



# ACQuiring Knowledge in Speech, Language and Hearing

Volume 12, Number 2 2010



## Working with Families

### In this issue:

Family perceptions of  
Aphasia rehabilitation

Clinical report writing

Parents as therapists in  
stuttering intervention

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# From the editors

Nicole Watts Pappas and Marleen Westerveld



Nicole Watts Pappas (left) and Marleen Westerveld

**WELCOME TO ANOTHER EDITION OF ACQuiring KNOWLEDGE IN Speech, Language and Hearing.** In this issue we focus on the important topic of “working with families”. Current philosophies of best practice recommend speech pathologists involve, support, and respect the families of both our paediatric and adult clients. Families can provide important insights into our clients’ abilities, interests and needs. Additionally, as Hersh remarks on page 59 of this issue, family members often act as the “gatekeepers for intervention”, controlling whether intervention is accessed and the format and frequency of home practice. Establishing good relationships with family members is an important part of providing the best possible service to our clients.

In this issue we address working with families in a number of client groups. In a qualitative case study of intervention for a client with aphasia, Hersh highlights the miscommunications that can occur between family members and clinicians. Trajkovski and colleagues discuss common problems (and possible solutions) which can arise when working with families in early intervention for stuttering and Watts Pappas outlines the importance of considering families when writing assessment reports. Our Asia Pacific column continues with a report on speech pathology in the Philippines and the Illawarra group of speech pathologists provide a very practical “top 10 resources” column. We hope this issue inspires you to consider the way you work with families and provides some clinically useful tools to facilitate change in your clinical practice.

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### 2010 National Tour “Working with Children from Multilingual Backgrounds” by Cori Williams, B App Sci (Speech and Hearing), BA (AS) (Hons), Dip Ed, Ph D

The Continuing Professional Development (CPD) is thrilled that Dr Cori Williams is the 2010 National Tour speaker in Speech Pathology Australia’s CPD program. We are very fortunate and privileged to have Cori presenting in the area of “Working with Children from Multilingual Backgrounds” as this area is very relevant in an increasingly multicultural Australia, with speech pathologists needing to bring to their workplace an understanding of the complex issues when working with children exposed to more than one language.

The National Tour will incorporate a one-day workshop in a number of Branches covering assessment and intervention when working with children from multilingual backgrounds, plus a 2-hour national videoconference on working with children from Indigenous populations.

Check the Association website for further details.

[www.speechpathologyaustralia.org.au](http://www.speechpathologyaustralia.org.au)





# From the president

Christine Stone



Christine Stone

**WHAT A COMPLEX, CRITICAL, AND DIVERSE ROLE** families play in communication across our lifespan. They witness and facilitate our first communication attempts, catalogue our progress, share our secrets, our struggles, and our triumphs, recognise and celebrate our idiosyncratic style, and participate in so many of the myriad social exchanges that make up our lives. Whatever our role(s) – parents, siblings, life partners, children - families are as central to communication as communication is to families.

We know that when one family member experiences difficulty with communication, the impacts are felt throughout the family unit. It is families that grapple with the potential diminishment of social, vocational, and relationship opportunities and with their own personal grief, isolation, and loss of relationship. At the same time, they are often asked to take on a range of vitally important roles for which they may feel ill-equipped.

This issue of *ACQuiring Knowledge in Speech, Language and Hearing* turns the spotlight on these families and challenges us to explore how we best partner with them as they undertake critical therapeutic roles and deal with significant personal challenges. And what demanding responsibilities these families shoulder. Whether as a therapist, a communication partner, a source of accurate case history information, an advocate, or a consumer of our services, their skilled and active engagement is pivotal to successful therapy outcomes.

The articles within encourage us all to “walk a mile in their shoes” and to evaluate our therapeutic practice from their perspective. They challenge us to critically appraise the effectiveness of some time-honoured practices and to seek new and innovative models with the family at the centre.

I hope you will draw inspiration from the articles about the amazing families we all have the privilege of working with.

## Speech Pathology Week is on its way...

Speech Pathology Week

Vocation Communication



Speech Pathology Week will take place from **22 – 28 August** this year and there's still plenty of time to organise an event in your area.

- A **theme document**, **activity ideas** and **colouring competition** are available on the website to help get you started.
- Promotional packs and items will be available to order from Monday 15 June. Items include pens, balloons, brochures, flyers, posters, notepads and t-shirts.
- To make sure the fun things get to you in time for your event, the last date to order is **Monday 6 August**.



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# Family (mis)interpretation, (mis)communication, and (mis)judging aphasia therapy

## A case study

Deborah Hersh

**This article describes a single case study of the perceptions of aphasia rehabilitation by the wife of a client with severe aphasia and contrasts her perspective with that of her husband's therapist towards the end of his course of treatment. The article, based on in-depth interviews and analysed according to the principles of grounded theory, demonstrates misunderstandings, miscommunications, and misjudging by both parties about each other and the therapy. It argues that family members may be gatekeepers for therapy and may need to be supported to make their involvement as productive and rewarding as possible.**

The need to involve family members of people with aphasia in therapy and rehabilitation is now well understood by speech pathologists and accepted as good practice (Holland, 2007; Michallet, Le Dorze, & Tétreault, 2001; Purdy & Hindenlang, 2005; Servaes, Draper, Conroy, & Bowring, 1999; Worrall, Brown, Cruice, Davidson, Hersh, Howe, & Sherratt, 2009). Family carers of stroke patients often experience considerable stress, have to deal with role change, caregiver burden, and alterations to interpersonal relationships both within and outside the family (Visser-Meily, Post, Gorter, Berlekom, Van Den Bos, & Lindeman, 2006). Families often have an urgent need for information which may vary according to the stage of recovery of the person with aphasia (Avent, Glista, Wallace, Jackson, Nisioka, & Yip, 2005). With a shift in thinking towards social approaches to rehabilitation and social contexts of communication (Simmons-Mackie, 2000), consideration of the role of family members is moving from being at the periphery of therapy to being at its centre (Cunningham & Ward, 2003; Hopper, Holland, & Rewega, 2002; Turner & Whitworth, 2006).

In this context, it is important to examine how speech pathologists involve family members in aphasia rehabilitation. There is already some evidence that clinicians and family members perceive aspects of aphasia differently (Oxenham, Sheard, & Adams, 1995) and that these differing perceptions can be approached by investigating single cases (Hemsley & Code, 1996). Therefore, this paper describes a real case in order to explore the perspectives of the wife of a man

with severe aphasia and the speech pathologist. It looks at each of their interpretations, communication, and judgments about therapy with particular reference to the wife's involvement and contribution.

### Research approach

This case is taken from a larger data set collected for a qualitative study on client, family and speech pathologists' experiences of aphasia treatment termination (Hersh, 2003). In that study, the people with aphasia were recruited through their previous speech pathologist, having been discharged at least six months earlier. Participants with aphasia and family members (usually spouses) were interviewed together at home (they were given the choice to be interviewed separately, but chose to be together) and the interview was audio-recorded and later transcribed by the author. They talked about their experiences from stroke onset and early hospitalisation through rehabilitation, discharge from therapy, and then to life after leaving formal speech pathology services. Speech pathologists were interviewed at their place of work and talked about therapy and rationale for discharge of the person with aphasia. Their interviews were also audio-recorded and transcribed by the author. The data collection and analysis were influenced by grounded theory methodology and the ideas and techniques proposed by Strauss and Corbin (1998) which involved systematic collection and analysis of material which "allows the theory to emerge from the data" (p. 12). In addition to analysis of themes across the data, the larger study involved specific and detailed analyses of linked cases which allowed comparison of client and professional perspectives of the same treatment and discharge event. This article draws on one of those linked case studies. It provides specific, focused information which is of clinical value (Damico & Simmons-Mackie, 2003). Detailed observations were made of the spouse's and speech pathologist's perspectives about therapy and the main themes were examined within each of the participants' broader life or work contexts. All names used are pseudonyms.

### Case study

Ruth, a woman in her early 60s, was the wife and carer of David who was 64 years old at interview, hemiplegic, and severely aphasic. The couple lived in a rural area so when David had his stroke, 15 months earlier, he had to be transferred to the nearest large city, where he spent a month in an acute setting, followed by three months in residential

#### KEYWORDS

APHASIA  
REHABILITATION

FAMILY  
PERSPECTIVE

QUALITATIVE  
RESEARCH

SINGLE CASE

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HAS BEEN  
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Deborah Hersh

rehabilitation and then six months (20 sessions) of domiciliary (home-based) therapy with a community brain injury service. This latter service involved weekly home visits initially, and then sessions gradually less frequently. When the domiciliary service ceased, a handover was made to the local community health service. The interview material presented here was collected from the community health speech pathologist, Rachel, who took on David's case. At this time, David remained severely expressively and moderately receptively impaired.

### **Perceptions of the family member**

Ruth was not sure why the domiciliary speech pathology service had ceased but assumed it was a funding issue. She felt that her husband should have received continued regular support: "You need more. If you want to talk, you have to be taught how to do it". For her, therapy stopped with the handover to Rachel at the community health service. She reported that Rachel had visited once: "never ever done anything at all. We never had anything from them... All she did, she came and met me and told me to carry on doing what we'd been doing, which we haven't". Ruth felt that Rachel did not really know David because she had never provided him with therapy. Ruth was very positive about the previous domiciliary therapist, describing her as "easy to talk to... she was very nice". But, despite sitting in on therapy sessions, she wasn't convinced of the usefulness of David's therapy: "I didn't feel it was very beneficial. Not really". She mentioned "a lot of cards", pointing to body parts and repeating sentences. She was reluctant to ask for a continued domiciliary service because "you don't know what to ask for" and because she did not see it as the best service on offer. She had considered private therapy:

*You would demand it if you were paying for it. You would demand it to be done properly. But if it is a government service that they are providing for you, you don't really know what you are allowed to do or just even if you could say "I'm not happy with this, send me somebody else.*

The couple were devout Christians and Ruth had a strong belief that David could still return to "normal". She still, despite contradictory professional advice, believed that signing and gesture were bad and that David must say words before she could accept his attempt. She said: "He wants to talk. He wants to be able to communicate" and this meant that non-verbal expression was to be discouraged: "And then of course, she [the therapist] encouraged him with signing, pointing, which I don't like... So I'm not going to do it [anything he asks for] unless he says it."

Ruth was very grateful for the intensive therapy offered at the rehabilitation unit but felt it was given too early for David to have benefited fully. She would have preferred a more intensive program later. She did not approve of attendance at group therapy because she said David wanted to be with "normal" people. Ruth reported receiving very little information about aphasia itself, about the likely course of recovery or about therapy. She described the improvements made by a friend's child who had received speech therapy and expected that David would therefore do the same:

*I think he could do very well. But I don't understand a lot about speech therapy. I only know what I've heard and, like I have a friend who had a little boy and they always said he was just like David, the aphasia part of it was so frustrating for him. And he went to speech therapy... and he came on tremendously and he's great now and I think David could do the same.*

Her lack of information was possibly compounded by her reluctance to ring agencies or ask for assistance on the telephone, and her deference to her therapists: "I think they tell you what they'll do and you agree with it. Well, some people might not agree. See, I just agreed with everything... it's not laid out on the line so you completely understand..."

### **Perceptions of the speech pathologist**

Rachel was an experienced, generalist therapist working with paediatric and adult caseloads over a large rural area. Her work base was about 50 kilometres from David's home which, she reported, made it difficult to justify regular visits, particularly because she was not funded for aphasia rehabilitation services. However, she was careful to consider the recommendations made by previous services, such as those in the rehabilitation unit discharge report, that David should receive regular therapy despite his lack of improvement there. Rachel suggested that this recommendation had been made because he was relatively young at the time of his stroke. She described feeling slightly uncomfortable at not being able to provide this level of service despite the handover from the domiciliary therapist suggesting that David had since plateaued and only required monitoring and support for his wife. Rachel met the couple once at the handover meeting a year post onset and monitored by telephone over the next three months. She suggested that David attend a group which offered conversation opportunities for people with aphasia, but understood that David did not wish to go. Rachel explained that time was very limited and she did not feel that David was a priority because of his lack of change in a year despite previous intensive therapy, and lack of interest in homework. However, Rachel still found the case time consuming and she referred to a file thick with records of her involvement: "a great deal of negotiating, phone calls, meetings with my colleagues". She discharged David in consultation with his general case manager, with a sense of relief. Rachel was disturbed that even after all the speech pathology input, Ruth still viewed non-verbal strategies as inferior and still believed that David would talk and return to normal. Rachel felt supported in her difficult decision to discharge David by other colleagues and his case manager.

Table 1 contains a brief summary of how both Ruth and Rachel interpreted, communicated and judged the therapy provided for David and also includes a little context on previous services.

## **Discussion**

Exploring this case study in depth reveals a number of important issues in relation to the role and involvement of a family member in rehabilitation. The first issue is that Ruth was, in many ways, the gatekeeper for David's therapy. His communication impairment was sufficiently severe that he could not have telephoned services independently or requested particular changes to therapy. He was dependent on her to do this for him, despite her reluctance to use the telephone. David was reliant on Ruth for all of his travel needs. Her views about the value of particular aspects of therapy determined what was practised or not practised between sessions. Her opinion of group work may or may not have been a genuine reflection of his, but even if he was nervous about going to a group, her attitude would have done nothing to encourage him to see its advantages. As gatekeeper for her husband's rehabilitation, Ruth was crucial to how David engaged in treatment and she influenced what he did in therapy.

**Table 1: Summary of the themes relating to the different family and clinician perspectives in this case study of a man with severe aphasia**

	(mis)interpretation	(mis)communication	(mis)judging aphasia therapy
Ruth's (wife's) perceptions	Full recovery is possible; religious conviction Private services are better than public ones Hands-on treatment is the only real service and therefore Rachel had done nothing despite her telephone follow-up Funding issues were the reason for discharge Confused by service structures, transitions between agencies and multiple health personnel	Felt unable to make requests to therapist for explanation of rationale of therapy; assumed you have to do what you are told Superficial understanding of aphasia Was willing to drive David to a centre if it meant more service but had not discussed this option Reluctant to use the telephone to ask for information, nervous about phoning people	More, but different, therapy would have resulted in change Pointing and gesture only detract from the real aim of talking Being with disabled people in groups is not helpful A friend's child had speech therapy and improved so David could too The homework was useless and had no relevance
Rachel's (speech pathologist's) perceptions	Assumed that Ruth would be happy to continue what she had been doing with the previous therapist	Assumed that no telephone calls from Ruth meant that everything was okay Not aware of Ruth's view of home practice or consultancy model	Frustrated by Ruth's attitude to non-verbal strategies Busy with case meetings and negotiating group services but no funding for direct provision
Influences from previous services	Metropolitan services assuming and recommending more intensive rural provision than is possible	Domiciliary therapist did not hand over any complaint and therefore unaware of Ruth's view of therapy	No apparent discussion about changing therapy direction or homework options

The second issue is that as well as being a gatekeeper, Ruth was a potential resource for the speech pathologists. Certainly, she sat in on sessions both at the rehabilitation unit and within her own home. She found this useful and her inclusion in sessions was clearly encouraged by the therapists. From her perspective, however, there was inadequate effort put into helping her really understand the nature of aphasia and therapy, what her role was, what she was entitled to, what decisions she could share, how the various services functioned, and what they could offer. Her involvement in David's rehabilitation might have been more productive had she been well informed, included in decisions, and convinced by the benefits of therapy. Her understanding and knowledge of her husband could have been tapped in order to tailor therapy to him more effectively.

A third issue was that Ruth's own needs were not adequately addressed during the different stages of her husband's rehabilitation. She reported receiving little information from the health services and therefore gathered it from people around her and made assumptions about recovery based on her beliefs and previous experience. These assumptions, including how to reconcile her belief in full recovery with the reality of having a husband with severe aphasia a year post onset, had not really been aired. She obviously had to deal with the frustrations of daily communication breakdown, manage the appointments for a range of allied health services, including physiotherapy and occupational therapy, drive long distances for non-domiciliary appointments, and act as full-time carer. Her lack of interest in homework may have been related, at least in part, to her own fatigue and time pressures but this was not fully explored. Pushing David to do something that he did not enjoy may have had a negative impact on their relationship. Perhaps if Ruth had been better supported and if her religious beliefs, reluctance to initiate contact and concerns about the value of therapy had all been understood, she could have played a different role in therapy.

The final issue is that speech pathologists are perhaps not sufficiently supported in developing this level of

understanding and involvement for family members. Rachel reported that time was short and she was restricted in what she could offer by service constraints, particularly working in a rural area. Having to deliver therapy from a distance meant a reliance on home practice but this was difficult for Rachel, and previous therapists, to tailor or monitor. It appears that home practice was not underpinned by sufficient explanation or shared understanding and the couple's failure to view home practice seriously was not fully evaluated. At Rachel's handover session, she advised the couple to continue doing what they had been doing. This was flawed because she did not understand the implications of this directive in the light of Ruth and David's attitude to the homework. Within three months, the couple were discharged from therapy.

On the one hand, speech pathologists are recognising the importance of family involvement in rehabilitation but on the other, they are not always being resourced to do what is necessary to make this possible. Involving family in goal planning can be difficult (Levack, Siegert, Dean, & McPherson, 2009). Both time and family-centred approaches are needed to build trusting relationships and develop understandings, not only with the client with the communication disorder, but also with the family. Detailed case studies like this one are useful in revealing the realities of practice and highlighting what can go wrong, especially when the signs and consequences of misinterpretation, miscommunication, and misjudging are not immediately obvious. Involving families means exploring their interpretations about therapy, spending time communicating, answering questions, sharing information, and judging how the client can be most appropriately assisted in therapy. Ultimately, such an investment is surely worthwhile.

## References

- Avent, J., Glista, A., Wallace, S., Jackson, J., Nishioka, J., & Yip, W. (2005). Family information needs about aphasia. *Aphasiology, 19*(3/4/5), 365–375.
- Cunningham, R., & Ward, C. D. (2003). Evaluation of a training program to facilitate conversation between people with aphasia and their partners. *Aphasiology, 17*, 687–707.

Damico, J. S. & Simmons-Mackie, N. N. (2003). Qualitative research and speech-language pathology: A tutorial for the clinical realm. *American Journal of Speech-Language Pathology*, 12, 131–143.

Hemsley, G. & Code, C. (1996). Interactions between recovery in aphasia, emotional and psychosocial factors in subjects with aphasia, their significant others and speech pathologists. *Disability and Rehabilitation*, 18, 567–584.

Hersh, D. (2003). *Experiences of treatment termination in chronic aphasia*. Unpublished PhD thesis, Flinders University, South Australia.

Holland, A. L. (2007). *Counseling in communication disorders: A wellness perspective*. San Diego, CA: Plural Publishing.

Hopper, T., Holland, A. L., & Rewega, M. (2002). Conversational coaching: Treatment outcomes and future directions. *Aphasiology*, 16, 754–761.

Levack, W. M., Siegert, R. J., Dean, S. G., & McPherson, K. M. (2009). Goal planning for adults with acquired brain injury: How clinicians talk about involving family. *Brain Injury*, 23, 192–202.

Michallet, B., Le Dorze, G., & Tétrault, S. (2001). The needs of spouses caring for severely aphasic persons. *Aphasiology*, 15, 731–747.

Oxenham, D., Sheard, C. & Adams, R. (1995). Comparison of clinician and spouse perceptions of the handicap of aphasia: everybody understands “understanding”. *Aphasiology*, 9(5), 477–493.

Purdy, M., & Hindenlang, J. (2005). Educating and training caregivers of persons with aphasia. *Aphasiology*, 19(3/4/5), 377–388.

Servaes, P., Draper, B., Conroy, P., & Bowring, G. (1999). Informal carers of aphasic stroke patients: Stresses and interventions. *Aphasiology*, 13, 889–928.

