Parent Perspectives on Family-Centered Care in Speech and Language Therapy Across Different Settings

By

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The purpose of this study was to examine the differences in family-centered care (FCC) among speech and language pediatric therapy settings, including a university clinic setting. The logistics of speech and language therapy settings can help or hinder parent involvement and parent-therapist relationships, two key elements in FCC. High levels of parent involvement and collaborative parent-therapist relationships can produce the following benefits: increased parent satisfaction with therapy, decreased parent stress, and increased progress for the child. Six participants were recruited from the University of Wisconsin – Eau Claire Center for Communication Disorders (CCD). Participants' children received services at the CCD and at least one other speech and language therapy setting. Each participant engaged in one face-to-face interview, which was transcribed and analyzed using an open and axial qualitative coding method. The primary investigator (PI) and a research assistant (RA) collaborated to analyze and code the interviews to reach conclusions based on the presenting data. Results indicated that parents experienced various levels of involvement and collaboration with SLPs in the different settings. However, the logistics of the different settings may not be the primary influence; rather, it appeared that the SLPs and parents themselves were the more effective factors of collaborative relationships and levels of parent involvement. It was also discovered that parent perspectives of the university clinic differed from that of the other settings. Specifically, student clinicians were viewed more positively than practicing SLPs and the university clinic was reported to be more effective, possibly due to the integration of research. These results demonstrate the need for SLPs working with children to create a positive relationship with parents to facilitate involvement and to integrate research into practice to further benefit the child.

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To Zack, my parents, and supportive friends:

No one accomplishes anything alone. Thank you for your endless support. This one is for you.
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PROLOGUE

This master’s thesis was inspired by a brave and remarkable little boy and his family. We will call this boy, “Joey.” By the time Joey was four years old, he had been through a significant history with cancer. He had been in and out of the hospital the good part of his early life. Joey was also diagnosed with severe Childhood Apraxia of Speech (CAS) that impacted his speech and language development.

When I first met Joey, he had 10 to 15 words and hand signs. But it was evident there was more to this little guy than what he could express – he vocalized, gained joint attention, and was motivated to engage in all activities. During our first session, it became apparent that Joey’s parents were passionate about helping their son communicate. They lit up the room with their love and support for Joey. I expected there to be some level of anxiousness or protectiveness because of their son’s history, but all I felt in that room was a sense of calmness.

My supervisor picked up on this as well, and she and I decided to pursue a coaching model for service delivery to best involve them in the therapy process. Joey and his parents responded well to this model – they commented on how they enjoyed their involvement. Over the course of a month and a half of therapy at the university clinic, Joey made significant progress. He gained four functional words, learned five new signs, and connected phonemes that were previously segmented in his speech.

I continued to see him for speech therapy the next semester. He returned following the summer break – a time when children have the potential to regress in the skills they learned in speech therapy – and his progress was astounding. As I was assessing his current level of functioning, I had tears in my eyes. Joey was speaking in two to three word phrases, had acquired many phonemes and signs, used 10 to 15 more verbal and functional words, and gained
a handful of sight words. I shared with his mother how astonished I was with his progress, and
gave her the credit and recognition she deserved for her hard work. Joey continued growing with
his speech and language throughout that semester with the help of his parents. By the end of that
semester, Joey was speaking in three to four word phrases, had mastered several new syllable
shapes, and expressed himself in an effective and motivating way.

Although my supervisor and I acted as facilitators for this progress, it was ultimately
Joey’s mother and father who promoted his significant growth. They were so willing to be
involved, learn, and help their child communicate. Joey and his parents made a wonderful and
positive impact on my clinical practice to foster parent involvement. They also inspired me to
pursue family-centered care as my master’s thesis topic – by writing this thesis, I hope to help
clinicians and parents alike to have positive speech and language therapy experiences.
I. LITERATURE REVIEW

Evidence-Based Practice

Evidence-based practice (EBP) began in the medical field and has undergone various changes in definition to better serve clinical needs. EBP first became prevalent in the mid-1990s within the medical community to improve the quality of healthcare (Claridge & Fabian, 2005; Friesen-Storms, Bours, van der Weijden & Beurskens, 2014). Initially, an informal definition of EBP simply stated that research was necessary to guide clinical decisions within healthcare (Friesen-Storms et al., 2014). To better serve clinical needs and formalize the definition, a more inclusive definition was created to also include clinical expertise and patient values (Claridge & Fabian, 2005; Friesen-Storms et al., 2014). As its prevalence began to rise, it became adopted and adapted by related professions (Friesen-Storms et al., 2014).

EBP was adopted by the American Speech-Language-Hearing Association (ASHA) in 2005 to provide efficient and effective treatment, hold professionals accountable for clinical decisions, and prove effectiveness of treatment (Reilly, 2004). ASHA’s official position statement defines EBP as “current, high-quality research evidence integrated with practitioner expertise and client preferences and values into the process of making clinical decisions,” (ASHA, 2005). There are three elements to EBP—external evidence, clinical expertise, and patient values.

Definitions and Importance

External evidence. External evidence relates to clinical decisions, assessment, and treatment supported by and proven through research. The purpose of external evidence in speech and language therapy is to guide clinical practice. According to Reilly (2004) and Roulstone (2011), there are a variety of different forms of research ranging from clinical observations in natural environments to randomized-control trial (RCT) research. External evidence must be
utilized to guide clinical practice to deliver current, efficient, and effective services (ASHA, 2005). Integrating external evidence into practice can accomplish two goals within speech-language pathology: increasing professional knowledge regarding communication and its associated disorders as well as addressing therapy-related issues to improve quality of services (Olswang & Prelock, 2015).

Clinical expertise. Clinical expertise within speech-language pathology is often defined as professional skills gained through clinical experience (Haynes, Devereaux & Guyatt, 2002) as well as a set of skills that allow clinicians to integrate both external evidence and patient values into therapy (Haynes et al., 2002; Kamhi, 1995; Roulstone, 2011). Haynes et al. (2002) asserted that it is at the clinician’s discretion to identify appropriate external evidence for each individual client. Clinical expertise utilized within clinical practice has been found to have positive outcomes. For example, Chall (1967) discovered that factors of clinical expertise (e.g. pacing, enthusiasm, advocacy) generated more positive impact on learning than teaching techniques alone.

Patient values. Within speech-language pathology, patient values relate to the process of involving patients and caregivers in an appropriate manner to make clinical decisions regarding their own care (Dollaghan, 2007). Most patients desire to be more involved in the decision-making process (Baratt, 2008) and involving patients respects the ethical principle of patient autonomy (Parker, 2001). Baratt (2008) argued that involving patients in the clinical decision-making process may strengthen evidence-based practice. Clinicians must utilize their expertise to identify appropriate research, then provide education to the patient regarding the best possible options (Baratt, 2008). Therefore, educating patients to make informed decisions satisfies all three elements of evidence-based practice at once. Further, there are benefits to incorporating
patient values in clinical practice. Allowing for patient input can lead to improved outcomes, higher patient satisfaction (DiLollo & Favreau, 2010; Dollaghan, 2007; Stewart, Brown, Donner, McWhinney, Oates, Weston & Jordan, 2000), and increased motivation to meet goals (Carlson, 1996). Although research has been conducted to identify and understand patient values, this is an area that warrants further exploration due to the necessary individualization of patient values.

**The Role of Patient Values in Evidence-Based Practice**

Although each element of EBP has been discussed separately, ASHA (2005) advocates for relationships between evidence and expertise, expertise and patient values, as well as evidence and patient values through its definition: "The term evidence-based practice refers to an approach in which current, high-quality research evidence is integrated with practitioner expertise and client preferences and values into the process of making clinical decisions" (ASHA, 2005, Line 12). Each element is related to the other and should be addressed as such to provide the most efficient and effective services to clients (Roulstone, 2015). External evidence should provide current and practical knowledge to better clinical practice (Roulstone, 2011) and be utilized in clinical decision-making (Olswang & Prelock, 2015; Ruggero, McCabe, Ballard & Munro, 2012). However, it is the clinician’s responsibility to seek, apply, and adapt research to fit clinical practice (Roulstone, 2015). Further, it is the clinician’s responsibility to educate patients regarding external evidence and explore the preferences of their patients (Haynes et al., 2002). This may be executed effectively and efficiently utilizing a shared decision-making approach (Friesen-Storms et al., 2014; O’Connor et al., 2007).
Such an approach entails the professional delivering information to the patient, explaining options, discussing advantages and disadvantages of each option, checking in on patient understanding, and following up on the decision reached between both parties (Friesen-Storms et al., 2014). This method echoes Roulstone’s (2011) position that advocates for evidence-based patient choices (EBPC), specifically within the profession of speech-language pathology. Similar to the shared-decision making approach, EBPC allows the clinician to present relevant external evidence to clients, then outline the advantages and disadvantages of each option. This facilitates informed decision-making on the client’s part, and in this way, clinician and client collaborate to make clinical decisions (Roulstone, 2011).

**Incorporating Patient Values**

**Patient-and family-centered care.** One method of service delivery that facilitates a collaborative approach between clinicians, patients, and families is known as patient-and family-centered care (PFCC). This method demands two key elements: *strong relationships between professionals, families, and patients as well as collaboration of all three parties to make clinical decisions* (Prelock & Hutchins, 2008; Rathert, Wyrwich & Boren, 2012). More specifically, it requires the professional, patient, and family to communicate openly with each other (Just, 2005). The professional must understand the values of the patient and family, facilitate choices through patient and family education, build confidence to make those choices (Clay & Parsh, 2016), and educate the patient and family on their role to promote engagement in decision-making (Barry & Edgman-Levitan, 2012); the patient and family must communicate values and desires with the professional (Barry & Edgman-Levitan, 2012). PFCC can be used throughout the lifespan – from birth to end-of-life care (Clay et al., 2016). Involving patients and their
families is critical to the patient’s recovery, regardless of the age of the patient (Clay et al., 2016). PFCC provides numerous benefits at all stages of life.

**Benefits.** There are several benefits to using PFCC in practice – these include improved outcomes for patients, families, and professionals. Involving patients within clinical decisions increases patient satisfaction (Rathert et al., 2012), improves patient well-being and mental health (Stewart et al., 2000), and facilitates positive intermediate and long-term outcomes (Rathert et al., 2012). As reported by families, being involved in clinical decisions also resulted in an increased understanding of options and associated outcomes (Barry & Edgman-Levitan, 2012). In addition, this method increases cooperation, lowers anxiety levels for the patient and family (Just, 2005), and improves coping strategies (Mitchell, Chaboyer, & Burmeister, 2009) – all of which aid in patient recovery (Mitchell et al., 2009).

Professionals benefit from the use of PFCC as well by improving the effectiveness of treatment. By utilizing this approach, professionals gather more information regarding the patient’s and family’s wishes (Clay et al., 2016). Accounting for patient and family values improves follow-through on recommendations (Clay et al., 2016) and increases participation in treatment (Barry & Edgman-Levitan, 2012). These two elements are critical within the therapy process for effective treatment (Barry & Edgman-Levitan, 2012).

**Family-centered care in a pediatric context.** Although PFCC can be utilized throughout the life span, family-centered care (FCC) is often emphasized for a pediatric population due to the primary caregiver role of the parent. It has the same philosophies, benefits, and methods as discussed above, but is more specific to families of children receiving care. It is utilized most often within pediatric hospitals, pediatric outpatient clinics, and Birth-to-Three programs. In a pediatric context, FCC can be defined as a method of service delivery that fosters
parent participation and allows parents to collaborate with professionals to make clinical
decisions for the child (Prelock et al., 2008). It promotes parent involvement as well as strong
relationships between parents, professionals, and children, and in this way helps to maintain the
wholeness of the family (Just, 2005). This method of care is consistent with the social-interaction
theory (Vygotsky, 1934).

The social-interaction theory asserts that as children learn through experience and social
interactions, their interpersonal behaviors become intrapersonal mental constructs and processes
(Vygotsky, 1934). Individuals appropriate their ways of talking and thinking from social and
cultural routines (Vygotsky, 1934). Therefore, Hagstrom (1994) argued that the role of at least
one parent is critical to the speech and language therapy process for change to occur. By
involving one or both parents, it is possible to provide services within everyday circumstances
(i.e. environment and frequent communication partners) which allows for therapy within natural
contexts. Crais (1991) argued that utilizing FCC and involving parents within the child’s natural
context could help determine goals, promote generalization, and increase reliability of behavioral
samples (e.g., the child’s performance). Therefore, it is the professional’s role to intertwine
knowledge and promote change within a natural context to best support the child’s development
(Hagstrom, 1994).

When parents are involved within the speech and language therapy process for their
child, it can result in more positive therapy outcomes (King, King, Rosenbaum, & Goffin, 1999;
interaction therapy (PCIT) with young children who stutter. Children involved in this study
demonstrated improved clinical outcomes (i.e. less frequent stuttering) especially if both parents
were involved (Millard et al., 2008). Both children and parents benefit from FCC. King et al.
(1999) discovered FCC was a predictor of better parent emotional well-being, increased parent satisfaction, and decreased levels of reported parent stress. Likewise, Just (2005) discovered lower anxiety levels for both families and children when parents were involved in care. Therefore, King et al. (1999) argued that there is a link between involving parents within the therapy process and better parental well-being.

*Parent-therapist relationships*. Traditionally, when delivering various types of therapy to children, a child-centered approach was utilized (Hanna & Rodger, 2002). This approach had a central focus on the relationship between the child and therapist, but only included the parent in a passive role (Hanna & Rodger, 2002). A passive role can be defined as the therapist making all clinical decisions and informing the parents of those decisions. In the 1970s and 80s, a collaborative approach between parents and therapists became more common practice (Hanna & Rodger, 2002). A collaborative approach allows equal weigh-in of parents and therapists on clinical decisions and regards both as experts; therapists as the experts on practice and profession, and parents as the experts on their children (Hanna & Rodger, 2002). This allows for the parent and therapist to work closely and form a relationship to best serve the child.

Bordin (1979) guided techniques and procedures to achieve a collaborative parent-therapist relationship and was utilized as a framework in various studies since publication. Bordin (1979) expressed three key ideas: creating a bond, jointly establishing goals, and executing tasks based on these goals. Bordin (1979) asserted that there must be a level of trust between client and therapist to facilitate open and honest conversations. During these conversations, it is the therapist’s role to listen and understand the client’s unique circumstances and desires and integrate these factors into realistic goals (Bordin, 1979). Lastly, the client and
therapist must establish actions to work towards these goals, leading to improved outcomes (Bordin, 1979).

Although Bordin (1979) provided a framework for establishing strong therapist and client relationships, a continuum of parent-therapist relationships continues to exist (Broggi & Sabatelli, 2010). Broggi & Sabatelli (2010) conducted research on parent-therapist alliances in physical therapy. The parent-therapist relationship framework from Brooks-Gunn, Berlin, and Fulgini (2000) was used to structure the study. This framework asserted that parent-therapist relationships may be measured by parental satisfaction in therapy and level of control in therapy. Brooks-Gunn et al. (2000) placed parents on a continuum from a distant role (low satisfaction, low control) to a collaborator role (high satisfaction, high control). There were two other roles identified that assisted to define the continuum – discordant (low satisfaction, high control) and traditional (high satisfaction, low control). Broggi & Sabatelli (2010) recruited 39 participants from an early intervention program to complete a survey and standardized assessments. Results revealed that there were significant differences between distant and collaborator roles; there was no significant difference between the discordant and traditional roles or these roles in relation to distant and collaborator. Based on the participants’ survey and standardized assessment scores, the following percentages were determined for each role: 44% collaborator, 21% traditional, 17.5% discordant, and 17.5% distant. Parents that reported working as collaborators with the therapist expressed lower levels of parental stress, higher levels of parent competence, and more positive perceptions of family-centered care compared to the other roles.

