Family-Centered Practice Knowledge and Use Amongst Speech-Language Pathologists: A National Survey

by

Emma DeCarlo

A thesis submitted to the Graduate Faculty of
Auburn University
in partial fulfillment of the
requirements for the Degree of
Master of Science

Auburn, Alabama
May 7, 2022

Key words: Family-centered practice, speech-language pathology, training, treatment

Approved by

Allison Plumb, Chair, Associate Professor of Speech, Language, and Hearing Sciences
Laura Plexico, Professor of Speech, Language and Hearing Sciences
Megan-Brett Hamilton, Assistant Professor of Speech, Language, and Hearing Sciences

Abstract

The purpose of this study is to investigate the degree to which practicing speech-language pathologists (SLPs) engage in family-centered behaviors within the pediatric population. Additionally, this study aims to determine the amount of preservice training SLPs receive regarding family-centered practice (FCP). Data was collected through an anonymous 71-question, web-based survey designed for practicing SLPs. One hundred and fifty-four SLPs met the inclusion criteria and completed the survey. The majority of SLPs indicated that they would have benefitted from additional training in FCP, with strengths and weaknesses noted academically and clinically. Results of the Measures of Processes of Care for Service Providers (MPOC-SP) revealed a strength in SLP's implementation of Communicating Specific Information (CSI) with a weakness noted in Providing General Information (PGI), or having general information available to families (e.g., financial assistance, respite care, dating and sexuality). The findings of the current investigation highlight the need for graduate programs to ensure that FCP is emphasized across the curriculum and clinical experiences. Regarding implementation of FCP, SLPs must understand the local, regional, and state resources available to caregivers so they are able to support families and provide them with the necessary referral information specific to their unique needs.

Acknowledgments

I would like to thank my advisor, Dr. Plumb, for all the help and support she has provided me throughout this research process. I am very grateful for the opportunity to work closely with Dr. Plumb alongside Dr. Hamilton and Dr. Plexico to gather more research on the ideals of family-centered practice in the speech-language pathology profession. I cannot express enough how encouraging and helpful Dr. Plumb has been in every step of my thesis process and I will continue to be grateful for many years to come. In addition to Dr. Plumb, I would like to thank Dr. Hamilton and Dr. Plexico for their insight, feedback, and dedication to my research. I would not have been able to complete this project without the help from these three professors and I am so thankful for each of them. They have helped me grow as both a speech-language pathologist and researcher.

Contents

Contents

Contents

Contents

List of Tables

Chapter 1

Introduction

Family-centered practice (FCP), as defined by Child Welfare Information Gateway (2016), is a way of engaging families, both formally and informally, to ensure children are receiving the most beneficial services possible while also promoting child safety and well-being. According to the American Academy of Pediatrics (2012), the core principles of FCP include respect and dignity, information sharing, participation, trust, empathy, active listening, open communication, and collaboration (Arango, 2011; Rouse, 2012). Family involvement in a child's therapy is the main objective of FCP. The key elements in FCP include understanding that families know their children best and this knowledge makes them a crucial element in the treatment process; intervention must be flexible to tailor each session to the needs of the individual family; and the focus must be on strengthening and supporting the family as a unit.

Family-centered practice benefits both the child and the family. The parents of children receiving therapy based in FCP showed increased psychosocial functioning when compared to those who did not (Salvador, Crespo, & Barros, 2019). Additionally, children receiving therapy using FCP are given more opportunities for generalization of their newly learned therapeutic skills into their natural settings due to caregiver training in implementation of these therapeutic skills (Douglas et al., 2020; Russel et al., 2018).

Despite the benefits associated with FCP, there are noted challenges in its practical implementation for intervention. For example, some parents may have an inflexible work schedule and do not have time to work with their children frequently on therapy goals (McBride, 1995). Additionally, FCP may be inefficient due to limited resources that can be provided to families and restricted therapy time with the client due to the requirements of family-education

(Michalopoulos et al., 2012). Also, FCP may be challenging due to difficulty teaching parents therapy objectives because of the challenging nature, principles, or rules of these therapy objectives (Douglas et al., 2020).

Family-centered practice is implemented across child developmental levels. However, differences in FCP implementation are noted across professional settings. One setting that frequently incorporates FCP into intervention is home-based therapy. Specifically, home-based therapy enables consistent and extensive communication with the parents while also providing a mechanism for therapists to incorporate all elements of FCP into the treatment process (Fingerhut et al., 2013). Early intervention, for children between the ages of birth to three, is commonly associated with FCP and incorporates family-centered elements into the foundations of therapy directly and indirectly (Dunst, 2000). In contrast, schools are associated with the least amount of FCP. More specifically, school-based speech-language pathologists (SLPs) report having minimal communication with parents and incorporation of FCP elements into their treatment (Fingerhut et al., 2013). As children advance in education level, in both primary and secondary school, less emphasis is placed on parent involvement (Mandak & Light, 2018). The use of FCP in outpatient clinics is variable, ranging from quick conversations with parents before or after therapy to actively involving parents in sessions (Fingerhut, 2013). The final setting to consider, in which SLPs frequently word, is a hospital. Hospital settings, like a variety of other SLP-settings, give SLPs the opportunity to work directly with the families of the children receiving treatment and have the opportunity to incorporate FCP by allowing parents or caregivers to assist in treatment planning and implementation. The implementation of FCP may vary depending on the hospital administration, targeted age group of the hospital patients, and family visitation.

Although the benefits of incorporating FCP into intervention is extensively noted in research, preservice training programs provide minimal to moderate training in this area with minimal impact on student's thoughts and opinions regarding their preservice education. (Giallourakis et al., 2005; Mandak et al., 2020). Due to insufficient preservice training reported by SLPs (Roberts & Magrab, 1991), there is a gap between the ideal implementation of FCP and the practical, observable implementation of FCP by professionals (Woodside et al., 2001; Mandak & Light, 2018). While only a small body of research exists on the subject, initial findings indicate SLPs frequently follow a professionally centered model and dictate therapy objectives, procedures, and materials as opposed to allowing the family to take a more active, collaborative role in decision-making for treatment (Mandak & Light, 2018). Further investigation into the SLPs' use of FCP is needed to determine the gaps that remain in pre-professional training. This information can inform graduate programs in areas of strength and weakness in the profession.

Chapter 2

Review of the Literature

This chapter describes literature relevant to the purposes of the thesis. It is organized in the following sections: a) Family-Oriented Program Models; b) Overview of Family-Centered Practice (FCP), c) FCP across Settings, d) Personnel Preparation in FCP, and e) The Speech Language Pathologist's (SLP's) use of FCP

Family-Oriented Program Models

Family involvement in intervention can range from no involvement to significant involvement in the decision making and planning. Dunst, Johanson, Trivette, and Hamby's framework (1991) differentiates four family-oriented models: the professional-centered model, the family-allied model, the family-focused model, and FCP. This framework is based on assumptions about the capabilities of family members to provide crucial support in the therapy process and the roles that interventionists and clients (i.e., help givers and help receivers) play within intervention. When looking at the models across a continuum of involvement of the family, the professional-centered model is the least family-oriented while the family-allied model, family-focused model, and family centered practice (FCP) model provide increasing levels of caregiver involvement, respectively.

The Professionally Centered Model

According to Trivette et al. (1995), professionally centered models establish the professional as the expert and primary decision-maker. Family members are not viewed as experts in their child's care or seen as an essential asset for targeting therapy goals. Therefore, family members are typically not involved in treatment. Goals for the child are exclusively made by the professional without familial input. This method is the least family-oriented approach as the professional provides the least amount of family care and support. In Dunst and colleagues' 2002 study, caregivers rated both relational and participatory helpgiving practices poorly in professionally-centered models. Ratings in the relational component include clinical skills such as active listening, compassion, empathy, and respect as well as maintaining positive professional beliefs and attitudes toward families and their capabilities. The participatory component, on the other hand, rates practices based on their flexibility and tailoring to the family's specific concerns and goals, providing the families opportunities to actively participate in decision-making, collaboration, and reaching goals. Additionally, Wade and colleagues (2007) discovered that parents rated professional-centered therapy for children with intellectual disabilities to be less helpful than family-centered therapy. Specific outcomes related to the child's goals can be achieved in therapy depending upon the type of model and helpgiving practices that are implemented by the therapist (Dunst et al., 2002).

Family-Centered Models

The family-allied, family-oriented, and FCP models all involve the caregivers to varying degrees based on assumptions about the families. In family-allied models, families are not viewed as capable of independently providing effective change for the child, making professional support necessary. In this model, professionals involve families in the child's therapy when needed (Dunst, 1991). The family-allied model acknowledges the necessity of caregiver involvement to produce the most gains in the child's progress and promote positive family functioning. The SLP models the therapeutic strategy and has the family member assist with implementation. The family members' role can include holding the child, redirecting the child's focus onto the therapist, providing a cue following the clinician's prompt, or prompting on their own given clinician instruction. Within the family-allied model, the family would not implement strategies learned in therapy to their child without clinician involvement. The SLP is viewed as the expert in therapy while the caregivers are viewed more as an assistant to the SLP in the process. Even so, the caregivers are encouraged to participate throughout therapy.

To continue, in the family-focused model, professionals view families as consumers of services rather than experts of the child. However, the family members' opinion and personal goals are viewed as necessary for cooperation and goal achievement. Therefore, professionals center their treatment around the family's needs and desires. Dunst et al. (1991) state that professionals view families as more capable of providing therapeutic strategies with this method than family-allied or professional-centered models, thus leading to more opportunities for familial involvement. However, professional input is still necessary for guidance. The family-focused model differs from the family-allied model in that the family's specific goals are considered. While the family-allied model believes family involvement is helpful for therapeutic success, it does not, account for the family's personal goals and beliefs. The family-focused model strives to incorporate the family's goals to best support the family's wants and needs.

The fourth and final model is FCP, in which the professional provides maximal family support and allows for the greatest amount of family decision-making (Brown, et al., 1991). Professionals are viewed as instruments designed to intervene for the family in two ways. First, the professional must tailor therapy to meet the needs of the family while remaining flexible and responsive to changing concerns. Second, the professional should support and strengthen family functioning. The family is viewed as an expert of their child and a necessary component to therapy. The aim of FCP includes teaching the parent to serve as a crucial and knowledgeable member of their child's care team, as they are viewed as equals to the therapists. FCP is the most widely researched family-oriented model with documented benefits for both children and families. Early interventionists note FCP as the best practice (Dunn, 2000; Fordham, Gibson, & Bowes, 2012). As such, it will be the focus of the current investigation.

Family-Centered Practice Overview

Family-centered practice (FCP) is a philosophical approach with accompanying principles intended to serve as a guide for healthcare delivery. FCP is used synonymously with other terms, such as Family-Centered Care, Family-Centered Service, and Family-Centered Helpgiving. According to Child Welfare Information Gateway (2016), FCP is a way of engaging families, both formally (e.g., explaining the child’s case history) and informally (e.g., using the caregiver as a model within the session) to ensure their child is receiving effective and successful service while promoting the well-being of the child. FCP considers more than just the clinician or service-provider. The goal of FCP is to involve the family as much as possible in the child’s therapy to achieve the greatest therapeutic outcome. Olson (2019) states that the two main objectives of FCP include improving the patient’s overall health while also respecting their wishes.

Historical Overview of Family-Centered Practice

Prior to the implementation of FCP, the medical model of service provision was the standard of care for pediatric patients. In the medical model, like the professional-oriented model discussed above, professionals make decisions for treatment goals and objectives based on their expertise without family input or participation (Rouse, 2012). The rationale and impetus for the development and implementation of FCP originates, in large part, from Bowlby’s early work on attachment (1944a, 1944b, 1973), as well as the separation anxiety and grief experienced by hospitalized children. Following World War II, children began to show detrimental effects of separation from their parents, especially during traumatic situations (Bowlby, 1953). During this time, caregivers were not permitted to stay with their child in the hospital. Therefore, children had little to no interaction with their family. Jolley's more recent work (2004, 2007) continues to support the earlier findings of Bowlby. The findings from these studies indicated that children who were admitted into hospitals without their parents remembered the trauma decades later as opposed to children who had their parents present. Additionally, Jolley and Shields (2009) stated that children who were separated from their families experience greater mental health issues along with decreased overall well-being. Jolley's work highlights the need for continued implementation of FCP within the hospital setting.

As time progressed and the evidence supporting caregiver involvement continued to increase, as did the role of parents with FCP. As noted above, parents of children in hospitals did not see their child throughout the treatment process. Greater parent involvement in their child's treatment process led to greater therapeutic gains largely due to increased comfort of the child. Now, however, best practice dictates that parents take an active role in the decision-making process for their child's care (Moeller et al., 2013). The original implementation of FCP primarily impacted nurses. At the start of FCP, nurses' attitudes were split regarding this implementation. Some nurses did not believe FCP was in the best interest of the child. This transition to incorporation of FCP in the hospital setting was slow, but with the support of parent advocacy groups, FCP became the norm for child treatment (Jolley & Shields, 2009; Rosenbaum et al., 1998).