Simmons-Mackie, N. (2000). Social approaches to the management of aphasia. In L.E. Worrall & C.M. Frattali

(Eds.), *Neurogenic communication disorders: A functional approach*. New York: Thieme.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory*. Thousand Oaks, CA: Sage.

Turner, S. & Whitworth, A. (2006). Conversational partner training programmes in aphasia: A review of key themes and participants' roles. *Aphasiology*, 20(6), 483–510.

Visser-Meily, A., Post, M., Gorter, J. W., Berlekom, S. B. V., Van Den Bos, T., & Lindeman, E. (2006). Rehabilitation of stroke patients needs a family-centred approach. *Disability and Rehabilitation*, 28(24), 1557–1561.

Worrall, L., Brown, K., Cruice, M., Davidson, B., Hersh, D., Howe, T., & Sherratt, S. (2009). The evidence for a life-coaching approach to aphasia. *Aphasiology*. Advance online publication. DOI: 10.1080/02687030802698152

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## Paperwork... sooo last year!

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# Clinical report writing for paediatric clients: A tutorial

Nicole Watts Pappas

**While clinical reports represent a primary and sometimes the only form of communication between families and speech pathologists (SPs), some studies indicate that parents find allied health reports difficult to read, lacking practical information, and containing limited family input. Negative family experiences with reports can lead to a lack of engagement in their child's intervention and a disinclination to follow the recommendations of professionals. Creating reports that are informative, positive, and a focus of action for families is therefore of great importance in establishing a family-SP partnership. This tutorial reviews the literature investigating family members' perceptions of assessment reports and identifies key clinical implications and strategies that can be used by SPs to increase the acceptability and usefulness of their reports to families. A report-writing tool is presented to facilitate SPs' use of family-friendly practices in their report-writing.**

Reports are one of the primary methods of communication of a child's assessment information to families and fulfil an important role as a permanent record of the assessment that parents can refer back to and share with others (Donaldson, McDermott, Hollands, Copley, & Davidson, 2004). The way in which assessment results are conveyed to families can have either a negative or positive effect on their perceptions of their child's difficulties and the formation of a family-professional partnership (Farrell, O'Sullivan, & Quinn, 2009). When assessment reports are written in a positive, accessible manner, with family input, family satisfaction with the speech pathology service and their engagement in their child's intervention may increase. Conversely, reports that focus only on the child's delays and/or are difficult for families to understand may hinder their ability and desire to fully participate in their child's intervention (Carroll, in press).

While, traditionally, families were allowed limited involvement in their child's care, allied health professionals are now encouraged to use models of practice that involve and support families (Rosenbaum, King, Law, King, & Evans, 1998; Watts Pappas & McLeod, 2009). The most dominant

of these models, family-centred practice, considers the whole family as the client and promotes families as the primary decision-makers in their child's care (see Rosenbaum et al., 1998). Family-friendly practice is another approach in which families are respected and supported in the assessment and intervention process. In family-friendly practice the speech pathologist (SP) uses their expertise to guide the intervention process, supporting families to be involved in assessment, intervention planning, and intervention provision (see Watts Pappas & McLeod, 2009).

Although family-focused models of care are now acknowledged as best practice in early intervention, some studies have found that the reporting practices of health professionals (including SPs) could be described as more clinician-centred than family-centred (Donaldson et al., 2004). SPs' assessment reports have been described by parents as difficult to read, focused on the child's delays, and containing limited practical information (Donaldson et al., 2004; Flynn & Parsons, 1994). Family-centred practices such as asking the parent if they agree with the assessment findings and allowing parents to suggest changes to the report before it is finalised do not universally occur (Crais & Belardi, 1999; Crais, Poston Roy, & Free, 2006; Watts Pappas, McLeod, McAllister, & McKinnon, 2008). In some instances, while professionals indicate they are using family-friendly practices in their reporting, parents indicate that this is not the case (Crais et al., 2006).

Recently, Leitão, Scarinci, and Koenig (2009) highlighted the ethical responsibility that SPs have to make their reports readable and useful to clients. In fact, it has been suggested that if reports are difficult for parents to read this can limit their access to information about their child (Carrigan, Rodger & Copley, 2001). It is suggested therefore, that reporting may be one area of practice in which SPs can use family-friendly approaches to improve the acceptability and usefulness of their service to families. To create reports that are family-friendly, the needs and opinions of families should be considered. This paper expands on Leitão et al. (2009) by considering the findings from the literature which indicate what practices may influence families' positive and negative perceptions of reports. From these findings, practical strategies are identified that clinicians can use to make their reports more family-friendly.

## Literature review

While a number of studies have been conducted investigating families' views of intervention for young children and their feelings about their interactions with allied health professionals (see Watts Pappas & McLeod, 2009 for a full

### KEYWORDS

FAMILY-CENTRED PRACTICE

FAMILY-FRIENDLY PRACTICE

PARENT PERCEPTIONS

REPORT WRITING

THIS ARTICLE HAS BEEN PEER-REVIEWED



Nicole Watts Pappas

<b>Table 1: Studies investigating family members' perceptions of clinical report writing (in chronological order)</b>			
<b>Study</b>	<b>Type of investigation</b>	<b>No. of participants</b>	<b>Discipline of professionals</b>
Flynn & Parsons, 1994	Parent and professional surveys	31 parents 80 professionals	SPs and special education teachers
Crais & Belardi, 1999	Family and professional surveys	23 families 58 professionals	Early intervention professionals (including SPs)
Band et al., 2002	Parent focus groups	65 parents	SPs
Carrigan, Rodger, & Copely, 2001	Parent focus groups	11 parents	Occupational therapists
Donaldson et al., 2004	Professional surveys Parental interviews Analysis of content and style of reports	15 parents 11 professionals	SPs and occupational therapists
Crais et al., 2006	Professional and family member surveys	134 professionals 58 family members	Early intervention professionals (including SPs)
Watts Pappas, 2008	Parent interviews Professional focus group	7 parents	6 SPs
Farrell, O'Sullivan, & Quinn, 2009	Parent focus groups	19 parents	Early intervention professionals (including SPs)
Carroll, in press	Parent surveys Parent focus groups	103 parents surveyed 17 parents participated in focus groups	SPs

review), there have been comparatively few studies which have focused on the assessment process, and of these only a small number examine families' views of reporting. A review of the literature from the past 20 years found 9 papers that included discussion of parental (or other family members') perceptions of reports written by allied health professionals (see table 1). The studies accessed family opinion via surveys (n = 3), individual interviews (n = 2), focus group interviews (n = 3) or a combination of those formats (n = 1). Many of the studies also included professionals' views of reporting (n = 5). The majority of the studies were investigations of parents' perceptions of intervention as a whole and had only a small focus on parents' and professionals' views of the reporting process specifically. Only two studies exclusively focused on parental views of report writing. While most studies investigated parents' (predominantly mothers') views, other family members, such as grandparents, were occasionally included in the studies.

In 1994 Flynn and Parsons conducted a survey study investigating 31 parents', 40 SPs' and 40 special education teachers' satisfaction with computer-generated reports versus traditional reports. For three case example children both a computer-generated (using a computer program entitled the Communicative Skills Assessment [COMA]) and a traditional report were produced. The participants were then required to comment via a survey about the clarity, individualisation, and usefulness of each report. The study found that all of the participants expressed increased satisfaction with the computer-generated reports, possibly because these reports contained additional information and explanations regarding the child's difficulties and the implications of these difficulties on their everyday functioning. The "traditional" reports produced in the study contained no explanations of technical terms, no recommendations other than that the child required intervention, and no descriptions of functional implications of the child's delays. Thus the reports may not have been representative of a typical report produced by an SP in the workplace. Additionally, the study did not include what could have been a third option – a report which was written for an individual child and family using family-friendly principles. The use of this form of reporting may have led to an even more useful and readable report than the computer-generated template.

The most thorough investigation of reports was conducted by Donaldson et al. (2004) who interviewed 15 parents regarding their perceptions of the SP and/or occupational therapy assessment reports they received when their child had attended a university clinic. In addition, 11 of the clinicians who supervised students in the clinic (8 SPs and 3 occupational therapists) completed surveys regarding their views on report writing. The study also included an analysis of the readability and style of a selection of reports from the clinic. Donaldson and colleagues found that the parents were dissatisfied with a number of aspects regarding the reports, particularly their readability, the lack of inclusion of practical strategies, and the limited information included regarding the functional implications of poor performance on the assessment tasks. While the reports were written by SP and occupational therapy students, they were supervised by clinicians and produced to a standard deemed acceptable for families (see table 1).

The remainder of this article will discuss the findings of this literature with regard to clinical implications for SPs in their report-writing practice.

## **Clinical implications**

In the studies reviewed, families identified a number of factors which impacted on their positive or negative perceptions of assessment reports. The clinical implications for these findings will now be discussed and presented in a framework of recommendations for SPs to consider when writing reports. Thus, to increase family satisfaction with reports, SPs should consider using the strategies which follow.

### ***Ask parents what information they would like included in the report***

Parents interviewed by Donaldson et al. (2004) found that the occupational therapy and speech pathology reports they received often varied substantially to what they expected the report would be like. To make reports as useful as possible to families, SPs should describe the usual content of assessment reports and ask if the family would like any additional information to be included. This discussion could take place at the end of the assessment session when time might be set aside to also discuss the families' perception of the assess-

ment, the SP's preliminary observations regarding the child's performance, and when to expect the assessment report.

### ***Provide a verbal explanation of the report***

A finding in many of the studies reviewed was that verbal discussion and explanation of the report facilitated the families' understanding (Carrigan et al., 2001; Donaldson et al., 2004; Watts Pappas, 2008). A dedicated assessment feedback session is an ideal venue for this to occur and provides a comfortable, unrushed time in which families can discuss the findings of the assessment with the SP. However, family and/or SP time and distance limitations may mean that a formal assessment feedback session is not possible. In these instances, a possible alternative is a pre-arranged verbal discussion of the assessment over the phone or internet.

Some studies have also found that providing a brief summary of initial findings at the assessment appointment aids parents' later understanding of the contents of the report (Carrigan et al., 2001; Donaldson et al., 2004). The findings given at this time may consist of initial clinical impressions of the child's abilities and the possible impact of their difficulties on their participation in daily tasks, rather than normed scores. While sharing preliminary findings immediately after the assessment may be daunting for some clinicians, Donaldson et al. (2004) suggest that the benefits to families make this a worthwhile skill to develop.

### ***Ask the family if they agree with the information contained in the report***

Some of the studies reviewed indicated that families would like to be asked if they agree with the findings outlined in the report and to be given the opportunity to suggest changes (Crais & Belardi, 1999; Crais et al., 2006). For example, the majority of parents surveyed in a study conducted by Crais and Belardi (1999) indicated they would like the opportunity to review intervention reports before they were finalised. An assessment feedback session can provide an ideal opportunity to both discuss the findings of the assessment and incorporate family changes. Presenting the report to families in a "draft" form (with the word "draft" written on the report) may make families feel more comfortable to suggest changes.

### ***Write the report for the family - not for other professionals***

#### **Individualise the language used for the recipient family**

The readability of reports was one of the one of the most frequently mentioned features which contributed to family satisfaction in the studies reviewed. Parents reported that the assessment reports they received were often difficult to understand, containing numerous, unexplained technical terms (Band et al., 2002; Donaldson et al., 2004; Watts Pappas, 2008). While the use of profession-specific terms or "jargon" is helpful for communication between professionals, it is possible that parents may feel uncomfortable or embarrassed if they do not understand the meaning of the terms (Donaldson et al., 2004). Donaldson et al. concluded that it may be helpful for reports to contain technical terms to facilitate families' discussion of their child's difficulties with other professionals. However, they also indicated that jargon should be followed by simple explanations of what these terms mean. SPs should attempt not only to reduce the use of professional jargon but also to consider the individual family that will receive the report. Different families (and individual members of families) have varying cultural, educational, and occupational backgrounds. Rather than using a 'one style fits all' approach, the SP should attempt to individualise the writing in the report to the unique needs and abilities of each family.

#### **Individualise the structure of the report for the recipient family**

Although models of best practice in early intervention have changed substantially, Flynn and Parsons (1994) reported that the format of SP reports has changed little over time. Another method of increasing the usefulness and readability of reports for families may be to consider individualising the overall structure of the report to each family. Donaldson et al. (2004) reported that the families they interviewed wanted the report to answer the questions they had about their child's functioning. Families may find assessment reports easier to follow and more useful if they are organised according to their expressed concerns about their child rather than in order of skills or assessment tools used.

### ***Focus the report on the child's strengths as well as their weaknesses***

In a bid to gain access to services, allied health professionals are often under pressure to write reports that highlight a child's weaknesses (Paikoff Holzmueller, 2005). However, this practice can be disheartening to families. While it is clear that information about the child's difficulties needs to be included in the report, parents identify they would prefer that their child's information be reported in a positive or neutral manner, with information about their strengths and abilities given similar emphasis to their weaknesses (Farrell et al., 2009; Paikoff Holzmueller, 2005). In this way a more holistic picture of the child is presented, and abilities or aspects of the child that may facilitate intervention are identified (such as a willingness to attempt difficult tasks).

The use of dynamic assessment can help to focus both the assessment session and the report on the child's potential for progress rather than their current delays. In dynamic assessment the clinician not only identifies what the child cannot do but also investigates what skills the child is able to achieve with varying levels of support (Law & Camilleri, 2007). So, for example, rather than listing which sounds the child could not produce, information about their stimulability for error sounds and the support they required to produce those sounds would also be included. This helps create a document that not only provides a description of the child's difficulties but also highlights what the child can achieve with support.

### ***Include information provided by the family in the report***

If parents are to feel that their opinions and knowledge about their child's skills are valued by SPs then this information needs to be incorporated into the written report. Rather than being included in a separate section, information sourced from the family should be reported with and given as much weight as the findings of formal assessments. When families' knowledge about their child is disregarded, parents can feel disempowered, making the establishment of parent-professional partnerships difficult (Paikoff Holzmueller, 2005; Watts Pappas, 2008). Moreover, in disregarding parent's information about their child's skills, the information contained in reports could be inaccurate and misleading. For example, in her account of her own experiences of accessing occupational therapy intervention for her child, psychologist Paikoff Holzmueller (2005) described an incident in which "much was made of my child's lack of familiarity with having his hair combed, but relatively little was made of my comment that he was still bald and had never had his hair combed!" (p. 582).

It is important for clinicians to bear in mind that assessments take place in a brief period of time and often in

settings which are unfamiliar to the child. The child's performance in this situation may thus not be typical of their regular functioning. Formal assessments may also provide little information regarding how the child is able to participate in daily activities. Families are able to provide much important information to contribute to the assessment findings, such as their child's temperament on the day of the assessment, whether the child's performance is typical and whether the child's poor performance on tasks may be due to unfamiliarity with the materials used. Most importantly, families can also provide information about how the child functions in the activities of their daily life. Family involvement in the assessment can be facilitated in many ways. Some possible suggestions include providing assessment tasks that can be completed by the family before the formal assessment, consulting the family prior to the assessment regarding what may help the child perform best in the assessment setting, asking parents to write down observations during the assessment, and setting aside time at the end of the assessment session to discuss the families' perceptions (see Crais, 1993 for further suggestions).

### ***Link the assessment results to functional activities and skills***

Formal assessments often measure the child's ability to perform abstract tasks such as "recalling sentences", "sound segmentation", and "stimulability of sounds". However, the functional implications of poor performance on these tasks may not be immediately obvious to parents. To make the information provided in reports meaningful to families, it is important to provide a context for the assessment results by giving practical examples of how the child's difficulties may affect daily performance (Donaldson et al., 2004). For example, if a child performs poorly on a task designed to assess short-term auditory memory, indicate in the report that this may affect their ability to remember instructions given to them by family members or teachers. Linking the findings of the formal assessment to the family's report of their child's participation in daily activities may also help families understand why their child is having difficulty in certain areas. For example, the child may find it difficult to sit still when they are being read a story as they do not understand the longer, more complex sentences that occur in written language.

### ***Provide functional strategies and information about resources that the family can use to help their child***

The provision of information about resources has consistently been reported as an area of weakness in parents' perceptions of early intervention services (Raghvendra, Murchland, Bentely, Wake-Dyster, & Lyons, 2007). While information about the child's performance on assessment tasks is of interest to families, a report that highlights problems without offering solutions can be frustrating. Parents expect the professional to tell them about other resources that are available to them such as support groups, additional financial support, websites that may be of interest, different options for intervention and/or educational options (Donaldson et al., 2004; Watts Pappas et al., 2008). SPs could incorporate this into their practice by building up a bank of information regarding resources that may be of interest to families of children with different areas of delay. This information could then be inserted into individual reports as necessary.

Parents also report that they would like practical strategies that they could use to help their child included in the report (Donaldson et al., 2004). For example, in their study of parents' perceptions of SP and occupational therapy reports, Donaldson and colleagues (2004, p. 29) stated that

the recommendations section of the SP reports in particular were "considered by most parents to be inadequate", identifying merely that the child required intervention. Rather than simply providing confirmation that the child has difficulties, the inclusion of functional strategies allows the report to act as a "focus for action" (Carrigan et al., 2001, p. 63) and gives parents some immediate actions they can take to begin helping their child.

### ***Provide specific information regarding the intervention required***

Parents report that they would like detailed information regarding the intervention required for their child to be included in assessment reports (Donaldson et al., 2004; Paikoff Holzmueller, 2005; Watts Pappas, 2008). This information would ideally include where they might access the intervention, the cost, what the intervention would involve, and how often they would need to attend. Not all families are confident drivers of the communication process between themselves and intervention services. Clear information about what actions they need to take next in the intervention process may allow them to play an active role in coordinating their child's intervention and to ensure that follow up occurs in a timely fashion.

Additionally, parents wish to know for how long intervention might be required. As a parent in a study conducted by Watts Pappas (2008, p. 224) indicated: "I would like an outline, I know it's hard because every child is individual, but maybe some sort of outline of expected progress."

If families are offered a certain number of intervention sessions they may assume that this is all the child requires. Clearly, the length of time that the child may need to spend in intervention needs to be discussed with parents even if this is not written in the report. It is acknowledged that it is often difficult to predict how much intervention a particular child might need. Moreover, it may be awkward to disclose to families that the service may not be able to provide all the intervention that their child may require. However, providing parents with a general idea about anticipated intervention time may help the family with future planning and, in cases where long-term intervention may be required, to come to terms with the extent of their child's difficulties.

### ***Coordinate the report with other professionals***

Children with developmental delays and disabilities are frequently involved with a number of different health and educational professionals. The complicated role of coordinating these services often falls to the family, whose job is made much more difficult when communication between the different professionals and services is inadequate. For example, parents in a study conducted by Band et al. (2002) felt that the professionals who saw their child did not always communicate with each other when reports were provided. These parents indicated that the reports they received from different professionals sometimes contradicted each other or were repetitive. If the child is assessed by more than one professional in a team, or sees professionals from another agency, it is useful to attempt to coordinate reports rather than write them in isolation. This could be achieved by writing a joint report with the other professionals or, alternatively, accessing reports to identify any areas of incongruity and address these in the report.