A collaborative relationship between parent and therapist may be cultivated through promoting parent empowerment. Parent empowerment, or competence, allows the parent to gain experience and knowledge of therapy, validating their role as the expert on the child. Mianaei,
Karahren, Rassouli, and Tafreshi (2014) explored the effects of parent competence with Iranian mothers whose children were in the neonatal intensive care unit (NICU) due to premature birth. They used a program entitled Creating Opportunities for Parent Empowerment (COPE), comparing mothers enrolled in this program with a control group. The COPE program provides education and empowerment through audiotapes and printed materials that provide detailed information regarding development and behavior of premature infants over the course of the infant’s stay in the NICU. By involving mothers in this program, Mianaei et al. (2014) discovered that mothers participated more, had decreased levels of stress and anxiety, and had more positive parent-child interactions than mothers in the control group. These positive results were also reflected in Broggi & Sabatelli (2010) for parents whose children were enrolled in physical therapy in an early intervention setting. Therefore, encouraging parent empowerment enables not only positive parent-therapist relationships, but also increases parental participation in therapy (Mianaei et al., 2014), lowers parental stress levels (Broggi & Sabatelli, 2010; Mianaei et al., 2014), and promotes positive interactions between child and parent (Mianaei et al. 2014). These positive interactions are critical to the child’s growth and development (Vygotsky, 1934). One aspect of FCC is strong parent-therapist relationships, while the other is parent involvement.

**Parent involvement.** Although specified as parent involvement, it should be noted that many studies mentioned within this section only involved mothers. There is little research regarding this topic and the involvement of fathers and guardians. However, to remain consistent and concise, each article reviewed below will be discussed in terms of parents.

Parent involvement may be conceptualized on a spectrum from dependent to collaborative roles within the speech and language therapy process (Forsingdal, St John, Miller,
Harvey, & Wearne, 2013). Forsingdal et al. (2013) described three key roles of parents within the speech and language therapy process: dependent, active participants, and collaborators. Parents that assume dependent roles tend to rely on speech-language pathologists (SLPs) for meeting therapy needs. These parents are generally more dependent on SLPs to make clinical decisions, prefer the SLP to take the lead with therapy, and desire to be involved less in clinical decisions (Forsingdal et al., 2013). Those within the dependent role tend to view themselves as consumers of information presented and are typically content with the plan the SLP has created (Forsingdal et al., 2013). These parents are generally glad to carry out therapy techniques at home if they understand and can feasibly do them (Forsingdal et al., 2013). Some parents stay within this role throughout the therapy process; however, it is more likely to exist towards the beginning of the therapy process due to newness, uncertainty, and anxiety to begin treatment (Glogowska & Campbell, 2000). Although parents beginning treatment may convey confidence and certainty, they still may feel dismayed at the reality of their child’s challenges (Glogowska & Campbell, 2000). This may make them hesitant to fully participate in the therapy process.

Therefore, Forsingdal et al. (2013) asserted that early in the speech and language therapy process, parents require time and opportunities for experience to become more confident and competent to be involved in clinical decision-making.

When given time and experience, parents may transition out of being dependent into more active participatory roles. Parents that are active participants tend to be past the beginning stage of therapy. They seek to increase their knowledge and understanding of therapy, follow-up with activities at home, and are more likely to report progress (Forsingdal et al., 2013). These parents provide feedback to their SLP, and in doing so, feel confident and competent (Forsingdal et al., 2013). Although these parents demonstrate more involvement than the dependent role,
they still require guidance from the SLP throughout the therapy process (Forsingdal et al., 2013). Further, they rely on SLPs to present opportunities in which to participate (Forsingdal et al., 2013).

Some parents do not continue to progress in their participation, but those who do become collaborators (Forsingdal et al., 2013). Parents who are collaborators function within a partnership between themselves and the SLP. This partnership may entail mutual planning and developing goals (Forsingdal et al., 2013). These parents utilize the SLP as a resource to effectively meet the child’s needs and do not rely on the SLP to always lead in making clinical decisions (Forsingdal et al., 2013). Parents within a collaborative role feel empowered and experience a sense of ownership over clinical decisions (Forsingdal et al., 2013). This role is often cultivated through SLP guidance and encouragement as well as an increased understanding of the therapy process (Forsingdal et al., 2013). It is crucial to note that some parents may remain stagnant in their role throughout the therapy process while others are more fluid along the spectrum regardless of circumstances (Forsingdal et al., 2013).

Although time and experience may influence the role of the parent, other factors have been discovered to influence these roles as well (Forsingdal et al., 2013; Glogowska et al, 2000). Glogowska and Campbell (2000) emphasized the need to recognize and explore parental perceptions, needs, and concerns early in the speech and language therapy process to promote future involvement (Glogowska & Campbell, 2000). The early reliance on SLP decision-making may influence a lack of involvement in future therapy (Glogowska & Campbell, 2000). Instead, Glogowska and Campbell (2000) suggested SLPs utilize a shared decision-making approach (Freisen-Stroms, 2014) from the beginning and throughout the therapy process to best involve parents at any stage of speech and language therapy. The level of involvement is also determined
by factors such as belief in goals, personal situations, and relationships with SLPs (Forsingdal et al., 2013). Further, parents reported an increased willingness to commit to speech and language goals that were clear, realistic, (Forsingdal et al., 2013) and functional (Law, Roulstone, & Geoff, 2015). Parents were more likely to engage collaboratively in setting goals if they were made aware of a general timeline for progress and the level of involvement required to achieve those goals (Forsingdal et al., 2013). In addition, parents tended to be more satisfied with services if there was not a discrepancy between what was expected and what was realistic for their child to achieve (Carroll, 2010).

**Barriers to Parent Involvement and FCC**

Although parent involvement and FCC can result in positive outcomes, there are a number of challenges to the implementation of these practices. Some challenges include professional beliefs, parental attitude and time (Pappas et al., 2008), and logistical issues within various settings (Carroll, 2010). Of these issues, settings will be addressed in the following sections to provide insight into each pediatric therapy setting.

**Settings.** There are various settings in which speech and language services may be delivered to children and their families. These include school-based services, outpatient clinics, Birth-to-Three services, private practice, in-patient (hospital) services, and university clinic services. Each of these settings will be briefly described in terms of logistics, practices, and unique features to provide the reader with context of each pediatric therapy setting.

**School-based services.** School-based services are provided within the school environment. Children can be seen in the classroom or resource room, in groups or individually, as well as one time or multiple times a week. “School-based SLPs work with a wide range of age levels, from preschool through young adult, including infants and toddlers in some states...they
also serve children with a wide range of communication disorders, including language/literacy, articulation, fluency, voice/resonance, auditory processing disorders, hearing impairment, and swallowing” (Lubinski & Hudson, 2013, p. 319). In this setting, children must qualify for an Individualized Education Plan (IEP) by demonstrating academic or social needs that cannot be addressed through general education. Because school-based services are typically delivered over the course of the school day, parents are rarely present for their child’s therapy sessions. Parents are involved in the therapy process in other ways such as giving consent to evaluate and treat as well as providing input to develop and amend the Individualized Education Plan (IEP) to meet the child’s needs. The IEP requires parent consent and a team meeting once a year. These forms of parental involvement are safeguarded by the Individuals with Disabilities Education Act (IDEA) (2004), subpart E.

**Outpatient clinics.** For pediatric outpatient clinics, SLPs provide services within the outpatient facility. Patients that receive services in this setting may have been discharged from the hospital or have conditions that do not warrant hospitalization (Lubinski & Hudson, 2013). Although children may be referred to an outpatient clinic following a hospital stay, they may also be referred to an outpatient clinic by their physician, parents, teachers, etc. The disorder types can vary much like in the school setting. However, children who receive services in this setting must provide payment; this is typically within the form of insurance or self-pay. Parents are responsible for providing the child with transportation to and from the facility. It is typically at the discretion of the SLP or clinic policy whether parents are directly involved in the sessions. Parent involvement is also dependent on parent motivation; some parents may prefer to wait in the waiting room, while others may prefer to observe sessions or actively participate in activities.
**Birth-to-three services.** Birth-to-Three programs provide services to infants and toddlers who have or are at risk for developmental delays. This program typically emphasizes the use of family-centered care (Lubinski & Hudson, 2013). Services within this setting are generally provided in a natural environment – this may include the child’s home or other settings in which the child participates in the community (Lubinski & Hudson, 2013). Parents are typically encouraged to participate in sessions through approaches such as the coaching model (Lubinski & Hudson, 2013). The coaching model is a therapy approach used to facilitate parent engagement within a natural context to best support the child’s learning (Lubinski & Hudson, 2013). Through this approach, the parents are actively guided through the therapy process to build partnerships between the SLP and families as well as enhance effectiveness (Lubinski & Hudson, 2013).

**Private practice.** Private practice is a broad term for various settings. “Private practices describe those who work for themselves, work full or part time for others and then for themselves after hours, contract with other professionals and work in a variety of locations, have a single business location, supply professional staff to other agencies and corporations that require services, and serve as consultants,” (Lubinski & Hudson, 2013, p. 356). Therefore, SLPs in this setting may serve children in whichever setting the SLP deems appropriate – some options may include the client’s home, a community location or a rented space as settings. The SLP then decides which approaches to implement. Private practice requires the clients to provide payment (Lubinski & Hudson, 2013).

**Pediatric hospitals.** SLPs serving children within this setting do so at the hospital facility where the child may be staying short or long-term. There is a common link between childhood illnesses and communication and/or swallowing disorders, creating a need for SLPs in this
setting (Lubinski & Hudson, 2013, p. 296). “Pediatric hospitals also have the specific mission of being child-centric and family-centric. They are particularly attuned to the illnesses of childhood, to the stressors that are common when a child is ill, and usually have programs and staff customized to address this very important group of patients (and families),” (Lubinski & Hudson, 2013, p. 296). Therefore, this setting is typically attuned to family-centered care.

**University clinic programs.** University clinic programs function similarly to a pediatric outpatient setting, however a unique feature of this setting is that student clinicians provide services to clients with a licensed SLP acting as a supervisor. It is at the discretion of the student clinician, supervisor, parent, and clinic guidelines to decide the extent of parent involvement in the therapy process. At the UW-Eau Claire CCD, student clinicians are also reassigned to new clients each semester to be exposed to a breadth of clinical experiences. In other words, clients at the CCD typically are assigned a new student clinician every three to four months.

**SLP perspective on settings.** Despite differences between settings, most SLPs across pediatric settings find parent involvement important to effective treatment. Through a survey of 277 respondents, Pappas et al. (2008) discovered that 98% of SLPs across settings find parent involvement important to effective treatment, but 40% stated they were unhappy with the level of family involvement in practice. Although professionals may prefer to use FCC, they may be unable to do so due to logistical issues. Crais et al. (2006) found that some FCC practices identified as ideal by professionals were utilized infrequently due to time limitations and access to resources. One of the settings identified by SLPs as being less conducive to family involvement was a school-based setting, possibly due to logistical issues (Pappas et al., 2008). Some logistical issues may include services being provided over the course of the school day
(Lubinski & Hudson, 2013), which can discourage direct parent involvement during therapy sessions.

**Comparing settings in terms of FCC.** Although there is research regarding FCC for each setting, there is little research directly comparing settings. Carroll (2010) discovered that parents were more satisfied with speech and language services in a clinic-based setting than a school setting. Carroll (2010) asserted this was because the clinic-based setting provided more direct contact with the SLP and more direct involvement in therapy as opposed to more indirect involvement in a school setting (e.g., not being present for therapy sessions). However, this is an area that warrants further exploration.

**The Current Study**

FCC is an important practice within speech and language therapy due to its positive outcomes for children as well as parents (King et al., 1999). However, FCC may be impacted by the logistics and unique features of each setting (Carroll, 2010). Because there is little research regarding how the logistics of different settings impacts FCC, this area warrants further exploration. In addition, Glowgoska et al. (2000) argued that in order to involve parents, the SLP must have a focus on the parent’s perception. Therefore, it is critical to obtain information from the parent’s perspective. Therefore, the aims of this research attempted to answer the following questions:

1. Are there differences in parent involvement and parent-therapist relationships between settings?
2. How do parents feel about differences between settings?
3. According to parents, how do parent involvement and parent-therapist relationships affect a child’s success in speech and language therapy?
II. METHODS

Evidence-based practice is comprised of three elements: external evidence, clinical expertise, and client perspectives. Therefore, it is a crucial aspect of speech and language therapy to incorporate client perspectives for assessment, intervention, and clinical decisions. However, no current research has investigated parent perspectives regarding university clinic speech and language services, compared to speech and language services in a different setting. The purpose of this study was to explore parent perspectives and preferences regarding speech and language services at the UW-Eau Claire CCD and another setting.

Grounded Theory and Qualitative Analysis

This study was conducted using the grounded theory approach to qualitative analysis. Grounded theory is a method of qualitative analysis that derives a theory from the data collected (Strauss & Corbin, 1990). It requires the PI to begin data collection without a theory to prove – rather, the theory must come from the phenomena discovered in the data (Strauss & Corbin, 1990). To follow qualitative analysis protocol, data may be collected in a variety of ways, which includes interviews, conversations, and observations (Strauss & Corbin, 1990). Analyzing the data qualitatively calls for the PI to code and conceptualize the data as opposed to conducting statistical analysis (Strauss & Corbin, 1990).

The PI conducted the current study according to the description above. The PI did not have a theory to prove; rather, the theories derived were extrapolated from the data. The data were collected primarily through interviews and follow-up conversations. The PI conducted analysis in a qualitative manner – through coding and conceptualization. In addition, grounded theory calls for a minimum of six participants; this study recruited that minimum.
Participants

Twelve parents were invited to participate in this study through the CCD clinic at UW-Eau Claire. Six participants returned the consent form to participate. Participants were parents or guardians of children who were currently receiving speech and/or language services at the CCD in addition to other settings. All children’s parents that fit this criterion were invited to participate, regardless of the child’s communication disorder type and number of sessions attended at the university clinic.

The PI emailed all clinical supervisors in the communication and sciences disorders (CSD) department, described the study, and outlined the requirements for potential participants. Potential participants were identified and reported to the PI via email. The PI contacted assigned student clinicians to provide a cover letter and contact information to potential participants. If parents were interested in participating in the study, they mailed back the consent form. The participants are described below to provide context for the results and discussion sections.

Participant 1. Participant 1 was a mother of multiple children enrolled in speech and language services at the CCD and through the public-school district. She primarily discussed her twins (one daughter and one son), who were six years old. Her son was diagnosed with a phonological disorder and had, in her words, “issues with disfluency” while her daughter was diagnosed with an articulation disorder. The twins had an older brother who received speech and language services in the past through his school for a possible fluency disorder, but he was not receiving speech and language services at the time of the interview. This participant also had a younger son who was in the process of being evaluated at the CCD for a possible phonological disorder. The twins were in their fourth semester of speech and language services at the CCD at the time of the interview. During the semester the interview was conducted, the twins attended
individual sessions once a week for an hour; they attended all scheduled sessions throughout that semester. Participant 1 reported that she was not the primary point of contact throughout this semester due to her work schedule; rather, her husband assumed this role (he was not present for the interview). She reported that in the past, she was very involved at the CCD and occasionally joined the therapy sessions by playing games.