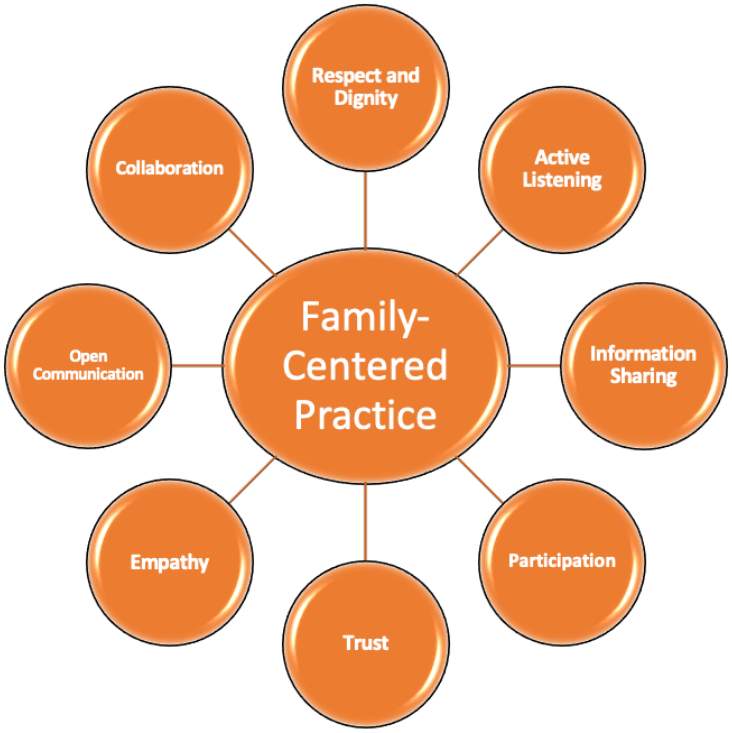
Additionally, Jolley and Shields (2009) found that following WWII, a large emphasis was placed on homecare of children and adults experiencing emotional trauma due to the loss and separation of loved ones. This helped move the idea of FCP to the homes, not just hospital settings. Eichner and Johnson (2012) state that in 1992, the Institute for Family Centered Care was developed which also helps promote the use of FCPs in all settings. Today, most healthcare professionals agree that FCP is the most beneficial form of care for children in hospitals and children receiving services in wider health services (Jolley & Shields, 2009).

Principles of Family-Centered Practice

According to Ahn, Keyser, and Hayward-Everson (2016), providing services using a family-centered perspective involves working together with family members, emphasizing family resourcefulness, making culturally respectful decisions, molding treatment to fit the families' individual needs, and providing empowerment to increase family members' accountability and engagement in their child's therapy. Specifically, Fingerhut et al. (2013) establishes the following three key elements of FCP: understanding that families know their child best, which makes them essential to the treatment process; flexible intervention tailored to the needs of the individual family; and a focus on strengthening and supporting the family unit. Johnson et al. (2008) notes the concepts of respect and dignity, information sharing, participation, and collaboration as primary to FCP: Respect and dignity incorporate the caregivers or family members in therapeutic choices along with incorporation of knowledge, values, beliefs, and cultural backgrounds into therapy. Information sharing encompasses complete, honest communication with family members to assist them in making informed decisions and effectively participating in the child's therapy for purposes regarding generalization of targeted skills. Participation encourages familial and client comfortably participation in decision-making. Collaboration promotes inclusion of family members and clients in therapy with opportunities to collaborate across environments and professional fields. To effectively implement these principles, the clinician or service-provider must put the needs, desires, and values of the family before their own beliefs and expectations for the child. Doing so will ensure a stronger therapeutic bond between the service-provider and the family while also helping the family develop a greater sense of comfort and empowerment with the therapeutic process. The following figure shows an image of the core elements of family-centered practice.

Figure

Core Principles of Family-Centered Practice



Benefits

Various benefits are associated with FCP for both the child and family, including improved psychological well-being, increased generalization of therapy skills into the child's natural environment, and reinforcement of therapy goals across multiple disciplines. FCP has been shown to increase treatment gains in the child, which is a direct result from the benefits produced using FCP principles (Douglas et al., 2020; Sugden et al.; 2020).

General Well-Being. Parents of children experiencing therapy tend to have a better perspective and mental well-being when using a FCP approach (Mas et al., 2019; Barnes et al., 2020; Al et al., 2019; Russel et al., 2018). For children, FCP is associated with decreased hospitalizations, more compliance to take medications, greater emotional well-being, and fewer missed school days (Murrell et al., 2018). For example, Salvador, Crespo, and Barros (2019) found that FCP resulted in improved psychosocial functioning for clients and families regardless of the child's age or stage in treatment.

Satisfaction of Care. Additionally, families who have received family-centered care reported greater satisfaction with services and less difficulty accessing the healthcare system, such as receiving the proper referrals for their child's condition(s) (Russel et al., 2018; Salvador et al., 2019). Motyer et al. (2021) investigated parents' well-being in services including and excluding FCP. The results showed that being provided appropriate information and support from their healthcare provider reduced anxiety during their child's treatment process. Satisfaction with care, ease accessing healthcare, and support provided by their healthcare provider may lead to greater mental well-being and create a sense of comfort in the parents regarding their child's therapeutic services.

Skill Attainment, Generalization, and Maintenance. Children whose families were implementing FCP principles achieve quicker development and mastery of therapy skills (Douglas et al., 2020). According to a study conducted by Sugden et al. (2020) on effects of parent training on children with moderate-to-severe phonological disorders, combining intervention conducted by both the parent- and the SLP led to greater generalization of the child's treatment to words not specifically taught in therapy. This research shows increased generalization of therapeutic strategies and skills when the parent is involved with therapy, which can reinforce the child’s newly taught skills in a variety of settings.

Reinforcement Among Multiple Disciplines. In addition to increasing generalization, FCP can aid in creating a connection between the multiple therapy providers involved in a child’s treatment, resulting in a significant increase in the child’s progress. Reva et al. (1998) found that incorporating FCPs into treatment leads to more common ground between families and professionals which can ultimately accelerate progress in therapy. Incorporating FCP principles is likely to occur through an increase in communication between service providers which will allow the providers to coordinate therapeutic goals for a child receiving services. Ultimately, more opportunities to reinforce the child’s learning will develop among the various services a child is receiving. More therapeutic gains can be made when the therapist and the families are working together to meet the child’s goals. In conclusion, FCP benefits not only the child’s mastery and generalization of therapy skills but also emotionally supports both the parents and the child.

Challenges

While there are many benefits in using a family-centered approach, barriers to the successful implementation of FCP have been identified. These challenges include time constraints, misunderstanding of cultural differences, lack of efficiency, difficulty managing caregivers, and language barriers between the family and clinician. These challenges of FCP should be taken into account by the clinician prior to implementation with the family. Additionally, the clinician should communicate these obstacles of implementing FCP with the families in order to avoid confusion and possible negative effects for both the family and the child.

Time Constraints. Parents of children needing therapy may not have the time availability to learn and implement their child's therapy needs. Time expenditure of parents is a demand placed on the parent by the speech-language pathologist (Lonner, 1994). Time expenditures may consist of travel time or time away from work and/or family (Lonner, 1994). McBride et al. (1995) found that employed parents may require time off from work along with childcare. Some employed parents may not have the luxury of a flexible work schedule or be able to afford to take time off of work. Additionally, when the parent is present for the speech therapy session, SLPs found they had to spend more time with that client (Boztepe & Gizem, 2017). This additional time spent with each client may cause interference with the clinician's schedule which could impact the time spent with other patients. While FCP may be beneficial for some patients, other patients may suffer as a result. With time being a necessary component for proper implementation of FCP, many clinicians may begin to feel overwhelmed by their caseload. These feelings of stress and exhaustion may lead to less personalized therapy approaches and a less efficacious implementation of FCP (Boztepe & Yildiz, 2017).

Lack of Cultural Competence. FCP is individualized to each family's environmental and cultural background. Therefore, a lack of cultural competence can create challenges to the use of FCP as intended. Michalopoulos et al. (2012) found that FCP training typically does not address family diversity. Due to the large variety of cultural and religious backgrounds that health care providers may encounter, many teachers and professors may have difficulty finding an appropriate method for thoroughly teaching this information. Lonner (1994) states that culture and dialect are major barriers to service as it can lead to professional bias against those families. For example, individuals lacking cultural competence and humility may associate speakers of dialects other than Mainstream American English as being less educated and from a lower socioeconomic class (Lonner, 1994). As a result, professionals may treat these individuals with less respect than they would a person of their own culture and dialect. The healthcare provider may assume a professionally-centered model is more appropriate as opposed to a FCP model that values having an equal partnership with the family. Additionally, people of different cultures and backgrounds may have different views on disorders and treatment (Lonner, 1994). Professionals may ignore these beliefs which could lead to parent mistrust or dislike of the professional working with their child. One method discussed by Snyder and McWilliam (1999) is recognition of one's own limitations and how that may affect therapy. It is impossible to teach students about every belief from all cultural groups. Therefore, it is important for therapists to be open with parents and caregivers of clients whose cultural backgrounds differ from their own. Specifically, therapists can acknowledge biases or a lack of knowledge of social norms for a particular ethnic group. The therapist should ask for clarification or information regarding that particular cultural group in order to best support the family's cultural identity through their child's therapy. It is necessary to create a culturally supportive environment in order for FCP to be successfully implemented and sustained (Wong, 2014).

Inefficiency. FCP may not be the most efficient therapy approach for some children and families. Child welfare workers in Michalopoulos et al.'s (2012) article suggest that FCP has standards that cause inefficiency in therapy due to limited resources and overlapping requirements of FCP. Inefficiency also exists between the different service providers who are caring for a family. A study conducted by Murrell et al. (2018) that surveyed parents of children receiving FCP services for type 1 spinal muscular atrophy found that a common complaint amongst the parents was a lack of communication between the different service providers caring for their child, which caused a lot of repetition and additional burden on the parents.

Additionally, Reva et al. (1998) suggested possible controversy related to FCP in that it may not take into account the best interest for the child because there is too much emphasis on the family. With a focus on empowering the families, the child obtaining treatment may not be receiving the most effective or direct therapy which could lead to less therapeutic gains. Although inefficiency can easily occur when attempting to implement FCP, efficient communication and organization is necessary to see the greatest therapeutic gains and receive the most benefits from implementation of FCP (Lonner, 1994).

Lack of Knowledge. There are many skills that a provider must utilize during a therapy session for the parent to properly implement therapy without the provider present. In the absence of this knowledge, it may be difficult to manage the caregivers coaching and training process. For example, Douglas et al. (2020) list necessary skills that a provider must employ during an FCP session: "…teaching, demonstrating, observing, providing practice and feedback, problem solving, and interacting with a variety of caregivers… building rapport, reviewing important information, modeling for the caregiver, providing feedback, and building caregiver independence" (p. 85). As illustrated in the previous quote, many factors are involved in a FCP approach in which a provider must follow to effectively implement this method of delivery. If the provider is not properly trained or has little experience implementing these strategies, then the family will not be able to properly utilize this therapy method and the child who requires necessary services will suffer. Additionally, Douglas et al. (2020) found that many parents or caregivers have difficulty stepping outside their comfort zones and actively participating in the therapy session due to unestablished roles. Many parents were unable to see themselves as a teacher for their child and saw the provider as a therapist exclusively working for their child instead of the whole family. Parents need to have the proper mindset and understanding of the

FCP approach in order for it to be an effective strategy for their child. As a result, clinicians must be able to manage the caregivers' stress, anxiety, and depression regarding fear of implementation of intervention with their child. Finding ways for the clinician to implement and encourage the caregivers to participate as well as empowering them in the therapeutic and caregiving process may provide added difficulty on behalf of the clinician (Etemadifar et al., 2018).

Language barriers. Language barriers between the client and clinician can limit the effective implementation of FCP. Douglas et al. (2020) found that many therapists were not able to properly implement a FCP approach due to misunderstandings and an inability to effectively communicate to the families of the child receiving services. Misunderstandings could decrease a child's therapeutic progress due to their parents or caregivers being misinformed on the treatment process. Clarification of specific instruction or ideas proves difficult if a language barrier exists (Vernooij-Dassen et al., 2010). However, interpreters can be a vital solution when working with individuals who differ in their native languages. According to Saenz and Langdon (2019), interpreters were found to be helpful when assisting SLPs with assessments and treatment for individuals speaking another language. However, despite these potential drawbacks, FCP may still be the best option for a family and child receiving treatment if the clinician is properly trained in the use and implementation of this approach and if the child's family actively participates in therapy.

Implementation of FCP across Settings

Another lens through which to view FCP is the setting in which it occurs. A study conducted by Fingerhut et al. (2013) examined where, how, and how frequently occupational therapists implemented FCP into their treatment. Fingerhut et al. (2013) found that occupational therapists provide services in four main settings, which includes homes, clinics, schools, and hospitals. In those four settings, the authors found that home-based intervention implements the most amount of FCP while school-based intervention uses the least amount of FCP. Clinic-based intervention and hospital-based falls somewhere in the middle of home-based and school-based intervention. These findings can be applied to speech-language pathology due to the similarities in settings, therapeutic goals, and collaboration between the two professions.

School-Based Family-Centered Intervention

In McWilliam, Maxwell, and Sloper's (1999) article, providing FCP in a school involves using a framework that enables service providers to develop a relationship with families in order to empower the families while also addressing the needs of the family. School-based therapists stated they had very little communication with the child's parents and did not incorporate many elements of FCP into their therapy (Fingerhut et al., 2013). According to Longley (2015), as children transition from early intervention into the school systems, their treatment and relationship with their service providers becomes less family-centered and more professionally driven. Mandak and Light (2018) further this point by stating that their findings showed the majority of service providers in schools made the majority of therapeutic decisions without consulting the families or caregivers and developed a more professional relationship with the children. As children get older, less emphasis is placed on the family and more on the student-teacher relationship. As a result, elementary and secondary schools become less family-centered and more focused on the child. According to Mandak and Light (2018), this reduced level of FCP is due to several barriers school SLPs have, such as time restraints, not as many successful collaborations with the families, and less than ideal training on how to specifically work with families. These barriers limit school-based SLPs from fully involving the families into the decision-making process and cause many SLPs to not incorporate FCP into their professional practice.