### ***Putting it all together***

While SPs report a willingness to use a more family-friendly approach in their practice, they often experience barriers to its use such as limited time and the restrictions of the service for which they work (Watts Pappas et al., 2008). Donaldson

et al. (2004) found that although clinicians may intend to use family-friendly reporting styles, this intention is often not realised in practice. While family-centred practices have been promoted in early intervention it appears that the report-writing practices of SPs and other allied health professionals may have undergone limited change. A number of solutions to this problem are suggested:

1. It is suggested that the use of standard report proformas, in which children's details are inserted into pre-written documents, may lead to a lack of individualisation of reports and limited consideration of the unique needs of each family. Alternatively, Donaldson et al. (2004) suggested that report guidelines should be established to encourage clinicians to individualise the report for each family. A bank of explanations and information regarding resources could be used to aid SPs; however, it is important that these insertions are individualised for each child. Expanding on Donaldson et al.'s suggestion, a report-writing guideline is presented in this article as a possible method to prompt the SP to gather important information from the family during the assessment and to ensure that the report produced is useful and accessible to families (see appendix 1). This tool could be used in tandem with other tools (such as example reports and banks of information) to ensure that reports are family-friendly while maintaining an individual focus for the recipient family. Applying the report checklist to a selection of previously written reports is suggested as a useful exercise for individual SPs to determine whether they use family-friendly approaches in their report-writing practice.
2. University training programs may need to consider whether SP students are provided with sufficient instruction to produce reports that meet families' needs.
3. The use of family-friendly reporting practices also requires the support of workplaces. Individual services could consider the use of quality assurance projects to evaluate the reporting practices of clinicians and to identify any barriers to the use of more family-friendly reporting styles.

## Conclusion

Assessing family perceptions and experiences regarding assessment reports is a useful method by which to identify strategies to increase the family-friendliness of SP reports. This review of the literature has indicated that SPs and other allied health professionals may not always use family-friendly practices when writing reports. Family perceptions of assessment reports were synthesised to produce a number of clinical strategies for SPs to consider in their report-writing practice. A report writing guideline has been presented to facilitate SPs use of family-friendly practices in assessment and report-writing. However, changing SPs' report writing styles may require institutional as well as individual change. An increased focus on the use of family-friendly reporting styles in university training programs and the support of workplaces may also be required to align SPs reporting practices with current models of recommended best practice in early intervention.

## References

Band, S., Lindsay, G., Law, J., Soloff, N., Peacey, N., Gascoigne, M., & Radford, J. (2002). Are health and education talking to each other? Perceptions of parents of children with speech and language needs. *European Journal of Special Needs Education, 17*(3), 211–227.

Carrigan, N., Rodger, S., & Copley, J. (2001). Parent satisfaction with a paediatric occupational therapy service: A pilot investigation. *Physical and Occupational Therapy in Pediatrics, 21*(1), 51–71.

Carroll, C. (in press). "It's not everyday that parents get a chance to talk like this": Exploring parents' perceptions and expectations of speech-language

pathology services for children with intellectual disability. *International Journal of Speech-Language Pathology*. DOI: 10.3109/17549500903312107

Crais, E. (1993). Families and professionals as collaborators in assessment. *Topics in Language Disorders, 14*(1), 29–40.

Crais, E. R., & Belardi, C. (1999). Family participation in child assessment: Perceptions of families and professionals. *Infant-Toddler Intervention, 9*(3), 209–237.

Crais, E. R., Poston Roy, V., & Free, K. (2006). Parents' and professionals' perceptions of the implementation of family-centred practices in child assessments. *American Journal of Speech-Language Pathology, 15*, 365–377.

Donaldson, N., McDermott, A., Hollands, K. Copley, J., & Davidson, B. (2004). Clinical reporting by occupational therapists and speech pathologists: Therapist's intentions and parental satisfaction. *Advances in Speech-Language Pathology, 6*(1), 23–38.

Farrell, A. F., O'Sullivan, C., & Quinn, L. (2009). Parent perspectives on early childhood assessment: A focus group inquiry. *Early Childhood Services, 3*(1), 61–76.

Flynn, M. C., & Parsons, C. L. (1994). A consumer view of computer generated versus traditional assessment reports. *Australian Journal of Human Communication Disorders, 22*(1), 24–39.

Law, J., & Camilleri, B. (2007). Dynamic assessment and its application to children with speech and language learning difficulties. *Advances in Speech-Language Pathology, 9*(4), 271–272.

Leitão, S., Scarinci, N., & Koenig, C. (2009). Ethical reflections: Readability of speech pathology reports. *ACQuiring Knowledge in Speech, Language and Hearing, 11*(2), 89–91.

Paikoff Paikoff Holzmueller, R. L. (2005). Case report – Therapists I have known and (mostly) loved. *American Journal of Occupational Therapy, 59*, 580–587.

Rahagvendra, P., Murchland, S., Bentely, M., Wake-Dyster, W., & Lyons, T. (2007). Parents' and service providers' perceptions of family-centred practice in community-based paediatric disability service in Australia. *Child: Care, Health and Development, 33*(5), 586–592.

Rosenbaum, P., King, S., Law, M., King, G., & Evans, J. (1998). Family-centred service: A conceptual framework and research review. *Physical and Occupational Therapy in Pediatrics, 18*, 1–20.

Watts Pappas, N. (2008). *Parental involvement in intervention for speech impairment*. Unpublished doctoral dissertation, Charles Sturt University, Bathurst, Australia.

Watts Pappas, N., & McLeod, S. (2009) *Working with families in speech-language pathology*. San Diego, CA: Plural Publishing.

Watts Pappas, N., McLeod, S., McAllister, L., & McKinnon, D. (2008). Parental involvement in speech intervention: A national survey. *Clinical Linguistics and Phonetics, 22*(4), 335–344.

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**Appendix 1: Report-writing guidelines**

**To be completed during the assessment session**

Questions posed by the family:

1.

2.

3.

4

Family's report of the child's difficulties:

Family's perception of the child's performance during the assessment session (reflective of usual abilities?)

Information family would like included in the report:

1.

2.

3.

Preliminary findings given to family at assessment:																														
Child's strengths	Areas for improvement	Possible impact on daily functioning																												
<p><b>Report checklist</b></p> <table border="1"> <thead> <tr> <th>Does the report?</th> <th>Tick if correct</th> </tr> </thead> <tbody> <tr> <td>Answer the questions posed by the family?</td> <td></td> </tr> <tr> <td>Include the information the family requested to be included in the report?</td> <td></td> </tr> <tr> <td>Contain explanations of any technical terms used?</td> <td></td> </tr> <tr> <td>Represent a readable document that is set out in a way that is easily accessible by the family it is written for?</td> <td></td> </tr> <tr> <td>Include the family's report of the child's skills?</td> <td></td> </tr> <tr> <td>Include the family's opinion regarding the accuracy of the findings?</td> <td></td> </tr> <tr> <td>Provide information on the child's strengths as well as their weaknesses?</td> <td></td> </tr> <tr> <td>Give information regarding the implications of the child's difficulties on their participation in the activities of their daily life?</td> <td></td> </tr> <tr> <td>Provide detailed information regarding the child's therapy needs?   Place  When intervention should begin  Length/structure of intervention sessions  Possible family involvement  Focus of intervention  Expected length of intervention</td> <td></td> </tr> <tr> <td>Provide information regarding the implications of the child's difficulties in the future?</td> <td></td> </tr> <tr> <td>Provide information regarding other services the family may be able to access?</td> <td></td> </tr> <tr> <td>Provide practical strategies the family or teachers can use to help the child? (or indicate that a home program will be provided)</td> <td></td> </tr> <tr> <td>Coordinate with reports produced by other members of the early intervention team (if applicable)?</td> <td></td> </tr> </tbody> </table>			Does the report?	Tick if correct	Answer the questions posed by the family?		Include the information the family requested to be included in the report?		Contain explanations of any technical terms used?		Represent a readable document that is set out in a way that is easily accessible by the family it is written for?		Include the family's report of the child's skills?		Include the family's opinion regarding the accuracy of the findings?		Provide information on the child's strengths as well as their weaknesses?		Give information regarding the implications of the child's difficulties on their participation in the activities of their daily life?		Provide detailed information regarding the child's therapy needs?  Place When intervention should begin Length/structure of intervention sessions Possible family involvement Focus of intervention Expected length of intervention		Provide information regarding the implications of the child's difficulties in the future?		Provide information regarding other services the family may be able to access?		Provide practical strategies the family or teachers can use to help the child? (or indicate that a home program will be provided)		Coordinate with reports produced by other members of the early intervention team (if applicable)?	
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# Parents as therapists in early stuttering intervention: Problem-solving for the speech pathologist

Natasha Trajkovski, Cheryl Andrews, and Ann Packman

KEYWORDS
CHILD
LIDCOMBE PROGRAM
PROBLEM-SOLVING
STUTTERING
TREATMENT
WESTMEAD PROGRAM

THIS ARTICLE HAS BEEN PEER-REVIEWED

The aim of this paper is to suggest ways of addressing some common problems that may arise in those interventions for early stuttering where parents deliver the treatment. Common problems are discussed and possible solutions are suggested to the following seven issues:

1. The child gets bored during treatment.
2. Rewards do not motivate the child to participate in treatment.
3. The child is overly talkative during the treatment session.
4. The parent has difficulty using the severity rating scale.
5. The parent has difficulty identifying stutters.
6. Parents are unable to schedule regular treatment times.
7. The child's siblings distract the parent or child during treatment.

For ease of reference, problems are divided into those which relate to the child and those which relate to the parent.

Stuttering is a speech disorder that emerges during early childhood. It is characterised by repeated movements and fixed postures of the speech mechanism. While a proportion of children recover naturally from stuttering (Yairi & Ambrose, 2005), a child who does not recover or receive effective treatment will likely have lifelong, intractably impaired speech. The consensus, therefore, is to conduct treatment during the preschool years. A number of treatments for early stuttering exist (see Onslow & Packman, 1999), each associated with specific advantages and disadvantages.

It is not the authors' intention to evaluate all treatments for early stuttering; rather, the purpose of this paper is to address some of the common problems that can arise when working with families in the treatment of early stuttering. Accordingly, this paper draws on the experiences of three speech pathologists (SPs) who have specialised in the

treatment of early stuttering. At the time of writing, all of the authors held clinical and research positions at the Australian Stuttering Research Centre (ASRC) and, as such, were experienced in the use of the Lidcombe Program (Onslow, Packman, & Harrison, 2003) and the Westmead Program (Trajkovski, Andrews, O'Brian, Onslow, & Packman, 2006) of early stuttering intervention.

## Parents as therapists for early stuttering

In both the Lidcombe Program and the Westmead Program, a parent (or carer) delivers the treatment in the child's everyday environment. They do this under the guidance and supervision of an SP. In the Lidcombe Program, the child and parent attend the clinic each week and the SP trains the parent to deliver verbal contingencies (comments) for stuttering and for periods of stutter-free speech (the manual of the program can be downloaded from the ASRC website, [www.fhs.usyd.edu.au/asrc](http://www.fhs.usyd.edu.au/asrc)). The parent also learns how to measure and record the child's stuttering severity each day on a 10-point scale. Initially, the parent delivers treatment for short periods in highly controlled situations, for example, sitting with the child and talking about a book. As the child's speech improves, treatment is conducted in less controlled situations, for example, playing with toys. This transition can be daunting for some parents. Nevertheless, it is imperative for the SP to ensure that parents complete treatment safely and as instructed. To do so, the SP observes the parent demonstrating how treatment is being conducted each week and suggests modifications for the following week. The Lidcombe Program is now used routinely in Australian speech clinics (Rousseau, Packman, Onslow, Robinson, & Harrison, 2002).

The Westmead Program has been developed more recently, and differs from the Lidcombe Program in that a novel speech pattern, namely syllable timed speech (STS), is used to instate fluency. It is well known that stuttering decreases or completely disappears when people speak rhythmically (for an overview see Packman, Onslow, Richard, & van Doorn, 1996). Initial trials of the Westmead Program indicate that even very young children can use STS to control stuttering on imitation and with minimum instruction. Hence, the task of instating fluency in the Westmead Program is much simpler for the parent than in the Lidcombe Program. The parent simply models STS for set periods



Natasha Trajkovski (top) and Ann Packman



each day and encourages the child to use the pattern. Again, the parent uses the Lidcombe severity rating scale to measure the child's stuttering each day.

## Problem-solving

Generally, participation in treatment for early stuttering is a positive experience for families (Packman & Langevin, 2009). With the Lidcombe Program, parents report being willing and enthusiastic about treatment, while children demonstrate overall enjoyment participating in therapeutic activities (Packman, Hansen, & Herland, 2006). When stuttering does not decrease over time as expected, conducting treatment can become burdensome and frustrating for all involved (Hayhow, 2009). For the SP, the situation may become overwhelming given the constant drive toward healthcare efficiency that is common in the Australian public sector. While the implementation of the Westmead Program is simpler than the Lidcombe Program, many of the logistic difficulties faced by parents acting as therapists are the same. However, evaluation of the Westmead Program is still in its early stages and the experiences of parents have yet to be fully investigated.

Below, the experiences of two clinicians who specialise in stuttering are presented in order to provide SPs with direction when addressing some common problems that may arise when working with parents in the treatment of early stuttering. It is hoped that this paper will assist SPs to customise treatment for each child. For ease of reference a problem-solving format is used, which is divided into problems involving children and problems involving parents.

## Problems involving children

### Problem 1

#### **The child gets bored during treatment.**

*Possible solution* As with treatment for other communication disorders, children tend to demonstrate boredom when an activity is either too difficult or too simple. Even though it is important to set the child up for success during treatment, it is equally as important to provide the child with opportunities to challenge the child's system. As a general rule of thumb, it may be useful for the parent to commence each treatment session at a level that will ensure the child is successful and gradually work toward more challenging goals as the session progresses. It is often the case that, in order to set the child up for success, structured activities such as imitation, modelling, or picture description tasks may be necessary. Such tasks, however, can have the effect of limiting language output and as a result may become frustrating for the child. To combat the situation, a reward system may be introduced.

For younger children, rewards should be tangible and immediate, e.g., a tick on a page, a peg on a string, or a gem in a box. Where possible, the parent should avoid using rewards that will distract the child from the treatment task. If immediate rewards do not provide sufficient motivation, the child may exchange them for a more interesting reward once treatment has been completed, e.g., a trip to the park, time on the computer, or the opportunity to play a game. For older children, immediate rewards become less relevant and the topic of conversation tends to present as the motivating factor. Discovering relevant subjects can take time; it is well

worth investigating with the parent the personal interests of each child so as to ensure compliance during treatment.

### Problem 2

#### **Rewards do not motivate the child to participate in treatment.**

*Possible solution* More often than not, reward systems are abandoned prematurely for being ineffective. However, with a tailored system that is relevant to the individual child, rewards can be a powerful treatment tool. Generally, children tend to express lack of interest toward a particular system when the reward is either repetitive, or delivered in an inconsistent manner. It thus may be necessary for the parent to vary the form of reward used along with the way in which it is delivered, until an effective system is achieved. It is important for SPs to support the parent in developing reward systems that are both motivating for the child and practical for the parent to deliver. If a particular system is not feasible, or not suited to the child, its components are less likely to be followed through. Such inconsistency will only lead the child's lack of interest and non-compliance.

### Problem 3

#### **The child is overly talkative during the treatment session.**

*Possible solution* In the Lidcombe Program it may be necessary for the parent to limit the child's speech output in order to establish fluency. Contingencies will not be effective if the child does not hear them, which can happen when a child talks incessantly. In order to control the amount of speech elicited from a child during treatment, the SP may consider training parents to use conversational techniques such as mirroring and closed-ended questions. Mirroring involves the listener repeating part of the conversation back to the speaker in order to convey their attention and understanding, for example:

*Child: "Dolly is going to the shops today to buy a new dress."*

*Parent: "To buy a new dress?"*

When used for the purposes of controlling speech output, mirroring provides a natural conversation break, allowing parents to re-direct speech output. Similarly, closed-ended questions can be effective in establishing speech constraints, whereby the child is only required to respond using specific pieces of information. In practice, closed-ended questions can be combined with mirroring, for example:

*Child: "Dolly is going to the shops today to buy a new dress."*

*Parent: "To buy a new dress, what colour will it be?"*

Together, these conversational techniques give parents a natural, yet purposeful method of conversing with their talkative child for the purposes of conducting treatment.

## Problems involving parents

### Problem 4

#### **The parent has difficulty using the severity rating scale.**

*Possible solution* A 10-point severity rating scale is used by parents in both the Lidcombe Program and the Westmead Program. The aim is to provide information about a child's response to treatment beyond the clinic. Usually, parents

demonstrate great insight into the fluctuations of their child's stuttering each day and require only minimal training in the task of collecting scores. Nevertheless, when initially instructing parents to use a severity rating scale it is important to calibrate readings between users, or risk the scale becoming potentially meaningless. To do so, a sample of the child's speech within the clinic can be rated independently by both the clinician and parent. Severity scores can then be compared and discussed until they differ by no more than 1-scale point. During the calibration stage, it is important for clinicians to emphasise that the severity scale does not require parents to count the actual number or type of stutters present. Rather, scores should be a subjective reflection of the child's typical level of stuttering each day. On the whole, provided that the clinician discusses severity rating scores regularly, it is likely that parents will continue collecting them consistently.

### **Problem 5**

#### **The parent has difficulty identifying stutters.**

*Possible solution* Given that many preschool children exhibit normal disfluency as they acquire language, it can be difficult for parents to identify stuttered moments during the day. Accordingly, parents can be instructed to consider only unambiguous stuttering when attempting to assess severity in this age group. Unambiguous stuttering refers to speech behaviours that can be clearly and unequivocally categorised as either repeated movements or fixed postures (see Teesson, Packman, & Onslow, 2003). When uncertain, the general rule should be to overlook ambiguous disfluencies. Some parents, however, may need assistance in distinguishing stuttering from normal disfluency. To do so, a sample of the child's speech within the clinic can be assessed by the clinician, reporting back to the parent when stuttering has occurred. With modelling and clear instruction, it is likely that parents will learn to identify stuttering quickly and accurately.

### **Problem 6**

#### **Parents are unable to schedule regular treatment times.**

*Possible solution* It is common for parents to feel overwhelmed with the addition of treatment tasks to their

already demanding schedules. If the situation is not discussed and monitored closely, some parents may end up feeling guilty and discouraged about the treatment process, or worse, conceal the reality of their circumstances. Rather than focusing on what the parent has not achieved, the SP should attempt to build on what the parent has already accomplished. For example, if a parent reports being able to complete treatment for only 5 minutes per day, the SP may suggest that an additional 2 minutes of treatment be applied each week, until the recommended dose of treatment is achieved. It is equally important to give parents the opportunity to suggest their own solutions to any scheduling problems. In doing so, parents may be more inclined to take ownership of their ideas and follow through with the solutions discussed. By setting parents up for success in this way, the completion of treatment tasks should become a more feasible part of their daily routine.

### **Problem 7**

#### **The child's siblings distract the parent or child during treatment.**

*Possible solution* When one child receives parental attention to the exclusion of siblings, as may occur during stuttering treatment, it is almost inevitable that siblings will attempt to disrupt the session. If not resolved, the situation could result in an overall reduction of treatment quality or duration. One potential solution to the problem is to allow all children to participate in treatment. In doing so, the parent can focus treatment on the child for whom it is intended while also attending to the demands of other siblings. Another solution may be to prepare, in advance, an alternate activity for siblings to complete while stuttering treatment is being delivered. For this to succeed, the activity must be appealing enough to keep the siblings' interest for the entire treatment session. A reward system may need to be developed to ensure that the alternative activity is sufficiently engaging and motivating. In fact, if a reward system has already been developed for the child receiving stuttering treatment, it may be advantageous to apply a similar reward system to the alternative activity so as to minimise sibling dispute.

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## Conclusion

For the most part, treating early stuttering is a relatively straightforward process. Difficulties tend to arise, however, when a child who is stuttering does not respond as quickly to treatment as anticipated. Even so, it is important for the SP to remain positive and support families through any challenges that may arise. By doing so, many potential complications associated with treatment may be resolved, if not avoided. We conclude by saying that this paper does not provide an exhaustive list of potential problems and possible solutions to the treatment of early stuttering. Therefore, conferring with colleagues who are experienced in working with parents of preschoolers who stutter can be of assistance. SPs at the Bankstown Stuttering Unit (<http://www.sswahs.nsw.gov.au/Bankstown/Stuttering/>) and the ASRC ([www.fhs.usyd.edu.au/asrc](http://www.fhs.usyd.edu.au/asrc)) are available for consultations about apparently insoluble problems.

