of the activity guidelines (Edelman, 1991), the assumptions the words represented were discussed and the potential impact on (a) the clinician’s attitude when interacting with the family and (b) the family’s trust were hypothesized. Students then engaged in brainstorming to generate guidelines for speaking in respectful ways about families.

**Visit Arrangements**

*Information Provided to the Students.* Each student was given the name and phone number of a family who had agreed to participate in the project. The students were told to arrange the visits at the family’s convenience in the upcoming 2 to 3 weeks and to be flexible in scheduling to accommodate the opportunities the families presented. They were assured that the families had agreed to participate and were looking forward to the visits, though students still reported feeling ill at ease with the visit assignment. The students were advised that they (a) had no observation task or set of objectives for the visit, (b) were to leave their “clinical selves” at the university and “meet this family just as if you were meeting a new next door neighbor or friend of a friend,” and (c) were to think about what they might learn from the families that would be helpful to them as service providers. In the days following the introduction of the visit assignment, the students contacted the families and explored visit options.

*Information Provided to the Families.* The Parent to Parent Coordinator alerted the families that the students would have no prior information about their child’s disability and had only begun to embark on their professional education. It was emphasized that the student would not be in a position to offer professional consultation. The families were advised that the purpose of the visit was to give these future health care professionals the opportunity to discover what the life of a family with a child with special needs was like. The families were invited to think about what they would like the student to learn from the visit and to see this as a chance to have some impact on the student’s clinical education and professional growth. What things would they like a service provider to know or be sensitive to when working with families?

Families were encouraged to structure the visit in whatever way they thought would be a useful experience for the student. Suggestions offered for the visit included a family recreational outing after school or on the weekend, or an extracurricular event or school activity. Others generated by families included an informal visit in the home during routine family activities after school or in the evening, a mealtime visit, attending an Individualized Education Plan (IEP) meeting with the parent, and accompanying the family on a trip to the shopping mall or the grocery store.

**Post-Visit Activities**

*Journal Writing by Students.* Each student was instructed to make a journal entry of one to three pages in length within 24 hours of the visit, capturing their reactions, both as a person and as a person training to become a professional. The journal was NOT to be a travel log of the visit or about the family. It was to be about the student and his or her response to the experience (e.g., What felt good? What felt sad? What was distressing? What was surprising?). The written journal reflected the degree to which the student was developing a sensitivity to or understanding of families’ circumstances and strengths. Subsequently, students were free to include the journal in their professional growth portfolios that each assembled during the course of their graduate program. (Excerpts from students’ journals are presented in Table 1 of the Results and discussed in terms of recurring themes.)

*Class Discussion of Visits.* On completion of all family visits, students brought their journals to class and used them as references in a discussion of their experiences. They reflected on what surprised them, saddened them, excited them, and/or concerned them. They shared what they learned from the families about their experiences and interactions with the health care and educational systems, many of which were not perceived as family-centered. The students discussed what they gained from the visit and how it would influence their work with clients and families next week, next month, and in their future careers. As an outgrowth of the discussion, students formulated individual action plans for being more family-centered in their
clinical involvement in the upcoming weeks.

Family Feedback. Families were contacted by the Parent to Parent Coordinator for feedback subsequent to the visits. They were asked such questions as: Why did they volunteer to participate? How was the visit a positive experience? Were there concerns? A summary of the family feedback is provided in Table 2 of the Results. It should be noted that although family feedback has been used to evaluate the effectiveness of the project activities, it has not been shared with students. This is a limitation in the study that will be addressed in the discussion section.

Student Feedback Shared With Families. With the students’ knowledge and permission, excerpts from the students’ journals were compiled for the Parent to Parent Coordinator to distribute to the participating families. Families were appreciative of this feedback, and 80% have volunteered to participate in the visit project again.