**Participant 2.** Participant 2 was a mother of a seven-year-old son diagnosed with autism spectrum disorder (ASD) that received speech and language services at the CCD and at school. This participant also had an older, typically developing son. Her younger son was diagnosed with ASD at the age of three by the school district. This participant shared that her son was being raised bilingually, which complicated interpretation of his test results. However, deficits were noted in both languages, qualifying him for speech and language services. Participant 2 expressed that her son had primarily social communication deficits; it was also noted in his file that he had deficits in expressive language (such as using correct syntax) and receptive language (such as following directions). At the time of the interview, her son had been receiving services at the CCD for four semesters; during the semester the interview was conducted, he attended speech and language therapy at the CCD four times a week for an hour. He rotated between three different student clinicians during the semester and attended about 90% of his scheduled sessions. Participant 2 reported that she attended the majority of her son’s therapy sessions and commented that during sessions she observed through the one-way mirror and took notes to replicate techniques at home. She reported that the clinicians typically invited her into the last ten minutes of each session to review techniques, ask questions, and make suggestions.
Participant 3. Participant 3 was a father of a three-year-old son that was diagnosed with ASD that received speech and language services at the CCD and through the public-school district. He also had a younger daughter that was typically developing. His son was diagnosed with a language delay before the age of one and was officially diagnosed with ASD when he was two years old. There was a history of Childhood Apraxia of Speech (CAS) reported by the participant as well. When a language delay was noted, his son began receiving speech and language services through an outpatient clinic and a different university clinic. A few months before the interview was conducted, the family relocated to the area. They were referred to the CCD from the other university clinic. Participant 3 reported that despite the ASD diagnosis, his son enjoyed attention and socializing, but had more difficulties with expressive and receptive language as well as speech sound production. The child communicated via verbalizations, signs, and an alternative and augmentative communication (AAC) device. His son was in his second semester of therapy at the CCD and attended the CCD twice a week for an hour. During the semester the interview was conducted, the family missed one scheduled appointment.

Participant 4. Participant 4 was both a mother and a father of a 5-year-old boy diagnosed with CAS. Their son was an only child at the time of the interview. He received services through the public-school district, at the CCD, and at a pediatric outpatient clinic. Their son had a significant medical history that lead to an extended period of hospitalization. This hospitalization and his condition impacted his overall development. He began receiving speech and language services at the age of one through the hospital and an outpatient clinic. When he was discharged from the hospital around the age of three, he received speech and language services through the school district and an outpatient clinic. He was in his third semester of speech and language services at the CCD when the interview was conducted. Participant 4 reported that their child
was motivated to communicate verbally and these verbal communication skills improved drastically over the past few years. Although the child’s receptive language was intact, expressive language had significant areas of deficit which were targeted in speech and language therapy. Participant 4 reported being very involved at the CCD by being present in the therapy sessions, engaging in all activities, and following-through with home programming. The family attended sessions twice a week for an hour and attended all scheduled appointments.

**Participant 5.** Participant 5 was a mother of a 15-year-old son diagnosed with ASD that received services at the CCD and through the public-school district. He was diagnosed with ASD and attention-deficit hyperactivity disorder (ADHD). Her son received speech and language services at the CCD for a summer semester when he was five years old for a phonological disorder. He discontinued receiving services at the CCD until the semester the interview was conducted; therefore, he was in his first semester of services. He received therapy in the form of a social group to improve social communication skills, but it was noted in his file that speech sound errors continued to persist. He attended speech and language therapy at the CCD once a week for an hour and a half and attended 75% of these scheduled appointments. This participant reported that her son functioned well overall, but struggled with social communication skills. It is important to note that this participant viewed the social group therapy sessions as a social outing for her son and not speech and language therapy.

**Participant 6.** Participant 6 was a grandmother of a 15-year-old diagnosed with ASD that received services at the CCD and through the public-school district. This participant reported that her grandson was diagnosed with ASD in middle school. She described her grandchild as “either pleasant or difficult” due to noted behavioral issues and social communication deficits. The child had ten siblings, but it is not known if these children were typically developing. She
reported that she was actively involved in his life because she lived close to the child’s father’s house. The child’s parents were divorced – this participant shared that expectations between the mother’s and father’s households were very different, which caused the child to be “a product of two different worlds.” The child attended one social group session each week for an hour and a half, in addition to a thirty minute individual session prior to the group session. The individual session targeted expectations for the social group as well as debriefing on previous sessions. The child attended about 85% of the scheduled sessions. Participant 6 discussed many suggestions to improve the CCD and school programs. These primarily addressed more communication between parents and therapists. She suggested mid-term parent-therapist meetings and more hand-outs to facilitate parent involvement and knowledge. She reported that she discontinued watching her grandson’s therapy sessions because she began to treat her grandson negatively after the sessions based on his in-session behavioral challenges, which was her reasoning for wanting other forms of involvement.

Interviewers and Ethnographic Interviewing

Two undergraduate social work students who had completed an interview course (Social Work 320) at UW-Eau Claire with a grade of “B” or higher conducted the interviews. The instructor of the course recommended the students based on this criterion. The PI emailed the recommended students and received responses from two students who volunteered to participate. Recruiting interviewers in this way ensured that the interviewers had experience in interviewing and an unbiased perspective. An unbiased perspective was critical for interviewers so they would follow the lead of the parent as opposed to leading the parent in their answers.

The interviewers attended a one-hour orientation to learn about the study, review interview techniques, and ask questions. The interviewers received a training packet during the
orientation (see 'Training Packet' in Appendix B). This acted as a guide during orientation and a take-home resource. The training packet also contained the interview handout which detailed the parent interview questions and suggested follow up questions to ask during the interview (see 'Interview Handout' in Appendix A). The interviewers were encouraged to take notes on the interview handout during the interview. This included brief notes on the participants’ answers and any remarkable observations (e.g., body language). In addition, the PI explained that if the participant offered any further information before or after the interview, making a note of the information was critical to ensure all data was captured. The interviewers were instructed to place these field notes in the PI’s on-campus mailbox. During the training, the PI provided broad information regarding the CSD department and the profession of speech-language pathology as a whole because the interviewers expressed a lack of knowledge on the subjects. This assisted to validate the students’ unbiased perspectives prior to conducting the interviews.

To elicit descriptive and unbiased client perspectives, a semi-structured ethnographic interview process was utilized (Spradley, 1979; Westby, 2003). Ethnographic interviewing is meant to be conducted in a conversational format (Westby, 2003). Initial questions are broad and open-ended to elicit rich descriptions based on experiences. Secondary to client responses, the interviewer will ask more specific questions (Spradley, 1979). Interviewers were encouraged to utilize these principles during the interview process. They were also instructed to read a script and ask broad, open-ended questions verbatim as listed on the interview handout to allow for a semi-structured interview.
Interview Questions

The following principles of ethnographic interviewing were applied to formulate questions in order to elicit honest and descriptive responses: asking for use, not meaning; utilizing open-ended questions; avoiding multiple questions; neutralizing questions to avoid leading the client to the answer; and avoiding why questions (Westby, 2003). Categories for interview questions were selected based upon issues regarding the use of FCC as well as benefits and outcomes of FCC. These categories include: perceived involvement (e.g., “Are you involved in the therapy process at the university clinic?”), parent perception on parent-therapist relationships (e.g., “Tell me about your speech-language pathologist at the university clinic.”), and the perceived impact of parent involvement and parent-therapist relationships on outcomes (e.g., “Do you feel your involvement impacts your child’s success?”). Each category included required questions to be asked during the interview to ensure consistency of questions asked between interviewers. Optional follow-up questions were utilized at the interviewer’s discretion. The interviewer was also provided with scripts and a list of information that was to be elicited from each participant. The list of information served as a guide if participants did not directly answer the required questions; the interviewer could then see what information was not addressed and ask follow-up questions to elicit the necessary information. A copy of the interview questions can be found in Appendix A.

Procedures

The Institutional Review Board (IRB) at the University of Wisconsin-Eau Claire approved this research on January 19, 2017. Interviews were held in treatment rooms at the CCD. Interviews lasted approximately 20 minutes. The PI called or emailed participants as a follow-up procedure to obtain feedback and answer any further questions. All interviews were
video recorded via VALT (a protected video recording system) and audio recorded via a digital voice recorder (DVR) – Olympus WS-400S DNS. The PI and research assistant (RA) transcribed audio recordings verbatim with the exception of identifying details which were transcribed generically (e.g., “My child goes to Robbins Elementary in Eau Claire” was transcribed as “My child goes to [elementary school] in [location]”) to maintain confidentiality of participants and their children. Transcripts were cross-checked by the investigator who did not transcribe the sample to ensure reliable transcriptions. Conflicts within transcripts were resolved electronically and finalized. All transcripts were kept on Microsoft Excel documents.

Analysis. The PI segmented the finalized transcript into codeable units. A codeable unit was defined as a cohesive thought and the context that surrounded it regardless of sentence length or complexity. Codeable units were then assigned meaning (i.e., schemes, categories, and subcategories). A codeable unit may have contained more than one meaning unit if segmenting the codeable unit would eliminate part of the context for understanding the overall meaning of the codeable unit.

The PI established five schemes: Background information, Speech-language pathologists, Parent involvement, Settings, and Parent reflections. These schemes were decided based on content areas of the interview; the content areas were determined based on the elements of FCC and previous research on FCC outcomes (Mitchell et al., 2009; Pappas et al., 2008; Rathert et al., 2012; Stewart et al., 2000). It is important to note that the coding of schemes to thought units was often confined to the question posed (e.g., answers to the question, “Tell me about your child,” was often coded as background information). However, there were times that participants discussed content that was off-topic from the questions, in which case, the PI and RA honored the content of the thought unit and definition of the scheme.
Background information was identified as “demographic information or any historical details about the child.” This scheme was created due to participants’ answers to the first two interview questions, “Tell me about your child” and “Where is your child currently receiving speech and language services?” These questions were primarily intended to build rapport between the interviewer and participant and provide the interviewer necessary information to proceed with the interview. This scheme was also identified in other responses if the context provided any form of general background information. Some examples included the name and age of the child, the child’s diagnosis, past and current therapy services, etc.

Speech-language pathologists was identified as “any description about the child’s speech-language pathologists.” During this portion of the interview, participants were initially asked broad and open-ended questions about their child’s SLPs per the ethnographic interview protocol (Spradley, 1979). The first question asked of parents was “Tell me about your speech-language pathologist at the university clinic.” Consequently, participants responded in broader terms than just the parent-therapist relationship. Therefore, this scheme was deemed more appropriate to describe the participants’ responses. It was typically used when participants responded to questions that explicitly asked about the child’s speech-language pathologists. Any comment regarding the SLPs’ communication style, relationship with the family, characteristics, etc. were coded the speech-language pathologist scheme regardless of exact question and answer responses.

Parent involvement was identified as “comments related to the parent’s types and levels of engagement within the therapy process.” This scheme was created based on the research questions. Parent involvement was typically used when participants responded to questions that asked about their involvement in each setting (e.g., “In what ways are you involved at the
university clinic?”). However, any comment directly related to the parents’ involvement (e.g., the importance of involvement, how they are involved) was coded this scheme regardless of exact question and answer responses.

*Settings* was defined as “broad comments that were in reference to the school program, university clinic program, or pediatric outpatient program.” This scheme was created based on participants speaking in general terms regarding the different settings. Since the study intended to elicit information to compare and contrast settings, participants offered general comments that did not relate to the SLPs or parent involvement. For example, participants spoke about the logistics of each setting as well as the effectiveness of the programs their child attended.

*Parent reflections* was defined as “parents expressing their thoughts in broad terms - these did not explicitly relate to their involvement, the child’s SLPs, or clinical settings.” This scheme was created based on participants’ responses to the last interview question – “Is there anything else you would like to share?” However, this scheme could be applied in other responses if these responses fit the definition.

These schemes were assigned to each codeable unit by the PI based on the operational definition of codeable units: a cohesive thought and the context that surrounds it at the phrase, sentence, or multi-sentence levels. The transcript of codeable units with applied schemes and operational definitions of those schemes was provided to the RA. These analysis pages were stored in Microsoft Word documents and included columns for transcription by codeable units, collapsed meaning, schemes, potential codes, and finalized categories and subcategories. The codeable units were analyzed using open and axial manual coding method (Strauss & Corbin, 1990).
To achieve open coding, the PI and RA generated categories independently based on the content of the thought unit. Initially, the PI and RA created broad categories that associated with and encompassed the meaning of each unit. Through multiple independent read-throughs of the data, both parties summarized possible operational definitions and created tentative labels. These labels and possible definitions were based on meanings that emerged from the data. As categories were generated, the PI and RA continued to create and eliminate categories independently until each party believed their categories concisely and broadly represented the data.

To achieve axial coding, the PI and RA independently drilled down to specific points in the data, creating subcategories. This allowed for representation of data that were more unique and precise than the categories could encompass. The PI and RA read through the data multiple times to create subcategories that grouped alike ideas and meanings, but also remained specific to the thought units. Possible operational definitions and tentative labels were assigned to each subcategory. As subcategories were generated, the PI and RA independently created and eliminated subcategories to specifically and categorically represent the data. Relationships between schemes, categories, and subcategories were established as categories and subcategories were generated. These relationships were determined based on possible operational definitions and noted within a visual representation in a Microsoft Excel document. As themes emerged, coding was refined and made consistent across thought units within transcripts and across participants by both the PI and RA independently.

Although this protocol was primarily utilized throughout the coding process, deeper information was initially more evident in some thought units. This lead to the PI and RA generating some subcategories before categories, then using the subcategories to generate
appropriate categories. The same process of creation and elimination was utilized to ensure the
data were represented accurately.

Following independent analysis of categories and subcategories, the PI and RA held two
consensus coding meetings on separate dates, with each meeting lasting roughly four hours.
These meetings fulfilled the following purposes: establishing mutually agreed upon category and
subcategory names, negotiating each unit’s code, and defining each category and subcategory.
The PI and the RA examined each thought unit in each of the participant’s analysis pages. The PI
and RA compared their own categories and subcategories. If categories and subcategories were
semantically similar, the PI and RA either generated a new term or jointly decided which of the
existing terms to select for the category or subcategory. If categories or subcategories were not
similar, the PI and RA debated and reached an agreement to either generate new categories and
subcategories or select an existing category or subcategory to fit the thought unit. As these
categories and subcategories were created, the PI made note of these codes in a Microsoft Excel
document. The PI and RA jointly defined each code. As codes were established, the PI and RA
went back to thought units as appropriate to achieve consistent coding throughout each
transcript. It was critical to return to the codes and operational definitions established in the first
consensus coding to ensure stability of the codes. This multiple round approach to coding
increased rigor and internal consistency.

The analysis pages were thoroughly examined to establish a list of codes and their
respective definitions. The data were reviewed again by the PI at a later date to ensure stability.
In spite of a rigorous process of consensus coding between the PI and RA, a large number of
categories and subcategories remained. In order to identify meaningful but manageable
interpretations and implications, it was deemed necessary to provide further condensing of like
codes, while remaining consistent with the underlying principles that were used to establish consensus coding with the RA. Taking care to remain consistent with operationalized definitions of unique categories and subcategories, the PI reviewed the jointly formulated categories and subcategories in an attempt to consolidate any categories and subcategories that were similar given operational definitions. Upon this review, the PI combined and reduced alike units to achieve concise coding. Jointly identified categories were reduced from 23 to 18 in this process. Likewise, subcategories were reduced from 121 to 40 in this process. The PI then analyzed each subcategory within the speech-language pathologist and parent involvement schemes in a setting context to compare the three different settings.

**Triangulation and Validation**

Triangulation is an approach for validating qualitative data and verifying it by cross-referencing two or more sources. Triangulation and validation was achieved in this study by comparing the following sources: the results of the manual coding, results of the consensus-coding, the field notes taken by the interviewers, and follow-up conversations that took place between February 28, 2017 and March 8, 2017 (see Figure 2). The PI and RA established one aspect of triangulation by independently and manually coding the transcripts, then holding two face-to-face meetings to negotiate coding assignments until 100% consensus was reached. Another step towards triangulation and validation included referencing field notes that the interviewers provided. Field notes were utilized with the intent of validating qualitative interpretations; information provided on the field notes was consistent with qualitative findings. Further, the PI followed up with participants following the interviews via phone calls or emails. Participant responses to the follow-up contact were consistent with qualitative interpretations. If inconsistencies were recognized in one of these modes, the PI reconsidered the qualitative
interpretations. However, there were not obvious inconsistencies that arose during follow-up conversations or after review of the field notes. The consistency of information from the field notes, follow-up conversations, manual and consensus coding validated and triangulated the codes and qualitative information generated.