## References

- Hayhow, R. (2009). Parents' experiences of the Lidcombe Program of early stuttering intervention. *International Journal of Speech-Language Pathology*, 11, 20–25.
- Onslow, M., & Packman, A. (1999). The early stuttering intervention debate: Generating light and heat. *Advances in Speech Language Pathology*, 1, 143–145.
- Onslow, M., Packman, A., & Harrison, E. (2003). *The Lidcombe Program of Early Stuttering Intervention: A clinician's guide*. Austin, TX: Pro-Ed.
- Packman, A., & Langevin, M. (2009). Working with families of children who stutter. In L. Pappas & S. Mcleod (Eds.), *Working with families in speech-language pathology* (pp. 171–187). San Diego, CA: Plural Publishing.
- Packman M., Onslow, M., Richard, F., & van Doorn, J. (1996). Linguistic stress and variability: A model of stuttering. *Clinical Linguistics and Phonetics*, 10, 235–263.
- Packman, A., Hansen, E.J., & Herland, M. (2007). Parents' experiences of the Lidcombe Program: The Norway-Australia connection. In J. Au-Yeung & M.M. Leahy (Eds.) *Research, treatment, and self-help in fluency disorders: New horizons*. Proceedings of the Fifth World Congress on Fluency Disorders, Dublin, Ireland (pp. 418-422). International Fluency Association.

Rousseau, I., Packman, A., Onslow, M., Robinson, R., & Harrison, E. (2002). Australian speech pathologists' use of the Lidcombe Program of early stuttering intervention. *Acquiring Knowledge in Speech, Language and Hearing*, 4, 67–71.

Teesson, K., Packman, A., & Onslow, M. (2003). The Lidcombe behavioral data language of stuttering. *Journal of Speech, Language, and Hearing Research*, 46, 1009–1015.

Trajkovski, N., Andrews, C., O'Brian, S., Onslow, M., & Packman, A. (2006). Treating stuttering in a preschool child with syllable timed speech: A case report. *Behaviour Change*, 23, 270–277.

Yairi, E. & Ambrose, N. (2005). *Early childhood stuttering: for clinicians by clinicians*. Austin, TX: Pro-Ed.

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# Bullying of school-age children who stutter and potential coping strategies

Nathania van Kuik Fast and Marilyn Langevin

KEYWORDS

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THIS ARTICLE HAS BEEN PEER-REVIEWED

**Bullying is an important social problem that has serious and long-lasting effects on children who are victims. Because many school-age children who stutter are bullied, it is important that speech pathologists (SPs) have an understanding of the issues involved in bullying and the potential coping strategies that can be considered when helping children deal with bullying.**

**This article aims to (a) provide a general overview of what is known about bullying and coping responses in typical school-age children, (b) summarise what is known about bullying and coping strategies in school-age children who stutter, (c) describe several interventions that have been used with children who stutter and who have been bullied, and (d) discuss clinical implications of the current state of knowledge and the need for further research with children who stutter.**



**Nathania van Kuik Fast (top) and Marilyn Langevin**

## Bullying of typical school-age children

### *Definition and types*

Bullying is a subtype of aggression that has as its core features: (a) an intent to harm, (b) repetition over time, and (c) a power differential in which children who are victims have difficulty defending themselves against a more powerful individual or group of individuals (Salmivalli & Peets, 2009). Bullying can take a number of forms, including physical, verbal, and relational bullying. It can be direct (e.g., verbal attacks) or indirect (e.g., social exclusion). Verbal bullying includes name-calling, ridicule, insults, and hurtful teasing. Relational bullying includes behaviours that are intended to harm a child's social status or peer relationships (e.g., spreading nasty rumours or orchestrating social rejection and humiliation). More recently, cyber-bullying (i.e., bullying through the use of mobile phones, email or Internet web pages) has emerged as another significant form of bullying (Salmivalli & Peets).

### *Prevalence and correlates of bullying in school-age children*

Card and Hodges (2008) reported that between 30% and 60% of children are bullied at least once during a given school semester or year, and between 6% and 15% of children are bullied at least once a week. Being bullied has been linked with a host of problems including diminished psychological well-being (e.g., low self-esteem and negative emotional states), poor social adjustment (e.g., school avoidance and rejection by peers), psychological distress (e.g., high degrees of anxiety, depression, and suicidal thoughts), and physical ill-health symptoms (for a review see Rigby, 2003).

### *Bullying as a relationship problem*

Bullying is now widely viewed as a relationship problem in which children who bully use power and aggression to control others and children who are victims become trapped in abusive relationships, from which escape is difficult (Craig & Pepler, 2008). Bullying can be viewed as a subtype of goal-directed proactive aggression in which children who bully "attempt to gain (and maintain) social status within the peer group" (Salmivalli & Peets, 2009, p. 327). Salmivalli and Peets posit that this view explains why some children are repeatedly targeted and why peers get involved. That is, "the victim can be seen as a means to achieve one's goals, and the group is needed, because status is something that the group assigns to its members" (p. 328).

### *Roles and intrapersonal and interpersonal characteristics*

A child may fill one of the following roles in a bullying episode: a child who bullies, a child who is a victim of bullying, a child who is a victim and also bullies others, and a child who neither bullies nor is victimised. Children who are not involved in a bullying episode may be bystanders, whose failure to take action may reinforce the bullying, or defenders, who may intervene on behalf of the victim.

In addition to engaging in proactive bullying, some children who bully engage in reactive bullying, or aggression in response to perceived provocation by the child who is victimised (Marini & Dane, 2008). In contrast to the earlier view that children who bully are insecure and have low self-esteem, research has shown that children who bully proactively are socially skilled and can be central members of the peer group (see Salmivalli & Peets, 2009).

Children who are victims have been described as either passive or provocative victims. Passive victims represent

the large majority of children who are victims, whereas provocative victims make up between 10% and 20% of the victim group (Olweus, 2001). Passive victims have been shown to be shy, anxious, sensitive, and submissive (Olweus, 1993). In contrast, provocative victims show a combination of anxious and aggressive patterns and may be hot-tempered and retaliate ineffectively (Olweus, 1993). In addition to these intrapersonal characteristics, children's social status (i.e., their interpersonal relations) can place them at risk of being bullied. Children who have few friends or are rejected by the peer group are easy targets because it is less likely that the peer group will defend them (see Salmivalli & Peets, 2009).

### ***Coping strategies***

The following review focuses on coping strategies used by typical children that have been associated with the escalation or perpetuation of bullying and with the de-escalation or escape from bullying. In general, research has shown that behaviours associated with the escalation or perpetuation of bullying include: (a) aggressive/externalising responses to bullying (e.g., getting angry, losing one's "cool", and using verbal or physical counter-aggression), (b) helpless behaviour (e.g., being paralysed with fear or being unable to respond in any way), and (c) internalising (e.g., engaging in self-blame for the bullying) (Kochenderfer-Ladd & Skinner, 2002; Mahady Wilton, Craig, & Pepler, 2000; Salmivalli, Karhunen, & Lagerspetz, 1996).

In contrast, instrumental coping (e.g., using constructive actions and problem-solving), and passive coping (e.g., ignoring, acquiescence/compliance, and avoidance) were found to be associated with de-escalation or resolution of observed bullying episodes (Mahady Wilton et al., 2000). However, Mahady Wilton and colleagues noted that passive coping responses may actually perpetuate the cycle of bullying because these strategies may be reinforcing for both the child who bullies and the child who is victimised. That is, the child who bullies achieves the desired personal gain, and the child who is victimised receives temporary relief when the bullying episode ends.

Other coping strategies associated with diminished bullying or cessation of bullying include nonchalance, particularly for boys (Salmivalli et al., 1996), and conflict resolution (Kochenderfer-Ladd, 2004). When acting nonchalant, the victim stays calm, acts as if the bullying is not being taken seriously, or acts as if he/she does not care (Salmivalli et al.). Conflict resolution strategies include talking to someone, telling the perpetrator to stop, making a plan for how to get along with the perpetrator in the future, taking some time to cool off, and using 'I' messages (Kochenderfer-Ladd). Finally, talking to someone and making more friends was found to be associated with escape from victimisation (Smith, Talamelli, Cowie, Naylor, & Chauhan, 2004).

### ***Bullying and children who stutter***

In regard to children who stutter, Langevin, Bortnick, Hammer, and Wiebe (1998) found that of the 27 children who stutter and were surveyed, 81% reported being teased or bullied about stuttering or about other things. Fifty-nine percent were teased or bullied about their stuttering, and 56% of this group were teased or bullied about their stuttering once a week or more often. Sixty-nine percent of the children were teased about other things, and 50% of this group were teased or bullied about other things once a week or more often. Participants reported that children most frequently called them names, or imitated or made fun of

their stuttering. Davis, Howell, and Cooke (2002) found that children who stutter were less accepted socially, less likely to be perceived as leaders, and more likely to be bullied than non-stuttering children. Taken together, this suggests that children who stutter may be at a greater risk of being bullied than are children who do not stutter.

Reported consequences of bullying for children who stutter are consistent with those reported for typical children. In a retrospective study by Hugh-Jones and Smith (1999), adult participants who stutter reported experiencing the following negative effects of being bullied as children: loss of self-confidence and self-esteem, anxiety, shyness, shame, depression, difficulty making and maintaining friendships, truancy, and increased speech problems. A recent cross-sectional study by Blood and Blood (2007) found that boys who stutter and who reported being frequently bullied were more likely to have higher levels of anxiety.

### ***Coping strategies and children who stutter***

Research focusing on the coping strategies used by children who stutter to deal with bullying is limited. An interesting finding by Davis et al. (2002) was that children who stutter tended to project social profiles similar to those projected by their classmates. The authors suggested that these results might indicate that children who stutter seek to avoid standing out and try to be as much like their classmates as possible to avoid being bullied.

In a report that included case presentations, Langevin, Kully, and Ross-Harold (2007) described the resolution strategies that helped two children who stutter and who had been teased. For one child, the teasing stopped when his friends stood up for him. For the other child, the problem was resolved when the teacher intervened. Murphy, Yaruss, and Quesal (2007) described a case in which a 9-year-old boy reported that he no longer had concerns about being bullied after he participated in the bullying component of their therapy. This component involved problem-solving activities in which the boy learned effective ways of dealing with bullying in addition to preparing a presentation to make to his class in order to educate his classmates about stuttering. In Turnbull's (2006) case study, two speech-language pathologists made a presentation about stuttering to the class of a 10-year-old girl who stuttered. In the presentation, the speech-language pathologists talked about stuttering and how to interact positively with children who stutter. After the presentation, the girl who stuttered and her classroom teacher gave positive feedback about the presentation.

### ***Current suggestions for interventions for children who stutter and who are victims***

The common components of current suggestions for helping children who stutter deal with bullying include teaching the child about bullying, discussing possible response strategies, and educating the child's classmates about stuttering in order to create a more supportive classroom environment (Langevin, 2000; Langevin et al., 2007; Murphy & Quesal, 2002; Murphy et al., 2007; Turnbull, 2006). An important aspect of the works of Langevin, Langevin et al. and Murphy and Quesal is helping the child to differentiate between friendly teasing and teasing in which there is an intention to harm. These researchers also focus on ways to increase the child's assertiveness and self-esteem. All of the interventions make use of role-playing to help the child who stutters practise and evaluate his or her responses to bullying scenarios and try out new responses.

## Clinical implications

Following are some clinical implications and suggestions for coping with bullying that SLPs may want to consider when they are working with a child who stutters or children with other communication disorders. With the exception of item 7 below, which relates specifically to children who stutter, these suggestions also relate to typical children. When considering potential strategies, SLPs and other adults should keep in mind that children will go through a complex process of assessing the risk associated with using a specific coping strategy (Oliver & Candappa, 2007).

1. Children who bully are often socially competent and bully to achieve and maintain social status. This suggests that not giving the reaction that the child who bullies desires may be effective in stopping the bullying. That is, responses such as acting nonchalant (Salmivalli et al., 1996) and responding with assertiveness (Craig, Pepler, & Blais, 2007) may prevent the child who bullies from achieving or maintaining the desired gain in social status. Ignoring the moment of bullying is another possible strategy. However, ignoring can place the child at risk for continued victimisation if it means that the child pretends that the bullying has not happened. As Langevin (2000) pointed out, ignoring the bullying should not mean that the child does not tell someone about the bullying or does not seek help.
2. Specific coping strategies may be more or less effective depending on the following factors:
  - (a) *The type of bullying.* For example, if the type of bullying is of a serious nature or the child's safety at school is of concern, school officials should likely be contacted before any suggestions are made to the victim to try different strategies (Langevin, n.d.).
  - (b) *Whether the child who is a victim is characterised as a passive or provocative victim or is a child who also bullies others.* For example, if a victim is submissive, the child may benefit from role-playing in which assertiveness is practised. In contrast, if the child has difficulty managing emotions, he or she may benefit from assistance to develop more adaptive emotion management skills (Mahady Wilton et al., 2000).
  - (c) *Gender.* For example, Salmivalli et al. (1996) found that boys tended to use counter-aggression as a coping strategy and that it was associated with continued victimisation. Therefore, if the victim is a boy, he may be counselled against using counter-aggression.
  - (d) *Age of the victim.* For example, Kochenderfer-Ladd (2004) found that younger elementary-age children were more likely to seek advice than older elementary-age children. Therefore, adults need to be aware that older elementary-age children may be more fearful that talking to an adult may make the situation worse. This highlights the critical importance of developing a relationship of trust with the child and keeping the child involved in any decision-making regarding a potential intervention (Langevin, n.d.). As Andrew Mellor indicated (Langevin, n.d.), it is important for an adult to create opportunities for children to talk about sensitive issues so that a relationship of trust is developed and that talking to an adult about a problem will become a natural response, and to encourage the child to view the interaction as a two-way process to help the child develop full confidence in the adult.
  - (e) *How long the bullying has been occurring.* That is, if the bullying has been occurring for some time, it may be more difficult for the victim to stop the bullying without the help of an adult due to the victim's lack of power (Craig et al., 2007).
3. Easy targets. Children who are easy targets are those who react to aggression with high levels of emotion (Kochenderfer-Ladd, 2004), or are shy, anxious, and submissive, and have few or no friends. Having friends and quality friendships protects against victimisation (e.g., Boulton, Trueman, Chau, Whitehead, & Amatya, 1999). Kochenderfer-Ladd suggests that children should be taught to manage their emotional reactions. Craig et al. (2007) suggest that children should be helped to recognise healthy relationships, to develop skills to enable them to be appropriately assertive in peer interactions, and to solicit the required support. Mahady Wilton et al. (2000) suggest that assertive behaviour develops a child's sense of social mastery and facilitates peer acceptance.
4. Distress. Being bullied has been linked with psychological and emotional distress as well as poor health symptoms (Rigby, 2003). Thus, children may need referrals to allied professionals to help them cope with the psychological, emotional, or health sequelae of being bullied.
5. Bullying interactions become habitualised (see Salmivalli & Peets, 2009). Therefore, children who are victims and children who bully may need the ongoing support of adults to help them replace habitualised maladaptive patterns with more adaptive ones. For example, children who are victims may need help to replace aggressive responses to bullying with nonchalance, or to replace submissive responses with assertive responses. Children who bully by engaging in reactive aggression may benefit from anger management counselling that helps them to reduce their tendency to respond with hostility to perceived provocations, and from social skills training to help them learn non-aggressive solutions to social issues and to improve their peer relations (see Marini & Dane, 2008). Children who bully by engaging in proactive aggression may have difficulty recognising the detrimental outcomes of their behaviour due to the status they gain from bullying (see Marini & Dane). Therefore, it has been recommended that these children be helped to build empathy for the children that they are harming and learn non-aggressive ways of achieving or maintaining social status (see Marini & Dane).
6. Bullying occurs within the context of relationships in the peer group. Thus, it is widely recommended that mobilising the peer group to support and defend children who are victims is an integral component of bullying prevention and intervention programs. It may be helpful for SLPs to liaise with teachers or counsellors who are involved in bullying prevention programs. As well, incorporating potential peer supporters or defenders into clinical sessions (e.g., as conversation partners to promote generalisation of speech management techniques) may facilitate the development of a network of supportive peer relationships for the child who stutters and who is a victim of bullying.
7. As described above, educating classmates about stuttering has been suggested as a helpful strategy. Such education also has been perceived to be helpful by peers of children who stutter (Link & Tellis, 2006) and has been reported to be helpful to individual children who stutter (Murphy et al., 2007; Turnbull, 2006).

## Future research

This review of the literature reveals that research is urgently needed to inform clinical practice about coping strategies that children who stutter have found to be effective in decreasing or stopping teasing and other forms of bullying. A qualitative investigation that addresses this gap in knowledge is underway. The authors are using in-depth semi-structured interviews to learn about the bullying experiences of children who stutter, their responses to the bullying, and their perceptions of helpful and unhelpful strategies to deal with bullying.