Results

As stated earlier, the instrument, “Issues in Early Intervention” authored by Humphry and Geissinger (1993), was used as a pre-post measure of the degree of family-centeredness of each student (see appendix). The differences in the pre and post scores were analyzed using the nonparametric Wilcoxon Signed-Ranks Test (Siegel, 1956). Thus, for each student, the sum of the pretest scores on the questionnaire items was compared to the sum of the posttest scores, and the differences were ranked in order of absolute value (i.e., from 41 to 1). A T value was then derived from totaling the ranks with the less frequent sign (i.e., plus or minus). The differences in the pre and post scores reflected a significant increase in the “family centeredness” of students’ responses to the questions, as evidenced by the T value of 7 and z of 5.46 (p < .0009; one-tailed test). A pretest mean of 67.37 and posttest mean of 83.50 resulted in a mean difference score of 16.13, with a standard deviation of 8.5. The range of the difference scores was −10 to 33 with only one student earning a lower posttest score compared with the pretest. Forty of the 41 students demonstrated a positive difference in measured attitude, and of those, 35 earned difference scores in double digits. Thus, there was a significant increase in students’ awareness and expression of a family-centered philosophy of intervention following the family visits and associated learning activities, reflecting positively on the effectiveness of this approach to personnel preparation.

The reliability of the items was examined to verify that the items were internally consistent. A Cronbach’s alpha (Allen & Yen, 1979) for the 23 items was calculated for both the pretest and the posttest, resulting in alpha values of .78 and .85, respectively.

Analysis of individual questionnaire items was also conducted using the Wilcoxon Signed-Ranks Test (Siegel, 1956) to determine across participants the comparative change in response to individual items. Thus, the posttest scores that increased were compared to those that decreased. Of the 23 items, 20 demonstrated significantly positive differences (p ≤ .05). Those items that reflected the greatest positive change in student’s responses were items 18, 4, 2, 13, 11, 16, 3, and 17, in that order (see appendix for items). Overlapping themes of these items were recognition of families over interventionists as the primary decision-makers, the importance of families’ priorities, the abilities of families to effectively communicate with their child, and respect for the knowledge and information caregivers possess. These themes correlate with the messages emphasized in the described program and paralleled those evident in the students’ visit journals that are reported later in this article.

Those statements that reflected negligible change in students’ responses were items 6 and 12. These are “To be the most effective, therapy needs to occur with a caregiver in the room,” and “During the first few months after a family learns of their child’s disability, it is not realistic to expect them to be involved in planning services.” Item 8, “Information about available services should be provided to parents before establishing goals,” reflected a negative change in response upon posttesting. This finding highlighted attitudes that appeared to be more resistant to change and indicated areas needing more emphasis in the preparatory classroom material preceding the family visits. That is, there were three areas of family-centered service delivery represented by items 6, 8, and 12 that did not appear to have been sufficiently integrated by the students through the family visit experience, the classroom exercises, or the course material. The pre and post questionnaire results offer a useful method of examining attitude outcome of the teaching and experiential methods. The item analysis of the students’ responses is useful in directing refinements in the preparatory classroom material and experiences that precede the family visits.

Anecdotal Information

Student Comments. Student feedback regarding their family visits offered compelling anecdotal evidence supporting the value of this training program. This evidence was gathered by reviewing each student’s journal and examining those statements that reflected the impact of or the student’s reaction to any aspect of the visit. Only those statements in which an attitude was represented were considered. Statements that merely supplied contextual information about the logistics of the visit with no reflection of attitude were disregarded. The themes that appeared frequently across students’ journals are displayed in Table 1 along with representative excerpts.

The writings were rich in content that reflected the impact of the visit. Although students were not asked to address the comparative impact of the visit versus the classroom activities on the insights they gained, 88% of the students indicated that the visit clarified for them the importance of family-centered approaches and values they had learned about in class. It was striking to discover the representation of cardinal principles of family-centered practice (Shelton, Jeppson, & Johnson, 1989) in the themes of the students’ journals.

It also appeared that the knowledge gained may have had a positive impact on the perspective of some students over time, as evidenced by the following unsolicited...
feedback from a student 6 months after her visit. “In my medical placement this summer, the experience of my first year that proved to be most important was the family visit and insight I gained from it.”