It is important to note that the data were interpreted based on quantitative and qualitative results. On one hand, the PI counted frequencies of schemes, categories, and subcategories to determine frequency counts. The frequency counts allowed the PI to investigate topics that the participants spoke about frequently, which allowed interpretations to be couched on numerical data. On the other hand, the PI also identified qualitative importance based on the significance of the statement. Several statements were identified that were not frequent, but carried significant meaning that assisted to answer the research questions. Interpreting the data quantitatively as well as qualitatively allowed for a more iterative process and achieved salient points through two methods, further validating and triangulating interpretations.

![Diagram of triangulation and validation process]

*Figure 2. Triangulation and Validation of the Current Study*

**Interviewer Checklist**

An interviewer checklist was created by the PI to assess consistency between the two interviewers. This was created based on ethnographic interviewing principles (Spradley, 1979;
Westby, 2003). All interviews were viewed via the VALT system (a secure video recording system) by the PI and RA separately. This checklist (see Appendix B for more details) was utilized to rate the interviewers on their performance to ensure an acceptable level of consistency between the two interviewers. A five-minute segment was selected by the PI from each interview for rating. This segment was selected based on interview length and if the interview started earlier or later than the expected time. The PI and RA compared results to obtain an inter-rater reliability rating which represented the consistency of the PI’s and RA’s perceptions of how the interview was conducted. The PI scored the interviewer checklists. The number of checkpoints the PI and RA had in common was divided by the total number of possible checkpoints to obtain 83% inter-rater reliability.
III. RESULTS

The research questions investigated in this study were:

1. Are there differences in parent involvement and parent-therapist relationships between settings?

2. How do parents feel about differences between settings?

3. According to parents, how do parent involvement and parent-therapist relationships affect a child’s success in speech and language therapy?

Qualitative coding of interview transcripts was conducted in the context of five schemes: 

- Background information,
- Speech-Language Pathologists,
- Parent Involvement,
- Settings,
- Parent reflections.

From these schemes, 18 categories were identified which were further divided into 40 subcategories.

A total of 427 codeable statements were analyzed across the six participants. Of these codeable units, 189 fit within the scheme of speech-language pathologists (44%); 93 fit within the scheme of parent involvement (22%); 91 fit within the scheme of background information (21%); 46 fit within the scheme of parent reflections (11%); and 43 fit within the scheme of settings (10%). The total number of schemes (462) exceed the total number of codeable units (427) because some statements were double coded. The percentages were calculated by dividing the number of schemes coded with the total number of codeable units (427). See Figure 3 for an illustration of these numerical proportions. See Table 1 for the schemes, categories, and subcategories.

The numerical analyses relate to the number of times a scheme, category, or subcategory was discussed. This alone does not dictate qualitative value, as a single statement may carry more weight than multiple statements in a scheme.
Figure 3. Number of Schemes Coded in Relation to Total Codeable units.
<table>
<thead>
<tr>
<th>Objective information</th>
<th>Parent Involvement</th>
<th>Settings</th>
<th>Parent Reflection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Background Information</td>
<td>Demographic information</td>
<td>Confirmation</td>
<td>University clinic program</td>
</tr>
<tr>
<td>Relationships</td>
<td>Affirmation</td>
<td>Effectiveness</td>
<td>Relationships</td>
</tr>
<tr>
<td>Minimal contact</td>
<td>Denial</td>
<td>Unique features</td>
<td></td>
</tr>
<tr>
<td>Positive qualities of parent-therapist relationship</td>
<td></td>
<td>Challenges and/or suggestions</td>
<td></td>
</tr>
<tr>
<td>Between therapist and child</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uncertainty</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Length of relationship</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subjective information</td>
<td>Traits</td>
<td>Impact</td>
<td>School program</td>
</tr>
<tr>
<td>Child's progress</td>
<td>Related to disposition</td>
<td>SLP perception</td>
<td>Unique features</td>
</tr>
<tr>
<td>Child internal</td>
<td>Related to experience and education</td>
<td>Parent learning</td>
<td>Challenges and/or suggestions</td>
</tr>
<tr>
<td>Child diagnoses and/or challenges</td>
<td>Related to experiences</td>
<td>Progress</td>
<td></td>
</tr>
<tr>
<td>Environmental factors</td>
<td>Protocol</td>
<td>Affirmation</td>
<td></td>
</tr>
<tr>
<td>Structure of sessions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home program</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication</td>
<td>Methods of involvement</td>
<td>Outpatient clinic program</td>
<td>Unique features</td>
</tr>
<tr>
<td>Between professionals</td>
<td>Present for sessions</td>
<td>Challenges and/or suggestions</td>
<td></td>
</tr>
<tr>
<td>Modes of communication</td>
<td>Not present for sessions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent input</td>
<td>Active involvement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Importance</td>
<td>Dual role</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reliance on SLP</td>
<td>Passive involvement</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Speech-Language Pathologists

This scheme was counted 89 times and defined as “Descriptions of the child’s speech-language pathologists.” This scheme was further divided into five categories: demographic information, relationships, traits, protocol, and communication. These categories were determined based on the participant’s discussion of their child’s speech-language pathologists. These categories are defined and reported as number of incidents and percentages within Table 2. A visual representation of this scheme, categories, and subcategories can be found in Figure 4.

Figure 4. Visual of the Scheme, Speech-Language Pathologists, and its Categories and Subcategories
Table 2.

*Categories of the Scheme, Speech-Language Pathologists*

<table>
<thead>
<tr>
<th>Category</th>
<th>Definition</th>
<th>Number of Coded Instances</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Demographic information</em></td>
<td>Comments related to the SLP’s place of work. Example: “She’s employed by [outpatient clinic] in [location] and then they come to our school and do therapy.”</td>
<td>11</td>
<td>6%</td>
</tr>
<tr>
<td>Relationship</td>
<td>Statements about the nature of the relationship between SLP and child/parent.</td>
<td>59</td>
<td>31%</td>
</tr>
<tr>
<td>Traits</td>
<td>Statements regarding the characteristics of the child's SLPs.</td>
<td>53</td>
<td>28%</td>
</tr>
<tr>
<td>Protocol</td>
<td>Information about how the SLP conducts assessment/treatment.</td>
<td>45</td>
<td>24%</td>
</tr>
<tr>
<td>Communication</td>
<td>Statements about the SLPs' communication with the child, parent or other.</td>
<td>55</td>
<td>29%</td>
</tr>
</tbody>
</table>

*Note: The percentage listed is category’s relation to the overall scheme.*

*Demographic information did not contain any subcategories, therefore an example is provided along with the definition.*

**Relationship.** In the scheme of speech-language pathologists, the category of relationship was further divided into six subcategories. These subcategories are defined, assigned an example, and reported as number of incidents in Table 3.
Table 3.

**Subcategory Operational Definitions, Exemplars, and Number of Incidents for the Relationship Category**

<table>
<thead>
<tr>
<th>Subcategory</th>
<th>Definition</th>
<th>Example</th>
<th>Number of Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal contact</td>
<td>When parents reported connecting with the SLP infrequently.</td>
<td>“I honestly don’t have a lot of interaction with her.”</td>
<td>7</td>
</tr>
<tr>
<td>*Positive qualities of the parent-therapist relationship</td>
<td>Any comment related to positive qualities of the relationship between the therapist and parent.</td>
<td>“Well, we’ve had really good relationships.”</td>
<td>10</td>
</tr>
<tr>
<td>Between therapist and child</td>
<td>Any comment related to the relationship between the therapist and child.</td>
<td>“I think they do a good job interacting with [child], um, they understand him well.”</td>
<td>17</td>
</tr>
<tr>
<td>Uncertainty</td>
<td>When the parent reported being unsure about the SLP — used when parents stated they forgot the name or details of the SLP.</td>
<td>“I knew you were going to ask me [her name]. Can’t remember...[name]?”</td>
<td>10</td>
</tr>
<tr>
<td>Length of relationship</td>
<td>Comments related to the newness of the relationship between the therapist and the family.</td>
<td>“I feel like she’s just kind of just started to know [child] and how he kind of runs the session.”</td>
<td>5</td>
</tr>
<tr>
<td>Positive effects</td>
<td>When parents commented that their relationship with their child’s SLP affected the child positively.</td>
<td>“Oh, sure. Because we can get on top of things more quickly.”</td>
<td>14</td>
</tr>
</tbody>
</table>

*Note: This subcategory is referred to as its abbreviated name, “Positive qualities,” in Figure 5.*
**Traits.** In the scheme of speech-language pathologists, the category of traits was further divided into three subcategories. These subcategories are defined, assigned an example, and reported as number of incidents in Table 4.

Table 4.

*Subcategory Operational Definitions, Exemplars, and Number of Incidents for the Traits*

<table>
<thead>
<tr>
<th>Subcategory</th>
<th>Definition</th>
<th>Example</th>
<th>Number of Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related to disposition</td>
<td>Comments about the personality, temperament, or character of the SLP.</td>
<td>“But yeah it’s... here it’s weird, they’re so cheerful.”</td>
<td>30</td>
</tr>
<tr>
<td>Related to experience and education</td>
<td>Comments regarding the longevity of the SLP’s career, educational background, level of training, or area of expertise.</td>
<td>“She went to school here [UW-Eau Claire]. She was a student of... [supervisor].”</td>
<td>20</td>
</tr>
<tr>
<td>Related to techniques</td>
<td>Comments regarding specific practices the SLP uses during assessment and treatment.</td>
<td>“I think she does a good job of look at um at evidence-based techniques.”</td>
<td>7</td>
</tr>
</tbody>
</table>

**Protocol.** In the scheme of speech-language pathologists, the category of protocol was further divided into two subcategories. These are listed in Table 5 along with their definitions, examples of each, and number of incidents.
Table 5.

**Subcategory Operational Definitions, Exemplars, and Number of Incidents for the Protocol**

**Category**

<table>
<thead>
<tr>
<th>Subcategory</th>
<th>Definition</th>
<th>Example</th>
<th>Number of Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structure of sessions</td>
<td>Comments related to the design of the sessions (e.g., logistics, rules, type of therapy) This also included activities and targets of the sessions.</td>
<td>“And when [child] works with [clinician 1] for the first half hour and then at [time] is the larger group and both [clinician 1] and [clinician 2].”</td>
<td>47</td>
</tr>
<tr>
<td>Home program</td>
<td>Comments related to recommendations of homework sent home by the SLP.</td>
<td>“And they’re able to provide us with you know stuff to work on at home.”</td>
<td>11</td>
</tr>
</tbody>
</table>

**Communication.** In the scheme of *speech-language pathologists*, the category of *communication* was further divided into five subcategories. These are listed in *Table 6* along with their definitions, examples of each, and number of incidents.
Table 6.

Subcategory Operational Definitions, Exemplars, and Number of Incidents for the Communication Category

<table>
<thead>
<tr>
<th>Subcategory</th>
<th>Definition</th>
<th>Example</th>
<th>Number of Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between professionals</td>
<td>Comments related to the SLP communicating with other professionals that also serve the child.</td>
<td>“I think they do a really good job of communicating with his school. Getting his IEP and stuff when it’s available from [outpatient clinic].”</td>
<td>5</td>
</tr>
<tr>
<td>Modes of communication</td>
<td>Methods in which the SLP communicates with the parents.</td>
<td>“She does a good job of sending videos on his iPad and what they worked on.”</td>
<td>19</td>
</tr>
<tr>
<td>Parent input</td>
<td>When parents report they share their opinions and ideas with the SLP.</td>
<td>“And then I it's weird because at the very first session she was like, &quot;what do you want me to change or do different?&quot; And I'm like, ‘you're doing fine. You're doing great. Keep doing what you're doing, He's talking go go go.’”</td>
<td>24</td>
</tr>
<tr>
<td>Importance</td>
<td>Any statement that explains why it's important for communication.</td>
<td>“I think so, just because if I’m not speaking with ya know with them they don’t know what’s going on.”</td>
<td>11</td>
</tr>
<tr>
<td>Reliance on SLP</td>
<td>The SLP is more assertive in communication and the parent reports relying on the SLP to either initiate communication or facilitate it.</td>
<td>“… so I’m relying on what they tell me [about the sessions].”</td>
<td>6</td>
</tr>
</tbody>
</table>
The subcategories in the *speech-language pathologists* scheme were counted in the context of each different setting (university clinic program, school program, and outpatient clinic program) due to the study’s intention of comparing parent-therapist relationships between different settings. The numbers listed within *Figure 5* represent the number of times participants discussed the subcategory in the setting context.

It is important to note that there were subcategories that could not be placed in this context due to participants discussing the topic without referencing a specific setting. The following subcategories were discussed without specific references to the settings and therefore are not included in *Figure 5*: *positive effects* (category of *relationships*) and *importance* (category of *communication*).

Overall totals of each subcategory could not always be placed in a setting context. Participants often discussed subcategories in a setting context, but occasionally discussed these topics without referencing a setting. For example, *related to disposition* was discussed a total of 30 times, but only 27 of those times were in a setting context; the remaining three were broad observations. Therefore, the subcategories listed and counted within a setting context in *Figure 5* may not equal their total number.
Figure 5. Subcategories of the Scheme, *Speech-Language Pathologists*, Within a Setting Context
Parent Involvement

*Parent involvement* was counted 93 times and defined as “comments related to the parent’s types and levels of engagement within the therapy process.” The scheme of *parent involvement* was further divided into four categories: *confirmation, impact, methods of involvement,* and *parent feelings.* Each of these categories was defined, counted amongst all participants, and calculated into a percentage as it related to the *parent involvement* scheme. The results are listed in *Table 7.* A visual representation of this scheme, categories, and subcategories can be found in *Figure 6.*

---

*Figure 6. Visual of the Scheme, Parent Involvement, and its Categories and Subcategories*
Table 7.

**Categories of the Scheme, Parent Involvement**

<table>
<thead>
<tr>
<th>Category</th>
<th>Definition</th>
<th>Number of Coded Instances</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confirmation</td>
<td>When parents report if they are or are not involved within the different settings, generally an answer to a yes/no question.</td>
<td>11</td>
<td>11%</td>
</tr>
<tr>
<td>Impact</td>
<td>Comments regarding how parents feel their involvement impacts their child’s success.</td>
<td>36</td>
<td>39%</td>
</tr>
<tr>
<td>Methods of involvement</td>
<td>How parents report being involved within the therapy process.</td>
<td>46</td>
<td>49%</td>
</tr>
<tr>
<td>Parent feelings</td>
<td>Any comments related to parent feelings toward involvement.</td>
<td>16</td>
<td>17%</td>
</tr>
</tbody>
</table>

*Note: The percentage listed is category’s relation to the overall scheme.*

**Confirmation.** In the scheme of parent involvement, the category of confirmation was further divided into two subcategories: affirmation and denial. This code was most often used when parents answered the yes/no question of “Are you involved?” These are listed in Table 8 along with their definitions, examples of each, and number of incidents.

Table 8.

