



AOTA Evidence Briefs

Multiple Sclerosis

**A product of the American Occupational Therapy Association's Evidence-Based Literature Review Project*

MS #8

Self-help guides can help clients to become better advocates

Seekins, T., Fawcett, S. B., & Mathews, R. M. (1987). Effects of self-help guides on three consumer advocacy skills: Using personal experiences to influence public policy. *Rehabilitation Psychology, 32*(1), 29–38.

Level IB2a

Randomized controlled trial, less than 20 participants per condition, moderate internal validity, high external validity

Clinical bottom line

Self-help guides may be a viable and financially sound way to assist patients in becoming better advocates.

The researchers compared the performance of consumer advocates using a letter-writing guide with that of advocates working only from a model letter. The guide, which was based on a task analysis of the skills involved in letter writing, focused on a sequence of behaviors: open the letter, write something about yourself, tell why you are writing the letter, summarize your understanding of the issue being considered, etc. The model letter contained all the behaviors targeted by the guide.

Sample

The participants were 10 members (gender not reported) of an independent-living consumer advocacy group, ranging in age from 19 to 57 (average not reported). Multiple sclerosis was among the disabilities represented in the 10.

Procedures

Five members of the group were selected at random to use the self-help guide in writing one letter to a newspaper editor and another to a public official. Letters address the issue of an advisory board's allocations of funds from community development block grants to remove architectural barriers and purchase a van with a lift.

The remaining five members (the control group) received a model letter prepared in response to another local issue. They were given the same assignment as the treatment group.

Outcomes

The outcome area of interest was performance in writing effective letters. An observer read all the letters and scored them for occurrence and nonoccurrence of the desired behaviors. Three public officials rated their overall satisfaction with the letters and the likelihood of the letters influencing their opinions on the subject.

Analyses

The researchers compared the outcome scores of the treatment group with those of the control group.

Results

The treatment group made **significantly** (*see Glossary*) greater use of the targeted behaviors than the control group did. It also received significantly higher ratings for overall quality and influence.

Limitations

The sample sizes were small, so one letter writer's ability could have artificially inflated the whole group's results (**sample size bias**) (*see Glossary*). Also, the researchers did not state whether the letter reviewers were **blinded** (*see Glossary*) to the group status of the participants.

Glossary

blinded/blinding—Blinding refers to the practice of keeping members of the research study unaware of which group a participant is assigned to (treatment or control) in the study. Single blinding usually refers to keeping study participants unaware of whether they are receiving the experimental or the sham treatment. Double blinding usually refers to keeping the participants and those who are administering the treatment unaware of who is receiving the experimental and who is receiving the sham treatments. In some cases, where it is impossible to blind those administering treatment, the individuals who are administering the outcome measures can be blinded to group status.

Studies in which blinding does not occur can have significant biases. When the participants know that they are receiving the experimental treatment, they often get better because they think they ought to (this is often referred to as the placebo effect). When researchers know that a participant is receiving the experimental treatment, they often subconsciously favor those participants when evaluating them on outcome measures. For instance, when timing a participant in the treatment group, researchers may unknowingly stop the watch a little faster or slower so the treatment participant seems to do better.

sample size bias—Significance is strongly related to sample size. A study that has too small a sample will not show significance (a type II error), even when a treatment effect is present. Some research studies that are nonsignificant demonstrate a trend toward the treatment having the desired effect, suggesting that a larger sample is needed to detect a significant treatment effect. On the other hand, too large a sample can prove just about anything.

significance (or significant)—A statistical term, this refers to the probability that the results obtained in the study are not due to chance, but to some other factor (such as the treatment of interest). A significant result is likely to be generalizable to populations outside the study.

Significance should not be confused with clinical effect. A study can be statistically significant without having a very large clinical effect on the sample. For example, a study that examines the effect of a treatment on a client's ability to walk may report that the participants in the treatment group were able to walk significantly longer distances than the control group. However, if you read the study you may find that the treatment group was able to walk, on average, 6 feet, whereas the control group was able to walk, on average, 5 feet. Although the outcome may be statistically significant, a clinician may not believe that a 1-foot increase will improve his or her client's function.

■ Terminology used in this document is based on two systems of classification current at the time the evidence-based literature reviews were completed: *Uniform Terminology for Occupational Therapy Practice—Third Edition* (AOTA, 1994) and *International Classification of Functioning, Disability and Health (ICIDH-2)* (World Health Organization [WHO], 1999). More recently, the *Uniform Terminology* document was replaced by *Occupational Therapy Practice Framework: Domain and Process* (AOTA, 2002), and modifications to *ICIDH-2* were finalized in the *International Classification of Functioning, Disability and Health* (WHO, 2001).

This work is based on the evidence-based literature review completed by Nancy Baker, ScD, OTR, and Linda Tickle-Degnen, PhD, OTR/L, FAOTA.

For more information about the Evidence-Based Literature Review Project, contact the Practice Department at the American Occupational Therapy Association, 301-652-6611, x 2040.



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