## References

- Blood, G. W., & Blood, I. M. (2007). Preliminary study of self-reported experience of physical and bullying of boys who stutter: Relations to increased anxiety. *Perceptual and Motor Skills, 104*, 1060–1066.
- Boulton, M. J., Trueman, M., Chau, C., Whitehand, C., & Amatya, K. (1999). Concurrent and longitudinal links between friendship and peer victimization: Implications for befriending interventions. *Journal of Adolescence, 22*, 462–466.
- Card, N. A. & Hodges, E. V. E. (2008). Peer victimization among schoolchildren: Correlations, causes, consequences, and considerations in assessment and intervention. *School Psychology Quarterly, 23*, 451–461.
- Craig, W., & Pepler, D. (2008). Understanding and addressing bullying: An international perspective. In D. Pepler & W. Craig (Eds.), *Understanding and addressing bullying: An international perspective* (pp. xix–xxvi). Bloomington, IN: AuthorHouse.
- Craig, W., Pepler, D., & Blais, J. (2007). Responding to bullying: What works? *School Psychology International, 28*, 465–477.
- Davis, S., Howell, P., & Cooke, F. (2002). Sociodynamic relationships between children who stutter and their non-stuttering classmates. *Journal of Child Psychology & Psychiatry & Allied Disciplines, 43*, 939–947.
- Hugh-Jones, S., & Smith, P. K. (1999). Self-reports of short- and long-term effects of bullying on children who stammer. *British Journal of Educational Psychology, 69*, 141–158.
- Kochenderfer-Ladd, B. (2004). Peer victimization: The role of emotions in adaptive and maladaptive coping. *Social Development, 13*, 329–349.
- Kochenderfer-Ladd, B., & Skinner, K. (2002). Children's coping strategies: Moderators of the effects of peer victimization? *Developmental Psychology, 38*, 267–278.
- Langevin, M. (2000). *Teasing and bullying: Unacceptable behaviour (TAB)*. Edmonton, Alberta: Institute for Stuttering Treatment & Research.
- Langevin, M. (n.d.). *Teasing and bullying: Helping children deal with teasing and bullying: For parents, teachers and other adults*. Retrieved 26 February, 2010 from [http://www.stutterisa.org/CDRomProject/teasing/tease\\_bully.html](http://www.stutterisa.org/CDRomProject/teasing/tease_bully.html)
- Langevin, M., Bortnick, K., Hammer, T., & Wiebe, E. (1998). Teasing/bullying experienced by children who stutter: Toward development of a questionnaire. *Contemporary Issues in Communication Science and Disorders, 25*, 12–24.
- Langevin, M., Kully, D. A., & Ross-Harold, B. (2007). The Comprehensive Stuttering Program for school-age children with strategies for managing teasing and bullying. In E. G. Conture & R. F. Curlee (Eds.), *Stuttering and related disorders of fluency* (3rd ed., pp. 131–149). New York: Thieme.
- Link, J., & Tellis, G. (2006). Children who stutter are bullied in schools: Counseling strategies for speech-language pathologists. *Advance for Speech-Language Pathologists and Audiologists, 16*, 14–15.
- Mahady Wilton, M. M., Craig, W. M., & Pepler, D. J. (2000). Emotional regulation and display in classroom victims of bullying: Characteristic expressions of affect, coping styles and relevant contextual factors. *Social Development, 9*, 226–245.
- Marini, Z. A., & Dane, A. V. (2008). Matching interventions to bullying subtypes: Ensuring programs fit the multifaceted needs of children involved in bullying. In D. Pepler & W. Craig (Eds.), *Understanding and addressing bullying: An international perspective* (pp. 97–126). Bloomington, IN: AuthorHouse.
- Murphy, W. P., & Quesal, R. W. (2002). Strategies for addressing bullying with the school-age child who stutters. *Seminars in Speech & Language, 23*, 205–212.
- Murphy, W. P., Yaruss, J. S., & Quesal, R. W. (2007). Enhancing treatment for school-age children who stutter II: Reducing bullying through role-playing and self-disclosure. *Journal of Fluency Disorders, 32*, 139–162.
- Oliver, C., & Candappa, M. (2007). Bullying and the politics of "telling". *Oxford Review of Education, 33*, 71–86.
- Olweus, D. (1993). *Bullying at school: What we know and what we can do*. Cambridge: Blackwell Publishers.
- Olweus, D. (2001). Peer harassment: A critical analysis and some important issues. In J. Juvonen & S. Graham (Eds.), *Peer harassment in school: The plight of the vulnerable and the victimized* (pp. 3–20). New York: The Guilford Press.
- Rigby, K. (2003). Consequences of bullying in schools. *Canadian Journal of Psychiatry, 48*, 583–590.
- Salmivalli, C., Karhunen, J., & Lagerspetz, K. M. J. (1996). How do the victims respond to bullying? *Aggressive Behavior, 22*, 99–109.
- Salmivalli, C., & Peets, K. (2009). Bullies, victims, and bully-victim relationships in middle childhood and early adolescence. In K. H. Rubin, W. M. Bukowski, & B. Laursen (Eds.), *Handbook of peer interactions, relationships, and groups* (pp. 322–340). New York: The Guildford Press.
- Smith, P. K., Talamelli, L., Cowie, H., Naylor, P., & Chauhan, P. (2004). Profiles of non-victims, escaped victims, continuing victims and new victims of school bullying. *British Journal of Educational Psychology, 74*, 565–581.
- Turnbull, J. (2006). Promoting greater understanding in peers of children who stammer. *Emotional & Behavioural Difficulties, 11*, 237–247.

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# Students' experiences of family-centred strength-based practice in a non-traditional clinical setting

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KEYWORDS
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THIS ARTICLE HAS BEEN PEER-REVIEWED

**The Special Needs Unlimited Group (SNUG) program of the University of Newcastle's Family Action Centre conducts camps for children with special needs and their families in rural NSW. At the camps, families access much-needed respite, support and healthcare. SNUG also provides undergraduate speech pathology students with the opportunity to augment their clinical education by becoming SNUG volunteers. Through the camps students experience strength-based, family-centred practice and gain insights into the lives of families living with special needs. This paper addresses the theoretical framework and skills required by SNUG volunteers, and the potential benefits for students in an intensive non-traditional learning environment.**

## Family-centred practice

Family-centred practice involves a number of values, attitudes and approaches to working with children with special needs and their families (Moore & Larkin, 2005). In family-centred practice, the family, rather than just the child, is the focus of intervention. The family is recognised as “the expert” in relation to the child and the constant in the child’s life. A family-centred approach not only treats families with dignity and respect, but works in partnership with families by ensuring they have the information they need to make decisions about service provision (Dunst, Trivette, & Hamby, 2007).

Family-centred practice can be widely applied in speech pathology. In regards to alternative and augmentative communication, it is seen as vital in working with both adults and children, and may reduce issues such as speech generating device abandonment (Goldbart & Marshall, 2004; Johnson, Bloomberg, Perry, & Reilly, 2003). It applies in the area of paediatric swallowing, in which a family commonly experiences grief and loss associated with feeding difficulties in the child (Mathisen, 2009). It is consistent with the principle that, in dealing with complex communication needs, “training and support should be available for all regular and/or significant communication partners” (Johnson et al., 2003, p. 2).

In particular, family-centred practice is seen as critical in the area of special needs (Goldbart & Marshall, 2004). Over the last twenty years, the rights of a person with special needs have been recognised and legalised internationally (Caudrey & Dissinger, 2007), reminding healthcare providers of the centrality of the rights of their clients, and of the importance of developing mutual respect in client–clinician relationships. When working with children, this legislation reminds practitioners of the importance of respecting the needs, rights and expertise of the family as a whole.

Treating the whole family as the client is seen as central to family-centred practice. The family is a child’s primary environment and plays a vital role in child development (Watts Pappas, McLeod, & McAllister, 2009). Improving the way individuals function in their natural environment is not only a target of speech pathology, but also a measure of quality of life (Cruice, 2008).

The relationship between parents and clinicians is also a central theme in family-centred practice; incorporating mutual respect and participation. Within this partnership, the right of the parent to make decisions is valued and respected (Watts Pappas et al., 2009). Parental decision-

The importance of family-centred practice in healthcare is now widely acknowledged (Watts Pappas & McLeod, 2009). An increase in community-based care, the complexity of client needs, and a deeper understanding of the needs of families have contributed to the relevance of family-centred practice in health service provision in Australia (Caudrey & Dissinger, 2007; Goldbart & Marshall, 2004; McAllister, 2005).

A strength-based approach enhances family-centred practice by recognising that parents have many strengths and resources that support their child’s development (Johnson, Cournoyer, et al., 2003). Incorporating both these approaches to healthcare delivery is associated with fewer hospital visits and fosters independence in families, facilitating self-sustaining healthcare benefitting both families and service providers (Caudrey & Dissinger, 2007; Goldbart & Marshall, 2004; Warmington, 2003). The Special Needs Unlimited Group (SNUG) combines these approaches in residential camps for families of children with special needs run by The Family Action Centre at the University of Newcastle and supported by student volunteers.

Student learning and professional development is supported by practical experience to facilitate an integrated understanding of practice known as deep learning (Fieldhouse & Fedden 2009). This paper addresses the theoretical framework and skills required as a SNUG student volunteer in a family-centred, strength-based and non-traditional setting.



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making can be supported through the provision of relevant, up-to-date information written in simple language (Payne, 2009). Although it is unclear to what extent families are involved in decision-making and intervention processes in speech pathology practice at present, parental involvement in home practice appears the most common form (Watts Pappas & McLeod, 2009).

What works for a family varies between families and across time (King, Batorowicz, & Shepherd, 2008). This requires flexibility on the part of the speech pathologist, as well as a communicated willingness to tailor meaningful and manageable goals to the particular family's needs (King et al., 2008). Sensitivity to the family's situation is critical in goal development, influencing the success of intervention (Goldbart & Marshall, 2004; King et al., 2008; Payne, 2009).

## Strength-based practice

Strength-based practice offers an approach to working with families and individuals that focuses on strengths, abilities and potential rather than problems, deficits and pathologies. Strength-based practice complements family-centred practice through a forward focus to problem-solving (Walsh, 2002).

Strength-based practice recognises that individuals, families and social environments have many strengths and resources; and is based on the premise that interventions should focus on these strengths and resources in collaboration with individuals and families, thereby promoting resilience (Saleebey, 2006). Resilience is the ability to move forward during life challenges and stresses. It can be viewed both as a strength or skill of a family, and a process that a family works through as they persevere through crises (Lee, Lee, Kim, Park, Song, & Park, 2004).

Of the many strengths a family may have, one of the greatest predictors for coping in mothers of children with intellectual disability is the strength of the marriage sub-system, seen to promote adjustment and to encourage a positive attitude (Yau & Li-Tsang, 1999). Support from friends and extended family has also been identified as a source of strength for families. Utilising this support may help a family adapt to changes in a crisis situation (Darley, Porter, Werner, & Eberly, 2002; Yau & Li-Tsang 1999).

Flexibility and effective problem-solving skills have been recognised as characteristic strengths of adaptive parents. Fathers have felt that problem-solving skills are particularly important to their role, and parents have found that flexibility enables them to find creative ways of adapting to challenges, such as accessibility issues in the home (Darley et al., 2002; Yau & Li-Tsang, 1999).

In addition to these skills, families may identify other valued attributes that help them cope. The uniqueness of these skills and strengths requires an understanding of the family unit, which is best achieved through integration of both family-centred and strength-based approaches.

## Special Needs Unlimited Group

The Special Needs Unlimited Group (SNUG) program through the Family Action Centre at The University of Newcastle adopts both family-centred and strength-based approaches in an innovative way. The SNUG program consists of a 5-day residential camp, in which rural families with children with special needs receive respite and access healthcare services during the one residential stay. The aims of SNUG are to:

1. improve access to medical, dental and allied health services for children with special needs who live in rural communities;
2. create support networks for families with a child with special needs living in a rural community;
3. improve the resilience of families with a child with special needs living in a rural community;
4. educate undergraduate students, including speech pathology students, in understanding the issues faced by families with children with special needs.

## *The background to SNUG*

The SNUG program is based on camps offered by Agrenska, a National Competence Centre for Rare Diseases in Sweden, in which families dealing with similar special needs meet together for a residential camp. At the camps families are educated about their child's disorder and receive information regarding available specialist services (Dellve, Samuelsson, Tallborn, Fasth, & Hallberg, 2006). The Dellve et al. (2006) large sample study on the benefits of this model gives robust evidence into the benefits of this program for caregivers, with baseline measures compared with results from follow-up at six and twelve months after the camp.

Dellve et al. (2006) assessed stress, well-being and supportive resources experienced by mothers and fathers of children with rare disabilities who were attending an Agrenska program and how these variables were affected by an intensive family-centred intervention. They found that the Agrenska model resulted in increased feelings of competence, and increased levels of active coping among parents of children with special needs. While fathers felt that they had a greater knowledge of care, mothers did not report any systematic decreases in stress levels; however, there was a perceived reduction in tiredness and physical strain in those mothers who were continuing employment. Compliance with intervention was greater, as was a perceived improvement in coping. These positive effects were particularly noted in fathers, mothers employed full-time, and parents with children aged under 7 years (Dellve et al. 2006).

## *SNUG and support networks for families*

A significant feature of both the Agrenska model in Sweden and the SNUG program in Australia is the opportunity for families to create new networks of social support. SNUG brings families together in an informal setting where they are able to share their experiences and provide support to each other. Up to the end of February 2010, there had been five camps attended by 24 families consisting of 30 children with special needs, 21 parents, seven grandparents with permanent care of their grandchild with special needs, 5 foster or adoptive parents and 33 siblings.

Both qualitative and large comparative studies have identified the need for social support in families living with special needs (Goldbart & Marshall, 2004; Lach et al., 2009; Payne, 2009). Social support may help alleviate the feelings of isolation that are common especially in mothers of children with special needs (McGuire, Crowe, Law, & VanLeit, 2004).

Families in similar situations are able to support each other by providing insights into the everyday aspects of interventions (Carter, Cummings, & Cooper, 2007). Families may also be more willing to talk with other families facing similar challenges in times when coping is problematic (Carter et al., 2007). Within family support groups, a cycle of sustainability allows isolated families to connect and to feel emotionally supported, resulting in increased coping levels,

a feeling of empowerment and an increased ability to access services (Warmington, 2003).

### **Student involvement in SNUG**

Consistent with the aims of SNUG, student volunteers from a range of undergraduate degrees at The University of Newcastle have the opportunity to interact with families while assisting with the residential camp. Fifty-eight students have volunteered over the first five camps and primarily come from disciplines relating to children with special needs, including speech pathology, occupational therapy, education and nursing. These students receive specific training for strength-based practice by the Family Action Centre staff preceding the camp. Students also receive supervision throughout the program from the two SNUG coordinators and participate in group discussion where they reflect on their experiences during the camps.

Throughout the camp, students work with families, coordinators and other volunteer students to ensure the program runs smoothly. They help facilitate activities for the families, assist the children with special needs to participate in camp activities, provide practical assistance (e.g., with meals), help families attend medical appointments and generally provide practical support to the families. Importantly, the students also have many informal opportunities to get to know family members, learn more about the roles of other professions, and gain valuable insights into the reality of life for families facing a range of challenges.

The student experience for SNUG program volunteers may be considered non-traditional, as supervision is not provided by clinicians from their own discipline. Formal assessments are not incorporated for speech pathology students, and the camp setting is not typical of clinical placements, nor of a typical speech pathology setting. The qualitative studies of non-traditional placements suggest that they provide a greater opportunity for reflective practice and evaluation to facilitate deep learning and the development of a strong professional identity (Fieldhouse & Fedden, 2009; Overton, Clark, & Thomas, 2009). Non-traditional settings like SNUG may provide opportunities for skills such as assertiveness, negotiation and collaboration to be continually practised, and lead to a greater focus on the client rather than the student's own performance (Fieldhouse & Fedden, 2009; Overton et al., 2009).

As students from different disciplines work together in a real setting with families, there is a great opportunity for peer learning and the potential for students to develop an awareness of different professional perspectives, marking the way for an understanding and expectation of interdisciplinary practice (Geller, Rhyne, Hansbarger, Borrego, VanLeit, & Scaletti, 2002). Evidence from a systematic review suggests that peer learning increases clinical skills and knowledge (Secomb, 2008). As a result, it is now common for speech pathology programs in Australia to place more than one student with the one clinical educator (McAllister, 2005).

### **Future research**

The SNUG program is in its infancy and so the benefits for students are the subject of ongoing research. A pilot study involving six speech pathology students investigated the SNUG volunteer experience through focus group discussion based on the first two camps conducted in 2009. Preliminary results from these focus group discussions indicated that the students reported a greater insight into the family's experience, increased confidence in working in the area of special needs, and a greater sense of commitment and compassion. Students highlighted the experience as unique,

compared to other traditional clinical placements, in relation to working with interdisciplinary students and the experiential nature of the program (see Mathisen & Edmunds, 2009, for a summary of the focus group notes).

Unpublished preliminary findings from an evaluation by the Family Action Centre are consistent with the pilot study data for speech pathology students. So far 15 student volunteers have participated in focus groups discussing their experiences during the camp and have been very positive about what they learnt during the camps. In particular they felt they had a greater understanding of the daily experience for families with children with special needs and reported that the SNUG program helped them to recognise the importance and complexity of family-centred practice, as illustrated by the following quotes:

*Student 1: I guess I learned to take the whole family approach and not just about the person in front of you. I think that was the biggest thing I learned.*

*Student 2: I've got a few clients at the moment, at my placement and they'll come in with parents and say, "Oh sorry, we're just so busy, we didn't get time to do the homework [set by an allied health professional]". Before I was at the camp, I would just think, "Oh they don't care much or they're just a bit lazy", but you can really see why people just don't get the homework done.*

It is worth noting that the families also appreciated the fact that the camps are helping to produce therapists with greater awareness of living with special needs. In particular, they emphasised the importance of the camp providing students with insights into family life when a child has special needs.

The SNUG volunteer role is both active and direct. Research from other non-traditional placements has suggested that an active role may facilitate experiential and deep learning (Fieldhouse & Fedden, 2009; Healey, 2008). It appears from the evidence regarding non-traditional placements that there is potential for students to learn valuable interpersonal and collaborative skills through their roles as SNUG volunteers. These skills are seen to be important in managing rapid change in healthcare service delivery, and in particular in the speech pathology discipline (McAllister, 2005).

The SNUG program is an example of students being engaged in real-life experiences that enhance their professional development as speech pathologists. Through the camps, they are able to experience strength-based, family-centred practice and gain valuable insights into the lives of families living children with special needs. While further research is needed into the benefits of SNUG for the students' future practice, the feedback to date suggests that students feel they are gaining valuable experience through the camps.

### **Summary**

Practical experience in non-traditional settings such as SNUG plays an important role in developing an integrated understanding of practice known as deep learning (Fieldhouse & Fedden, 2009). With the emerging awareness and place of family-centred and strength-based practice in speech pathology, practical student experience may facilitate the development of the required skills and knowledge in these areas.

### **References**

Carter, B., Cummings, J., & Cooper, L. (2007). An exploration of best practice in multi-agency working and the

experiences of families of children with complex health needs: What works well and what needs to be done to improve practice for the future? *Journal of Clinical Nursing*, 16, 527–539.

Caudrey, D., & Dissinger, M. (2007). Health support of people with disabilities in South Australia: Innovations in policy and practice. *Disease Management & Health Outcome*, 15(6), 341–353.

Cruice, M. (2008). The contribution and impact of the International Classification of Functioning, Disability and Health on quality of life in communication disorders. *International Journal of Speech-Language Pathology*, 10(1–2), 38–49.

Darley, S., Porter, J., Werner, J., & Eberly, S. (2002). Families tell us what makes families strong. *The Exceptional Parent*, 32(12), 34–36.

Dellve, L., Samuelsson, L., Tallborn, A., Fasth, A., & Hallberg, L. R. M. (2006). Stress and well-being among parents of children with rare diseases: A prospective intervention study. *Journal of Advanced Nursing*, 53(4), 392–402.

Dunst, C. J., Trivette, C. M., & Hamby, D. W. (2007). Meta-analysis of family-centered helping practices research. *Mental Retardation & Developmental Disabilities Research Reviews*, 13(4), 370–378.

Fieldhouse, J., & Fedden, T. (2009). Exploring the learning process on a role-emerging placement: A qualitative study. *British Journal of Occupational Therapy*, 72(7), 302–307.

Geller, Z. D., Rhyne R. L., Hansbarger, L. C., Borrego, M. E., VanLeit, B. J., & Scaletti, J. V. (2002). Interdisciplinary health professional education in rural New Mexico: A 10 year experience. *Learning in Health and Social Care*, 1(1), 33–46.

Goldbart, J., & Marshall, J. (2004). "Pushes and pulls" on the parents of children who use AAC. *Augmentative and Alternative Communication*, 20(4), 194–208.

Healey, W. E. (2008). Physical therapist student approaches to learning during clinical education experiences: A qualitative study. *Journal of Physical Therapy Education*, 22(1), 49–58.

Johnson, H., Bloomberg, K., Perry, A., & Reilly, S. (2003). *An analysis of needs for people with a disability who have complex communication needs in Victoria 2001–2002*. Unpublished manuscript.

Johnson, H., Cournoyer, D., Fliri, J., Flynn, M., Grant, A., Lant, M., Parasco, S., & Stanek, E. (2003). Are we parent-friendly? Views of parents of children with emotional and behavioral disabilities. *Families in Society*, 84(1), 95–108.

King, G., Batorowicz, B., & Shepherd, T. A. (2008). Expertise in research-informed clinical decision making: Working effectively with families of children with little or no functional speech. *Evidence-Based Communication Assessment and Intervention*, 2(2), 106–116.

Lach, L. M., Kohen, D. E., Garner, R. E., Brehaut, J. C., Miller, A. R., Klassen, A. F., et al. (2009). The health and psychosocial functioning of caregivers of children with neurodevelopmental disorders. *Disability and Rehabilitation*, 31(9), 741–752.

Lee, I., Lee, E., Kim, H. S., Park, Y. S., Song, M., & Park, Y. H. (2004). Concept development of family resilience: A study of Korean families with a chronically ill child. *Journal of Clinical Nursing*, 13, 636–645.