**Subcategory Operational Definitions, Exemplars, and Number of Incidents for the Confirmation Category**

<table>
<thead>
<tr>
<th>Subcategory</th>
<th>Definition</th>
<th>Example</th>
<th>Number of Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affirmation</td>
<td>When parents reported that they were involved in the therapy process.</td>
<td>“Yes, [we are involved] very much.”</td>
<td>9</td>
</tr>
<tr>
<td>Denial</td>
<td>When parents reported that they were not involved in the therapy process.</td>
<td>“Not so much.”</td>
<td>2</td>
</tr>
</tbody>
</table>
**Impact.** In the scheme of *parent involvement*, the category of *impact* was further divided into four subcategories. These are discussed further in *Table 9.*

**Table 9.**

*Subcategory Operational Definitions, Exemplars, and Number of Incidents for the Impact Category*

<table>
<thead>
<tr>
<th>Subcategory</th>
<th>Definition</th>
<th>Example</th>
<th>Number of Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>SLP Perception</td>
<td>When parents report that their involvement assists the therapist to have a better understanding of their child.</td>
<td>“You [the parent] go in with them and they start talking the way they normally do or acting the way they normally do and the therapist can actually see how they are.”</td>
<td>2</td>
</tr>
<tr>
<td>Parent learning</td>
<td>When parents report that they learn as a result of being involved.</td>
<td>“[She] teaches us how to do what they’re doing and how that helps him be successful.”</td>
<td>16</td>
</tr>
<tr>
<td>Progress</td>
<td>When parents report that their involvement assists their child to make gains. This may also apply to parents comments regarding generalization.</td>
<td>“I think it helps to have my kids talking to me too you can see better with the speech.”</td>
<td>16</td>
</tr>
<tr>
<td>Validation</td>
<td>Parents report that they feel their involvement impacts their child’s success.</td>
<td>“So true. Oh, yeah. Yes. Very true [that my involvement impacts my child].”</td>
<td>6</td>
</tr>
</tbody>
</table>
Methods of involvement. In the scheme of parent involvement, the category of methods of involvement was further divided into five subcategories. These subcategories are defined, assigned an example, and reported as a number of incidents in Table 10.
Table 10.

Subcategory Operational Definitions, Exemplars, and Number of Incidents for the Methods of Involvement Category

<table>
<thead>
<tr>
<th>Subcategory</th>
<th>Definition</th>
<th>Example</th>
<th>Number of Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Present for sessions</td>
<td>When the parent reported being present for the sessions; this may include in sessions or observation.</td>
<td>“We’re in the session with them, so…”</td>
<td>8</td>
</tr>
<tr>
<td>Not present for sessions</td>
<td>When parents reported not being present for the therapy sessions.</td>
<td>“So I think it goes the same at his elementary school – we’re not there.”</td>
<td>9</td>
</tr>
<tr>
<td>Active involvement</td>
<td>When parents reported participating in various aspects of the therapy process. This included acting as a consult, attending meetings, making decisions, participating in conversations with the SLP, participating in sessions, and following through with treatment at home.</td>
<td>“Yeah so also we meet at the IEP meeting and we tell our expectation, so she knows that.”</td>
<td>26</td>
</tr>
<tr>
<td>Dual role</td>
<td>When parents view their role in involvement as being a parent as well as a therapist</td>
<td>“So we are parents but we also should be a therapist, too.”</td>
<td>5</td>
</tr>
<tr>
<td>Passive involvement</td>
<td>When parents reported allowing or accepting the SLP to make decisions and act as the primary leader with minimal involvement on the parent’s part.</td>
<td>“Um yeah, I’m involved in what they decide.”</td>
<td>3</td>
</tr>
</tbody>
</table>
**Parent feelings.** In the scheme of *parent involvement*, the category of *parent feelings* was further divided into two subcategories. These subcategories are defined, assigned an example, and reported as a number of incidents within *Table 11.*

**Table 11.**

*Subcategory Operational Definitions, Exemplars, and Number of Incidents for the Parent*

*Feelings Category*

<table>
<thead>
<tr>
<th>Subcategory</th>
<th>Definition</th>
<th>Example</th>
<th>Number of Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Desire to Increase Involvement</td>
<td>When parents commented on wanting to be involved more.</td>
<td>&quot;...you wish you had more time with him, really that's the only thing I wish I could be more of with him so.&quot;</td>
<td>6</td>
</tr>
<tr>
<td>Satisfaction with Involvement</td>
<td>When parents reported enjoying their current level of involvement.</td>
<td>&quot;I think it's [parent involvement] working out really well.&quot;</td>
<td>13</td>
</tr>
</tbody>
</table>

The subcategories within the *parent involvement* scheme were counted within the context of each different setting (university clinic program, school program, and outpatient clinic program) due to the study's intention of comparing parent involvement between different settings. The numbers listed within *Figure 7* represent the number of times participants discussed the subcategory within the setting context.

It is important to note that there were subcategories that could not be placed within this context due to participants discussing the topic without referencing a specific setting. This included the category, *impact*, and its subcategories: *SLP perception, parent learning, progress,* and *validation*. Under the category of *methods of involvement*, the subcategory of *dual role* was also discussed broadly, without referencing the settings. Therefore, these subcategories will not be included in *Figure 7.*
Overall totals of each subcategory could not always be placed within a setting context. Participants often discussed subcategories within a setting context, but occasionally discussed the topic without referencing a setting. For example, *active involvement* was discussed a total of 26 times, but only 21 of those times were within a setting context; the remaining five were broad observations. Therefore, the subcategories listed and counted within a setting context in *Figure 7* may not equal their total number.
Figure 7. Subcategories of the Scheme, Parent Involvement, Within a Setting Context
Background Information

This scheme was counted 91 times and defined as “demographic information or historical details about the child.” Two categories of this scheme were determined: objective information and subjective information. Each of these categories was defined, counted amongst all participants, and calculated into a percentage as it related to the settings scheme. See Table 12 for details. A visual representation of this scheme, categories, and subcategories can be found in Figure 8.

Figure 8. Visual of the Scheme, Background Information, and its Categories and Subcategories
Table 12.

**Categories of the Scheme, Background information**

<table>
<thead>
<tr>
<th>Category</th>
<th>Definition</th>
<th>Number of Coded Instances</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Objective information</td>
<td>Basic and objective information regarding the child – this may include services, age of the child, name of the child, or education level. *Example: He’s a freshman in high school.</td>
<td>42</td>
<td>46%</td>
</tr>
<tr>
<td>Subjective information</td>
<td>Descriptions that were inherently more subjective than basic information regarding the child.</td>
<td>59</td>
<td>64%</td>
</tr>
</tbody>
</table>

*Note: The percentage listed is category’s relation to the overall scheme.
*Objective information did not have any subcategories, therefore an example is provided within the table.*

**Subjective information.** The category of subjective information was further divided into four subcategories. These subcategories are defined, assigned an example, and reported as a number of incidents in Table 13. It is important to note that this category was created based on participant report; therefore, information may differ from that of reality. For example, Participant 3 reported that his son was diagnosed CAS, but this diagnosis was not confirmed based on a review of written reports in the clients’ files. Therefore, although a subcategory within this category may appear objective, it is entirely based on participant report which is subjective in nature.
Table 13.

_Subcategory Operational Definitions, Exemplars, and Number of Incidents for the Subjective Information Category_

<table>
<thead>
<tr>
<th>Subcategory</th>
<th>Definition</th>
<th>Example</th>
<th>Number of Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child’s growth</td>
<td>The gains the child has made until the point of the interview.</td>
<td>“He respond[s] more to friends [now].”</td>
<td>6</td>
</tr>
<tr>
<td>Child internal</td>
<td>Comments related to the child’s strengths, personality and/or interests. May also include a general depiction of the child.</td>
<td>“He has interests in plumbing and electricity.”</td>
<td>12</td>
</tr>
<tr>
<td>Child’s diagnoses and/or challenges</td>
<td>Description of the child’s struggles. Comments related to the child’s diagnosis that impacts their speech and language development.</td>
<td>“… but he’s still working on asking [his] teacher. Like when he [would] like to go to [the] bathroom, he just go[es] back and forth so [his] teacher just has to assume.”</td>
<td>23</td>
</tr>
<tr>
<td>Environmental factors</td>
<td>Any environmental or family effects that impact or are unique to the child’s current circumstances. May also include major life events that have impacted the child’s development.</td>
<td>“So at 13 months old he was diagnosed with his first cancer, neuroblastoma, and that’s a cancer.”</td>
<td>18</td>
</tr>
</tbody>
</table>
Parent Reflections

*Parent reflections* was counted 46 times and defined as “parents expressing their thoughts in broad terms - these did not explicitly relate to their involvement, the child’s SLPs, or clinical settings.” This scheme was further divided into four categories. These categories are defined, assigned an example, and reported as number of incidents in *Table 14*. A visual representation of this scheme and categories can be found in *Figure 9*.

![Diagram](image)

*Figure 9. Visual of the Scheme, Parent Reflections, and its Categories*
Table 14.

*Categories of the Scheme, Parent Reflections*

<table>
<thead>
<tr>
<th>Subcategory</th>
<th>Definition</th>
<th>Example</th>
<th>Number of Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Holistic perceptions</td>
<td>Comments regarding the child’s functioning within daily routines as well as the parent’s overall outlook on the child; this included parent goals.</td>
<td>“So he goes to therapy. So therapy is a small part of his life, daily life.”</td>
<td>17</td>
</tr>
<tr>
<td>Parent relationships with others</td>
<td>When parents discussed their relationship with others, often between the parent and child.</td>
<td>“Because [it’s] my child and I know him more than anybody else.”</td>
<td>13</td>
</tr>
<tr>
<td>Feelings</td>
<td>When parents described their feelings towards any entity.</td>
<td>“Sometimes it’s tiring, he’s talking all the time. It’s like, ‘oh, I see, then what happen[ed]??’”</td>
<td>4</td>
</tr>
<tr>
<td>Child’s perception</td>
<td>When parents discussed their child’s response or feelings towards any entity – most commonly discussed was the SLP and overall program.</td>
<td>“It’s hardest thing of OT and like um I don’t know… even feeding you know, feeding for him is horrible.”</td>
<td>14</td>
</tr>
</tbody>
</table>
Settings

This scheme was counted 43 times and defined as "broad comments that were in reference to the school program, university clinic program, or pediatric outpatient program."

This scheme was further broken into three categories: university clinic program, school program, and outpatient clinic program. Each of these categories was defined, counted amongst all participants, and calculated into a percentage as it related to the settings scheme. The results are listed in Table 15. A visual representation of this scheme, categories, and subcategories can be found in Figure 10.

*Figure 10. Visual of the Scheme, Settings, and its Categories and Subcategories*
Table 15.

*Categories of the Scheme, Settings*

<table>
<thead>
<tr>
<th>Category</th>
<th>Definition</th>
<th>Number of Coded Instances</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>University Clinic Program</td>
<td>Comments related to the university clinic program that did not concern the SLPs; typically about the program in general terms.</td>
<td>24</td>
<td>56%</td>
</tr>
<tr>
<td>School Program</td>
<td>Comments related to the school program that did not concern the SLPs; typically about the program in general terms.</td>
<td>16</td>
<td>37%</td>
</tr>
<tr>
<td>Outpatient Clinic Program</td>
<td>Comments related to the university clinic program that did not concern the SLPs; typically about the program in general terms.</td>
<td>4</td>
<td>9%</td>
</tr>
</tbody>
</table>

*Note: The percentage listed is category’s relation to the overall scheme.*

**University clinic program.** In the scheme of *settings*, the category of *university clinic program* was further divided into three subcategories. These are listed in *Table 16* along with their definitions, examples of each, and number of incidents.
Table 16.

Subcategory Operational Definitions, Exemplars, and Number of Incidents for the University

Clinic Program Category

<table>
<thead>
<tr>
<th>Subcategory</th>
<th>Definition</th>
<th>Example</th>
<th>Number of Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effectiveness</td>
<td>Comments regarding how the child has improved due to the program.</td>
<td>“Yeah I would say I think the therapy he gets is probably the most effective set up for therapy and the most effective program that I’ve seen him in.”</td>
<td>4</td>
</tr>
<tr>
<td>Unique features</td>
<td>Comments related to specific aspects of the university clinic program; parents typically discussed student clinician turn-over, helping students to learn, and supervisors. May also include scheduling and logistics.</td>
<td>“I’ve had many students, well... [child]’s been involved in the university for 3 or 4 years and so every semester new students come.”</td>
<td>10</td>
</tr>
<tr>
<td>Challenges and/or suggestions</td>
<td>Any comment that discussed a challenge to this program or a suggestion to improve it.</td>
<td>“Um it would be nicer... I guess here’s one, to have a little more interaction with them [student clinicians]”</td>
<td>9</td>
</tr>
</tbody>
</table>
School program. In the scheme of settings, the category of school program was further divided into two subcategories. These are listed in Table 17 below along with their definitions, examples of each, and number of incidents.

Table 17.

Subcategory Operational Definitions, Exemplars, and Number of Incidents for the School

Program Category

<table>
<thead>
<tr>
<th>Subcategory</th>
<th>Definition</th>
<th>Example</th>
<th>Number of Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unique features</td>
<td>Comments related to specific aspects of the school program; parents typically discussed IEP meetings and conferences. May also include scheduling and logistics.</td>
<td>“We discuss that at the IEP meeting, um, kinda talk about what they see are his needs.”</td>
<td>7</td>
</tr>
<tr>
<td>Challenges and/or suggestions</td>
<td>Any comment that discussed a challenge to this program or a suggestion to improve it.</td>
<td>“I just wish we could see them more.”</td>
<td>10</td>
</tr>
</tbody>
</table>

Outpatient clinic program. Within the scheme of settings, the category of outpatient clinic program was further divided into two subcategories. These are listed in Table 18 below along with their definitions, examples of each, and number of incidents.
Table 18.

Subcategory Operational Definitions, Exemplars, and Number of Incidents for the Outpatient

Clinic Program Category

<table>
<thead>
<tr>
<th>Subcategory</th>
<th>Definition</th>
<th>Example</th>
<th>Number of Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unique features</td>
<td>Comments related to specific aspects of the outpatient clinic program; parents typically discussed insurance. May also include scheduling and logistics.</td>
<td>“Yeah it’s not the fault of the SLP or anything it’s just with insurance, you know, you have to wait for approval.”</td>
<td>4</td>
</tr>
<tr>
<td>Challenges and/or suggestions</td>
<td>Any comment that discussed a challenge to this program or a suggestion to improve it.</td>
<td>“I think if I were to change anything I would try to change his sessions at [outpatient clinic].”</td>
<td>4</td>
</tr>
</tbody>
</table>

Positive and Negative Connotations

There were several subcategories and one category that were initially identified and labeled without obvious intentional positive or negative connotations (e.g., related to disposition). However, participants sometimes discussed these with positive or negative connotations. For example, Participant 2 commented about what she liked about her son’s SLPs at the university clinic: “They are easy to talk to [and] that’s important.” This was a comment labeled related to disposition that carried a positive connotation. However, there were some comments that carried a negative connotation. For example, Participant 2 also commented about what she would like to change about her relationship with her son’s SLP at the school: “It’s just her style… she speaks fast… so I feel like I need to speak fast and leave [as quickly] as I can.”
This was a comment labeled *related to disposition* that carried a negative connotation. A visual representation and frequency counts of these subcategories and category are identified in *Figure 11*.
Figure 11. Visual of the Category and Subcategories with Positive and Negative Connotations

*Note: Unique features is defined as ‘comments related to specific aspects of each setting.’ For the university clinic program, this often referred to clinician turn-over, helping students learn, and supervisors. For the school program, this often referred to IEP meetings and conferences. For the pediatric outpatient program, this often referred to insurance. Scheduling and logistics may also be included in this definition for each of the settings.
The frequency counts of the positive and negative comments were counted within a setting context. For example, Participant 2 spoke about her son’s SLPs at the university clinic (positive connotation) and at the school (negative connotation) in terms of related to disposition. These comments were counted towards the related to disposition subcategory as one positive comment and one negative comment to the university clinic and school setting, respectively. The results of the positive and negative connotations as they related to each setting can be found in Figure 12.
Figure 12. Frequency Counts of Positive and Negative Comments in the Setting Context
Responses to Follow-Up Contact

The PI contacted participants after the interview to obtain feedback and allow an opportunity for any follow-up questions. Three participants were contacted via email – Participants 1, 4, and 6; two of the three participants responded. Participant 1 stated that the interview went well and she had no further questions. Participant 6 also stated that the interview went well, then restated suggestions she made during the interview to improve the university clinic. The other three participants were contacted via phone calls, which lasted approximately one minute each. Participants 2 and 4 expressed that the interviews were amicable and they had no further questions regarding the study. Participant 5 was asked to describe her child’s therapy at the university clinic due to her assertion that her child did not receive services in that setting. She described therapy as a social group but stated again that her child did not receive speech and language therapy at the university clinic.