Family Comments. Why are families of children with special needs willing to give of their time to educate these students? Several families have participated in the project for the 4 years of its duration and have indicated willingness to continue to participate in future years. The Parent to Parent Coordinator gathered feedback, both written and oral, from the participating families after students’ visits had been concluded. Most families felt the experience was a positive one and felt good about their contributions to the educational experiences of the students. Different families wanted to specify different agendas for the students. For example, one family invited the student to attend their child’s school IEP meeting; another family invited the student to share a meal with them; one family wanted the student to observe an in-home tutoring program that had been set up by the family and the school; and many families felt having the student visit during some unstructured, relaxed family time was most meaningful and least disruptive to family life. Families were asked, specifically, what they wanted students to learn from their visits. The feedback from participating families, summarized by the Parent to Parent Coordinator, appears in Table 2. This anecdotal information clarifies the reasons families participated in the project, offers the reader the families’ perspectives as participants in the visits, and provides insight into what students may gain from participating in this type of experience.

Not all home visits were entirely positive. In the first year of the project, this feedback, anecdotal in nature, proved particularly useful in identifying a weakness in the execution of the pre-visit activities and led to refining the orientation of both students and families in subsequent semesters. One family reported that early in the visit, the student commented to the parents, “Well, he doesn’t look retarded.” Later in the visit the student commented, “Well, that’s autism for you.” The family was surprised with the student’s limited knowledge base and judgmental perspective.

The feedback from this visit was extremely valuable because it led to a greater emphasis on language sensitivity with students in the classroom before their visits and to more explicit information (e.g., written handout) being given to parents before the students’ visits. The handout let parents know that students had no information about their family except the knowledge that the family had a child with some sort of special need, and that the students were
importance of family-centered approaches and values. A family visit served to increase their understanding of the positive effects observed in this study, because all students participated in all aspects of the program. Would the in-class preparation in the absence of a family visit yield a similar change in family-centered attitudes? Such control procedures would offer clarity and might be accomplished through collaboration with other university programs that currently rely on in-class preparation to expose their students to family-centered attitudes. However, the findings of the 1991 investigation by Eichinger, Rizzo, and Sirotnik cited earlier support of the likelihood that direct contact is significantly more influential in changing attitudes than either information or persuasive messages provided in the classroom or through readings, as was the case in their study of students’ attitudes toward people with disabilities. It seems likely that the increase in students’ family-centered attitudes was facilitated by the addition of family-centered experiences during a family’s life over the past 12 years, I felt really good. “Look how far we’ve come,” I thought to myself. “He really is part of our family.”

TABLE 2. Main themes of family feedback reported by Parent to Parent coordinator.

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<th>Main Themes</th>
<th>Family Comments</th>
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<td>Recognize children first as individuals, rather than basing their identity on their disabilities. Respect and support families.</td>
<td>“I wanted the student to see my child as a child first, and a child with a disability second. I hoped the student would understand how very much our family cares about our child, and would not pass judgment on why parents advocate in certain ways for their children with special needs.”</td>
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<td>Consider service delivery from the family’s perspective.</td>
<td>“I talked about the different experiences I had had with professionals over the course of the past few years. I could only hope that this student would learn from her visit with me, and perhaps do things differently as she took her place as a professional.”</td>
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<td>Recognize the knowledge parents possess.</td>
<td>“I hope that the student would realize how very much parents know about speech and language disorders and treatments just from raising their special needs children. Parents are great resources who should not be overlooked when assessments are made or when decisions are made in regard to treatment plans. I also hope that the student would realize how crazy-normal our home life is and how very much we accept our child with a disability.”</td>
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<td>Collaborate with parents in planning assessment and intervention.</td>
<td>“I wanted the student to realize how very capable our children who can’t express themselves really are. Although my child cannot communicate verbally, he was able to demonstrate in his own home the facial and hand gestures he uses to get his needs met. Do not underestimate the intelligence of our communication-impaired children, but rather take the time to understand how they are able to communicate.”</td>
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<tr>
<td>Recognize a child’s strengths and capabilities.</td>
<td>“I wanted the student to learn how very capable our children can’t before programmatic and goal considerations are dis-</td>
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<tr>
<td>Take time to understand how the child communicates.</td>
<td>“I dreaded the visit at first—it was one more intrusion in a busy life. But after we spent time together, and my husband and I shared the experiences of our son’s life over the past 12 years, I felt really good. “Look how far we’ve come,” I thought to myself. “He really is part of our family.”</td>
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<tr>
<td>Families can find it valuable to revisit their growth and accomplishments during a student’s family visit.</td>
<td>“I dreaded the visit at first—it was one more intrusion in a busy life. But after we spent time together, and my husband and I shared the experiences of our son’s life over the past 12 years, I felt really good. “Look how far we’ve come,” I thought to myself. “He really is part of our family.”</td>
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just that—students—with no expertise or agenda except to observe and learn from the family. Thus, the families were more clearly in charge of how the visit was structured and what they wanted the students to learn.