Preschool. Preschool is an important developmental time for children. The preschool age-group involves 3-year-olds to kindergarten. This age group typically receives services in a school-based setting. Involving the parents in necessary therapeutic services is crucial in order to see the largest gains from treatment. Dunst (2002) found that special education programs in preschools are the most family-allied in their approach, regardless of the educational or therapeutic focus, but they also incorporate some professionally centered approaches as well. Woods and McCormick (2002) describe the importance of involving the parents in not only the treatment process, but also the assessment of their child. They also identify FCPs in preschools as incorporating the child's strengths and the family's specific concerns as the basis of planning treatment goals. Based on these strengths and family concerns, SLPs are able to determine what type of intervention would most benefit the child. Having the parents or caregivers of preschool children identify their concerns and areas of strength for their child is necessary to make the most appropriate therapeutic goals and determine the necessary assessments for that child. Preschool programs have been shown to provide many FCPs and should continue to incorporate family-centered approaches into therapeutic treatment.

Elementary School. After extensive research, Dunst (2002) suggests that family-centered practice is rarely used or studied in the elementary school setting. Additionally, elementary schools have primarily employed family-allied models as opposed to a FCP approach (Dunst, 2002, p. 145). "Family allied models are described as family guided models in the early childhood education field and as direct guidance models in the helpgiving field" (Dunst et al., 2004, p. 221). On the other hand, Dunst et al. (2004) describe the family focused model as families having the ability to make their own choices and decisions, but the options are limited to the specific professional involved as well as the resources and supports available to that family. While many schools actively provide family allied support, a family-centered model should be incorporated in order to make the most progress with children's therapeutic goals and allow the families of these children to have the ability to make decisions and play an active role in their child's treatment.

Middle School and High School. Research is limited in the field of FCP for adolescent children. According to Dunst (2002), FCP is not incorporated in many secondary schools. Families are generally seen as a less crucial component to their child's success and overall effectiveness of secondary school practices. Many parents believe that disengagement from schools is important for their child's development and growing independence into young adulthood. Additionally, at this stage in the child's education, many students have multiple teachers which makes communication with families more difficult. Dunst (2002) also found that secondary schools used mainly a professional model and remained mostly family-allied in their approaches to working with families. As shown from research, professionals are not incorporating many aspects of FCP with the adolescent age group. However, according to Dishion and Kavanagh (2003), family involvement is crucial to understanding, preventing, and treating adolescent problem behavior. This shows that adolescence may benefit from increased FCP approaches and more consideration of the children's families should be taken into account.

Based on this knowledge, school systems generally do not implement many FCP principles into their practice. Preschool special education programs have been shown to use FCP principles in their practice while secondary schools treating adolescent age groups (middle through high school) are the least likely to use FCP.

Home-Based Family-Centered Intervention

Home-based therapists have consistent and extensive communication with parents and report incorporating all of the elements of FCP into their therapy (Fingerhut et al., 2013). Barnes et al. (2020) found that incorporating the child's family or natural household environment into therapy is helpful due to the child developing, maintaining, and changing many health behaviors, both good and bad, in this environment. Due to it being the most natural setting for the child, home-based intervention is the most conducive to learning and will aid the most in language or speech development and/or alterations. Additionally, Stewart et al. (2020) have found that FCP use by professionals is one of the most crucial components to early intervention services because of the promotion of language development in the child's natural home environment. It is crucial for SLPs to take advantage of the natural home-based setting to instruct the parents how to continue to reinforce treatment without the SLP present. Therefore, home-based intervention applies a great amount of FCP and is also the most important setting for applying this practice.

Early Intervention. While home-based intervention can occur across the life span, for children it is most associated with the provision of early intervention services. The foundations of early intervention are built on a family-centered approach. According to ASHA (n.d.), early intervention is a service provided for children ages birth to 3 and their families. Early intervention is used for parents who are concerned about their child's development. Many professionals are included in the early intervention team, including SLPs, and can help children develop cognitively, communicatively, physically, socially/emotionally, or adaptively. Early intervention assists in providing both direct and indirect support and resources to families of young children receiving therapy that affects the child, the parents, and the family unit as a whole (Dunst, 2000). As shown from the definition of early intervention, family and parent involvement are crucial for the most benefit from early intervention services. Mahoney and Bella (1998) discuss that child development is directly correlated to parental ability and effectiveness with regards to interacting and caring for their children. The authors illustrate the impact families have on child development and how necessary family-involvement is in any treatment or therapy children may be receiving. Mahoney and Bella (1998) also state the goal of FCP in early intervention services is to increase therapeutic outcomes by improving the effectiveness of parent/caregiver interaction with the child that will ultimately aid in the child's development and overall well-being. Family-centeredness is crucial to a young child's development and family-centered approaches should be continued to be incorporated into early intervention treatment.

Clinic-Based Family-Centered Intervention

According to Fingerhut et al. (2013), clinic-based therapists reported a variety of responses on their use of FCP. Their responses ranged from having a quick conversation with the parent before or after the therapy session to actively involving the parent in the session. Most therapists working at a clinic stated they found that a clinic setting was not ideal for FCP because they had busy schedules with clients back-to-back and did not have the time to fully involve the family. Michalopoulou et al. (2018) state that FCP can be successfully implemented into therapy as long as the patient and their families are engaged, well informed, and receptive while the clinicians establish a positive interpersonal relationship with the patient/family and use clear and respectful communication that promotes collaboration. Additionally, clinic-based intervention may include all age groups. Depending on the clinic's targeted population, specialties, and procedures, FCP may be more or less difficult to implement. Ultimately, FCP can be successfully incorporated into a patient's therapy in a clinic setting as long as the families are able and willing to participate, and the clinician properly teaches the parents/caregivers.

Hospital-Based Family-Centered Intervention

Hospitals that have successfully implemented FCPs into their treatment have been shown to increase both the patient's and family's treatment outcomes, improve patient and family happiness, expand upon the strengths of the child and family, improve the therapist's satisfaction, lower costs of healthcare, and increase effectiveness of the health care's resources. As an example, Georgia's children's hospital has been implementing FCP since 1993 which has allowed families to participate in program planning, staff education, and other hospital committees. Additionally, Georgia's children's hospital has consistently received one of the highest patient and family satisfaction scores that was determined through a nationwide survey comparing pediatric facilities. Additionally, according to Tallon et al. (2015), an extended period of hospitalization provides healthcare professionals the chance to work directly with families to plan, carry out, and evaluate interventions that are specifically designed for the family's goals and individual needs while also enhancing the child's treatment and developmental outcomes. In addition to child support, many parents are under more stress and worry while their children are in a hospital and would benefit from more active involvement in their child's therapeutic services. Foster et al. (2010) found that parents of hospitalized children have physical and emotional needs that must be met to be able to fully support and care for their child. FCPs are crucial in a hospital setting for the well-being, recovery, and emotional support of the child and family. Although a hospital setting may be well-suited for FCP, the implementation of FCP may vary depending on the hospital administration, targeted age group of the hospital patients, and family visitation.

Preservice Training of FCP

Due to the benefits associated with FCP for both children and their families, preservice training is critical; however, the degree of comfort professionals feel as a result of this training differs and many practitioners feel unprepared to implement FCP (Chavkin, 1991; Epstein, Sanders, & Clark, 1999; U.S. Department of Education, 1997; Mandak & Light, 2018). Michalopoulos et al.'s (2012) conducted nine focus groups with 64 child welfare workers who received training in FCP. Three themes emerged as a result: 1) FCP training was not individualized for specific and diverse needs of families; 2) the child welfare workers possessed the knowledge covered prior to training from their previous education; and 3) Follow-up training was still needed. The positive of these findings is that the participants had a foundational knowledge of FCP from their educational training. The findings also highlighted the need to view FCP as a life-long learning process and to remember that families are quite individual with diverse needs and that a cookie cutter approach should not be taken.

Despite the foundational knowledge attained during pre-professional training noted by Michalopoulos and colleagues (2012), the findings of Vilaseca et al. (2019) indicated that more FCP training must be implemented into preservice training programs of health professions for proper implementation of FCP in therapy. Vilaseca et al. (2019) selected 17 professionals from a variety of health professions, specifically teaching, pedagogy, physical therapy, psychology, social work, occupational therapy, and speech therapy to complete focus groups pertaining to FCP. The results showed that there is a gap between the recommended level of FCP use and what professionals are actually implementing. This shows that while health professions understand the importance of incorporating FCP principles into one's training, not enough is being done to educate professionals in this area. In addition, Bingham and Abernathy (2007) measured whether one course pertaining to FCP was enough training to develop and enhance preservice teachers' attitudes towards collaboration with their students' families. The results of the study revealed that the students' thoughts of being taught from a family-centered perspective made little impact on their holistic view of their practice. It was noted, however, experience proved to be very beneficial in teaching FCP principles. Field experience helped these professionals apply FCP principles and turn this into their core teaching beliefs. Roberts and Magrab (1991) also emphasized the importance of including practical experiences into FCP training.

Preservice Training of Speech-Language Pathologists

Preservice training of FCP in graduate school for SLPs is crucial. However, based on current research, FCP is not being properly incorporated into training for SLPs. Giallourakis et al. (2005) developed a 40-item survey pertaining to FCP training where graduate-student participants currently enrolled in early-childhood education programs stated their thoughts from 1 (strongly disagree) to 5 (strongly agree). The authors also included four open-ended questions regarding the participants' use and involvement in FCP. The results of the survey revealed that family involvement is moderately provided in preservice training programs while also modestly impacting students' thoughts and opinions of their preservice education. Additionally, the results showed that the amount of family-centered interaction students had with families was beneficial and helped shape their beliefs and practices regarding FCP. On the other hand, Mandak and Light (2018) surveyed 15 school-based SLPs who reported that they did not feel graduate school fully prepared them for training in FCP. McBride and colleagues (1995) found that engaging family members with the service provider in the training process is a useful and effective strategy for assisting the service provider in accumulating knowledge and experience in FCP while also providing instruction to students. Mandak et al. (2020) describe specific relational skills that are necessary for providing FCP and should be implemented into a graduate SLPs training: active and reflective listening, compassion, empathy, respect, effective communication, and displaying positive beliefs and attitudes towards families. These findings show the need for more extensive implementation of FCP principles into professionals' training. Based on current research and surveys, training has been implemented into the educational curriculum for graduate SLP students; however, more emphasis on FCP and family involvement should be incorporated into the students training to aid in an increased understanding of this practice.

The SLPs Use of FCP

There is a small, but growing body of evidence on SLPs use of FCP. Several of these studies include SLPs in a wider variety of service providers (Bruce et al., 2002; Dyke et al, 2006; Raghavendra et al., 2007; Woodside et al., 2001). Findings from these investigations show that there is a gap between the amount of recommended FCP implementation and what professionals are actually doing in practice. While there are areas of strength in the use of FCP, areas of weakness have also been demonstrated, such as continuity of care and provision of information (Dyke et al., 2006; Raghavendra et al., 2007). Part of this gap may have been caused by a misunderstanding of the FCP construct. Due to the lack of consistency in defining and measuring FCP, some key components to FCP were missing in many therapeutic relationships, such as families not seeing themselves as a decision maker, a lack of communication between professionals, and a more professionally driven relationship (Woods, et al. 2011; Mandak & Light, 2018).

Kang et al. (2017) reported a positive finding based on a survey of 94 healthcare professionals and service providers working with the early intervention population, including physical therapists, SLPs, occupational therapists, social workers, and early childhood educators. The results of the surveys revealed that years of experience increased service providers' perception of family centeredness implementation in their practice. The professionals with greater experience showed higher perceptions of sensitivity and respect when providing general and child-specific information. However, the authors found that years of experience was not the primary determinant in FCP. Other professional and service-related characteristics, such as age, discipline, or work status, could also be associated with professionals' view of their level of family centeredness.

This gap between the ideal of FCP and the practice of FCP principles has also been noted in a small body of literature specific to SLPs (Crais et al., 2006; McWilliam, 2000). With regard to parent involvement, Pappas (2009) survey of 277 SLPs revealed that while SLPs believed parent involvement was necessary, most were using a professionally-centered approach. Mandak and Light (2018) surveyed parents of children with complex communication needs and SLPs who were currently using FCP. The SLPs were queried as to which practices they found ideal and desirable versus what was actually being implemented. According to the results, SLPs use more of a professionally-centered model and maintain the role of decision-maker as opposed to allowing the family to take a more active role in treatment. Several limitations of FCP implementation were identified and agreed upon between both the family and service provider. These areas of needed improvement for service providers include assisting families in networking, addressing, and supporting the family's emotional needs, regularly providing the family with the child's strengths and weaknesses, continuity of care, and providing general written information. Other healthcare professionals have found similar weaknesses in their implementation of FCP.

Mandak and Light (2017) also conducted a web-based survey of SLPs and caregivers of autistic children. Two validated measures, the Measures of Processes of Care (MPOC-20; King et al. 2004) and the Measures of Processes of Care for Service Providers (MPOC-SP; Woodside et al. 2001) were used to investigate each group's experience with FCP. While it was not possible to make a direct comparison, findings indicated that parents rated Family Centered Care lower than the SLPs. This finding supports the implementation gap noted above (Crais et al., 2006; McWilliam et al., 2000). Further information is needed to determine if this pattern is representative of pediatric SLP as a whole or is limited to children with more complex communication needs, such as augmentative and alternative communication (AAC) and autism spectrum disorder (ASD).