Challenges and Suggestions

As participants spoke about each setting, they commented on the specific challenges each setting can present. These challenges were sometimes reconciled with workable solutions presented by the participants. These challenges and suggestions will be discussed in terms of each setting.

University clinic. There were two primary challenges of the university clinic that were identified, which concerned therapy time and parent-therapist interactions. Participant 3 expressed a desire for more therapy time overall at the university clinic. This parent suggested that more therapy time could be offered at the university clinic. Participant 6 expressed a desire for more parent-therapist interactions at the university clinic. She suggested mid-term meetings to address the child’s progress and more parent handouts to facilitate parent involvement.
School setting. There was one challenge identified which concerned the SLPs’ workload and availability. Participant 2 expressed that she felt the SLP at the school was too busy because of the number of children she served. This participant wanted her SLP to have more time to dedicate to interacting with her and her child. Participant 6 identified that she wished she could meet more often with school personnel to discuss her child’s progress. Although Participant 6 realized this may be too difficult logistically, this would be an ideal scenario to increase her involvement.

Pediatric outpatient setting. Participant 4 was the only participant that was receiving services a pediatric outpatient facility. Yet, this participant offered two primary challenges to this setting. First, the issue of insurance was discussed in depth. Participant 4 explicitly stated the blame did not belong to the SLP; rather, the insurance company held the authority to allow access to services, as is typical for this setting (Lubinski & Hudson, 2013). At the time of the interview, Participant 4 was experiencing challenges for authorization of services. This led to the second challenge, inconsistent services. The participant discussed that when they would service inconsistently, their child would have to reestablish a routine to make progress. Participant 4 would have preferred their insurance company to be more consistent to allow for consistent visitation.
IV. DISCUSSION

As previously addressed, FCC leads to improved outcomes for children and parents (King et al., 1999) and is comprised of two key elements: parent involvement and parent-therapist relationships. However, these elements can be impacted by logistical issues within settings (Pappas et al., 2008). Therefore, the current study aimed to address the following research questions:

1. Are there differences in parent involvement and parent-therapist relationships between settings?
2. How do parents feel about differences between settings?
3. According to parents, how do parent involvement and parent-therapist relationships affect a child’s success in speech and language therapy?

These questions will be addressed in sequential order as indicated by the primary headings. Questions will be addressed in terms of topics, including: differences in parent involvement, parent-therapist relationships, and settings; parent impressions and opinions; impact of the parent-therapist relationship and parent involvement; and other relevant themes. It is important to note that information presented in this section may be repeated from previous sections or within the section itself. This was intentional to appropriately guide the reader and highlight the major interpretations.

Differences in Parent Involvement, Parent-Therapist Relationships, and Settings

There were apparent differences across the different settings for the two key elements of FCC: parent-therapist relationships and parent involvement. Parent-therapist relationship differences will be discussed in terms of minimal contact, modes of communication, and length of relationship. Parent involvement differences will be discussed in terms of presence or absence
during sessions and varying levels of involvement throughout the therapy process. Lastly, settings will be discussed in terms of effectiveness.

**Parent-therapist relationships.** In the school setting, *minimal contact* was reported six times; there was only one mention of *minimal contact* for the university clinic (see Figure 5 on page 46). Participants often reported that they interacted face-to-face with their child’s school SLP at IEP meetings. The IEP team must hold a meeting at least once a year and formally invite parents to attend this meeting to discuss the child’s progress and future directions (IDEA, 2004). However, participants reported that they would only interact with their child’s SLP during these annual meetings. For example, Participant 5 stated: “I honestly don’t have a lot of interaction with her. Most of the time, I see her at his IEP meetings – which is once a year.” This lack of connection between SLP and parent may be likened to the Brooks-Gunn et al. (2000) framework of *distant* (low satisfaction, low control) or *traditional* (high satisfaction, low control) roles. For effective collaboration to take place, therapists and clients must hold open and honest conversations to work towards goals (Bordin, 1979). If these conversations are not taking place, or are far and few between, this can impact the child’s success (King et al., 1999).

Although the school-based SLP may not be connecting often with parents, this does not imply that they are not collaborating with others. Carroll (2010) discovered that SLPs in the school tend to directly involve the child’s teacher, but indirectly involve the parent. This indirect involvement may cause the parent to have less contact with the school SLP. However, not all participants stated that they had minimal contact with their school SLP. When asked how she interacted with the school SLP, Participant 6 responded: “Physically through emails. She always answers every email... and if she has an issue, she emails me.” Although participants reported five more instances of *minimal contact* in the school setting than at the university clinic, this
PARENT PERSPECTIVES ON FCC WITHIN MULTIPLE SETTINGS

does not mean that parents and school SLPs cannot communicate. Rather, the reason for the reported minimal contact may be more reliant on the SLP and parents themselves. As discussed by Pappas et al. (2008), there are other barriers to FCC that include parent motivation and professional attitude. In a school setting, logistics may present an initial barrier, but there are other options for communication.

In fact, the subcategory of modes of communication was discussed 13 times by participants in the school-based context and six times in the university clinic context (see Figure 5 on page 46). This may be because SLPs in the school do not encounter parents daily and must communicate with parents in other ways. For example, participants listed the following ways the school-based SLP communicated with them: conferences, IEP meetings, in-person visits, notes back and forth, videos sent home on an iPad, paper report, and e-mail. However, at the university clinic, parents bring their children for therapy which enables SLPs to interact with parents in-person each session. For example, participants listed the following ways the university clinic SLPs communicated with them: e-mail, in-person conversations, and phone calls. Interacting with parents in-person may simplify the communication process and consequently require fewer modes to communicate. Although not explicitly asked, none of the participants mentioned being disagreeable to any of these methods. Benson, Karlof, and Siperstein (2008) found that mothers of children with ASD reported they were involved in a variety of ways within the child’s school program. Like the participants in the current study, these mothers reported they communicated with staff via informal and formal communication measures, attended conferences, and participated in meetings (Benson et al., 2008). This reflects findings within the current study – parents are involved within a school setting, just in different ways. Therefore, it appears that if
the SLP communicates with the parents, the mode is not as consequential as the communication itself.

Another aspect of the parent-therapist relationship that was discussed by participants was the length of that relationship. This was discussed four times regarding the university clinic and one time regarding the pediatric outpatient facility (see Figure 5 on page 46). Participants often spoke about the newness of the relationship due to the timing of the semester. To provide their undergraduate and graduate students with a comprehensive and diverse clinical experience, the CCD typically reassigns SLPs to different clients every semester. In other words, a client will often switch SLPs every three to four months. The interviews were conducted in February and early March 2017 which was between one and three weeks after the clinic began seeing clients. Participant 6 stated: “I know very little about them because the semester is new… I’ve only basically met them.” The timing of the interviews may not have allowed time for relationships to form before parents were asked about these relationships. Despite the frequent change in clinician, parents did not report this as a negative aspect of the university clinic setting. One critical aspect of forming a collaborative parent-therapist relationship is trust (Bordin, 1979). Trust is formed primarily on the individual’s beliefs and perceptions (Holtz, 2014) and not necessarily the length of relationship (Levin, Whitener & Cross, 2006). The newness of parent-therapist relationships may not have necessarily impacted the relationship quality. Therefore, although participants mentioned the turn-over rate of student clinicians, it does not appear that the longevity of the relationship (secondary to logistics of a setting) impacted the quality of the parent-therapist relationship.

**Parent involvement.** Participants often discussed how they were involved in each setting. Only at the university clinic and outpatient clinic program did parents report being
present for sessions (eight instances); out of the nine instances of not present for sessions, eight of these were mentioned in the school setting context (see Figure 7 on page 54). It is more difficult for parents to be present during these sessions as they typically happen over the course of the school day (Lubinski & Hudson, 2013) when parents often work. This contrasts with a clinic-based setting where the parent is responsible for providing the child with transportation. Yet, only three instances of passive involvement were reported; all of which were in the context of a school-based setting. However, this level of involvement was only reported by Participant 5. There were 14 instances of active involvement reported in the school-based setting (see Figure 7 on page 54) affirming that the logistics of the setting may not be the primary contributor of involvement. Rather, the parent-therapist relationship (Forsingdal et al., 2013), therapists’ beliefs and attitudes as well as parent motivation (Pappas et al., 2008) may be stronger contributing factors to parent involvement than the logistics of the setting of care. It is interesting to note that Participant 5 was the only participant to discuss her involvement as passive. This same participant also reported two out of the six instances of reliance on SLP and four out of the seven instances of minimal contact. It appeared these elements were connected. Forsingdal et al. (2013) discovered that the parent-therapist relationship influenced parents’ involvement in collaborative goal setting. An ongoing and supportive relationship contributed to more parental involvement (Forsingdal et al., 2013). Therefore, Participant 5’s passive involvement may have been influenced by the lack of connection she had with the school-based SLP. According to the Brooks-Gunn (2010) framework, this excludes Participant 5 from the collaborative role. A collaborative role is known to increase parental competence (Broggi & Sabatelli, 2010). It is interesting to further note that Participant 5 did not recognize the speech and language services her son received at the university clinic as services, but as a social outing. It appeared that the
relationship between Participant 5 and the SLPs at the school and university clinic contributed to this participant’s lack of knowledge regarding the nature of speech and language services. This finding calls for more communication and stronger parent-therapist relationships to facilitate accurate parent knowledge.

**Effectiveness.** Although parents discussed differences among the settings, one subcategory contained significant meaning given its discussion in only one setting. The subcategory *effectiveness* was only discussed in terms of the university clinic. In other words, participants discussed the child’s success due to the university clinic program. For example, Participant 4 stated: “Yeah I would say I think the therapy he gets is probably the most effective set up for therapy and the most effective program that I’ve seen him in.” The effectiveness of the university clinic may be due to the educational nature of this specific setting. Goldstein (2008) argued that graduate students learn EBP directly through academic coursework; it is then the clinical supervisors that facilitate application of EBP into clinical practice. This direct transfer of research to clinical practice is not typical in other settings. In fact, the typical timeline for research becoming widely accepted clinical practice is 17 years in other clinical settings (Balas & Boren, 2000), consequently creating the research-practice gap.

The research-practice gap is a term used to describe the wait-time between research being published and application to clinical practice (Olswang & Prelock, 2015). According to practicing SLPs, this gap is caused by time and resource barriers (Zipoli & Kennedy, 2005). Yorkston and Baylor (2013) also identified factors impacting application of research into practice, including range and focus of research, interpreting results into practice, and doubt of research relevance to individual clients. Further barriers to EBP include age of the clinician and number of years since licensure (Jette et al., 2003). Specifically, Jette et al. (2003) discovered
that clinicians of an older age and greater number of years since licensure reported less EBP use; likewise, younger clinicians who were recently licensed used more EBP. This may be due to the younger clinicians’ recent exposure to research.

Exposure to research in the graduate program (Hill, Cheng, Litwin, Rone-Adams & Hellman, 2015; Zipoli & Kennedy, 2005) and research use within the first year of practice (Zipoli & Kennedy, 2005) are primary factors in clinicians utilizing EBP. Hill et al. (2015) discovered that students felt more confident in research and EBP following their coursework; clinical practice then allowed for relevant connections between research and practice. Further, Zipoli & Kennedy (2005) asserted that exposing new graduates to research in their first year of practice allows for more EBP to be utilized within practice for years to come.

However, utilizing evidence within practice is not solely dependent on the clinician. It is also the responsibility of researchers to explicitly draw clinical conclusions for a smooth transition from evidence to practice (Crooke & Olswang, 2015; Olswang & Prelock, 2015). Researchers are exploring new methodology to support practicing clinicians (Crooke & Olswang, 2015; Olswang & Prelock, 2015). These proposed methodologies include deriving research questions from practicing clinicians, drawing explicit clinical conclusions, and providing more detailed measures of how to apply the conclusions of studies to practice (Crooke & Olswang, 2015; Olswang & Prelock, 2015). However, these schools of thought are still within their infancy and are not yet globally used amongst researchers.

In conclusion of this finding, it’s possible that a university clinic setting integrates the latest research more readily into practice. Clinicians learn research through their coursework, then apply that research into practice through the facilitating medium of supervisors. This systematic approach assists to avoid the research-practice gap, meaning that the university clinic
may be utilizing the latest research more than other clinical settings. This constant updating of research use may influence the child’s progress, causing parents to report the university clinic as effective compared to other settings.

**Parent Impressions and Opinions**

**SLP experience.** Participants often discussed their SLPs in terms of experience or lack of experience. Lack of experience was noted positively within the university clinic context while experience was reported negatively within the school and outpatient clinic context. At the university clinic, the SLPs were discussed in terms of lack of experience, but this was discussed positively six times (see Figure 12 on page 68). On the other hand, practicing SLPs were referred to as experienced, but this was discussed negatively three times. It appeared that participants felt positively about the student clinicians' lack of experience whereas more experience led to negative feelings. The following paragraphs will discuss possible explanations for this finding in terms of student clinicians because there is little research directly comparing practicing SLPs and student clinicians.

Although there is little research specifically related to patient feelings towards student clinicians within speech and language therapy, there have been several studies conducted regarding patients’ feelings towards working with medical students (Cooke, Galasko, Ramrkha, Richards, Rose & Watkins, 1996; Scheffer, Edelhauser, Tauschel, Riechmann & Tekian, 2010; Stacy & Spencer, 1999). Ratings of patient feelings towards working with medical students have been generally positive across studies (Cooke et al., 1996; Scheffer et al., 2010; Stacy & Spencer, 2006), which is reflective of the current study. Specifically, patients in other studies reported that student involvement allowed for increased quality of care (Cooke et al., 1996; Scheffer et al., 2010). Cooke et al. (1996) discovered that 17% of 278 respondents to a
questionnaire reported that a student facilitated unhurried consultations, which they felt assisted in increasing the quality of care they received. This was also reflected by Scheffer et al. (2010) which explored patient and staff perspectives on including final year medical students within hospital settings. Patients reported that students spent more time with standard measures, like compiling medical and social history. They were also reported to be enthusiastic and active listeners. In fact, participants from the current study commented about these two aspects as well.

To speak to the student’s enthusiasm, Participant 6 stated: “I love the young people at the university who are newly trained and always full of enthusiasm.” This finding agrees with Scheffer et al. (2010) who discovered that medical students were more enthusiastic than licensed professionals. Approaching patients with motivation and enthusiasm was found to cultivate more individualized care, according to the patients (Scheffer et al., 2010). The students’ high levels of enthusiasm was perceived by patients to increase quality of care, leading to positive reports and greater satisfaction (Scheffer et al., 2010).

To speak to the student clinicians’ active listening, Participant 3 stated: “[student clinicians] take input because as parents you know your kid the best. And I mean [my child] has a lot of problems. But they take it upon themselves to do what you I guess ask.” Participant 2 felt this way as well. When asked what she liked about her relationship with the student clinicians, Participant 2 reported: “they are easy to talk to. That’s important… they always ask questions [on] what they can do to improve and that’s really good.” It appeared that participants in the current study valued active listening, which is commensurate with findings from Walters, Buszewicz, Russell, and Humphrey (2003). The researchers discovered that active listening on the student’s part can lead to patient empowerment, increased patient self-esteem, and better patient-doctor relationships (Walters et al., 2006). This also reflects findings by Stacy and
Spencer (1999) who interviewed 20 patients on their experience in a six-month community-based program for second year medical students. Patients were all diagnosed with long-term conditions and were well-informed of the program’s purpose: to teach students about long-term illness and its effect on quality of life. The patients reported that they felt they could talk about their illness with students because they were within a teaching role. This teaching role made participants feel like they were the expert of their condition and facilitators of student development. Participant 3 also reflected on his role as a teacher: “I mean, why not help them out now? Then when they become therapists they’ll be better along the way... they’re learning and [you] want [to] help them [as] best you can.” It appears that when clients are made aware of their status as a teacher, they feel like the expert of their own conditions. This allows clients to feel like they can openly communicate with students while students actively listen to learn.