The solicitation of family feedback following each group of student visits continues as a component for evaluating the effectiveness of these learning experiences and identifying any opportunities for refinements.

Discussion

It is impossible to determine exactly what caused the positive effects observed in this study, because all students participated in all aspects of the program. Would the in-class preparation in the absence of a family visit yield a similar change in family-centered attitudes? Such control procedures would offer clarity and might be accomplished through collaboration with other university programs that currently rely on in-class preparation to expose their students to family-centered attitudes. However, the findings of the 1991 investigation by Eichinger, Rizzo, and Sirotnik cited earlier support of the likelihood that direct contact is significantly more influential in changing attitudes than either information or persuasive messages provided in the classroom or through readings, as was the case in their study of students’ attitudes toward people with disabilities. It seems likely that the increase in students’ family-centered attitudes was facilitated by the addition of the family visits to the classroom events. Furthermore, there is ample evidence in the students’ journals that the family visit served to increase their understanding of the importance of family-centered approaches and values.

The authors would propose the following modifications in procedure to improve the program and potentially strengthen the outcome further. With last year’s group of students, the topic of family-centered service delivery was revisited midway through their second semester during a clinical seminar session that is held weekly. To reinforce the attitude changes students had experienced, they were encouraged to reflect on their current practicum placements and discuss the challenges and opportunities to promote family-centered service delivery in those settings. Positive experiences were celebrated and, in those circumstances where opportunities were limited, the barriers to the shift from child-centered to family-centered service delivery were discussed. Brainstorming ensued to develop approaches that would support family-centered efforts in the practicum setting. This revisiting experience served to reinforce the students’ family focus and offered guidance in their continuing efforts to be family-centered.

Based on the pre-post questionnaire item analysis, three areas of family-centered practice were identified that need additional emphasis in the program. Specifically, we need to better address (1) the critical role the caregiver can play by actively participating and contributing in the assessment and intervention processes and how to create this partnership; (2) the family’s involvement as a partner in planning, beginning as soon as a child’s special needs are recognized; and (3) the primary responsibility of the clinician to provide resource information about available services and options before programmatic and goal considerations are discussed. To accomplish this change, consultation with the Parent to Parent Coordinator will take place to brainstorm potential ways of creating more emphasis in these areas.
both during classroom activities and through the family visits. Additionally, we have discussed inviting a panel of parents to come speak with the class in the future, which might offer a forum for discussing some of these considerations and hearing families’ perspectives on the topics.

Another recommendation to improve the program is that of adding a process for sharing family feedback with the participating students. This would need to be done in a manner that preserved the confidentiality of the families. Currently, families receive the students’ feedback, but family feedback has not been shared with the students following the visits. If students are given an opportunity to reflect on what the families gained from the visit and why they chose to participate, it may provide additional information to support their commitment to be family-centered.

Subsequent surveys of the student participants would be useful in assessing the long-term outcomes that followed from participation in this program. Are the changes in family-centered attitudes sustained over time? Have the participants become successful agents of systems change in their work environments?

This study takes a step toward documenting the outcome of programmatic efforts to instill students with family-centered values. It is clear that further studies are needed to determine the most efficient and effective strategies for introducing students to family-centered attitudes and practices.