Conclusion

In conclusion, FCP takes the family of the child into consideration throughout the therapeutic process. FCP provides family members additional knowledge about treatment as well as improving their emotional well-being. The child receives additional benefit from FCP by having more opportunities for skill development and generalization due to the family having the ability to implement therapy throughout the child’s typical day. This increased practice will also assist in speeding the acquisition of the child’s skills. It is a reliable approach for increasing the family’s sense of comfort throughout the therapy process while also increasing their involvement in order to make the greatest gains in therapy, as well as additional benefits for the caregivers, such as psychological and general well-being. Despite the benefits associated with FCP, there are also challenges to its’ successful implementation, such as lack of knowledge of the service provider, time constraints for either the service provider or family member(s), and lack of cultural competence. While FCP is addressed in training programs, it is acknowledged that professionals feel underprepared to implement FCP. Consequently, a mismatch is likely to occur between the ideal of FCP and its actual implementation. Additional investigation into the use of FCP by SLPs across age levels and settings is therefore needed to better understand needs in pre-professional training and to inform graduate programs of areas of strength and weakness in this critical area of service provision within the profession.

Chapter 3

Justification

Family-centered practice (FCP) encourages health care and service providers to deliver services to both the child and families in a manner that promotes self-efficiency of the parent (Bandura, 1977). Child Welfare Information Gateway (2016) states that FCP is a way of engaging families, both formally and informally, to ensure their child is receiving the most beneficial service possible while also promoting the safety and well-being of the child. FCP is used to involve families as much as possible in order to see the greatest impact and benefit from therapy.

There are both benefits and challenges associated with the implementation of FCP. For example, children receiving therapy benefit from FCP by being provided more opportunities for generalization of their newly learned therapy skills into natural settings (Douglas et al., 2020; Russel et al., 2018). On the other hand, a challenge to the implementation of FCP is the time constraint that some parents may have from inflexible work schedules thus not allowing sufficient time for working with their child on therapy techniques (McBride, 1995).

Additionally, FCP varies amongst age-groups and settings. For example, the early-intervention age group (birth-3-year-olds) and home-based therapy users implement the largest amount of FCP into intervention (Fingerhut et al., 2013; Dunst, 2000). On the other hand, schools, particularly middle, junior, and high school settings incorporate the least amount of FCP into therapy (Dunst, 2002; Fingerhut et al., 2013).

Finally, with current research supporting greater outcomes achieved when therapists implement FCP (Douglas et al.,2020; Murrell et al., 2018; Russel et al., 2018), it is crucial that SLPs are properly trained in this area. Giallourakis et al. (2005) found that FCP training in early childhood intervention graduate programs is moderately discussed and modestly impacts students' thoughts and opinions regarding their preservice education. Additionally, training for FCP should incorporate family-engagement in order for students to gain more knowledge and practice using and implementing FCP in therapy while also receiving feedback from their instructors (Mandak et al, 2020). Based on current research, it has been demonstrated that speech-language pathologists' use of FCP is beneficial for both the parent and the child. However, more research is needed to determine how SLPs are using FCP and to what extent are they implementing these techniques into their current practice.

Purpose

The aim of this proposed investigation is to reveal whether practicing SLPs perceive that they have been properly trained in the use and implementation of FCP. Additionally, this study explores the extent to which SLPs are using FCP. Specifically, the study aims to answer the following questions:

1. Do SLPs report they could have benefitted from additional coursework addressing FCP?
    - Hypothesis – The majority of SLP will agree that they could have benefitted from additional coursework.
2. To what degree were the principles of FCP emphasized in their graduate coursework?
    - Hypothesis – SLPs will report a need for greater emphasis of principles of FCP in graduate coursework

3. To what degree were the principles of FCP model by their clinical supervisors during graduate study?

   - Hypothesis – SLPs will report a need for greater modeling of principles of FCP by clinical supervisors.

4. To what extent are SLPs providing services that are family-centered?

   - Hypothesis -Based on the MPOC-SP, SLPs will report implementing family-centered practice, but with areas a weakness noted in Providing General Information as noted in the literature for other disciplines.

Chapter 4

Method

Participants

A total of 212 individuals participated in the survey and indicated consent. Of the participants who consented, 154 participants completed the survey and met the inclusion criteria as follows: SLPs currently practicing in the United States who were working with children. If individuals indicated that they were not currently licensed, had not attained at least a master's degree, or were not working with children, the survey ended, and their answers were excluded as their responses may have detracted from the validity of the results. The largest percentage of participants reported discovery of this survey by means of social media (81.2%; *n*=125). This number is followed by ASHA community posts (13.0%; *n*=20), other (3.2%; *n*=5), and e-mail (2.6%; *n*=4).

Materials

To answer the questions of this study, the investigators created an electronic, web-based, 71-item survey via Qualtrics software to address questions in three main areas: (a) Background/demographic information, (b) Training experiences, and (c) SLP use of family-centered practice (FCP).

- Part I questions were used to obtain information regarding the participants' clinical and educational training as well as their demographics. The purpose of this section was to learn about the participants' educational backgrounds.
- Part II questions examined each participant's clinical and educational training as it relates to family-centered practice. This included the degree to which core principles of FCP were emphasized in academic and clinical training.

- Part III questions examined participant’s use of FCP using The Measure of Processes of Care for Service Providers (MPOC-SP; Woodside, Rosenbaum, King & King, 2001).

Development and Validation of the MPOC-SP

The MPOC-SP is a self-administered 27-item questionnaire developed to measure the family centered behaviors being used with children across healthcare settings. It is derived from the Measure of Processes of Care (MPOC; King, et al., 1996), a well-validated 56-item questionnaire developed for caregivers to survey the extent to which they experience behaviors associated with FCP. To complete the MPOC-SP service providers are asked to think back over the past year and indicate the degree to which they had engaged in family centered behaviors. The responses range from one (i.e., “never”) to 7 (i.e., “to a great extent”). Higher total scores indicate a greater use of family centered behaviors.

The original MPOC-SP began as 56-item questionnaire, with each item paralleling an item from the original MPOC. Following development, the questionnaire was sent for feedback to a group of developmental therapists working in Northern Ontario. Following feedback, the measure was shortened to 38-items after eliminating items addressing attitudes and beliefs. Other changes were also made, such as changing the Likert scale options from frequency words like “sometimes” to “to what extent.” Test-retest reliability of the 38-item version were for the four scales (i.e., Enabling and Partnership, Providing Information, Comprehensive and Coordinated Care, and Respectful and supportive care ranged from .79 to .97, indicating adequate to excellent reliability (Woodside et al, 2001).

To assess construct validity Woodside and colleagues (2001) investigated if a social desirability bias was intrinsic within the MPOC-SP. Social desirability bias is the inclination to overestimate the extent to which socially desirable behaviors are performed (Streiner & Norman, 1989). Nineteen service providers working in pediatric rehabilitation (*N* = 19) were asked to fill out the MPOC–SP twice. The first time they were asked to complete it based on their own professional behavior and 3 to 6 weeks later they were asked to rate what they would consider ideal with regard to FCP. The hypothesis was that participants would rate their actual professional behaviors lower than ratings of what is considered ideal. Paired samples t-tests were conducted and were significant at $p \leq .001$ for all four scales. These findings indicate that the MPOC–SP performs in the way it was expected.

Field testing of the 38-item version of the MPOC-SP was then conducted. Following factorial analysis, 27-items representing four factors were retained: Showing Interpersonal Sensitivity (SIS), Providing General Information (PGI), Communicating Specific Information (CSI), about the Treating People Respectfully (TPR). Cronbach's alpha was used to demonstrate that each of the 27 MPOC SP items belonged in their assigned scale. The coefficient alphas for SIS, PGI, CSI, and TPR were .86, .88, .76, and .84 respectively (Woodside et al., 2001). These scores indicate that internal consistency ranged between acceptable (i.e., CSI) and good (i.e., SIS, PGI, TPR). See Table 1 for the items associated with each scale.

Construct validity was further assessed through cross-discipline comparisons. The authors hypothesized that service providers whose role was support and guidance (e.g., social workers, case managers) would show significantly higher scores on the SIS and TPR items, while interventionists (e.g., SLPs, OTs) would score significantly higher on the CSI scale. Both of these hypotheses were confirmed, providing evidence that the MPOC-SP score patterns are reflective of differences in professional roles.

Table 1

Items and scaling of the Measure of Processes of Care for Service Providers (MPOC-SP)

Item no.	Item description*
	Showing Interpersonal Sensitivity
1	Suggest treatment/management activities that fit with each family’s needs and lifestyle?
2	Offer parents and children positive feedback or encouragement?
3	Take the time to establish rapport with parents and children?
4	Discuss expectations for each child with other service providers, to ensure consistency of thought and action?
5	Tell parents about options for services or treatments for their child?
8	Discuss/explore each family’s feelings about having a child with special needs?
9	Anticipate parents’ concerns by offering information even before they ask?
11	Let parents choose when to receive information and the type of information they wanted?
12	Help each family to secure a stable relationship with at least one service provider who works with the child and parents over a long period of time?
21	Help parents to feel competent in their roles as parents?
	Treating People Respectfully
6	Accept parents and their family in a non-judgmental way?
7	Trust parents as the ‘experts’ on their child?
10	Make sure parents had a chance to say what was important to them?
13	Answer parents’ questions completely?
17	Treat each parent as an individual rather than as a ‘typical’ parent of a child with a ‘problem’?
18	Treat parents as equals rather than just as the parent of a patient?
19	Make sure parents had opportunities to explain their treatment goals and needs?

Table 1 (continued)

Items and scaling of the Measure of Processes of Care for Service Providers (MPOC-SP)

Item no.	Item description*
20	Help parents feel like a partner in their child's care?
22	Treat children and their families as people rather than as 'cases'?
	Communicating Specific Information about the Child
14	Tell parents about the results from tests and/or assessments?
15	Provide parents with written information about their child's condition, progress, or treatment?
16	Tell parents details about their child's services, such as the types, reasons for, and durations of treatment/management?
	Providing General Information
23	Promote family-to-family 'connections' for social, informational or shared experiences?
24	Provide support to help families cope with the impact of their child's chronic condition?
25	Provide advice on how to get information or to contact other parents?
26	Provide opportunities for the entire family, including siblings, to obtain information?
27	Have general information available about different concerns?

*Each item begins, 'In the past year, to what extent did you…'

Adapted from Woodside, J. M., Rosenbaum, P. L., King, S. M., & King, G. A. (2001). Family centered service: Developing and validating a self-assessment tool for pediatric service providers. Children's Health Care,30(3), 237. https://doi.org/10.1207/S15326888CHC3003_5

Survey construction and distribution

While technological advances have allowed for the use of electronic surveys and provided further avenues by which to recruit potential participants, these same advances have also increased the likelihood that potential participants might ignore or overlook these electronic recruitment attempts (Dillman, Smyth, & Christian, 2014). To increase the likelihood of obtaining a response, various recommended cautions were observed.

Social exchange theory. The social exchange theory states that "... people are more likely to comply with a request from someone else if they believe and trust that the rewards for complying with that request will eventually exceed the costs of complying" (Dillman, et al., 2014, p. 24). According to this theory, investigators using electronic surveys to obtain data should adjust their instrument procedures to educate participants on the cause of the survey as well as reducing participants' concerns or barriers that would affect their participation. Implementation of these procedures into the survey construction and dissemination procedures might increase the amount of complete survey responses (Dillman et al., 2014). Due to the various ways in which the social exchange theory could be implemented, specificity measures must be taken. Specificity of precautionary measures that will be applied in accordance with the social exchange theory are described below.

Specific measures. As dissemination occurred through social media support groups related to SLPs who currently are or have worked with children, elements of the social exchange theory were utilized in a variety of ways. A short and clearly stated message of the purpose of the survey was included to increase trust and appreciation for the survey and its goal (Dillman et al., 2014). The principal investigator also introduced herself and provided the purpose of the study in posts on social media groups to increase the appreciation and need for participation in the survey. Also, the investigators provided Qualtrics' estimated time commitment for survey completion.

Additionally, another important aspect involved with survey construction and dissemination includes the reputability of the participation request. According to social exchange theory, participants need to trust the individuals/organizations conducting the research. Also, it is crucial for participants to trust that any associated risks do not have the potential to outweigh participation benefits (Dillman et al., 2014). Thus, investigators ensured that all respondents' participation in the study was anonymous and their specific answers are kept confidential. In no way will a participant's name be associated with the study or their particular answers. Using appropriate language that promotes acceptance, compassion, and professionalism aided in easing participant fears along with increasing their beliefs in the anonymity and confidentiality associated with participation in the survey.

Procedure

Before large-scale dissemination of the survey, the current instrument was piloted with two practicing SLPs who work with children. Provided feedback was used to improve the content, structure, and validity of the survey. Once the survey had been finalized and approval to initiate the survey was granted by the Auburn University Institutional Review Board, participants were to be obtained by three methods. First, the coordinator for ASHA's Special Interest Groups 16 (School-Based Issues) was contacted regarding the project. This special interest division was selected due to the likelihood that they will have members who provide services to a pediatric population. An introductory email, containing the weblink to the online survey, was sent to the coordinator and then distributed on the listserv. Following contact with the coordinator for this special interest group, Facebook was used for additional recruitment. The principal investigator posted a public message containing a brief description of the survey and its purpose on her Facebook page. Others then shared the post if interested. An invitation was also posted in 14 different Facebook groups for SLPs in which the primary investigator and/or faculty advisor were members. Finally, an introductory post with links to the survey were placed on five ASHA Community discussion boards of which the PI's faculty advisor was a member: Autism, Clinicians and Researchers Collaborating (CLARC), Rural and Remote Service Delivery, SLP Private Practice, and SLP Schools.

Once interested participants clicked on the embedded link within the posts to the SIGs, Facebook, or ASHA community groups, they were taken to the survey where the first question was the information letter. They indicated consent at that time by clicking "Yes, I would like to take the survey." The survey was administered using the online survey tool Qualtrics, which is a secure Internet-based software program used for online survey development. All data was collected anonymously and analyzed via Qualtrics and SPSS version 27. Participants were informed that all responses are confidential, and that no personal identifying information will be included in the analysis of the results.