Mathisen, B. (2009). Working with families of children with dysphagia: An interdisciplinary approach. In N. Watts Pappas & S. McLeod (Eds.), *Working with families in speech-language pathology* (pp. 245–278). San Diego, CA: Plural Publishing.

Mathisen, B., & Edmunds, K. (2009). *Speech pathology student volunteers focus group discussion: Summary notes*. Unpublished manuscript.

McAllister, L. (2005). Issues and innovations in clinical education. *Advances in Speech-Language Pathology*, 7(3), 138–148.

McGuire B. K., Crowe, T. K., Law, M., & VanLeit, B. (2004). Mothers of children with disabilities: occupational concerns and solutions. *Occupational Therapy Journal of Research: Occupation, Participation and Health*, 24(2), 54–63.

Moore, T., & Larkin, H. (2005). *More than my child's disability...: A comprehensive literature review about family-centred practice and family experiences of early childhood intervention services*. Glenroy, Victoria: Scope.

Overton, A., Clark, M., & Thomas, Y. (2009). A review of non-traditional occupational therapy practice placement education: A focus on role-emerging and project placements. *British Journal of Occupational Therapy*, 72(7), 294–301.

Payne, J. (2009). Supporting family caregivers: The role of speech-language pathologists and audiologists. *The ASHA Leader*, 14(3), 22–25.

Saleebey, D. (Ed.). (2006). *The strengths perspective in social work practice* (4th ed.). New York: Longman.

Secomb, J. (2008). A systematic review of peer teaching and learning in clinical education. *Journal of Clinical Nursing*, 17, 703–716.

Walsh, F. (2002). A family resilience framework: Innovative practice applications. *Family Relations*, 51(2), 130–144.

Warmington, R. (2003). *Family carers' health and well-being and community capacity building in rural areas*. Paper presented at 7th National Rural Health Conference, Hobart, Tasmania.

Watts Pappas, N., & McLeod, S. (2009). Parents' perceptions of their involvement in paediatric allied health intervention. In N. Watts Pappas & S. McLeod (Eds.), *Working with families in speech-language pathology* (pp. 74–110). San Diego, CA: Plural Publishing.

Watts Pappas, N., McLeod, S., & McAllister, L. (2009). Models of practice used in speech-language pathologists' work with families. In N. Watts Pappas, & S. McLeod (Eds.), *Working with families in speech-language pathology* (pp. 1–38). San Diego, CA: Plural Publishing.

Yau, M. K., & Li-Tsang, C. W. P. (1999). Adjustment and adaptation in parents of children with developmental disability in two-parent families: a review of the characteristics and attributes. *British Journal of Developmental Disabilities*, 45(88), 38–51.

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# Clinical insights

## TBI express: A communication training program for everyday communication partners of people with TBI

Leanne Togher, Emma Power, Skye McDonald, Robyn Tate, and Rachael Rietdijk

KEYWORDS
COGNITIVE-COMMUNICATION DEFICITS
COMMUNICATION PARTNER TRAINING
FAMILIES
REHABILITATION PROGRAM
TRAUMATIC BRAIN INJURY (TBI)

**Traumatic brain injury (TBI) can result in social communication breakdown that affects the person with TBI and their communication partners, especially their families. While we have shown that we can train people with TBI to have better social interactions, training programs to provide conversation-based communication strategies for communication partners of people with TBI have been non-existent. In this article, we introduce a partner-centered approach to communication training and describe our 10 week program. We outline our current treatment study and provide general communication strategies that can be the basis for more enjoyable and effective conversations.**

and mothers never asked people with TBI questions to which they did not already know the answer. Participants with TBI were more frequently questioned regarding the accuracy of their contributions and their contributions were followed up less often than the adults without TBI. The results from this research also revealed that communication partners sometimes used patronising comments, flat voice tone and slowed speech production and therefore compromised an adult interactional style.

The difficulty for communication partners is that they do not know how to deal with challenging communication behaviours and have not received training in this area. Changes in their communication style and interaction may be largely unconscious and may have developed over an extended period of time since the actual injury. However, research has demonstrated that when communication partners are provided with training (e.g., police officer trained on telephone service requests), partners can implement communication strategies that appear to enable the person with TBI to engage in more appropriate and successful interactions. If communication partners' behaviours can positively and negatively affect how a person with brain injury communicates, and training the communication partner may benefit the person with TBI's conversations, then it seems essential that training programs be developed to assist everyday communication partners, such as family and friends, in supporting people with TBIs. However, to date, no studies have investigated training everyday communication partners of people with TBI.

### Why involve communication partners?

The communication difficulties experienced by people with traumatic brain injury (TBI) have been a research focus for some members of our team for many years (Flanagan, McDonald, & Togher, 1995; Togher, Hand, & Code, 1997). People with TBI can have seeming disinterest in conversations, and an inability to generate and maintain topics. Alternatively, they may interrupt frequently, make disinhibited, inappropriate responses, or swear and get stuck on the same topics (Coelho, 2007). These frustrating and disturbing communicative behaviours are difficult to manage, particularly when in a community setting such as a shopping centre or at a social function. However, the person with communication difficulties represents only one side of the interaction. The behaviour of their conversational partner is also important. Indeed, it has been found that individuals with TBI are often disadvantaged in interactions because of the way their communication partners interact with them (Togher et al., 1997). In one study of telephone conversations, participants with TBI were asked to find out information from a range of communication partners, including therapists, their mothers, police officers and call centre service providers. For example, they asked the therapists about their current treatment goals, and they asked their mothers about their weekly program of activities. The matched control participants were brothers of the people with TBI. The results suggested that the individuals with TBI were asked for and were given less information than matched control participants (Togher et al., 1997). Therapists

### The communication partner training program

The innovative aspect of this training is that it focuses upon on the communication partner, providing education and training to improve their ability to successfully interact with the person with TBI. We have previously identified common communication problems in the interaction between staff, families and others in the community and people with TBI that can be targeted for training. Specifically, training uses a combination of approaches arising from programs we have previously developed (e.g., Togher & Grant, 1998) and also from the work of Dr Mark Ylvisaker from Albany, NY, USA. Ylvisaker advocates that specific scaffolding conversational strategies such as helping the person with TBI to elaborate and collaborate in the interaction can facilitate communication, cognitive and social recovery in people with TBI (Ylvisaker, Feeney, & Urbanczyk, 1993; Ylvisaker, Sellars, & Edelman, 1998).

The communication partner training program is divided into 10 modules run over 10 weeks (Togher, McDonald, Tate,



Leanne Togher (top) and Emma Power

Power, & Rietdijk, 2009). Each person with TBI and their communication partner attends a two and a half hour group session with 3–4 other pairs. Each pair then also attends their own weekly one-hour session without other group members. Here each pair can focus on their own specific needs related to the week’s topic and review home practice tasks that have been recorded onto supplied tape recorders. An overview of the 10-week program is provided in box A. The sessions incorporate a mix of role plays and conversational practice with peer feedback. Session handouts are also provided. A morning tea break each week allows people to socialise with and obtain support from other group members.

**Box A: The 10-week partner training program**

Session number	Title	Contents
Session 1	Introductions	Members are introduced to each other. Aims of training, group guidelines and home practice expectations are established.
Session 2	Brain Injury and communication	Educational component on TBI and communication
Session 3-4	Effective communication 1 and 2	Communication roles and rules in society. Barriers and facilitators to good communication in everyday life. General communication strategies.
Session 5	Collaboration	Techniques for communication partners to make conversations a collaborative process where both the “feel” and information exchange are more equal, shared and organised.
Session 6	Elaboration	Techniques for communication partners to organise and link conversational topics to support longer and more interesting conversations
Session 7	Asking questions	Use of appropriate and helpful questions to start and keep conversations going. Includes how to avoid negative or ‘testing’ questions and focus on a positive questioning style.
Sessions 8–10	Improving skill and confidence	Revision and practice of information and techniques learnt in previous sessions using the Communication Partner Communication Strategies Toolkit (figure 1). Celebration lunch for group members’ achievements.

The program teaches communication partners how to help the person with TBI actively engage in conversations in everyday life and so the strategies are immediately applicable in everyday situations. Some examples of the key messages that the training program participants receive are presented in box B, along with quotes from participants themselves or specific examples to illustrate the message.

**Research update**

To improve interactions for people with TBI, two approaches have been suggested as helpful. The most commonly researched approach has been to train the person with TBI to improve their social skills (e.g., Dahlberg et al., 2007),

	Your Specific Strategies
“What’s right for this situation?” Communication rules and situations	
“We’re doing this together.” Collaborative team	
“What can you help make this easier?” Cognitive support	
“I’m with you – it’s OK.” Emotional support	
“What can I ask to help you contribute?” Questions	
“I’m interested in sharing conversations.” Turn taking	
“We’ll choose topics which keep things going - in this conversation and into the future.” Elaboration of topics	
“I’ll help organise the conversation so we can talk in more detail.” Elaborate organisation	
“If the message gets lost, we’ll try to work it out together.” Repairing conversational problems	

Figure 1 Example of TBI express toolkit

whereas the much less investigated method described above is to train communication partners. While both approaches clearly have potential, to date, no study has compared the two methods. Our study aims to determine whether training people with TBI only or training communication partners of people with TBI jointly is beneficial in improving communication interactions compared to people who do not receive training (delayed treatment controls). We also want to establish whether one treatment is more effective than the other.

To investigate these questions, over the last 18 months we have been conducting a non-randomised clinical trial (Togher et al., 2009) funded by the National Health and Medical Research Council and administered by the University of Sydney and University of NSW. Forty-four people with severe TBI and their chosen communication partners have been recruited from brain injury units at Liverpool and Westmead Hospitals and the Royal Rehabilitation Centre Sydney. The people with TBI range from 18 to 62 years old and are 1–25 years post injury (average of 8 years). Based on communication partner availability, pairs were allocated to one of the three groups: the TBI only group, where only the person with TBI was trained, the JOINT group where both the communication partner and person with TBI were trained together, and a delayed treatment control condition. Tests, questionnaires and ratings of video conversations will be used to evaluate outcomes for communication, as well as measures of social skills, carer burden and self esteem. Currently, data collection and analysis are being finalised and we hope to provide readers with results next year. Preliminary results have been positive and participants have been given the opportunity to report on strategies they found useful and on any benefits of the program from their own point of view.

**Conclusion**

Training communication partners of people with brain injury, particularly their family members, is a promising way to enhance interactions and build personal relationships, which

## Box B. Messages for communication partners

1. Approach conversations with the goal of collaborating with each other to reach a common understanding or decision. Conversations need a balance of asking questions, listening and understanding, and sharing information about your own ideas and experiences.

*Participant: "I realised I just asked questions all the time like 'Did you enjoy the holiday, and what did we do?'. Now I use comments and give her time to spark her own memory. I say, 'It was a great holiday, my favourite day was the zoo and the white tiger, he was amazing'. When I give her a little bit of information she can build on it."*

2. Use conversations as a way of introducing new and more complex information and ideas (elaboration). People with traumatic brain injury may have a limited range of topics they can talk about. By talking about new topics in daily conversations, people with TBI can expand their knowledge of the world and have more interesting things to talk about with other people.

*One of our participants found that by introducing her son to other topics in the world and exploring those more, he was able to provide many opinions she thought he wasn't capable of expressing. He also reduced the amount of time he spent on the same topic and subsequently, also the frustration his family experienced with his repetition.*

3. Use thinking supports as part of daily conversations. For example, make reference to a diary when planning for the future, look back at photos when talking about past events, use a written organiser with headings (e.g. who, what, where, when) when talking about planning for an event.

*Rather than saying "no, we can't have the BBQ here, there's too many people, we'll have it at a community centre", use helpful "conversational guides" that encourage the person with TBI to think it through in collaboration. For example, "now I'm thinking we've got a lot of people coming, our place is pretty small [see if this triggers a response] ... let's think of bigger places we could have it ... [wait for response]".*

4. Avoid asking questions to which you already know the answer. Instead, try to use real questions which explore ideas, feelings and opinions. This creates a more natural, adult conversation and gives more confidence to the person with TBI in front of others.

*One participant said: "He went to the movies and I knew what he saw. Before the course I would have asked him, did he remember what it was called and who went with him. How boring! Now I ask him, what was the best bit of the movie, or did he prefer the other Die Hard movies or this one, how were they different? It's amazing what he remembers then. It's not perfect but wouldn't you rather talk about that ... I would!"*

5. Give specific, positive feedback when you have a successful conversation with the person with TBI, or when you notice the person having a successful conversation with someone else.

*For example: "It was great talking about the news this evening, you're giving me more detail about your opinions, and I enjoy the chat."*

are too frequently affected following the injury. This area requires further study and consideration, and it is hoped that the development of practical clinical tools may assist clinicians in more easily in their clinical practice working with families, friends and others in the social network of the person with TBI.

## Acknowledgements

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## References

- Coelho, C. A. (2007). Management of discourse deficits following traumatic brain injury: Progress, caveats, and needs. *Seminars in Speech & Language, 28*(2), 122–135.
- Dahlberg, C. A., Cusick, C. P., Hawley, L. A., Newman, J. K., Morey, C. E., Harrison-Felix, C. L., et al. (2007). Treatment efficacy of social communication skills training after traumatic brain injury: A randomized treatment and deferred treatment controlled trial. *Archives of Physical Medicine and Rehabilitation, 88*(12), 1561–1573.
- Flanagan, S., McDonald, S., & Togher, L. (1995). Evaluating social skills following traumatic brain injury: The BRISS as a clinical tool. *Brain Injury, 9*(4), 321–338.
- Togher, L., & Grant, S. (1998). *Community policing: A training program for police in how to communicate with people with traumatic brain injury*. Unpublished manuscript.
- Togher, L., Hand, L., & Code, C. (1997). Analysing discourse in the traumatic brain injury population: telephone interactions with different communication partners. *Brain Injury, 11*(3), 169–189.
- Togher, L., McDonald, S., Tate, R., Power, E., & Rietdijk, R. (2009). Training communication partners of people with TBI: Reporting the protocol for a clinical trial. *Brain Impairment, 10*(2), 188–204.
- Ylvisaker, M., Feeney, T. J., & Urbanczyk, B. (1993). Developing a positive communication culture for rehabilitation: Communication training for staff and family members. In C. J. Durgin, N. D. Schmidt, & L. J. Fryer (Eds.), *Staff development and clinical intervention in brain injury rehabilitation* (pp. 57–81). Gaithersburg, MD: Aspen.
- Ylvisaker, M., Sellars, C., & Edelman, L. (1998). Rehabilitation after traumatic brain injury in preschoolers. In M. Ylvisaker (Ed.), *Traumatic brain injury rehabilitation. Children and adolescents* (pp. 303–329). Newton, MA: Butterworth-Heinemann.

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# Webwords 37

## Families, the heart of the matter

Caroline Bowen



The complicated logo for the United Nations International Year of the Family (IYF) depicts a heart linked by another heart in a house. It symbolises life and love in a home characterised by warmth, caring, security, tolerance and acceptance. The opening represents continuity with a touch of uncertainty, while the roof's sweeping brushstroke hints at the complexity of the family. By contrast, the simple slogan for the year was 'Families, the Heart of the Matter'.

Since the IYF in 1994 the International Day of Families has been celebrated annually<sup>1</sup> on 15 May. Each international day has a special focus, and in 2010 it was the impact of migration on families around the world. This theme has immediate relevance for Australians grappling with the human rights issues embedded in immigration policy, humane treatment of asylum seekers, child protection, our roles and responsibilities in the Asia-Pacific region, racism and all things FaHCSIA.<sup>2</sup> It also draws Australians back an imponderable 40 to 60,000 years to the migration of the ancestors of today's Indigenous families<sup>3</sup> via the Malay Archipelago and New Guinea.

Adventurous Europeans visited in the 1600s and 1700s and colonisation began in 1788 with the arrival of the First Fleeters<sup>4</sup> who included representatives of 60 different nationalities. By the time they heard their first Sydney kookaburra, the country and coastal islands were inhabited by 700 indigenous cultural groups, speaking 250 different languages,<sup>5</sup> and bound by a spiritual closeness to country and a sense of kinship that stretches way beyond the non-Aboriginal and Torres Strait Islander concepts of geography, real estate and the nuclear family.

### The First Fleet

(Gillen, 1989, p.445)

Embarked at Portsmouth	Arrived at Port Jackson
Officials/passengers 15	Officials/passengers 14
Ships' crews 323	Ships' crews 306
Marines 247	Marines 245
Marines' wives/children 46	Marines' wives/children 54
Convicts (males) 582	Convicts (males) 543
Convicts (females) 193	Convicts (females) 189
Convicts' children 14	Convicts' children 22
Total embarked: 1420	

From that time onwards our population has observed increasing cultural diversity, remaining largely oblivious to the inexorable attrition of indigenous languages or language death (Crystal, 2000, pp. 1–27). It watched the ludicrous enforcement and slow dismantling of the White Australia policy (1901–73), softened in 1966, when a coalition government farcically permitted the immigration of a trickle of "distinguished" non-Europeans. It noted the pre-war obsession with "Britishness" and a preference for *northern* over southern Europeans as "New Australians" (Kunek, 1993). To our shame, it stood by and allowed assimilation

policy (1951 to the 1970s) with its attendant and ongoing tragedy of the Stolen Generation, and, more positively, it participated in the steady unfolding, since 1973, of multiculturalism.

### Values

Promoting multiculturalism,<sup>6</sup> the Commonwealth Department of Immigration and Citizenship (DIAC) upholds Aussie mateship, a fair go for all and the pleasing view that every Australian shares the benefits and responsibilities arising from the cultural, linguistic and religious diversity of our society. The department's website offers, in English and 37 community languages, booklets called *Beginning a Life in Australia*, welcoming new migrants and humanitarian entrants, and a 46-page downloadable book, *Life in Australia*.<sup>7</sup> Crammed with information about Australian history, culture and social structures, the publications are designed to help newcomers understand Australian values before signing the values statement on their visa applications. And everyone who wants a visa *has* to sign. The book may be useful for speech pathologists who work with migrants, refugees, and other clients, or indeed colleagues who have recently arrived in Australia.

The values are not uniquely ours, but they are agreed to, according to DIAC, in broad terms by our community and underpin Australian democracy, society, culture. They include:

- respect for the equal worth, dignity and freedom of the individual;
- freedom of speech;
- freedom of religion and secular government;
- freedom of association;
- support for parliamentary democracy and the rule of law;
- equality under the law;
- equality of men and women;
- equality of opportunity;
- peacefulness; and
- a spirit of egalitarianism that embraces tolerance, mutual respect and compassion for those in need.

As well as having a code of ethics, Speech Pathology Australia has a charter in which its vision, mission and values are briefly stated. Our values as speech pathologists are that "we strive to:

- be client centred and provide ethical services to our client communities;
- demonstrate excellence and continual improvement in providing maximum standards of service within our places of employment; and,
- uphold our professional integrity."

### Kinship

It is tempting to think that if an Indigenous Australian had participated in composing either set of values that the word "family", or even "kinship", would be in there somewhere. Indigenous people<sup>8</sup> comprise an important (to our national identity) 1.4% of the population. Their survival and the extraordinary preservation of unique, sustained Aboriginal and Torres Strait Islander cultures can probably be attributed in large part to strong, traditional kinship



Caroline Bowen

structures. But let's not forget that these structures, like the disappearing languages, have often been "removed" through a sorry process of colonisation, oppression and the removal of children from their parents.

Some new Australians may be thrilled to bits with the whole respect, freedom, support, equality, peacefulness, compassion and democracy thing. On the other hand, the original Australian families who live in third-world health conditions in communities around the country, and the professionals who work with them, are unlikely to view the values as part of their everyday reality. The parallels between the dislocation and trauma experienced by most humanitarian entrants to Australia, and the privations endured by many Aboriginal and Torres Strait Islander people are obvious.