Conclusions

The attitude transformation from an “expert” model to a “family-centered” philosophy is most likely to be fostered by exposing students early to opportunities to “learn” from families. A paradigm shift of this magnitude can be facilitated and achieved through experiences created by families willing to contribute to the professional education of speech-language pathologists. The family visit and associated learning activities described in this paper led students to recognize myths and biases they held regarding families of children with special needs. It is apparent that a family visit supported by related processing activities in the classroom can significantly affect the students’ perceptions of children with special needs. It is evident that a family visit supported by related processing activities in the classroom can significantly affect the students’ perceptions of children with special needs and their families. If a family-centered philosophy is to form the foundation of professional development, these attitudes and practices must be introduced early and be recurring throughout academic and clinical experiences.

In a follow-up letter of appreciation to participating families, the Director of Parent to Parent expressed the following aspiration: “It is hoped that these students, as clinicians, will be more apt to see a child as a unique person, who is also part of a family and will identify interventions with more insight and understanding of the child’s and family’s total needs.” Such aspirations raise several questions worthy of consideration by training programs. To what extent do the mental models clinicians hold reflect a family-centered philosophy? What family-centered experiences are being supplied during professional training as modeling material? Are the provided training experiences investing students with a family-centered perspective of service delivery?

In preparing professionals to deliver services to families, our academic programs have an ethical obligation to create training experiences that instill a philosophy of family-centered intervention. One vital means of enhancing these training efforts is the formation of partnerships with families early in the training initiative. This article provides one model of how to begin that process and initiate the dialogue between students and families that is so essential for relationships to develop. It is apparent that students’ family-centered perspectives can be shaped by offering preservice opportunities for students and families to develop meaningful relationships.

Author Note

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Portions of this paper were presented at the 1997 convention of the American Speech-Language-Hearing Association in Boston.

References


Appendix

Issues in Early Intervention (Humphry & Geissinger, 1993)

We would like you to share your opinions about issues in early intervention. Please circle the response which best reflects your opinion.

SA = Strongly Agree  
A = Agree  
U = Uncertain  
D = Disagree  
SD = Strongly Disagree

1. I have some concern about whether the early intervention legislation (P.L. 99-457) will actually work for the benefit of children with special needs.  
2. Interventionists are more likely to be realistic about a child with special needs than are the parents.  
3. I believe it is OK for a family to take a break from therapy even if I think that the child’s progress may suffer.  
4. Parents are as capable as interventionists in identifying needs of their child.  
5. The most appropriate time to include families in setting priorities for treatment is in the post assessment period when we know something about the child’s abilities.

6. To be the most effective, therapy needs to occur with a caregiver in the room.  
7. Families should help determine the nature of the assessment.  
8. Information about available services should be provided to parents before establishing goals.  
9. Interventionists should focus their attention on teaching mothers information about caring for their children.  
10. If a family does not follow through on recommended activities, the interventionist should explain their importance and make suggestions that would help them follow the recommendations.  
11. In setting priorities, the interventionist should adhere to what s/he thinks is best for the child even if the family requests alternative priorities.  
12. During the first few months after a family learns of their child’s disability, it is not realistic to expect them to be involved in planning services.
13. Families do not have adequate information to deal with setting goals until they hear about evaluation results.  
14. Using parent input for setting goals might compromise the quality of intervention services.  
15. It is hard for families to be realistic about the infant’s abilities when s/he has developmental delays.  
16.a Parents are in the best position to decide which disciplines should provide services for their child’s needs.  
17. Parents need help to communicate effectively with their child who has special needs.  
18. The child’s treatment needs should be identified before asking the parent’s priorities.  
19. Families have difficulty knowing what goals are important until they are informed about an agency’s services.  
20.a My experiences as a family member help me appreciate how other families function.  
21. In setting priorities the interventionist should act as the child’s advocate and be sure the parents understand the interventionist’s reasons for prioritizing goals as s/he has.  
22. Family involvement in goal setting is not realistic during the first few months after the family learns about their child’s handicap.  
23. Families need professional input to be realistic about the abilities of their child with special needs.  
24. When attendance is a problem the first thing an interventionist should stress is the importance of early treatment.  

a Scoring was reversed.

Note. The authors designed the first item to be neutral and excluded the item from analysis.