Results

Data Analysis

Upon closing the survey, survey responses were exported to an excel spreadsheet and SPSS for analysis. In total, 154 respondents initiated the survey, met inclusionary criteria, and completed the survey. In cases where some participants chose not to respond to a question, the mean responses were calculated using the number of respondents who responded to that item, as opposed to the number who completed the survey. Internal consistency of items on each of the four scales on the MPOC-SP was examined by Cronbach's α coefficient. Internal consistency is considered adequate if $\alpha>0.70$ (Salteret al., 2005).

Background Information

The majority of participants who completed this survey were white females who were not of Hispanic, Latino, or Spanish background. Over half of the respondents reported that they resided and practiced in the southeast region of the United States. The largest number of participants reported working with the early intervention birth-3 age-group, followed by elementary school age, preschool age, and middle or high school age. Over one-third of the participants reported working in the schools, while smaller numbers reported working in private practice, home health, and hospitals. Text entries were used when the choice "Other" was selected. Respondents who selected "other" were given an opportunity to provide their work setting in a text box and indicated university clinics and specific EI settings such as at state agencies and clinics. Regarding years of experience, slightly under 30% of participants reported working between 0-5 years with smaller numbers reporting less than 20 years' experience, 6-10 years' experience, 11-15 years' experience, and 16-20 years' experience. Table 2 below presents Participant Demographics.

Table 2

Participant Demographics

Demographic Variable	(Percentage %)	Demographic Variable	(Percentage %)
Sex	**(*n* = 154)**	**Primary age of clients**	**(*n* = 154)**
Female	150 (97.4%)	Early Intervention (Birth-3)	68 (44.2%)
Male	4 (2.6%)	Preschool	29 (18.8%)
		Elementary School	46 (29.9%)
		Middle or High School	11 (7.1%)
Race/Ethnicity	**(*n* = 154)**		
White	141 (91.6%)	**Employment Setting***	**(*n* = 154)**
Black/African American	2 (1.3%)	School	55 (35.7%)
Multiple Races	2 (1.3%)	Hospital (Inpatient)	1 (0.6%)
Asian	2 (1.3%)	Hospital (Outpatient)	16 (10.4%)
Native Hawaiian or Pacific Islander	1 (0.6%)	Private Practice	38 (24.7%)
		Home Health	31 (20.1%)
Other	2 (1.3%)	Other	13 (8.4%)
Prefer not to answer	4 (2.6%)		
		Location	**(*n* = 154)**
		Southeast (AL, FL, GA, KY, LA, MD, NC, SC, TN, VA, WV)	5 (35.7%)
Hispanic, Latino, or Spanish	**(*n* = 151)**		
Hispanic, Latino, or Spanish	3 (1.9%)	Midwest (ID, IL, IN, IA, MI, MN, MO, ND, OH, SD, WI)	30 (19.5%)
Not Hispanic, Latino, or Spanish	143 (92.9%)	West (AK, AZ, CA, CO, NV, NM, OR, TX, UT, WA)	34 (22.1%)
Other	1 (0.6%)		
Prefer Not to Answer	4 (2.6%)	Northeast (CT, MA, NH, NJ, NY, PA, RI, VT)	35 (22.7%)
Total years of SLP employment	**(*n* = 154)**		
0-5 years	45 (29.2%)		
6-10 years	34 (22.1%)		
11-15 years	20 (13.0%)		
16-20 years	13 (8.4%)		
More than 20 years	42 (27.3%)		

*N = total number of respondents; % = percentage of respondents based on number of respondents per question; *Employment setting question: check all that apply, will not sum to 100%.*

Participants were also asked questions related to language(s) spoken along with their perceived dialect. Of the 149 participants who indicated what language they spoke, all reported speaking English. Fewer than 10% indicated they were bilingual (9%; *n*=15) or trilingual (2%; *n*=2). Other languages participants listed included Mandarin, French, German, Russian, Spanish, ASL, Hebrew, Polish, Welsh, and Myanmar. Of the 120 participants who indicated what dialect they spoke, 114 (95%) indicated they were speakers of Mainstream American English. Of the remaining 6 participants who do not speak Mainstream American English, 3% (*n*=4) reported speaking Southern American English, 1% (*n*=1) reported speaking a dialect from Eastern North Carolina, and 1% (*n*=1) reported speaking African American English exclusively. It should be noted that participants were able to select more than one dialect. Six participants (.5%) noted they are bidialectal speakers. These two dialects consisted of Mainstream American English and an additional dialect. Additional dialects included Southern American English, New Jersey, Appalachian English, and British English.

Familiarity with FCP

Prior to questions related to FCP, participants were provided the definition of FCP and were asked their familiarity with the term. They were then asked to consider the provided definition when answering the following questions. The largest number of participants (44.2%; *n*=68) were 'extremely familiar' with the term FCP which was followed by moderately familiar (23.4%; *n*=36), somewhat familiar (16.9%; *n*=26), slightly familiar (9.1%; *n*=14), and not familiar with the term at all (6.5%; *n*=10).

FCP Training

Participants were asked a variety of questions related to their education and training of FCP. First, participants were asked their level of agreement with the following statement: "I could have benefitted from additional coursework addressing family-centered practice." One hundred and forty-six participants answered this question. The largest number of participants strongly agreed with this statement (44.8%; *n*=69) which was followed by somewhat agree (31.2%; *n*=48), neither agree nor disagree (13.0%; *n*=20), somewhat disagree (4.5%; *n*=7), and strongly disagree (1.3%; *n*=2). Next, participants were asked their level of agreement with the following statement: "Incorporating additional clinical experience and training for implementing FCP principles with clients would have benefitted my overall practice and education." The majority of participants either strongly or somewhat agreed that they would have benefitted from additional clinical training and experience with FCP (84.4%; *n*=130). This was followed by neither agree nor disagree (12.3%; *n*=19), somewhat disagree (1.9%; *n*=3), and strongly disagree (1.3%; *n*=2).

FCP in Graduate Courses

Participants were then provided with eight core principles of FCP and queried as to the level of emphasis these principles received in their graduate coursework. The core principles included were: 1) Showing respect and dignity towards the family; 2) Collaboration with the family; 3) Engaging in active listening when the parent or caregiver is speaking, 4) Openly communicating with the family; 5) Sharing all necessary information with the family related with the family related to their child; 6) Encouraging participating on the part of the family members; 7) Equal trust from both the therapist and family; and 8) Showing empathy towards the family. The majority of respondents indicated that each core principle was moderately or very emphasized. Table 3 presents the degree to which these core principles were emphasized during graduate study.

Table 3

FCP Emphasis in Graduate Coursework

N=154	*n (%)*				
	Degree of Emphasis				
Core Principles	*Very*	*Moderately*	*Somewhat*	*Slightly*	*Not at all*
Showing respect and dignity towards the family	69 (44.8%)	31 (20.1%)	27 (17.5%)	12 (7.8%)	15 (9.7%)
Collaboration with the family (*N*=152)*	59 (38.8%)	37 (24.3%)	27 (17.8%)	24 (15.8%)	5 (3.3%)
Engaging in active listening when the parent or caregiver is speaking	70 (45.5%)	40 (26.0%)	29 (18.8%)	9 (5.8%)	6 (3.9%)
Openly communicating with the family	71 (46.1%)	40 (26.0%)	31 (20.1%)	9 (5.8%)	3 (1.9%)
Sharing all necessary information with the family related to their child (*N*=152)*	75 (48.3%)	38 (25.0%)	29 (19.1%)	8 (5.3%)	2 (1.3%)
Encouraging participation on the part of the family member(s)	55 (35.7%)	37 (24.0%)	29 (18.8%)	23 (14.9%)	10 (6.5%)
Equal trust from both the therapist and family	61 (39.6%)	39 (25.3%)	24 (15.6%)	16 (10.4%)	14 (9.1%)
Showing empathy towards the family (*N*=153)*	82 (53.6%)	43 (28.1%)	16 (10.5%)	10 (6.5%)	2 (1.3%)

Note. *N for individual items in which not all 154 participants responded.

Areas of Weakness in Coverage of FCP in Graduate Coursework. The majority of respondents indicated that each core principle was moderately or very emphasized; however, SLPs feel some principles of FCP were more emphasized in their graduate coursework compared to others. Specifically, when looking at what was "very emphasized" the majority and largest number of SLPs indicated 'showing empathy towards the family.' For the purposes of this investigation, the authors determined that the items which at least 33% of the SLPs rated as 1-3 ('not at all' to 'somewhat') indicated a weakness in academic emphasis. Weaknesses were identified in four of the eight core principles of FCP: Showing respect and dignity toward family, Collaboration with family, Encouraging participation, and Equal trust. Table 4 presents the *n*'s and percentages of principles which SLPs responded as being emphasized somewhat or less in graduate coursework

Table 4

FCP Principles that 33% or more of SLPs responded as being emphasized somewhat or less in graduate coursework

FCP Principle	*n* (%)
Showing respect and dignity toward family	54 (35.0%)
Collaboration with family	56 (36.9%)
Encouraging participation	62 (40.2%)
Equal trust	54 (35.1%)

FCP Modeling by Clinical Supervisors

Participants were asked the degree to which core principles of FCP were modeled by their clinical supervisors. The majority of respondents indicated that all core principles were always or often emphasized. Table 5 presents the degree to which the core principles of FCP were modeled in clinical practicum.

Table 5

FCP Modeling by Clinical Supervisors

N=154			*n (%)*		
Core Principles	*Always*	*Often*	*Sometimes*	*Rarely*	*Never*
Showing respect and dignity towards the family	77 (50.0%)	50 (32.5%)	21 (13.6%)	4 (2.6%)	2 (1.3%)
Collaboration with the family	42 (27.3%)	54 (35.1%)	42 (27.3%)	15 (9.7%)	1 (0.6%)
Engaging in active listening when the parent or caregiver is speaking	63 (40.9%)	50 (32.5%)	36 (23.4%)	4 (2.6%)	1 (0.6%)
Openly communicating with the family	57 (37.0%)	58 (37.7%)	34 (22.1%)	4 (2.6%)	1 (0.6%)
Sharing all necessary information with the family related to their child	65 (42.2%)	57 (37.0%)	25 (16.2%)	6 (3.9%)	1 (0.6%)
Encouraging participation on the part of the family member(s)	41 (26.6%)	47 (30.5%)	42 (27.3%)	21 (13.6%)	3 (1.9%)
Equal trust from both the therapist and family	57 (37.0%)	46 (29.9%)	39 (25.3%)	11 (7.1%)	1 (0.6%)
Showing empathy towards the family (*N*=153)	71 (46.4%)	54 (35.3%)	24 (15.7%)	4 (2.6%)	0 (0%)

Areas of Weakness in FCP Emphasis by Clinical Supervisors. The FCP principles in which 33% or more of SLP responded as being ‘somewhat’, ‘rarely’, or ‘never’ modeled by their clinical supervisors were considered areas of weakness. Based on this criterion, three of eight FCP principles were considered weaknesses with regard to their limited emphasis by clinical supervisors: Collaboration with family, Encouraging participation, and Equal Trust. Table 6 presents the *n*'s and percentages of principles which SLPs responded as being emphasized somewhat or less by clinical supervisors.

Table 6

FCP Principles that 33% or more of SLPs responded as being emphasized somewhat or less by clinical supervisors

FCP Principle	*n* (%)
Collaboration with family	58 (37.6%)
Encouraging Participation	66 (42.8%)
Equal trust	51 (33%)

Self-Assessment of FCP

Descriptive statistics and internal consistency coefficients for each of the four scales MPOC-SP are presented in Table 6. These four scales include: showing interpersonal sensitivity (SIS), providing general information (PGI), communicating specific information (CSI), and treating people respectfully (TPR). These scales were developed from specific questions in the MPOC-SP pertaining to FCP. From this information, means and standard deviations were developed to analyze where SLPs showed the highest and lowest levels of FCP as well as where there was the most variation within each theme. All questions were completed by the 154 participants indicating no missing data present. The coefficient alphas for SIS, PGI, CSI, and TPR were .89, .87, .75, and 89. These scores are similar to Woodside's original validation of the instrument (2001) and indicate that internal consistency ranged between acceptable (i.e., CSI) and good (i.e., SIS, PGI, TPR). See Table 1 for the items associated with each scale. The highest ratings were in the domains of Communicating Specific Information (*M* = 5.82; *SD* = .91) and

Treating People Respectfully (*M* = 6.26; *SD* = .80). The domain Providing General Information was scored the lowest (*M*= 4.73; *SD* = 1.38).

Table 7

Analysis of Scales for MPOC-SP

Scales	*M*	*SD*	Cronbach's α
Showing Interpersonal Sensitivity (SIS)	5.82	0.91	.89
Providing General Information (PGI)	4.73	1.38	.87
Communicating Specific Information (CSI)	6.26	0.80	.75
Treating People Respectfully (TPR)	6.10	0.76	.89

Weakness in FCP

To identify weaknesses in service delivery the authors of the instruments recommend locating items for which 33% or more of the respondents scored a behavior occurring between 1 and 4 ('not at all' to 'to a moderate extent') on the MPOC's 7-point scale (King et al. 1995). One item on the PGI scale met the criteria indicating a need for improvement: "Have general information available about different concerns (e.g., financial costs or assistance, genetic counseling, respite care, dating and sexuality)." This item was rated between 1 and 4 by 49.3% of SLPs. No other items were considered areas of weakness.