Likewise, SLPs working in the school setting were often referred to as experienced. However, this statement often carried a negative connotation. For example, Participant 3 stated: “… when they've been in [this profession] for years it's strange because they look at you like you don't know what you're talking about.” Later, Participant 3 also commented: “you tell [experienced SLPs] all about your son and you leave going, 'did they even get what we said?'” This participant felt that the experienced SLPs relied on their expertise rather than the parent report, whereas the less experienced SLPs readily accepted input. Much like Zipoli & Kennedy (2005) discovered, practicing SLPs rely on clinical expertise and colleague advice to guide their practice. There is no available research regarding direct comparison between a practicing SLP and graduate students. However, this finding suggests a need for open and honest communication between parents and SLPs at any stage of experience.
Satisfaction of involvement. Participants were asked if they liked their level of involvement in each different setting; all affirmed, regardless of setting type. This reflects that although there are clear differences in parent involvement across settings, parents in this study enjoyed their level of involvement. Benson et al. (2008) discovered similar findings when mothers of children with ASD were asked about their involvement within a school program. It was discovered that mothers were involved equally whether their child was in a home program or a school program. Again, the setting may not impact parental satisfaction with involvement as much as other factors such as the therapist’s beliefs and parent motivation (Pappas et al., 2008). Parents might also understand that certain settings may or may not facilitate parent involvement. For example, Participant 4 stated: “Our involvement is just inherently less [at school] because we’re not there during the school day.” This was a common response among participants.

However, work is not the only barrier to a lack of parent involvement when a child is receiving services in school. Kohler (1999) explored differences and similarities between parent involvement at the pre-school and school-age levels for children with autism. The researcher found that parents reported observing and assisting providers significantly more often when their child was in pre-school versus elementary school (Kohler, 1999). Because parents may be working during the day over the course of a child’s pre-school and elementary school years, these differences may be due to policy barriers of the service provider (Hanna & Rodger, 2002; Kohler, 1999) rather than the logistics of the settings in general. Traditionally, parents were involved passively, but policy can change to better involve parents within a collaborative role across settings (Hannah & Rodger, 2002). Therefore, it is important to explore realistic options for policies that facilitate parent involvement across settings.
Yet, the differences between types and levels of involvement seemed to satisfy parents overall, meaning that parents may understand and accept the differences between the settings. Parents whose children are receiving speech and language services in the schools may find it sufficient to be involved in other ways, such as IEPs, emails, and progress reports. Likewise, parents involved at the university clinic may understand that their involvement can mean observations, giving input, and participating in sessions. Parents may find these levels and methods of involvement different, but neither is inferior nor superior to one another.

**Desire to increase involvement.** If participants denied that they were involved within the therapy process at each setting, the interviewers elicited information by asking a question similar to: “What are some ways you’d like to be involved?” For example, Participant 2 stated that she would like to observe during a school-based therapy session. A desire to increase involvement was discussed three times in a school-based context while it was discussed only one time at the university clinic. This finding is commensurate with Carroll (2010) who discovered parents were more satisfied with services in a clinic-based setting than a school setting. Parents indicated that in a clinic-based setting, they were more familiar with the program and had a developed relationship with the SLP (Carroll, 2010). Carroll (2010) hypothesized that a clinic-based setting may lead to improved parent satisfaction due to face-to-face contact with the SLP, and more direct involvement of the parent. It appears this hypothesis is true - at the university clinic, parents have the ability to be present for sessions which may make parents feel more satisfied with involvement due to direct contact with the SLP.

**Impact of the Parent-Therapist Relationship and Parent Involvement**

**Impact of parent-therapist relationship.** Five out of six participants affirmed that their relationships with the SLPs impacts their child’s success (see Table 3 on page 38). Participants
explained that they felt it helped the SLP to achieve a better understanding of the child. As Participant 3 described: “… to know [what] his ticks are and what motivates him really helps [the SLP] understand what he is.” Participants reported that both the SLP and the child benefited from the parent-therapist relationship by promoting the child’s progress. Participant 4 stated: “… it’s really good when we have a relationship with them so they can tell us what we should be doing and then we can practice at home and it helps him.” This participant felt that the better the parent-therapist relationship, the more they could implement practices at home to help their child succeed. In other words, the parent-therapist relationship may cultivate parent involvement. Forsingdal et al. (2013) discovered that the parent-therapist relationship influenced parents’ involvement in collaborative goal setting. An ongoing and supportive relationship contributed to more parental involvement (Forsingdal et al., 2013). Therefore, the parent-therapist relationship can impact parent involvement (Forsingdal et al., 2013) and parent involvement can impact progress (Hagstrom, 1994). This demonstrates the importance of the parent-therapist relationship.

**Impact of parent involvement.** All six of the participants felt their involvement, regardless of the reported level of involvement, impacted their child’s success (see Table 9 page 46). Participants reported that they felt their involvement helped their child to make progress and generalize skills. These factors were also identified by Crais (1991) that argued FCC promotes generalization, which leads to improved outcomes (King et al., 1999). In addition, several of the participants stated that their involvement helped them to learn. For example, Participant 6 stated: “it’s very helpful to be given information… otherwise, I’d have to stumble along on my own.” This highlights that by having parents assume a collaborative role, they experience increased competence (Broggi & Sabatelli, 2010). This increased competence can lead to more
participation and more positive parent-child interactions (Mianaei et al., 2014), leading to greater outcomes (Vygotsky, 1934). Therefore, it’s important for SLPs to give information to parents regardless of the setting of care.

It is important to note that although Participant 5 reported instances of passive involvement, she also reported one instance of active involvement – this was in the form of IEP meetings. She reported that she holds a discussion with the school personnel involved during these meetings, but followed this statement with: “They talk to me about what they think his needs are and I agree, of course I agree.” Further, she felt her involvement aided in her son’s motivation and attendance: “I think if I wasn’t involved somewhat then he probably wouldn’t be as successful, I mean he wouldn’t care as much about it, his success, either… he kinda just goes because I tell him he has to go.” This finding is significant because although this participant reported being passively involved in the therapy process, she still felt her involvement impacted her child’s success.

Although not discussed on a large scale, one subcategory dual role held significant qualitative value. Two participants mentioned their involvement in terms of roles (see Table 10 on page 48). Participants 2 and 3 defined their roles as twofold – parents, but also therapists. As Participant 2 explained: “… [child] goes to therapy. So therapy is a small part of his life, daily life. So we are parents but we should be a therapist too.” Both participants agreed that therapy is only a fraction of daily life, meaning that for progress to generalize, there need to be other supports in place. Parent involvement and generalization are two aspects of speech and language therapy known to promote progress (Crais, 1991; Hagstrom, 1994; King et al., 1999; Vygotsky, 1934). Therefore, both participants felt their involvement was to parent, but also intervene appropriately to facilitate progress. This was reflected in Forsingdal et al. (2013) which
established a collaborator role that some parents may achieve in the therapy process. Like the participants in the current study, Forsingdal et al. (2013) discovered that parents who assume this role worked in a partnership with the SLP and had a high level of involvement. Therefore, parents that assume this role may be more involved to facilitate home programs, and consequently, be more effective in their child’s progress (Hagstrom, 1994).

Other Relevant Themes

**Therapist-child relationships.** Participants discussed the relationship between the child and SLPs 17 times, while only discussing their relationships with the SLPs 10 times (see Table 3 on page 38). This was significant because participants were not explicitly asked to discuss the relationship between the child and SLP, but were asked to discuss their own relationship with the SLP. This phenomenon mirrored that of findings from Forsingdal et al. (2013) that discovered parents who were engaged in goal setting with SLPs found it especially important that the therapist built rapport with the child to better understand the child’s needs. In fact, one parent from the study reported that her relationship with the SLP was not as significant as the SLP-child relationship because of the direct interaction the SLP has with the child (Forsingdal et al., 2013). The university clinic, outpatient clinics, and schools typically provide services directly to the child, which may place an emphasis on the SLP-child relationship. Although facilitating parent relationships is important, parents may uphold a strong SLP-child relationship over their own relationship with the SLP. Therefore, it is crucial that practicing SLPs build positive relationships with both the child and their parents.

**Contextual Implications**

It is critical to interpret these findings in a clinical context to provide information to the speech and language field as well as related fields. First, readily seeking and implementing the
latest research practices can facilitate client success. Practicing SLPs should stay current with best practices to guide clinical decisions. Second, taking note of the parents’ perspectives in this study is critical to understanding how a practicing SLP can be perceived. It appeared that the more experience an SLP had, the more the parents in the current study felt dismissed. It is important to maintain active listening regardless of expertise because each child has individual nuances and needs; to fully understand those, SLPs must be active listeners. Lastly, forming strong relationships with parents facilitates parent involvement and parent involvement helps the child’s overall success. Therefore, building rapport with clients should not be overlooked—rather, it should be a foundation for therapy.

Limitations and Future Implications

This study recruited six participants through convenience sampling, which provided a detailed perspective on a select population. Although more participants would have given this study greater perspective, the required minimum of six participants was met for grounded theory standards. Findings and interpretations from this study may be cautiously applied to other populations given the powerful and broad insights participants offered. It is important to mention that the parents in this study may have been biased towards the university clinic given that they had to actively seek participation. However, this allowed the study to explore why parents choose to seek supplemental services at a university clinic. This uncovered meaningful findings which may have not been discovered otherwise.

Participants were selected if their child attended the university clinic and at least one other setting for speech and language services. Five out of six participants only received the university clinic and school-based services; Participant 4 received speech and language services
at the three settings discussed. This limited the opportunity to compare all three settings, but lent a detailed perspective comparing a school-based setting and a university clinic setting.

There are several potential future research considerations based on the data collected in the current study. First, a quantitative research approach regarding FCC and type of setting would contribute to correlational or causational effects of logistics in each therapy setting. Although a qualitative approach provides rich information about the nature of experiences and interactions, a quantitative, statistical analysis may be useful to provide direct comparisons regarding implementation across each setting type and FCC.

In addition, providing numerical data to corroborate parent report would validate qualitative data. Specifically, subcategories such as minimal contact were not explored through reports or the SLP accounts; rather, conclusions were derived through parent answers only. In reality, minimal contact may be entirely subjective based on the participant, so providing further numerical information to corroborate perspectives would help verify or explain personal attitudes and interpretations. Further, obtaining SLP perspectives across different settings may provide additional insight into setting differences and parent opinions. Another research option may be to gather information to directly compare licensed SLPs with more years of experience and student clinicians. Participants in the current study shared that they felt positively about the student clinicians' lack of experience; this result was also echoed in studies on patient perceptions of medical students (Scheffer et al., 2010). However, there is little research regarding specific comparisons of licensed SLPs and student clinicians. This topic may lend powerful insight to both licensed SLPs and student clinicians alike to better clinical practice. One specific option may include assessing the underlying level of EBP used by clinicians across different settings. It appeared that a university clinic setting encouraged more EBP to be used within clinical practice,
but this was not the central topic of the current study. A more in-depth analysis comparing the university clinic to other clinical settings in terms of EBP may determine key differences between SLPs and student clinicians in addition to a level of effectiveness between programs. The current study had a broad scope of exploring parent-therapist relationships and parent involvement within the different settings. Future studies may wish to explore one of these two topics between different settings. This would provide more in-depth analysis which may help to draw specific conclusions of parent involvement or parent-therapist relationships between settings.

This study addressed the differences in FCC between settings, but did not explore other factors that may have impacted FCC more than the setting itself. Other factors worth noting include parent motivation, therapist approach, professional attitudes, policy differences, and accessibility of communication between parents and therapists. These factors have been known to act as facilitators or barriers to FCC in clinical practice, so investigating these factors within a setting-by-setting context may determine the influence of each factor on FCC. A study such as this may help to draw conclusions on the factors that act as the most prominent barriers and facilitators of FCC in different settings of care.

It would be interesting to follow up on how observation of sessions affects parents and guardians. Participant 6 noted that by observing her grandson’s therapy, she treated him negatively after sessions because she witnessed his behavioral challenges. Therefore, she stopped observing sessions and relied on the student clinicians to keep her updated. It appeared the other participants enjoyed observing, but perhaps interviewing or giving a questionnaire to these parents on how observation affects them would lend more insight into parent perspectives.
Lastly, the participants in this study may have also been a unique population because their children were already receiving services in a different setting. Therefore, the speech and language services received at the university clinic were supplemental to the other services. Parents that consistently bring their children to the university clinic expend their own resources and time to do so. Therefore, it is important to raise the question: Could parents that seek university clinic services for their child in addition to services in another setting be going above and beyond? The results of this study cannot speak to this point, but future research may wish to explore the motivation and involvement of parents that bring their child to a university clinic for supplemental services.
References


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Appendix A
Interview Handout

Brief Demographic Questions to Build Rapport Between Interviewer and Participant

*Please note that bolded questions MUST be asked during the interview

Script: “Hello, my name is ___________ and I’m an undergraduate student with experience and training in interviewing. Before we begin, I just want to thank you for making time to be here. Do you have any questions before we move forward?”

1. Tell me about your child

2. Where is your child currently receiving speech and language services?
   a. When parents address the other setting(s) they receive services, please be sure to write the name down and use their term verbatim throughout the interview.
Therapists

Script: “Now we’re going to move on to talking about your speech-language pathologists. I will sometimes refer to speech-language-pathologists as SLPs.”

1. **Tell me about your speech-language pathologist at the university clinic.**
   a. **Information we’re looking for:**
      i. Description of speech-language pathologist (e.g., personality, qualities, how they interact with the parent)
         1. *If not addressed, move to #2*
      ii. Relationship between participant and speech-language pathologist
         1. *If not addressed, move to #3*

2. How would you describe your speech-language pathologist at the university clinic in terms of personality, qualities, and how they interact with you?
   a. *If description not elicited, provide the following questions:*
      i. What are some qualities you like about your speech-language pathologist at the university clinic?
      ii. What are some qualities that your speech-language pathologist at the university could improve on?

3. Tell me about your relationship with the speech-language pathologist at the university clinic.
   a. *If relationship not elicited, provide the following questions:*
      i. What do you like about this relationship?
      ii. What would you like to change about this relationship?
4. Tell me about your speech-language pathologist at (other setting(s)).
   a. Information we’re looking for:
      i. Description of speech-language pathologist (e.g., personality, qualities, how they interact with the parent)
         1. If not addressed, move to #5
      ii. Relationship between participant and speech-language pathologist
         1. If not addressed, move to #6

5. How would you describe your speech-language pathologist at (other setting(s)) in terms of personality, qualities, and how they interact with you?
   a. If description not elicited, provide the following questions:
      i. What are some qualities you like about your speech-language pathologist at the (other setting(s))?
      ii. What are some qualities that your speech-language pathologist at (other setting(s)) could improve on?

6. Tell me about your relationship with the speech-language pathologist at the (other setting).
   a. If nature of relationship not elicited, provide the following questions:
      i. What do you like about this relationship?
      ii. What would you like to change about this relationship?
7. Do you think your relationships with your speech-language pathologists impacts your child’s success?
   a. If yes… How do you think these relationships impact your child’s success?
      i. If impact isn’t described, provide the following questions:
         1. Describe how these relationships have impacted your child’s success.
   b. If no…. What makes you feel this way?
      i. If description not elicited, provide the following questions:
         1. Please describe why you feel your relationships with the speech-language pathologists do not have an impact on your child’s success.
Involvement

Script: “We’re going to move on to how you feel about your involvement within the therapy process at each setting(s). The therapy process relates to assessment, goal setting, treatment, and decision-making.”