## Resources

Speech pathologists working with families in either category will find a wealth of resources on the Internet. Webwords 32<sup>9</sup> addresses multicultural issues, culturally effective health care and education, and the development of mutually respectful dynamic relationships between providers and consumers. The Upper Hunter Community in NSW in a project of the Muswellbrook Shire Council Community Services Team has produced a helpful website on Working with Aboriginal and Torres Strait Islanders and their Communities,<sup>10</sup> including practice tips and the implications for practice of family and kinship structures, and the intimate connections between land, language and culture.

## References

- Commonwealth of Australia. (2007). *Life in Australia*. Canberra: Department of Immigration and Citizenship.
- Crystal, D. (2000). *Language death*. Cambridge: Cambridge University Press.
- Gillen, M. (1989). *The founders of Australia: A biographical dictionary of the First Fleet*. Sydney: Library of Australian History.
- Kunek, S. (1993). *The brides: A multimedia installation*. Melbourne: Kunexion.

## Links

1. <http://www.un.org/esa/socdev/family/IDF.html>
  2. <http://www.fahcsia.gov.au/Pages/default.aspx>
  3. <http://www.familiesaustralia.org.au/resources/atsi.htm>
  4. <http://gutenberg.net.au/first-fleet.html>
  5. <http://www.dnathan.com/VL/austLang.htm>
  6. <http://www.multiculturalaustralia.edu.au/>
  7. <http://www.immi.gov.au/living-in-australia/values/book/>
  8. <http://www.fahcsia.gov.au/sa/indigenous/overview/Pages/default.aspx>
  9. <http://www.speech-language-therapy.com/webwords32.htm>
  10. <http://www.workingwithatsi.info/index.htm>
- Webwords 37 is at <http://speech-language-therapy.com/webwords37.htm> with live links to featured and additional resources.

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# Speech pathology in the Philippines: Perspectives of an evolving profession

Johncy Rose M. Concepcion, Tricia Olea Santos, Carla Krishan A. Cuadro, Jocelyn Christina B. Marzan, Winston T. Cheng, and Fernando Alejandro C. Ligot

**In the almost three decades of its existence, the field of speech pathology in the Philippines has had tremendous achievements but continues to evolve to address the changing needs of the Philippines and its people. This paper aims to identify the major milestones in the history of the profession, describe the speech pathology professionals in terms of their work settings and areas of specialisation, as well as the unique features of their practice, and discuss the challenges that the profession continues to address creatively and resourcefully to ensure its growth.**

## Overview of the Philippines

The Philippines is comprised of 7107 islands situated in the western Pacific Ocean and is part of Southeast Asia. The entire archipelago is approximately 800 km from the Asian mainland and is bordered by the Philippine Sea on the east, the South China Sea on the west, and the Celebes Sea on the south. The Philippines is divided into three island groups: Luzon, Visayas, and Mindanao. Its total land area of 300,000 square kilometres holds a population of 88,574,614 Filipinos (NSO, 2009), with more than half residing in Luzon. Four out of 10 persons reside in Metro Manila (the capital), Central Luzon and Southern Tagalog (NSO, 2000). The population is relatively young with approximately 37% aged 14 years or younger. Individuals 15 to 64 years of age account for 59.2% of the population, while 3.8% were aged 65 and older. The average Filipino household size is five, and the average annual family income is Php172,730 (approximately US\$3,600). Eighty percent of Filipinos are Roman Catholics, 10% are Protestant Christians, and 5% adhere to Islam. There are about 180 native languages used in the islands, with Filipino (formerly known as "Tagalog") recognized as the national language. English is also an official language (The 1987 Constitution of the Philippines). Many families are of necessity multilingual.

## Healthcare and education systems

By age four, many Filipino children enter nursery school. By seven years of age, they enter elementary school that spans six to seven years, followed by secondary school (four years). After passing college entrance examinations, many enter tertiary institutions. Literacy rates are high, with 93.4%

of the population considered functionally literate (NSO, 2000).

Despite the establishment of a number of modern medical services in Metro Manila, it was estimated that there was only one hospital bed for every 909 Filipinos, and one doctor for every 9689 (ADB, 2000). Limited disability benefits are granted by the local social security system. The government has a low budget allocation for health and social services, and for a country consistently challenged by health problems, poverty, and malnutrition, rising healthcare costs remain a pressing problem especially for the 40% of the population that live in poverty.

## History of speech pathology education in the Philippines

It is in this environment that speech pathology (SP) in the Philippines has emerged and continues to evolve. The field of speech pathology was first introduced in the Philippines in 1978. After obtaining approval from the Board of Regents of the University of the Philippines (UP), Professor Rosella De Jesus-Sutadisastra, together with Kathleen Mary Boehigheimer and Kathleen A. Quigley (who were both US Peace Corps volunteers), developed and implemented a four-year academic program leading to a bachelor's degree in SP. Obtaining a bachelor's degree is the minimum requisite to practise speech pathology in the Philippines. The 4 year program includes coursework in normal speech-language structure and function, assessment and intervention for speech, language, and related conditions, and coursework in related skills such as organisation and management, as well as 1100 hours of supervised clinical practicum in various clinical environments (on-campus, hospital, specialty clinic, and school settings). The program aims to provide graduates with the minimum skills required for independent practice working with either adults or children in the Philippine setting. For 29 years, the Bachelor of Science in Speech Pathology (BSSP) has been offered only at the College of Allied Medical Professions (CAMP) in UP Manila (UPM). CAMP started the Master of Rehabilitation Science – Speech Pathology in 1997; this is a post-professional masters aimed at enhancing the professional competence of local practitioners. Both the University of the Philippines and the University of Santo Tomas (UST) instituted Master of Clinical Audiology degrees in 1999. More recently, in June 2009, UST introduced the Bachelor of Science degree in Speech and Language Therapy, making it the second university in the country to offer an undergraduate program relevant to speech pathology.

### KEYWORDS

BILINGUAL POPULATIONS

PHILIPPINES

SPEECH PATHOLOGY



**Johncy Rose M. Concepcion (top), Tricia Olea Santos (centre) and Carla Krishan A. Cuadro**



**Jocelyn Christina B. Marzan (top), Winston T. Cheng (centre) and Fernando Alejandro C. Ligot**

## The speech pathology profession in the Philippines

The majority of the speech pathologists (SPs) practising in the country are graduates of UP, which since 1982 has graduated 377 SPs. More than half (51%) are known to practise locally, a third (35%) have pursued graduate studies in other countries (usually the US or Australia) and/or are practising abroad, and the remaining 14% are in the country but are no longer practising speech-language pathology (Cuadro, Marzan, & Munar, 2008).

A handful of Filipino SPs with graduate degrees from foreign institutions have returned to the country to further develop the undergraduate and graduate SP curricula. On occasion, foreign-educated SPs have provided services to international schools in the Philippines. Governmental overseas aid programs (e.g., AusAID) have also recently offered SP services in Bacolod, one of the provinces in the Philippines. Most SPs work in at least two different work settings and carry the roles of clinician and advocate of the profession. A smaller number of SPs extend their roles of clinician to being an educator, researcher and administrator (Cuadro et al., 2008).

Accessibility and availability of SP services remain a challenge. To date, health insurance programs do not cover most SP services and these services are thus primarily paid out-of-pocket. Some government hospitals (e.g., Philippine General Hospital, Veterans Hospital), educational institutions (e.g., University of the Philippines internship programs) and community-based rehabilitation programs offer services free-of-charge or at minimal cost to those of low socioeconomic status. These programs, however, are few in number, and are not available in most regions of the country. Speech therapy services in public schools are also nonexistent. Sometimes teachers with limited background in speech correction provide services in elementary schools (Cheng, Olea, & Marzan, 2002).

The distribution of SPs across the country is disproportionate. In spite of efforts to increase services in remote provinces and cities, Cheng et al (2002) indicated that most SPs practise in the National Capital Region (NCR), within or around Metro Manila. Oftentimes, the reasons for practising in the NCR are financial and professional in nature (i.e., availability of continuing education, more opportunities at collaboration with medical and allied health professionals, etc.). Given the uneven distribution of SPs, families from remote areas travel to the nearest city where SP services are offered. Often, the SP does an evaluation, provides the family with education and a home program, and schedules a follow-up visit to monitor progress. This service delivery model appears practical but its effectiveness has yet to be evaluated.

There is also disproportion in terms of the areas SPs specialise in. Currently, the majority of SPs work with preschool children with speech/language disorders secondary to Down syndrome, autism, cerebral palsy, mental retardation, and hearing loss. Only a limited number of SPs specialise in managing speech and language disorders in the adult population. SPs who work with voice and swallowing disorders are even scarcer. The important contribution of the SPs in the evaluation and treatment of dysphonia and dysphagia, however, is gradually receiving recognition among the otolaryngologists, physiatrists, and other medical disciplines. Cases handled by SPs are diverse but oftentimes severe. Families frequently do not seek services until the disorders significantly disrupt an individual's quality and way of life. This may be attributed to lack of public awareness, education and financial constraints.

The number of dialects and languages used by the clients can pose as a challenge for clinicians. Therapy sessions are mainly conducted in Filipino because this addresses communication needs in the clients' daily environment. English, however, is also incorporated in order to address educational needs since the primary language of instruction is English or *Taglish* (codeswitching between Tagalog and English) (Cheng et al., 2002; Marzan, 2007). Service delivery is also affected when working with multilingual clients; SPs who do not speak the client's dialect /language compensate through modifying evaluation tools and resorting to family for translation when providing intervention.

Normative data on speech and language milestones of Filipinos are minimal. The "Early Childhood Care and Development Checklist" has recently been developed and was normed on Filipino children nationwide by the Council for the Welfare of Children et al. (2005). Research on other speech and language developmental milestones, however, is limited to undergraduate and graduate theses. Evaluation tools used in clinical practice are non-standardised adaptations/ translations of western tests, which raises validity and reliability concerns (Cheng et al., 2002). Thus, SPs are prompted to rely heavily on informal assessment and sound clinical judgment when evaluating and treating clients.

## The professional association

With the aims of advancing speech pathology both as an academic program and as a profession in the Philippines, promoting its relevance to society, and building camaraderie among SPs in the country, the Philippine Association of Speech Pathologists (PASP) was established in 1991 with Cynthia Rodriguez-Quiazon as the founding president. To date, PASP is the only national association for SPs with approximately 80 certified members.

Typically, highly skilled professionals have to pass a national licensure examination in order to be registered



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with the Professional Regulation Commission before they are allowed to start their professional practice. However, the practice of speech pathology is not currently legislated. PASP first called for the enactment of a national law regulating SP practice in 1993. Despite years of deliberations of a proposed act, the act has not been approved yet. While stakeholders realise the importance of having the SP practice regulated, the logistics required for initiating such a move were seen as economically not viable. There are only a small number of SPs to be registered since only one institution is producing graduates at this time.

Despite this, PASP has not been deterred from ensuring that SPs adhere to high professional standards. They developed and implemented an organisational policy for professional self-regulation through the PASP Certification of Speech Pathologists (PASP, 2005) to acknowledge practising clinicians who have completed a recognised speech pathology program. The certification is valid for two years and subject to renewal after meeting requirements set forth by the association.

## Future developments for the profession

Further development of knowledge base and skills among the local SPs is enhanced through short-term continuing education courses offered by visiting professionals or Filipino SPs who have graduated from foreign institutions. However, these continue to be limited. Some research studies conducted by Filipino SPs have been published in peer-reviewed journals and presented at international conferences such as International Symposium on Communication Disorders in Multilingual Populations and those held by the American Speech-Language Hearing Association. In recent years, UP SP alumni situated abroad have organised the donation of therapy materials, journals and textbooks to the University of the Philippines. Given the limited access to textbooks and therapy materials, the clinicians in the field are generally encouraged to use their creativity and resourcefulness when treating clients.

Some initiatives have been started to increase the availability of SP services and to improve the quality of healthcare service delivery. The University of the Philippines has started accepting lateral entrants (persons seeking a secondary degree in SP). Initially, entry to the BSSP program was only available for those entering the university as first-year students, with a quota of 30 students per year. The University of the Philippines has also begun fostering research and educational partnerships with the University of Illinois and the University of Hawaii. PASP has initiated Special Interest Teams with focus group discussions on dysphagia and motor speech disorders.

In cooperation with local government units, SP graduates and parent organisations have started initiatives of providing free clinics in provinces, such as Bicol, Baguio and Davao. Organisations specialising in particular disorders (e.g., the Down Syndrome Association of the Philippines, Autism Society of the Philippines, Aphasia Foundation) continue to support the profession through outreach programs and workshops involving SPs as resource speakers for professionals as well as clients and families.

The future of speech pathology in the Philippines remains to hold promise. A strong educational foundation, exposure to varied patient caseloads and language proficiency levels, and a push to rely heavily on creativity, resourcefulness, and clinical observation are among the focal points of SP practice in the Philippines. Speech pathology in the Philippines has definitely come a long way since its humble beginnings in

1982 and it continues to evolve to address the growing need for services in the country.

## References

- Cheng, W.T., Olea, T.M., & Marzan, J. (2002). Speech language pathology in the Philippines: Reflections on the past and present, perspectives for the future. *Folia Phoniatrica et Logopaedica*, 54, 79–82.
- Council for the Welfare of Children, Republic of the Philippines Department of Education, Department of Health, Republic of the Philippines Department of Social Welfare and Development, Australian Agency for International Development (AusAID), United Nations Children's Fund (UNICEF). (2005). *Early Childhood Care and Development (ECCD) Checklist*. Manila, Philippines: CWC and UNICEF.
- Cuadro, C.A., Marzan, J., & Munar, B.F. (2008). *The core competencies expected of speech pathologists practicing in the Philippines: A validation study*. Unpublished paper. Technical Committee for Speech Pathology Education, Office of Programs and Standards, Commission on Higher Education, Republic of the Philippines. [available from Committee Chair maesadicon@yahoo.com]
- Marzan, J. (2007). *The bilingual language learning environment in the Philippines: An exploratory study utilizing a focus group discussion*. Unpublished paper. Dept. of Psychology, College of Social Sciences and Philosophy, University of the Philippines – Diliman. [available from author jbmazan2@up.edu.ph]
- National Statistics Office (NSO), Philippines (2000). *2000 Census of population and housing*. Retrieved 28 June 2009 from [http://www.census.gov.ph/census2000/c2khighlights\\_final.html](http://www.census.gov.ph/census2000/c2khighlights_final.html)
- National Statistics Office (NSO), Philippines (2009). *The Philippines in figures 2009*. Retrieved 14 January 2010 from [http://www.census.gov.ph/data/publications/pif\\_2009.pdf](http://www.census.gov.ph/data/publications/pif_2009.pdf)
- The 1987 Constitution of the Republic of the Philippines. Retrieved 27 May 2010 from <http://www.chanrobles.com/article14language.htm>

## Further reading

- MCA Limited (2001). *The healthcare system in the Philippines*. Retrieved 28 June 2009 from <http://www.virtual-asia.com/ph/bizpak/reports/files/health.ph.pdf>
- Villaraza, C. (1995). *History of speech pathology in the Philippines*. University of the Philippines, Manila. Unpublished Paper.

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# Challenges and benefits for students participating in the Working With Developing Communities (WWDC) (Vietnam) Program

Edwina Stevens, Merran Peisker, Bernice Mathisen, and Sue Woodward

KEYWORDS
DEVELOPING COMMUNITIES
SPEECH-LANGUAGE PATHOLOGY
SPEECH-LANGUAGE PATHOLOGY CLINICAL EDUCATION
STUDENT TRAINING

Edwina Stevens and Merran Peisker graduated from The University of Newcastle and, as part of their course, had completed an additional international clinical experience in Viet Nam in 2008 with the Working With Developing Communities (WWDC) Vietnam Program, instigated by Dr Bernice Mathisen, Speech Pathology Program convenor and Ms Susan Woodward, clinical educator in Viet Nam and conjoint lecturer at The University of Newcastle. This article aims to highlight the skills developed during this experience and to facilitate preparation for future student clinical experiences working in a developing community.

Cultural competence is a crucial skill for students to develop due to the multicultural nature of contemporary Australia and to an increasingly global marketplace. One of the most effective ways to learn is through experiencing other countries as an undergraduate student (Whiteford, 2000). In response to this need, some Australian universities are now offering clinical placements in other countries as a way to develop intercultural communication skills (McAllister, Whiteford, Hill, Thomas & Fitzgerald, 2006).

In 2007, the Discipline of Speech Pathology at The University of Newcastle initiated the WWDC Vietnam Program. Two third-year speech pathology students accompanied Sue Woodward, from the Trinh Foundation Australia and Project Boomerang Cleft Care Team, to Viet Nam for two weeks in November. Students had the opportunity to work with an interdisciplinary team in various clinical settings including hospitals and orphanages and to observe and participate in assessment and intervention for a diverse adult and paediatric caseload. They also had the opportunity to provide resources and to assist in providing education for nurses, doctors, and teachers. While this placement, like many others, was a culture-specific experience, it gave the students exposure to and a unique opportunity to develop skills in intercultural competence.

For most Australian speech pathology undergraduate students, there are limited opportunities for intercultural learning or for developing cultural competency, largely due to the scarcity of clinical placements available. Additionally, there is often little in the curricula of speech pathology courses specifically addressing cultural competency. Pre-departure preparation is thought to be important for intercultural development (McAllister & Whiteford, 2008; McAllister et al, 2006). In 2008, this preparation was limited as the WWDC program was a very new initiative at the university (only one other student had experienced this program in 2007). Additionally, undergraduate student

perspectives of international clinical placements are lacking in the literature. The following discussion highlights challenges and benefits for students undertaking or thinking about undertaking an international clinical placement.

## Background of speech therapy in Viet Nam

Until February 2009, there was no formal tertiary education in speech therapy as it is known in Viet Nam (McAllister et al., 2010). That year, the Trinh Foundation Australia orchestrated and provided financial assistance for a short postgraduate course in Ho Chi Minh City in speech therapy in association with Dr Dung from the Ear Nose & Throat Hospital in Saigon (HCMC) (McAllister et al., 2010). For details of the development of speech therapy in Viet Nam and the short postgraduate course see McAllister et al. (2010).

In preparation for an intercultural clinical placement, it is important to have knowledge of the specific culture as well as an awareness and respect for cultural differences and their impact on service delivery (McAllister et al., 2006). When working in a foreign culture, the cultural values of the student and host professionals often conflict, which can be confronting. With the ongoing support of the university staff involved and significant mentoring by the clinical educator, the students felt more comfortable in addressing these differences by learning about and incorporating Vietnamese values into decisions about service delivery by the end of the placement. Specific cultural differences that were encountered are addressed in table 1.

## Addressing the challenges

During the two-week placement, student speech pathologists encountered a variety of challenges ranging from a lack of adequate preparation prior to departure to administering articulation and language assessments in Vietnamese (see table 2). Students worked in environments with very few clinical resources and as a result had to adapt and develop clinical skills. In order to overcome these challenges, students had to utilise the resources available such as parents, interpreters, the supervising clinical educator, and most importantly, each other (peer learning).

Students were made aware that there were few to no resources available in the various clinical settings prior to departure. Therefore, they gathered appropriate clinical equipment from Australia that were left in Viet Nam on departure. "First-hand" knowledge gained through contact with the 2007 student returnee of the WWDC program



From the top: Edwina Stevens, Merran Peisker, Bernice Mathisen and Sue Woodward

**Table 1: Specific cultural considerations for student clinicians in Vietnam**

“Quick fix” mentality	Clients assume that speech therapy can “fix” the problem as a doctor does with a prescription pad. It is unusual for clients to see the speech therapist on a weekly basis. This means students will have limited or no case history information. Students need to be prepared to provide “one-off” therapy sessions and give the client sufficient home practice.
Hierarchy of professions	A large degree of respect is related to the nature of one’s tertiary education and qualifications (especially for women). The use of appropriate titles is important for signifying the correct level of respect (Nguyen, 2000).
“Saving face”	Students need to be aware that they should always seek to preserve the relationship with the host professional by respecting their practices regardless of ethical tensions (McAllister & Whiteford, 2008)
Expectations of student clinicians	Clients and host professionals commonly had unrealistic expectations of students’ clinical competency in terms of an ability to provide the expected “quick fix.” This can be overwhelming for students who have limited clinical experience and are not accustomed to this approach. Students need to be aware of their position in the professional hierarchy.

was invaluable. As the program continues to develop, it is envisaged that these opportunities will be strengthened for future departing WWDC students.