Discussion

The current study investigated SLP's views of family-centered practice (FCP). Specifically, the authors investigated the degree to which FCP principles are being taught through both graduate SLPs coursework and in clinical practice. Additionally, SLPs completed the MPOC-SP, a self-assessment tool designed to measure the extent to which the services they provide are family-centered. It was hypothesized that SLPs would agree that they could have benefitted from additional coursework on FCP (Mandak & Light, 2018; Michalopoulos et al., 2012) and they would report a need for both greater emphasis of the principles of FCP both academically and clinically (Vilaseca et al., 2019; Giallourakis et al., 2005). With regard to service provision, it was hypothesized that SLPs would report that they implemented FCP, with an area of weakness in the scale Providing General Information (Dyke et al. 2006; Jeglinsky et al., 2011; Raghavendra et al. 2007). SLPs indicated an overall satisfaction with the coverage of FCP; however, weaknesses were noted both academically and clinically. Results of the MPOC-SP revealed that SLPs assessed themselves as providing satisfactory levels of FCP, with a weakness noted in one question in the PGI scale.

FCP Training

The first hypothesis is evidence supported. The majority of SLP participants indicated that they could have benefitted from additional coursework and clinical experiences addressing FCP. Results indicated that about 75% of participants either strongly agreed or somewhat agreed to the statement regarding whether receiving additional coursework on FCP would have been beneficial. Additionally, the results indicated that about 84% of participants either strongly agreed or somewhat agreed to the statement regarding whether additional clinical experience and training for implementing FCP principles with clients would have been beneficial. These results are in keeping with the current literature. Mandak and Light (2017) found that while some SLPs reported coursework or clinical experience working with families, more than half of the participants indicated that they received no training in FCP. Similarly, in Mandak and Light's 2018 study, most school-based SLPs indicated that they would have liked more preparation and coursework in working with families. Vilaseca et al. (2019) similarly recommended additional training and noted a gap between the recommended amount of FCP and what professionals are actually doing. Additionally, Michalopoulos et al. (2012) conducted a study that determined whether one additional training course in FCP would benefit service providers. The results showed that one additional training course was insufficient due to the lack of individualization so, therefore, follow-up training is still needed and necessary for service providers to feel skilled in the FCP approach.

FCP in Graduate Coursework

This hypothesis is partially evidence-supported. The majority of SLP participants felt FCP principles were 'very' or 'moderately emphasized' within their graduate coursework. This finding is similar to Gillourakis and colleagues' (2005) survey of graduate students in early childhood education (ECE). The ECE graduate students reported that their preservice programs incorporated moderate levels of family involvement. However, Mandak and Light's (2018) study found that over 50% of their 211 SLP participants stated they received no training in FCP during their graduate training program.

The current study also revealed areas of weakness with regard to certain principles of FCP which were less emphasized within graduate coursework. These principles of weakness included 'Showing respect and dignity toward family', 'Collaboration with family', 'Encouraging participation', and 'Equal trust'. This evidence is also in keeping with the literature. SLPs in Mandak and Light's study (2018) also reported areas in which they would have benefitted from additional training, including: FCP delivery models, family systems theory, counseling, and active listening. With more training on these topics, it is likely that the principles noted as weaknesses in the current investigation would also be addressed. For example, when addressing counseling, the principles of 'showing respect and dignity toward family, 'collaboration with family' and 'equal trust' could and should all be a part of this discussion.

One reason these specific principles may not be targeted within graduate training is because these skills may be taught in a more hands-on fashion and less in a classroom-based setting. Clinical experiences target concepts of action, such as treating a client and their family respectfully as well as encouraging participation and collaboration. These FCP concepts are areas that may be less effectively taught in a classroom. Therefore, while more work should be done to ensure students are understanding these concepts in the classroom, clinical experiences in these areas create a more well-rounded understanding.

FCP Modeling by Clinical Supervisors

This hypothesis is partially evidence-supported. According to the results, the majority of SLP participants felt FCP principles were 'always' or 'often' modeled by their clinical supervisors. However, some areas of weakness were noted. Specific principles of FCP were less demonstrated by the participants' clinical supervisors. These principles included 'Collaboration with family', 'Encouraging participation', and 'Equal Trust.' However, our results may have indicated these particular principles as being areas of weakness because of setting limitations or limited time graduate students were able to experience their supervisors' relationship and interactions with families. Mandak and Light (2018) noted that supervisor's willingness to allow students to interact with families varied and that it made a difference in the contact students had with families. Some SLPs reported that they desired more interaction with families with support from the supervisors. It is possible that SLPs who interacted less with families had limited opportunities to observe these principles being modeled in a supportive format. In addition, it should be noted that some settings may not allow for sufficient family involvement due to busy schedules or lack of in-person contact. This would also lead to less modeling of parent collaboration. Interestingly, the weaknesses in academic training and clinical training were quite similar with one exception. ‘Showing respect and dignity toward the family’ was not a weakness in clinical practicum; however, it was in academic coursework. It’s possible that students were able to observe a general sense of respect from their supervisors while principles, such as ‘establishing trust” would not be as easily observed and interpreted by the SLP.

Self-Assessment of FCP

Based on the results of the MPOC-SP, SLPs indicated they were implementing FCP principles. However, one area of weakness was noted. The four main scales of FCP included showing interpersonal sensitivity (SIS), providing general information (PGI), communicating specific information (CSI), and treating people respectfully (TPR). The results showed SLPs were the highest in communicating specific information (CSI). This may include explaining why or how an assessment or treatment was conducted as well as providing the child’s outcome and progress. Following CSI was treating people respectfully (TPR). This may involve SLPs acting nonjudgmental to the child’s family and beliefs as well as making the families feel as a contributing partner in the child’s therapy. After TPR, SLPs showed FCP strength in interpersonal sensitivity (SIS). This may include building rapport with the families and providing positive feedback and encouragement. Literature supports these findings, such as Kang et al. (2017) reporting a positive finding of many healthcare professionals (including SLPs) use of

FCP specifically in the early intervention setting. And finally, SLPs reported the lowest implementation of FCP on the scale providing general information (PGI) scale. This may include providing coping support for families by giving resources and/or information to address feelings or concerns related to their child's condition. Specifically, the following item was noted as a weakness: "Have general information available about different concerns (e.g., financial costs or assistance, genetic counseling, respite care, dating and sexuality)." From this, it appears that SLPs are not assisting families in locating support outside of the professional domain of speech-language pathology.

The lower scores in the PGI scale have similarly been found in other disciplines (Dyke et al., 2006; Raghavendra, 2007). Dyke et al. (2006), who researched MPOC-SP scores for a variety of pediatric service providers (the majority being physical therapists, SLPs, and occupational therapists), found that PGI scores increased as age of clients decreased, meaning healthcare providers are supplying more general information to families with younger children than older. This information gap based on the client's age could be due to preconceived notions that families with older children have already received all the information they need from doctors or other healthcare professionals. However, this may not be the case for the families of older children. In many instances, families are confused or have questions following explanations from their doctors which contain large amounts of medical jargon. Due to a number of reasons, families' questions remain unanswered following doctors' visits. Therefore, SLPs must be equipped to provide general information to families with children of all ages to ensure families are fully educated and knowledgeable on their children and any medical concerns. These results and supporting evidence show that while SLPs are sufficiently communicating specific information about their clients, they must work to improve their communication of general information regarding disorders and support systems available for their clients.

Limitations and Future Directions

Although the results of this research study demonstrated meaningful results, the limitations of this study should be considered. The majority of participants reported being white females currently practicing in the southeastern United States. This population majority could result in bias towards education, training, and life experiences of those who meet these criteria leading to results that do not generalize to all practicing SLPs. Additionally, this survey was self-initiated. Therefore, the participants who chose this survey most likely have an interest in FCP and those who have limited interest or knowledge in FCP were not accurately represented. If all participant populations were appropriately represented in this survey, the results may have depicted deflated levels of knowledge and training in FCP.

Additionally, this survey was un-monitored which allows participants the opportunity to find relevant FCP information online or in textbooks before answering questions. This could present a barrier in finding useful and accurate information from the participants as well as skewed results due to the utilization of outside sources. Additionally, the setting participants work may impact their use and knowledge of FCP. For example, providing FCP to families in an early-intervention setting may have created less challenges with family interaction than SLPs who work in the school setting. Therefore, the variety of SLP settings may have led to more variation in the data.

Conclusion and Clinical Implications

Findings from the current investigation highlight both strengths and weaknesses in the training and implementation of FCP. While SLPs felt that most of the queried FCP principles were appropriately emphasized in academic coursework and clinical practicum, the majority felt that they could have benefitted from additional coursework. It is possible that participants were referring to a desire for a course specific to FCP; however, FCP does not occur in a vacuum. While a seminar or course on FCP would be beneficial, it is of the utmost importance that the principles of FCP be emphasized across the curriculum. For example, FCP is often associated with EI, however it is important across the lifespan. Training programs are therefore encouraged to look across the curriculum to ensure that the principles of FCP are being reinforced throughout the entire course sequence.

Respondents indicated that three areas of weakness were noted across both academic and clinical instruction: collaboration with family, encouraging participation, and equal trust. As these three principles were noted as being less emphasized, graduate courses and clinical supervisors should ensure that students are being encouraged to involve the family as much as possible in their practice. Specifically, this can be accomplished by giving scenario situations within graduate courses to allow students to apply their knowledge of FCP in case studies. For example, the student may be asked ways they could involve the parent in specific situations as well as ways they could collaborate with the parents to create the best outcomes for the child. Additionally, clinical supervisors could give the student some responsibility in assisting with family support. This may include explaining therapeutic techniques parents could try with their child or providing homework to guide parents with at-home therapy. Involving the family is crucial for creating the greatest gains in a child’s therapy and also allowing for the greatest generalization of therapeutic strategies (Douglas et al., 2020; Reva et al., 1998; Russel et al., 2018).

With regard to the MPOC-SP, it is of interest that SLPs recorded the highest level of agreement with regard to questions on the CSI scale and the lowest on the PGI scale. These results reveal that while SLPs are effectively communicating specific information relating to their child's speech therapy (e.g., test scores, IEP goals, progress notes), some SLPs are not providing needed ancillary information to their clients' families (e.g., financial assistance, medical referrals, respite care). To do so, SLPs must be aware of the local, regional, and state resources available to caregivers. These include, but are not limited to physicians, respite services, support groups, and social services. Providing general information may be crucial for many families to successfully navigate their child's disorder which could lead to the best outcomes for the child.

References

Ahn, H., Keyser, D., & Hayward-Everson, R. A. (2016). A multi-level analysis of individual and agency effects on implementation of family-centered practice in child welfare. *Children and Youth Services Review*, *69*, 11–18. https://doi-org.spot.lib.auburn.edu/10.1016/j.childyouth.2016.07.014

Al, G. E., Long, T., & Shehadeh, J. (2019). Health satisfaction and family impact of parents of children with cancer: a descriptive cross-sectional study. *Scandinavian Journal of Caring Sciences,* 33(4), 815–823. https://doi-org.spot.lib.auburn.edu/10.1111/scs.12677

American Academy of Pediatrics. (2012). Patient- and family-centered care and the pediatrician's role. *Pediatrics*, 129, 394–404. http://pediatrics.aappublications.org/content/129/2/394

American Speech-Language-Hearing Association. (n.d.). Early Intervention. *American Speech-Language-Hearing Association.* https://www.asha.org/public/speech/early-intervention/.

Arango, P. (2011). Family-centered care. *Academic Pediatrics, 11(2),* 97–99. https://doi. Org/10.1016/j.acap.2010.12.004

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review*, 84(2), 191–215. https://doi.org/10.1037/0033-295X.84.2.191

Barnes, M. D., Hanson, C. L., Novilla, L. B., Magnusson, B. M., Crandall, A. C., & Bradford, G. (2020). Family-centered health promotion: Perspectives for engaging families and achieving better health outcomes. *Inquiry (00469580)*, *57*, 1–6. https://doi-org.spot.lib.auburn.edu/10.1177/0046958020923537

Bingham, A., & Abernathy, T. V. (2007). Promoting family-centered teaching: Can one course make a difference? *Issues in Teacher Education*, *16*(1), 37–60.

Bowlby, J. (1944). Forty-four juvenile thieves: Their characters and home-life. *International Journal of Psycho-Analysis, 25,* 19-53.

Bowlby, J. (1973). Attachment and loss: Volume II: Separation, anxiety and anger. *In Attachment and Loss: Volume II: Separation, Anxiety and Anger* (pp. 1-429). London: The Hogarth press and the institute of psycho-analysis.

Boztepe, H., & Kerimo glu Gizem. (2017). Nurses' perceptions of barriers to implementing family-centered care in a pediatric setting: A qualitative study. *Journal for Specialists in Pediatric Nursing, 22(2)*. https://doi-org.spot.lib.auburn.edu/10.111/jspn.12175.

Brown, W., Pearl, L. F., & Carrasco, N. (1991). Evolving Models of Family-Centered Services in Neonatal Intensive Care. *Children's Health Care*, *20(1)*, 50. https://doi.org/10.1207/s15326888chc2001_8

Bruce B., Letourneau N., Ritchie J., Larocque S., Dennis C. & Elliott, M.R. (2002) A multisite study of health professionals' perceptions and practices of family-centered care. *Journal of Family Nursing*, 8(4), 408–429. https://doi.org/10.1177/107484002237515

Chavkin, N.F.(1991). Building a multi-ethnic family-school-community partnership: Coalition for PRIDE. *School Community Journal*, *1*, 33-36.