1. Are you involved in the therapy process at the university clinic? (If no, skip to 4)

2. Tell me about how you are involved in the therapy process at the university clinic.
   a. Information we’re looking for:
      i. Description of how parents are involved
         1. If not addressed, move to #3
      ii. Whether they like how they’re involved or not
         1. If not addressed, move to #4

3. Please give me a few examples of how you are involved in the therapy process at the university clinic.

4. Do you like your level of involvement at the university clinic?
   a. If yes… What are some reasons you like your involvement at the university clinic?
   b. If no… What are some ways you’d like to be involved at the university clinic?
5. Are you involved in the therapy process at (other setting(s))? (If no, skip to 8)

6. Tell me about how you are involved in the therapy process at (other setting(s)).
   a. Information we’re looking for:
      i. Description of how parents are involved
         1. If not addressed, move to #7
      ii. Whether they like how they’re involved or not
         1. If not addressed, move to #8

7. Please give me a few examples of how you are involved in the therapy process at the university clinic.

8. Do you like your level of involvement at (other setting(s))?  
   a. If yes... What are some reasons you like your involvement at the (other setting(s))?  
   b. If not... What are some ways you’d like to be involved at (other setting(s))?
9. Do you feel your involvement in the therapy process impacts your child’s success?

   a. If yes… In what ways do you feel your involvement impacts your child’s success?

   b. If no… What are some things that you think impact your child’s success?

10. Is there anything else you would like to share?
Appendix B
Training Packet

Agenda (about 1 hour)

- Introduction to the study
- The interview process
  o Interview handout
  o Techniques to use
    ▪ Ethnographic interviewing resources
  o Interviewer rating sheet
- Logistics and scheduling
  o Show group the location of therapy rooms (rooms 122 through 134) and waiting room
  o Check out system and materials
  o Contact and Scheduling
  o Set up interviewers’ Outlook calendars
  o Emergency contact information
- Confidentiality Form
- Following the interview
- Question and answer opportunity
The study

Background

Children with communication disorders can receive speech and language therapy in a variety of settings. These include, but are not limited to, pediatric outpatient clinics, pediatric hospitals, schools, Birth-to-Three programs, and university clinics.

However, the logistics of these settings can influence what is known as “family-centered care.” Family-centered care is a form of service delivery that includes parents in speech and language therapy to best serve the child. This form of service delivery states that parents should be involved in clinical decisions and have strong relationships with the speech-language pathologist. Parents are important to include because they can impact therapy outcomes.

Purpose

The purpose of this study is to explore parents’ experiences and perspectives at the UW-Eau Claire Communication Disorders Clinic and any other setting(s) where their child may receive speech and language therapy. We will be comparing these settings in terms of family-centered care (i.e., involvement and relationship with speech-language pathologists). The results will give us information about the level of family-centered care in these various settings.

Your role

As the interviewer, your responsibilities will include:

1. Saying the script and questions as written.
2. Providing spontaneous follow-up questions as appropriate.
3. Gather the information as indicated on the “interview handout.”
4. Facilitating a welcoming and open environment to best elicit honest answers. This can be accomplished by building rapport with the parent.
5. Take hand written notes during the interview on the interview handout.
6. Complying with interviewer techniques (as indicated by the interviewer resources and interviewer rating sheet).
7. Keeping your Outlook calendar updated and alerting Leah to any conflicts that may arise.
8. Check your school email and Outlook calendar daily.
The Contribution of Ethnographic Interviewing To Culturally Competent Practice

"It is not possible to help until you have understood."

Practitioners in Minnesota must now continue to work with an ever-escalating diversity of clients. The fact that over 80 languages are spoken in the Minneapolis Public Schools is a clue to the rich mixture of culture, ethnicity and race that is now part of Minnesota. Culturally competent practice is generally recognized as indispensable for child welfare practitioners, yet skills and techniques are somewhat elusive. The issues are urgent and complex. Cultures have differing views and standards for acceptable parenting practices. The stakes are high in assessing risk of harm to vulnerable children.

How can the practitioner interpret, assess, and then address the problems of families whose lives and experiences are so different from their own? What questions to ask? What to focus on? How to construct a serviceable plan?

Ethnography provides a framework for delivering culturally competent services. The field of anthropology, which pioneered the ethnographic interview, leads the way in helping us to understand a life in a context unfamiliar to us. Two principles stand out: Active listening is required to understand the narrative of a family's life, and respect for the cultural knowledge of families requires us to learn from clients.

This issue of Practice Notes provides an introduction to ethnographic interviewing.


Definitions of Terms

- Ethnographic interview: Method of interviewing which began in the field of anthropology, and is currently widely practiced by social science researchers of all fields. The interviewer assumes the role of a "learner" rather than the expert. The interview is generally semi-structured, with the worker preparing a few broad questions in advance. The client guides the interview with his or her answers. This is also referred to as narrative.

- Open-Ended Questions: General, broad questions about some aspect of the client's life and possibly related to the presenting issue that the client brings.

- Cover Terms: Words and phrases used by the client that identify an important aspect of their life experience.

- Descriptors: Words used to describe the cover terms, which are used to build a portrait of the experiences of the client within their cultural context.

What is Ethnographic Interviewing?

- The goal of ethnographic interviewing is to understand and appreciate experiences and worldviews of people who are different from us. We do this by asking the client to be a cultural guide. The practitioner is no longer the expert, but a learner. The social worker assumes a position of "informed not-knowing," in which the clients educate the practitioner about their lives. This information should come from the clients' own words, since they can offer the most accurate description of their experience.

- This ethnographic stance is respectful, collaborative, and less hierarchical. It seeks to build on clients' strengths, rather than blaming them or pathologizing their experiences. The worker seeks to create the space where the voices of the clients can emerge, by asking global questions and listening intently. The worker is slow to assess and cautious to generalize.

- Ethnography is a means to culturally competent delivery of social services. Effective and culturally appropriate communication is necessary to engage clients. Ethnographic interviewing incorporates techniques that take into account the context of ethnically diverse clients and seek to understand their experiences and perceptions.

- The culturally competent worker values and respects the uniqueness of cultures, and is cognizant of the fact that cultural differences have an impact on service delivery—particularly when there is a conflict between the values of the minority group and dominant culture.

- The ethnographic interview is where the practitioner and the client begin to share information with each other. The practitioner needs to understand their position as outsider, as someone who is looking for information that the client can provide about their own experiences and the meaning they have within their own culture.


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Observation: Another Ethnographic Technique

- Another component of ethnography is participant observation. This is a process where the social worker makes a commitment to learning detailed characteristics of a community by observing and taking notes while minimally intruding on the lives of the residents.

- It is important to keep documentation of what is observed separate and distinct from the social worker’s interpretations.
Stages of the Interview

1. **Setting the Stage**
   - Set the tone with friendly conversation.
   - State the explicit purpose and goal of the interview.

2. **Expressing Ignorance**: The worker should state their own lack of knowledge about the client's culture. This establishes the client as expert on their experiences, as well as that of a cultural guide during the conversation. The worker's willingness to express their ignorance may also encourage the client to talk more freely.

3. **Open-Ended Questions**
   - The worker prepares a few questions before the interview.
   - At this stage of the interview, the worker is developing empathy and understanding for the client's experiences and story.
   - Even if the worker has familiarity with people of a certain culture, during this stage of the interview each person is treated as a stranger, with unique experiences to be discovered.
   - Two types of open-ended questions:
     a) questions regarding the client's perception of how their community views the definition of problems, group roles, norms, rituals, help seeking and problem resolution styles.
     b) questions regarding how the person relates to community cultural values and norms of behavior.

4. **Cover Terms**
   - Cover terms, words that are used frequently by the client, should be explored. Social workers and clients may both use jargon, which widens the cultural gap between them. By seeking to learn cover terms and understand their meaning, the social worker can narrow this gap.
   - Practitioners need to recognize the power and significance of language. Language can be used to label and limit ethnic minorities and other marginalized groups. Language can also bring about understanding of other cultures.

5. **Descriptors**: The worker can learn what meaning the client gives to cover terms by asking descriptive questions.

   **Descriptive Questions Include the Following:**
   - **Space Questions**: The objective of global space questions is to learn about the physical setting of the cultural scene.
   - **Time Questions**: Provides the sequence of activities for social relationships.
   - **Actor Questions**: Important to learn who the people are in relationship to each other and the titles used to describe each role.
   - **Evaluation Questions**: Asks for evaluations of people or things. This should be linked to factual questions.
   - **Example Questions**: These are very specific. They ask the cultural guide for an example of a single act or event.
   - **Experience Questions**: Asks the cultural guide for any experiences they have had in a specific setting.
   - **Language Questions**
     - **Hypothetical Questions**: Places the cultural guide in an interactive situation, in which the worker asks him or her to speak as if talking to a member of the cultural group.
     - **Typical Sentence Questions**: Asks the cultural guide to take a cover term and use it in a typical way.


THE ETHNOGRAPHIC INTERVIEW (from Spradley, 1979)

When we examine the ethnographic interview as a speech event, we see that it shares many features with the friendly conversation. In fact, skilled ethnographers often gather most of their data through participant observation and many casual, friendly conversations. They may interview people without their awareness, merely carrying on a friendly conversation while introducing a few ethnographic questions.

It is best to think of ethnographic interviews as a series of friendly conversations into which the researcher slowly introduces new elements to assist informants to respond as informants. Exclusive use of these new ethnographic elements, or introducing them too quickly, will make interviews become like a formal interrogation. Rapport will evaporate, and informants may discontinue their cooperation. At any time during an interview it is possible to shift back to a friendly conversation. A few minutes of easygoing talk interspersed here and there throughout the interview will pay enormous dividends in rapport.

The three most important ethnographic elements are its explicit purpose, ethnographic explanations, and ethnographic questions.

Explicit Purpose: The interviewer should inform the client of where the interview is supposed to go. Although there should be a reminder that it can be more of a conversation, the interviewer needs to use questions to direct the interview.

Ethnographic explanations: The interviewer should facilitate explanations when appropriate or when the client asks.

Ethnographic questions: These are questions designed for specific purposes and fit into certain categories. Each type elicits different responses and narrows from open-ended questions to close-ended questions. Examples are listed below.
Types and Examples of Ethnographic Interview Questions

1. Grand Tour Questions: Asking the client to generalize; very open-ended

   A. Tell me about your child.
   B. Tell me about your speech-language pathologist at the university clinic.
   C. Tell me about your speech-language pathologist at (other setting(s)(s)).

2. Details Through Questions: Asking follow-up questions about an act, event, or category

   A. How would you describe your speech-language pathologist at the university clinic in terms of personality, qualities, and how they interact with you?
   B. What do you like about this relationship?

3. Experience Questions: Asking about experiences

   A. Tell me about how you are involved in the therapy process at the university clinic.
   B. Please give me a few examples of how you are involved in the therapy process at the university clinic.

4. Native-like Questions: Asking the client to use his/her own words and expressions

   A. Where is your child currently receiving speech and language services?
Interview Check List

*Researcher and research assistant will select one item per group.*

**Rapport:**

___ The interviewer established clear rapport with the client.

___ It is not evident that the interviewer established rapport with the client.

**Body Language:**

___ The interviewer had relaxed body posture and appropriate eye contact for most of the segment.

___ The interviewer had relaxed body posture and appropriate eye contact for some of the segment.

___ The interviewer did not have a relaxed body posture and appropriate eye contact for the majority of the segment.

**Format of Interview:**

___ The interviewer conducted the interview in a conversational format.

___ The interviewer conducted the interview in a question-answer format.

**Spontaneous Questions:**

___ The interviewer used spontaneous follow-up questions when necessary information was not elicited from written questions.

___ The interviewer used spontaneous follow-up questions, but these questions were not always appropriate for the situation.

___ The interviewer didn’t use spontaneous follow-up questions.

**Protocol (Verbatim):**

___ The interviewer stated the questions and scripts verbatim.

___ The interviewer deviated slightly from the questions and scripts.

___ The interviewer deviated greatly from the questions and scripts.
Protocol (Order):

___ The interviewer stated the questions and scripts in the correct order for most of the segment.

___ The interviewer didn’t state the questions and scripts in the correct order for most of the segment.
Check out system and materials

Prior to each interview, you will need to check out 2 digital voice recorders (DVRs). You can find these items at the check-out window in the resource room. There will be a student worker in the check-out room. Please tell them you are looking for “Leah Carpenter’s Thesis Materials Box” and state your name. You can check out these items for the duration of the interview. Turn on the two DVRs and set them to “record” prior to bringing the client back to the interview room.

Once you have completed the interview, turn off the two DVRs and walk walked the participant back to the waiting room. Place all materials back into the box and return it to the check-out window.

On/off switch.

When it turns on, it will have different folder options. Select folder “A” with the “ok” button.

Click “rec” before going to get the participant from the waiting room.

Click “stop” after you finish the interview.
Contact and Scheduling
Leah will be in direct contact with the participant. Leah will look at your Outlook calendars to schedule interview at the parents’ convenience. Interviewers will be rotated through as appropriate; however, please be mindful that the schedule indicated by the parents will be the deciding factor of which interviewer will be selected. Interviewers will be notified at least 24 hours in advance of interview. Scheduling requests will be sent and interviewer will accept or reject time/room. You will only have knowledge of the participant number before meeting them.

At the scheduled interview time, you will collect the participant from the waiting room. Please wear your nametag at this time. When you meet the participant, please use the following script or similar phrasing:

“Hello, my name is (first name and last name). I’m going to be the student interviewing you for the study. What is your name?”

*Please refer to the participant by the name they introduce themselves as.

If there are multiple people in the waiting room, please use the following script or similar phrasing:

“Hello, my name is (first name and last name), and I’m here to interview a participant at (time). Who is here to be interviewed?” Then refer back to the script above.

Be sure your therapy room is already set with 2 DVRs recording.
Once the interview is completed, turn off the DVRs and walk the participant back to the waiting room. Come back to the interview room and collect all materials. Return these materials to the resource room.
How to Set up Outlook Calendar

These calendars will be used to schedule the interviews. Leah will access your calendar, then determine a time that works for both you and the parent. She will send you a "schedule request" and you can either accept or reject that request (these appear in your inbox). Accept it to put it into your calendar or reject with a reason why you cannot make that time work. It is your responsibility to keep your calendar up to date.

Start by going into your email and clicking here.

A drop-down menu will appear. Select the calendar option.
This is what the page will look like. To add an event, double click under the day and time you would like to schedule that event OR you may click "new."

Fill in the details of the event.

Be sure that if there is a reoccurring event (e.g., class) to click the "repeat" button to repeat it for the same day and/or time each week.

Click "save" when finished.
To delete an event...

1. Double click on the event- it is the colored box on your calendar.
2. Click “delete.”
3. If you have repeated this event, it will ask if you would like to delete the “occurrence” or the “series.” If, for example, your class gets cancelled one week, select the “occurrence” option to delete just that one time. However, if you drop a class for example, then you can select the “series” option to delete the repeated event.
Emergency contact:

- Deborah Elledge – located in room 121
  - Email: elledgdh@uwec.edu
- Cecily Weber – located in room 113
Department of Communication Sciences and Disorders  
University of Wisconsin – Eau Claire

CONFIDENTIALITY ASSURANCE ACKNOWLEDGMENT

I acknowledge that I, (print name) ____________________________, an undergraduate student assisting in research will be exposed to client-specific information through an interview which is confidential under Wisconsin Statutes and HIPAA.

By signing below, I acknowledge that:

- I will not discuss any information about these clients with anyone besides the researcher and research assistant. Any conversations with the researcher or research assistant that may reveal identifying information about the client will take place in a private space.
- I will refer to the client as their participant number in any email I may send the researcher or affiliates. I will not divulge any identifying information within the email(s) I send.
- I will hold personal liability for any breach of confidentiality I commit regarding the client.
- My assurance to these policies extends indefinitely.

______________________________  ______________________________
Signature                                      Date Signed
Following the interview, you must send Leah a brief email summarizing how the interview went. Please provide the following information:

- Participant number
- Confirm procedures (e.g., "I interviewed Participant 4 on Tuesday at 2:30pm.")
- Brief summary of the interview
- Any outstanding information (e.g., if the participant was visibly upset at any point, if the participant expressed concerning thoughts, if the participant exercised their right to not answer specific questions and which ones)