Child Welfare Information Gateway (2016). *Family Engagement: Partnering with Families to Improve Child Welfare Outcomes.* Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

Crais, E., Poston Roy, V., & Free, K. (2006). Parents' and professionals' perceptions of the implementation of family-centered practices in child assessments. *American Journal of Speech-Language Pathology, 15,* 365- 377. https://doi.org/10.1044/1058-0360(2006/034)

Dempsey, I., & Dunst, C. J. (2004). Helpgiving styles and parent empowerment in families with a young child with a disability. *Journal of Intellectual and Developmental Disability, 29(1),* 40-51. https://doi.org/10.1080/13668250410001662874

Dishion, T. J., & Kavanagh, K. (2003). *Intervening in Adolescent Problem Behavior: A Family-Centered Approach*. Guilford Press.

Douglas, S. N., Meadan, H., & Kammes, R. (2020). Early interventionists' caregiver coaching: A mixed methods approach exploring experiences and practices. *Topics in Early Childhood Special Education*, *40*(2), 84–96. https://doi.org/10.1177/0271121419829899

Dunst, C. J. (2000). Revisiting "Rethinking Early Intervention." *Topics in Early Childhood Special Education*, *20*(2), 95. https://doi.org/10.1177/027112140002000205

Dunst, C. J. (2002). Family-centered practices: Birth through high school. *Journal of Special Education*, *3*, 139-147. https://doi.org/10.1177%2F00224669020360030401

Dunn, W. (2000). *Best practice occupational therapy: In community service with children and families.* Thorofare, NJ: Slack Incorporated

Dunst, C. J., Boyd, K., Trivette, C. M., & Hamby, D. W. (2022). Family-oriented program models and professional helpgiving practices. *Family Relations, 51*(3), 221–229. https://doi.org/10.1111/j.1741-3729.2002.00221.x

Dunst, C. J., Johanson, C., Trivette, C. M., & Hamby, D. W. (1991). Family-oriented early intervention policies and practices: Family-centered or not? *Exceptional Children, 58*(2), 115–126. https://doi.org/10.1177/001440299105800203

Dyke, P., Buttigieg, P., Blackmore, A. M., & Ghose, A. (2006). Use of the Measure of Process of Care for families (MPOC-56) and service providers (MPOC-SP) to evaluate family-centered services in a pediatric disability setting. *Child: Care, Health & Development*, *32(2),* 167–176. https://doi-org.spot.lib.auburn.edu/10.1111/j.1365-2214.2006.00604.x

Eichner, J. M., & Johnson, B. H. (2012). Patient- and Family-Centered Care and the Pediatrician's Role. *Pediatrics*, *129(2),* 394–404. https://doi-org.spot.lib.auburn.edu/10.1542/peds.2011-3084

Epstein, J.L., Sanders, M. G., & Clark, L. A. (1999). *Preparing educators for school-family-community partnerships: Results of a national survey of colleges and universities.* Center for Research on the Education of Students Placed at Risk, Johns Hopkins University, Baltimore, MD, and Howard University, Washington, DC.

Etemadifar, S., Heidari, M., Jivad, N., & Masoudi, R. (2018). Effects of family-centered empowerment intervention on stress, anxiety, and depression among family caregivers of patients with epilepsy. *Epilepsy & Behavior, 88,* 106-112. https://doi.org/10.1016/j.yebeh.2018.08.030

Fingerhut, P. E., Piro, J., Sutton, A., Campbell, R., Lewis, C., Lawji, D., & Martinez, N. (2013). Family-centered principles implemented in home-based, clinic-based, and school-based pediatric settings. *American Journal of Occupational Therapy*, *67*(2), 228–235. https://doi.org/10.5014/ajot.2013.006957

Fordham, L., Gibson, F., & Bowes, J. (2012). Information and professional support: Key factors in the provision of family-centered early childhood intervention services. *Child: Care, Health and Development, 38(5)*, 647-653. https://

Foster, M., Whitehead, L., & Maybee, P. (2010). Parents' and health professionals' perceptions of family centred care for children in hospital, in developed and developing countries: A review of the literature. *International Journal of Nursing Studies*, *47(9),* 1184–1193. https://doi-org.spot.lib.auburn.edu/10.1016/j.ijnurstu.2010.05.005

Giallourakis, A., Kent, K. P.-F., Cook, B., & Harvard Family Research Project, C. M. (2005). Understanding family involvement in the preparation of graduate students: measuring family-centered beliefs, skills, systems, and practices. *Harvard Family Research Project*.

Jolley, J. (2004). *A social history of pediatric nursing: 1920–1970.* Unpublished PhD thesis, Hull, The University of Hull.

Jolley, J. (2007). Separation and psychological trauma: a paradox examined. *Pediatric Nursing*, *19(3),* 22.

Jolley, J., & Shields, L. (2009). The evolution of family-centered care. *Journal of Pediatric Nursing*, 24(2), 164-170.

Kang, L. J., Palisano, R. J., Simeonsson, R. J., & Hwang, A. -W. (2017). Measuring family-centred practices of professionals in early intervention services in Taiwan. *Child: Care, Health & Development*, *43(5),* 709–717. https://doi-org.spot.lib.auburn.edu/10.1111/cch.12463

Longley, J. M. (2015). How do administrators of New York City early intervention programs conceptualize and implement family-centered care? [ProQuest Information & Learning]. In *Dissertation Abstracts International Section A: Humanities and Social Sciences (Vol. 76, Issue 6–A(E)).*

Lonner, T. (1994). *Exploratory Study of Barriers in Birth to Three Services: Children with Disabilities and Special Health Care Needs in Washington State Public Programs.* Olympia, WA: Technical Report from the Office of Research and Data Analysis.

Mahoney, G., & Bella, J. M. (1998). An examination of the effects of family-centered early intervention on child and family outcomes. *Topics in Early Childhood Special Education*, *18*(2), 83–94. https://doi-rg.spot.lib.auburn.edu/10.1177/027112149801800204

Mandak, K., & Light, J. (2017). Family-centered services for children with ASD and limited speech: The experiences of parents and speech-language pathologists. *Journal of Autism and Developmental Disorders, 48,* 1311–1324. https://doi.org/10.1007/s10803-017-3241-y

Mandak, K., & Light, J. (2018). Family-centered services for children with complex communication needs: The practices and beliefs of school-based speech-language pathologists. *Augmentative and Alternative Communication*, *34*(2), 130–142. https://doi-org.spot.lib.auburn.edu/10.1080/07434618.2018.1438513

Mandak, K., Light, J., & McNaughton, D. (2020). The effects of an online training on preservice speech-language pathologists' use of family-centered skills. *American Journal of Speech-Language Pathology*, *29*(3), 1489–1504. https://doi-org.spot.lib.auburn.edu/10.1044/2020_AJSLP-19-00057

Mas, J. M., Dunst, C. J., Balcells-Balcells, A., Garcia-Ventura, S., Giné, C., & Cañadas, M. (2019). Family-centered practices and the parental well-being of young children with disabilities and developmental delay. *Research in Developmental Disabilities*, *94,* 103495. https://doi.org/10.1016/j.ridd.2019.103495

McBride, S. L., & And Others. (1995). Parents as Co-instructors in Preservice Training: A Pathway to Family-Centered Practice. *Journal of Early Intervention*, *19(4),* 343–355. https://doi.org/10.1177/105381519501900408

McWilliam, R. A., Maxwell, K. L., & Sloper, K. M. (1999). Beyond "involvement": Are 190 elementary schools ready to be family-centered? *School Psychology Review, 28(3),* 378-394. https://doi.org/10.1080/02796015.1999.12085972

McWilliam, R. A., Snyder, P., Harbin, G. L., Porter, P., & Munn, D. (2000). Professionals' and families' perceptions of family-centered practices in infant-toddler services. *Early Education & Development, 11,* 519–538. https://doi.org/10.1207/s15566935eed1104_9

Michalopoulou, G., Briller, S., Katzer, K. C., Muklewicz, K. C., Wasiluk, J., Crider, B., Myers-Schim, S., & Secord, E. (2018). Treatment collaboration when the stakes are high: Ethnographically studying family-centered care in an outpatient pediatric specialty clinic. *Journal of Patient Experience*, *5*(2), 72–82. https://doi.org/10.1177/2374373517723322

Michalopoulos, L., Ahn, H., Shaw, T. V., & O'Connor, J. (2012). Child welfare worker perception of the implementation of family-centered practice. *Research on Social Work Practice*, *22*(6), 656–664. https://doi.org/10.1177/1049731512453344

Moeller, M. P., Carr, G., Seaver, L., Stredler-Brown, A., & Holzinger, D. (2013). Best Practices in Family-Centered Early Intervention for Children Who Are Deaf or Hard of Hearing: An International Consensus Statement. *Journal of Deaf Studies & Deaf Education*, *18(4),* 429–445. https://doi.org/10.1093/deafed/ent034

Motyer, G., Dooley, B., Kiely, P., & Fitzgerald, A. (2021). Parents' information needs, treatment concerns, and psychological well-being when their child is diagnosed with adolescent idiopathic scoliosis: A systematic review. *Patient Education and Counseling*, *104(6),* 1347–1355. https://doi-org.spot.lib.auburn.edu/10.1016/j.pec.2020.11.023

Murrell, D. V., Crawford, C. A., Jackson, C. T., Lotze, T. E., & Wiemann, C. M. (2018). Identifying opportunities to provide family-centered care for families with children with type 1 spinal muscular atrophy. *Journal of Pediatric Nursing*, *43*, 111–119. https://doi.org/10.1016/j.pedn.2018.09.007

Olson, N. W. (2019). Why should medical care be family-centered? Understanding ethical responsibilities for patients' family members. *Kennedy Institute of Ethics Journal*, *29*(2), 159–185. doi:10.1353/ken.2019.0019.

Pappas, N. W., McLeod, S., McAllister, L., & McKinnon, D. H. (2009). Parental involvement in speech intervention: A national survey. *Clinical Linguistics & Phonetics, 22*, 335–344. https://doi.org/10.1080/02699200801919737

Raghavendra, P., Murchland, S., Bentley, M., Wake-Dyster, W. & Lyons, T. (2007) Parents' and service providers' perceptions of family-centered practice in a community based, pediatric disability service in Australia. *Child: Care, Health and Development, 33,* 586–592. https://doi.org/10.1111/j.1365-2214.2007.00763.x

Reva I., A., & Christopher G., P. (1998). Rethinking family-centered practice. *American Journal of Orthopsychiatry*, *68*(1), 4–15. https://doi-org.spot.lib.auburn.edu/10.1037/h0080265

Rosenbaum, P., King, S., Law, M., King, G., & Evans, J. (1998). Family-centered service. *Physical & Occupational Therapy in Pediatrics*, 18(1), 1-20. https://

Rouse, L. (2012). Family-centered practice: Empowerment, self-efficacy, and challenges for practitioners in early childhood education and care. *Contemporary Issues in Early Childhood*, *13(1),* 17-26. https://doi.org/10.2304/ciec.2012.13.1.17

Russel, L. T., Beckmeyer, J. J., & Su-Russell, C. (2018). Family-centered care and positive developmental outcomes for youth with special health care needs: Variations across family structures. *Journal of Family Nursing*, 24, 29–59. https://doi.org/10.1177/1074840717745520.

Saenz, T. I., & Langdon, H. W. (2019). Speech-language pathologists' collaboration with interpreters: Results of a current survey in California. *Translation & Interpreting*, 11(1), 43–62. https://doi-org.spot.lib.auburn.edu/10.12807/ti.111201.2019.a03

Salvador, Á., Crespo, C., & Barros, L. (2019). The benefits of family-centered care for parental self-efficacy and psychological well-being in parents of children with cancer. *Journal of Child and Family Studies*, *28(7),* 1926-1936. https://doi.org/10.1007/s10826-019-01418-4

Snyder, P., & McWilliam, P. (1999). Evaluating the efficacy of case method instruction: Findings from preservice training in family-centered care. *Journal of Early Intervention*, *22(2),* 114–125. https://doi.org/10.1177/105381519902200204

Stewart, V., Slattery, M., & McKee, J. (2020). Deaf and Hard of Hearing Early Intervention: Perceptions of Family-Centered Practice. *Journal of Early Intervention*, *43(3)*, 221-234. https://doi-org.spot.lib.auburn.edu/10.1177/1053815120962547

Sugden, E., Baker, E., Williams, A. L., Munro, N., & Trivette, C. M. (2020). Evaluation of Parent- and Speech-Language Pathologist-Delivered Multiple Oppositions Intervention for Children With Phonological Impairment: A Multiple-Baseline Design Study. *American Journal of Speech-Language Pathology*, *29(1),* 111–126. https://doi-org.spot.lib.auburn.edu/10.1044/2019_AJSLP-18-0248

Tallon, M. M., Kendall, G. E., & Snider, P. D. (2015). Rethinking family-centred care for the child and family in hospital. *Journal of Clinical Nursing*, *24(9–10),* 1426–1435. https://doi-org.spot.lib.auburn.edu/10.1111/jocn.12799

Trivette, C. M., Dunst, C. J., Boyd, K., & Hamby, D. W. (1995). Family-oriented program models, helpgiving practices, and parental control appraisals. *Exceptional Children*, 62(3), 237-248. https://doi.org/10.1177/001440299606200305

U.S. Department of Education. (1997). *New skills for new schools: Preparing teachers in family involvement.* Washington, DC: U.S. Department of Education.

Vernooij-Dassen, M., Joling, K., van Hout, H., & Mittelman, M. S. (2010). The process of family-centered counseling for caregivers of persons with dementia: barriers, facilitators and benefits. *International Psychogeriatrics*, *22(5),* 769-777.

Vilaseca, R. M., Galvan-Bovaira, M. J., Gonzalez-del-Yerro, A., Baques, N., Oliveira, C., Simo-Pinatella, D., & Gine, C. (2019). Training needs of professionals and the family-centered approach in Spain. *Journal of Early Intervention*, *41(2),* 87–104. https://doi-org.spot.lib.auburn.edu/10.1177/1053815118810236

Wade, C. M., Mildon, R. L., & Matthews, J. M. (2007). Service delivery to parents with an intellectual disability: Family-centred or professionally centred? J*ournal of Applied Research in Intellectual Disabilities*, *20(2),* 87–98. https://doi-org.spot.lib.auburn.edu/10.1111/j.1468-3148.2005.00297.x

Wong, O. L. (2014). Contextual barriers to the successful implementation of family-centred practice in mental health care: A Hong Kong study. *Archives of Psychiatric Nursing*, *28(3),* 212-219. https://doi.org/10.1016/j.apnu.2014.02.001

Woods, J., & McCormick, K. (2002). Toward an Integration of Child- and Family-Centred Practices in the Assessment of Preschool children. *Young Exceptional Children*, *5*(3), 2–11.

Woods, J. J., Wilcox, M. J., Friedman, M., & Murch, T. (2011). Collaborative consultation in natural environments: Strategies to enhance family-centered supports and services. *Language, Speech & Hearing Services in Schools*, *42*(3), 379–392. https://doi.org/10.1044/0161-1461(2011/10-0016)

Woodside, J. M., Rosenbaum, P. L., King, S. M., & King, G. A. (2001). Family-centered service: Developing and validating a self-assessment tool for pediatric service providers. *Children's Health Care*, *30*(3), 237. https://doi.org/10.1207/S15326888CHC3003_5

Appendix
Survey Instrument

FCP-SLP

Start of Block: Information Letter

Q54
INFORMATION LETTER for a Research Study entitled
"Family-Centered Practice Knowledge and Use Amongst Speech-Language Pathologists: A National Survey"

You are invited to participate in a research study to investigate the degree to which practicing speech-language pathologists (SLPs) engage in family-centered behaviors within the pediatric population. Additionally, this study aims to determine the amount of preservice training SLPs receive with regard to family-centered practice. The study is being conducted by Emma DeCarlo, under the direction of Dr. Allison M. Plumb, Associate Professor in the Auburn University Department of Speech, Language, and Hearing Sciences. You were selected as a possible participant because you are a speech-language pathologist who currently works or has worked with children in the past year. What will be involved if you participate? Your participation is completely voluntary. If you decide to participate in this research study, you will be asked to complete an electronic survey of 58 questions. Your total time commitment will be approximately less than 15 minutes.

What will be involved if you partciipate? Your participation is completely voluntary. If you decide to participate in this research study, you will be asked to complete an electronic survey of 58 questions. Your total time commitment is approximately less than 15 minutes.
Are there any risks or discomforts? The risk associated with participating in this study is the possibility that the answers to the survey may be intercepted between the participant's computer and Qualtrics.com. To minimize these risks, we will collect all data anonymously and all answers to survey questions are de-identifiable.

Are there any benefits to yourself or others? There are not direct benefits to participating in this study; however, if you participate in this study, you can expect to help speech-language pathologists have a better understanding of their knowledge and use of family-centered practice within the pediatric population and how their communication with family members/caregivers can be improved. We/I cannot promise you that you will receive any or all of the benefits described. Benefits to others may include better information made available to speech-language pathologists in the future about family-centered practice.

Will you receive compensation for participating? There is no compensation for completing this survey; however, your participation would be greatly appreciated.

Are there any costs? There are no costs associated with this survey, except for the few minutes of your time that it takes to complete the survey.

If you change your mind about participating, you can quit at any time by closing your browser window. Once you've submitted anonymous data, however, it cannot be withdrawn since it will be unidentifiable. Your decision whether or not to participate or stop participating will not jeopardize your future relations with the Department of Speech, Language, and Hearing Sciences at Auburn University.

Any data obtained in connection with this study will remain anonymous. We will protect your privacy and the data you provide by NOT asking for any identifiable information. Information collected through your participation may be presented at state or national conferences and may be published in a professional journal.

If you have questions about this study, please contact Dr. Allison M. Plumb at amp0016@auburn.edu.

If you have questions about your rights as a research participant, you may contact the Auburn University Office of Research Compliance or the Institutional Review Board by phone (334) 844-5966 or e-mail at IRBadmin@auburn.edu or IRBChair@auburn.edu.

HAVING READ THE INFORMATION ABOVE, YOU MUST DECIDE IF YOU WANT TO PARTICIPATE IN THIS RESEARCH PROJECT. IF YOU DECIDE TO PARTICIPATE, PLEASE CLICK ON THE LINK BELOW.

Thank you for your time,
Emma DeCarlo , Graduate Student in Speech-Language Pathology
Allison M. Plumb Ph.D., CCC-SLP

The Auburn University Institutional Review Board has approved this document for use beginning September 21, 2021. Protocol #21-446 EX 2109

○ YES, I do wish to participate in the study. (1)

○ NO, I do not wish to participate in the study. (2)

End of Block: Information Letter

Start of Block: Background

Q1 Do all three of the following statements apply to you?

I have obtained a master's degree or higher.

I am a fully-licensed, practicing speech-language pathologist in the United States with a Certificate of Clinical Competence (CCC).

I am currently or have treated a pediatric client within the past year.

○ Yes (1)

○ No (2)

Q51 We appreciate your participation. How did you hear about the survey?

○ ASHA Community Discussion Board (1)

○ Social media (e.g., post on Facebook) (2)

○ E-mail (3)

○ Other (please specify) (4) ____

Q7 In what state are you currently practicing?
▼ Alabama (AL) (1) ... Guam (GU) (53)

Q52 How long have you been practicing as a speech-language pathologist?

○ 0 to 5 years (1)

○ 6 to 10 years (2)

○ 11 to 15 years (3)

○ 16 to 20 years (4)

○ More than 20 years (5)

Q24 What is your gender?

○ Male (1)

○ Female (2)

○ Non-binary / third gender (3)

○ Prefer not to answer (4)

○ Other (please specify) (5) ____

Q25 Choose one or more races that you identify with.

☐ American Indian or Alaska Native (1)

☐ Asian (2)

☐ Black or African American (3)

☐ Native Hawaiian or Pacific Islander (4)

☐ White (5)

☐ Other (please specify) (6) ____

☐ Prefer not to answer (7)

Q26 Do you consider yourself as having a Hispanic, Latino, or Spanish background?

○ Hispanic, Latino, or Spanish (1)

○ Not Hispanic, Latino, or Spanish (2)

○ Other (please specify) (3) ____

○ Prefer not to answer (4)

Q43 What languages do you speak fluently?

☐ Arabic (1)

☐ Mandarin (2)

☐ English (3)

☐ French (4)

☐ German (5)

☐ Korean (6)

☐ Portuguese (7)

☐ Russian (8)

☐ Spanish (9)

☐ Vietnamese (10)

☐ Other (please specify) (11) ____

Q47 Which American English dialects do you speak?

☐ African American English (1)

☐ Appalachian English (2)

☐ Chicano English (3)

☐ General/Mainstream American English (4)

☐ Gullah/Geechee (5)

☐ Philippine English (6)

☐ Regional Dialect (please specify) (7)
____

☐ Other (please specify) (8) ____

Q42 What is the primary age group you work with? If you work with more than one age group, select the age group with whom you spend the most time.

○ Early Intervention (Birth-three) (1)

○ Preschool (2)

○ Elementary School (3)

○ Middle or High School (4)

Q30 What is your primary setting of employment? If you work in more than one setting, select the setting in which you spend the most time.

○ Hospital (Inpatient) (1)

○ Hospital (Outpatient) (6)

○ School (2)

○ Private Practice (3)

○ Home Health (4)

○ Other (7) ____

End of Block: Background

Start of Block: FCP_Training

Q32 Family-centered practice (FCP) is a way of engaging families, both formally and informally, to ensure their child is receiving the most beneficial service possible while also promoting the safety and well-being of the child (Child Welfare Information Gateway, 2016). Please consider this definition as you complete this survey.

What is your level of familiarity with the term family-centered practice?

	Extremely familiar (1)	Moderately familiar (2)	Somewhat familiar (3)	Slightly familiar (4)	Not at all familiar (6)
Level of familiarity	○	○	○	○	○

Q39 To what degree were the following core principles of FCP emphasized in your graduate coursework?

	Very emphasized (1)	Moderately emphasized (2)	Somewhat emphasized (3)	Slightly emphasized (4)	Not at all emphasized (5)
Showing respect and dignity towards the family	○	○	○	○	○
Collaboration with the family	○	○	○	○	○
Engaging in active listening when the parent or caregiver is speaking	○	○	○	○	○
Openly communicating with the family	○	○	○	○	○
Sharing all necessary information with the family related to their child	○	○	○	○	○
Encouraging participation on the part of the family member(s)	○	○	○	○	○
Equal trust from both the therapist and family	○	○	○	○	○
Showing empathy towards the family	○	○	○	○	○

Q40 How frequently were the following core principles of FCP modeled by your clinical supervisors?

	Always (1)	Often (2)	Sometimes (3)	Rarely (4)	Never (5)
Showing respect and dignity towards the family	○	○	○	○	○
Collaboration with the family	○	○	○	○	○
Engaging in active listening when the parent or caregiver is speaking	○	○	○	○	○
Openly communicating with the family	○	○	○	○	○
Sharing all necessary information with the family related to their child	○	○	○	○	○
Encouraging participation on the part of the family member(s)	○	○	○	○	○
Equal trust from both the therapist and family	○	○	○	○	○
Showing empathy towards the family	○	○	○	○	○

Q18 Please indicate your level of agreement with the following statement: I could have benefitted from additional coursework addressing family-centered practice.

	Strongly Agree (1)	Somewhat agree (2)	Neither agree nor disagree (3)	Somewhat disagree (4)	Strongly disagree (5)
Level of Agreement	○	○	○	○	○

Q50 Please indicate your level of agreement with the following statement: Incorporating additional clinical experience and training for implementing family-centered practice principles with clients would have benefitted my overall practice and education.

	Strongly agree (1)	Somewhat agree (2)	Neither agree nor disagree (3)	Somewhat disagree (4)	Strongly disagree (5)
Level of agreement	○	○	○	○	○

End of Block: FCP_Training

Start of Block: MPOC-SP

Q2
The following questions are adapted from the Measures of Processes of Care-Service Providers (MPOC-SP) created by Woodside, Rosenbaum, King, and King. Reprinted with permission from *CanChild* © 2001.

Q23 In the past year, to what extent did you...

	To a Very Great Extent (1)	To a Great Extent (2)	To a Fairly Great Extent (3)	To a Moderate Extent (4)	To a Small Extent (5)	To a Very Small Extent (6)	Not at All (7)	Not Applicable (8)
...suggest treatment/ management activities that fit with each family's needs and lifestyle	○	○	○	○	○	○	○	○
	○	○	○	○	○	○		○

...offer parents and children positive feedback or encouragement (e.g., in carrying out a home program							o	
...take the time to establish rapport with parents and children?	o	o	o	o	o	o	o	o
...discuss expectations for each child with other service providers, to ensure consistency of thought and action?	o	o	o	o	o	o	o	o
...tell parents about options for services or treatments for their child (e.g., equipment, school, therapy)?	o	o	o	o	o	o	o	o
...accept parents and their family in a nonjudgemental way?	o	o	o	o	o	o	o	o
...trust parents as the "experts" on their child?	o	o	o	o	o	o	o	o
...discuss/ explore each family's feelings about having a child with special needs (e.g., their worries about their child's health or function)?	o	o	o	o	o	o	o	o
...anticipate parents' concerns by offering information even before they ask?	o	o	o	o	o	o	o	o
...make sure parents had a chance to say what was important to them? (10)	o	o	o	o	o	o	o	o
...let parents choose when to receive information and the type of information they wanted?	o	o	o	o	o	o	o	o

...help each family to secure a stable relationship with at least one service provider who works with the child and parents over a long period of time?	o	o	o	o	o	o	o	o
...answer parents' questions completely?	o	o	o	o	o	o	o	o
...tell parents about the results from tests and/or assessments?	o	o	o	o	o	o	o	o
...provide parents with written information about their child's condition, progress, or treatment?	o	o	o	o	o	o	o	o
...tell parents details about their child's services, such as the types, reasons for, and durations of treatment/management?	o	o	o	o	o	o	o	o
...treat each parent as an individual rather than as a "typical" parent of a child with a "problem"?	o	o	o	o	o	o	o	o
...treat parents as equal rather than just as the parent of a patient (e.g., by not referring to them as "Mom" or "Dad")?	o	o	o	o	o	o	o	o
...make sure parents had opportunities to explain their treatment goals and needs (e.g., for services or equipment)?	o	o	o	o	o	o	o	o
...help parents feel like a partner in their child's care?	o	o	o	o	o	o	o	o
...help parents to feel competent in their roles as parents?	o	o	o	o	o	o	o	o

...treat children and their families as people rather than as a "case" (e.g., by not referring to the child and families by diagnosis, such as "the spastic diplegic")?	o	o	o	o	o	o	o	o
...promote family-to-family "connections" for social, informational or shared experiences?	o	o	o	o	o	o	o	o
...provide support to help families cope with the impact of their child's chronic condition (e.g., informing parents of assistance programs, or counseling how to work with other service providers)?	o	o	o	o	o	o	o	o
...provide advice on how to get information or to contact other parents (e.g., through a community's resource library, support groups, or the Internet)?	o	o	o	o	o	o	o	o
...provide opportunities for the entire family, including siblings, to obtain information?	o	o	o	o	o	o	o	o
...have general information available about different concerns (e.g., financial costs or assistance, genetic counseling, respite care, dating and sexuality)?	o	o	o	o	o	o	o	o

Q24 Are there any elements of family-centered practice not discussed above that you use when working with clients and their families? If so, please discuss.

End of Block: MPOC-SP