At the beginning of the placement, the students experienced “culture shock” relating to the Vietnamese hospital and some of its work practices. These confronting conditions evoked an emotional response which students were not expecting. As well as relying on each other for support, they found the supervising clinical educator invaluable in helping them deal with and process these emotional responses as they arose. It is well known that clinical educators have the potential to influence students through their own attitudes and values, especially in inter-cultural environments (Whiteford, 2000). The clinical educator was very respectful of the Vietnamese culture which had a profound effect on the way in which the students approached cultural differences. It would not be an exaggeration to state that the core values, beliefs, and personal and professional skills demonstrated by the supervising clinical educator were one of the strongest influences on the success of the clinical experience and the acquisition of cultural competence skills of the WWDC students.

Additionally, coursework during the Bachelor of Speech Pathology Program at the university had addressed the use of interpreters in service delivery; however, previous clinical placements provided no practical experience of this. Working with interpreters in Viet Nam was different to what was expected. Students undertaking international placements need to be aware of the significant role of the interpreter, the many complications which can develop and ways to address them.

Service delivery was hugely affected by the language barrier, which made it especially difficult to build rapport, administer clinical assessments, and correctly diagnose. This was further complicated by the need to educate the local speech therapist at the same time as treating the client. In order to overcome the language barrier, students relied on

alternative and non-verbal communication skills as well as the interpreters, family members, and other professionals. The lack of client files and information at assessment, the limited time available for each client, and the “quick fix” mentality where clients attended only one appointment also challenged the expectations that students had previously encountered on Australian clinical placements.

In facing and addressing these major challenges successfully, WWDC students developed personal and professional skills that will be generalisable to future clinical roles both in Australia and overseas.

## Conclusion

The WWDC (Vietnam) Program placement posed a variety of significant challenges which developed clinical skills that would not have been developed without this experience. While this placement was testing in many ways for the students, overall, it was judged by the students to be beneficial for personal and professional growth as speech pathologists. Although these experiences were specific to

**Table 2: Challenges faced and skills developed when addressing these challenges**

Being under-prepared	McAllister and Whiteford (2008) highlight the importance of preparation prior to departure in order to make the most of the experience. Opportunities for pre-preparation were limited. As a result, students had to become increasingly flexible and adaptable in order to cope with “the unexpected”. The support of the supervising clinical educator and peer learning was invaluable in dealing with common and unexpected challenges.
Culture shock (of the hospital and orphanage)	The working conditions were often emotionally challenging. In order to overcome this challenge, students supported and utilised each other as well as the supervising clinical educator. Regular debriefing opportunities with the interdisciplinary team allowed students to develop crucial self-reflection and self-awareness skills whilst additionally developing skills in teamwork building (McAllister et al., 2006; Trembath et al., 2006).
Using interpreters	The language barrier posed a challenge to administering clinical assessments and providing effective intervention. One way of overcoming this challenge was to use interpreters; however, using interpreters posed its own challenges. As a result student communication skills, both verbal and non verbal, significantly developed in order to cope successfully.
Providing assessment and intervention in Vietnamese	Assessments and interventions needed to be provided in Vietnamese. In order to overcome this challenge, students utilised parents and other host professionals who were observing and participating interpreters. Limited resources to use for assessment and intervention meant students became creative and resourceful in order to use what was locally available. Lack of accompanying information and patient files meant that students were often uncertain about the nature of the presenting problem(s). As a result, students had to become flexible and adapt clinical skills and knowledge to different situations and contexts.

one developing community, namely Viet Nam, the many skills that were developed by the students (such as a global perspective of speech pathology, self-confidence, empathy, interdisciplinary team participation, cultural competency, flexibility, adaptability, and alternative and non-verbal communication skills) can be applied equally to other international and domestic settings; remote, rural, regional and metropolitan.

As mentioned previously, cultural competency is an extremely important skill for speech pathologists working in any area. International clinical placements provide unique opportunities for developing cultural competency in a supported environment. The two weeks spent in Viet Nam

provided the students with an introduction to WWDC and has ignited a professional interest in this burgeoning area of practice. All WWDC returnees have reported wanting to return to Viet Nam and to continue this work in their future careers.

While the WWDC students of 2007 and 2008 had little opportunity for pre-departure preparation, future students undertaking international clinical placements in Viet Nam will be able to utilise this article and other formalised resources when preparing for the challenges ahead.



## References

- McAllister, L., Christie, J., Woodward, S., Duyen, Bui Thi, Miss Loan, Kim Yên, Hà thị, Ngọc, Trjnh Thị Kim, Winkworth, A., Mathisen, B., Dung, Nguyễn Thị Ngọc. (2010). Speech therapy services in Viet Nam: Past, present and future. *Acquiring Knowledge in Speech, Language and Hearing*, 12(1), 47–51.
- McAllister, L., & Whiteford, G. (2008). Facilitating clinical decision making in students in intercultural fieldwork placements. In J. Higgs, M. Jones, S. Loftus, & N. Christensen (Eds.), *Clinical reasoning in the health profession*. (3rd ed., pp. 357–365). Melbourne: Elsevier.
- McAllister, L. (2008). Speech pathology in the Asia-Pacific region: Learning from our neighbours. *ACquiring Knowledge in Speech, Language and Hearing*, 10(1), 24.
- McAllister, L., Whiteford, G., Hill, B., Thomas, N. & Fitzgerald, M. (2006). Reflection in intercultural learning: examining the international experience through a critical incident approach. *Reflective Practice*, 7, 367–381.
- Whiteford, G. (2000). Developing intercultural competence. *ACquiring Knowledge in Speech, Language and Hearing*, 2(1), 8–10.



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### Key dates

**15 June 2010**

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**17 September 2010**

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papers, workshops and posters

**24 January 2011**

Authors notified of successful  
papers, workshops and posters

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Bernice instigated the Working With Developing Communities Program at the university so third-year student speech pathologists could experience a supervised additional clinical experience. In addition, she was invited to teach into the first professional speech pathology course in this country in 2009.

**Edwina Stevens** and **Merran Piesker** graduated from The University of Newcastle at the end of 2009. Edwina has a keen interest in adult rehabilitation and Merran has particular interest in cleft lip and palate and paediatric feeding. Both hope to return to working with developing countries in their future careers.

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# Ethical issues in augmentative and alternative communication

Barbara Solarsh and Meredith Allan

**IN THIS EDITION OF ETHICAL CONVERSATIONS WE** consider ethical issues that may arise when working with people who require an augmentative and alternative communication device. Communication is a basic human right. This fact is at the core of all debate about augmentative and alternative communication (AAC) and ethical practice. Everyone has the right to a means of communication. People have the right to the communication aid and strategy that will enable them to have the best quality of life.

*I was happy with my communication device without voice output, until I saw a voice output device. Although it took months and months to acquire the voice output device, I did not mind. I had something to look forward to. Now I know the empowerment of voice, I do not like being without it. I can manage without voice output, but I do not like going back to second best. (AAC user)*

These rights have been clearly endorsed in the United Nations Declaration on the Rights of People with Disability (2006; <http://www.un.org/disabilities/convention/facts.shtml>) to which Australia is a signatory. For the first time ever, communication using an AAC device or strategy is recognised as a legitimate means of communication for people who do not speak, just as sign language is recognised as the communication system used by people who are deaf. As a signatory, Australia has made a commitment to work towards practice of these human rights for people who require and use AAC.

The complexity of providing AAC intervention is embodied in the belief that “a communication disability does not just belong to the individual. It belongs to the entire environment of which that person is the focal point” (Sandwell Centre, UK, personal communication). AAC intervention cannot succeed without the inclusion of people and issues related to the “entire environment”. AAC intervention is also applied across a wide range of disabilities and cognitive levels. It may include electronic communication devices and/or non-electronic communication aids and strategies.

For the speech pathologist working with an individual who uses AAC, four areas of intervention are key:

1. all aspects related to the individual, including physical ability, cognitive level, and diagnosis must be considered;
2. focus must also be upon environmental factors which will impact the success of the AAC intervention in real life;
3. the appropriate communication device, aid or strategy must be selected, with a particular focus on the inclusion of the communication aid user or family members, remembering the need for multi-modal intervention;
4. advocacy for an individual using AAC is imperative to enable the person to communicate effectively in the face of many practical limitations.

The “Participation model” as described by Beukelman and Mirenda (2005) provides practitioners with a comprehensive framework for AAC assessment and intervention. It identifies the barriers to participation that must be addressed if

a person using a communication aid is to become a successful communicator. To identify such barriers, a comprehensive assessment of the skills and abilities of the communication aid user (identify access barriers) is required, together with a review of relevant factors in the environment (identify opportunity barriers). Traditionally speech pathologists have developed a high level of skill in dealing with *the individual* with the communication difficulty, in this case the AAC user and the access barriers related to the individual. However, they also need to address the opportunity barriers related to the environment in which the person communicates. In reality, the essence of AAC intervention is based on a balance between what is ideal for the person, what the system provides, and what the therapist can deliver.

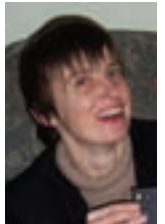
The scenarios below highlight some of the ethical issues AAC practitioners may face. These issues apply to both electronic communication aids (e.g., a Dynavox™ or Lightwriter™) and non-electronic communication aids (e.g., a picture-based communication book or board, or alphabet board). In addition to these aided strategies, they also apply to unaided strategies, such as key word signing (e.g., Makaton). The issues that arise will be considered within the ethical principles of: beneficence and non-maleficence (do no harm); truth; justice (fairness); autonomy; and professional integrity.

## Case scenario: Jenny

### Background

Jenny is a 4-year-old little girl with Down's syndrome, who lives with her mum Mandy, and 8-year-old brother, in a small regional town. Jenny is starting to show signs of frustration when she wants something and her mum cannot understand what she wants. Jenny does not use speech, but vocalises and will sometimes take her mum to something she wants and point to it. The visiting early intervention speech pathologist, Bev, has assessed Jenny and provided a comprehensive report, recommending that Jenny should use Makaton key word signing plus picture-based communication aids. Jenny was very responsive when Bev used basic gestures to ask Jenny to bring a ball. Bev also recommended that Jenny attend the local preschool where teachers have agreed to accept her but have expressed a need for information and support as they have never had a child with disability at the preschool before. They have also expressed the need for a teacher's aide. Bev feels that, with time, Jenny could learn to use a basic speech-generating device to make simple choices, like choosing a song at school, or to help her to actively participate at circle time (e.g., have animal sounds recorded on the device so she can “sing” “Old MacDonald had a farm”).

Jenny's mum, Mandy, works part-time and is overwhelmed by the need to learn Makaton and become the agent for developing all the aided language resources Jenny needs in order to learn to communicate effectively.



Barbara Solarsh (top) and Meredith Allan

Mandy is also concerned that if she introduces other ways of communicating, Jenny will never learn to speak. Bev can only offer her services monthly according to the service model of her organisation because of the demand for speech pathology services in her region.

### **Ethical dilemmas**

*Beneficence / non-maleficence:* Bev has a good understanding of what Jenny needs and the critical importance of introducing communication strategies immediately. She has the skills to offer the support needed, but does not know how she will do all this within a monthly visit of 2 hours. If Bev does not provide support both to mum and the teachers there is the potential for maleficence in that negative attitudes will develop towards the communication intervention and towards Jenny, placing strain on the system. Bev is very aware that Mandy is already feeling stressed by all the intervention Jenny will need. Bev realises that her hours with the family would be most beneficial if directed to developing Mandy's skills and confidence in facilitating Jenny's communication and to working with the teachers, rather than working directly with Jenny.

*Truth:* There is evidence of the importance of early intervention for AAC in establishing patterns for active communication, for cognitive development, and for social participation. Visual aids provide an immediate form of communication, but have to be designed, produced, and introduced in all communication environments. Makaton key word signing is an unaided strategy and Jenny has responded well to gesture, so there is good likelihood that Jenny will take to Makaton. It is also very effective in conveying meaning, but the system must be learnt by Mandy and Jenny's brother as well as the teachers. Bev also sees the potential for a basic electronic communication aid which she will need to apply for, and which again will require training and monitoring.

*Justice:* Bev needs many more funded hours for an effective AAC intervention. In addition to applying for the communication device, she needs to motivate and lobby for a class aide for Jenny. Travelling to a centre where a Makaton course may be held is not an option for Mandy, but it is possible for her to purchase a DVD and learn Makaton signing that way. This will require her to be very committed to the task. A class aide would take much pressure off the teachers, but Bev still needs to go through the process of applying, and it may take time.

*Autonomy:* Mandy has reservations about Makaton and aided language which will impact on her attitude to learning and implementing the communication strategies. Bev needs to counsel Mandy to help her understand the evidence that

aided language and Makaton key word signing facilitate oral language. However, if Mandy is not convinced by Bev's information, it is her right to refuse to use aided language. This would be very difficult for Bev, who knows how important this is for the development of communication.

*Professional integrity:* Bev is not a Makaton trainer, but could show Mandy some signs and refer her to the Makaton DVD. She could show Mandy and the teachers how to encourage Jenny to sign using the "hand-over-hand" technique ([http://en.wikipedia.org/wiki/Tactile\\_signing](http://en.wikipedia.org/wiki/Tactile_signing)). She could also assist Mandy by informing her about the Adapted Learning website ([Adaptedlearning.com](http://Adaptedlearning.com)), a website set up by Boardmaker™ for parents to share picture based resources. She could inform Mandy about Boardmaker™ and try to encourage the local library to purchase it. She realises the need to respond to the many opportunity barriers, but does not have sufficient hours to do so as effectively as she would like. She knows that unless Mandy and Jenny's teachers are motivated, Jenny's progress in learning Makaton will be slower than it should be.

## **Case scenario: Rachel**

### **Background**

Rachel is a 21-year-old woman with traumatic brain injury due to a hit-and-run car accident. While she is able to walk, her fine motor skills have not improved as well as the health professionals expected. Her parents and some family members can understand her dysarthric speech, but she is not understood by people who do not know her. She has a Lightwriter™ but due to a tremor in her better hand, her access is slow. She also has some problems with her memory.

Rachel's court case is scheduled for one month's time. She is determined to give evidence in court, but is very anxious that she will not be understood, that she will be slow when using her Lightwriter™, and that her evidence will not be taken at full value. When giving evidence, Rachel will need a communication assistant/facilitator to assist in the interpretation of her speech or to convey the messages composed on the Lightwriter™. At their last speech pathology session funded by the Transport Accident Commission (TAC; <http://www.tac.vic.gov.au/jsp/corporate/homepage/home.jsp?gclid=CJHqsuywJOCFc0vpAodgBRssA>), Rachel's speech pathologist, Susie, suggested that she have a word-based communication board made up, with sentences and phrases in case she becomes fatigued during the long hearing. It may also help her remember some important points she wishes to make. Rachel wants her speech pathologist to support her in court, but Susie has not been funded by TAC for this purpose.

### **ASD Education and Resources Online**

A range of Autism Spectrum Disorders (ASD) resources and education modules have been developed by Speech Pathology Australia with the aim of providing professional development and capacity building for speech pathologists working in the area of ASD, to assist in their provision of services under the Helping Children with Autism package.

These initiatives have been supported by funding from the Government Department of Health and Ageing.

The speech pathology specific resources available are as follows:

- ASD Position Paper
- Online Peer Support Discussion Board
- DVD production of the Autism National Tour presentation
- Independent Study Resource

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Rachel's family has heard that Communication Rights Australia<sup>1</sup> (CRA) have a communication support worker service<sup>2</sup> which is equivalent to a sign language interpreter service for the deaf. On making enquiries, they have been informed that they only have a small pool of communication support workers (CSW), none of whom are available at that time. If Rachel could find someone to take that role, CRA would offer the required training. It is very important that the communication support worker understands the CRA Code of Ethics (<http://www.caus.com.au/Products/tabid/57/Default.aspx>) which must be complied with in carrying out this role, to ensure that the message conveyed is what the communication aid user intended and is not influenced by the CSW. In addition to training the communication support worker, CRA would also need to train members of the legal team about hearing evidence from a person who uses a communication aid and the role of the CSW.

### Ethical dilemmas

*Beneficence and non-maleficence:* The issue of the court case was brought up at the last funded speech pathology session. Susie is in the best position to prepare Rachel for the court case, but time for an application to TAC for additional speech pathology hours is short. As Susie knows Rachel's parents would not be able to afford the fees, should she provide a few additional sessions to Rachel in the hope that money will be forthcoming? Preparing the word-based communication board would certainly take 2–3 sessions to ensure that the correct vocabulary and information was included. Having someone who is not adequately skilled design the communication board, or not having the communication board at the hearing could compromise the strength of Rachel's evidence.

*Truth:* Susie prognosticated early on in therapy that Rachel's dysarthria was severe and that she would need AAC to meet her communication needs in the future. However, Rachel has only reluctantly agreed to get a Lightwriter™, which she finds frustrating due to the slow pace of communication. Susie has continued to do basic speech therapy while encouraging practice of the Lightwriter™. She has wrestled with where to put the emphasis of therapy, however, and now feels that Rachel needs more therapy to support her to use the Lightwriter™. TAC has indicated that Rachel should now have a break in therapy. Susie knows Rachel needs a number of different ways of communicating, but she feels she has not been able to achieve this.

*Justice:* TAC has funded a significant number of speech pathology hours as well as providing attendant care dollars. Even if additional therapy hours are allocated after the 6-month break, it will not help Rachel with the court hearing. Rachel obtained her Lightwriter™ from the Aids and Equipment Program ([http://www.dhs.vic.gov.au/disability/supports\\_for\\_people/living\\_in\\_my\\_home/aids\\_and\\_equipment\\_program](http://www.dhs.vic.gov.au/disability/supports_for_people/living_in_my_home/aids_and_equipment_program)), but Susie feels there are other communication devices that Rachel could try when she is ready.

*Autonomy:* Susie feels that Rachel's dysarthria is unlikely to improve further and that Rachel would be advised to use her Lightwriter™ or word communication board in court. However, Rachel wants to use speech and only revert to AAC if necessary. This is her choice, although it is Susie's view that it may not be in her best interest.

*Professional integrity:* If Susie was to act as the CSW, she would need to be trained by CRA even though she is a qualified speech pathologist. She would need to be aware of and understand the CSW Code of Ethics. Susie would also have to accept that she would not be paid speech pathology fees, but at the rate of a CSW.

### Conclusion

The two scenarios outlined above demonstrate that AAC practice is highly complex, with many factors influencing the outcomes from the preschool classroom to the courtroom. Further, although people who apply to the Aids and Equipment Programs for communication aids across the country usually do receive a device, funding differs markedly between states. In Victoria, for example, 700 communication aids are allocated per year, where statistics indicate there are 10,220 people with complex communication needs (ABS, 2006). Our concerns are not only with those who never receive the AAC intervention they require, but also with those who do receive an AAC device without the appropriate support. When technology fails repeatedly, the desire to communicate decreases (Williams, Krezman, & McNaughton, 2008). Our journey towards ethical practice and AAC has just begun – a long road lies ahead.

### References

- Australian Bureau of Statistics (ABS). (2006). <http://www.abs.gov.au>
- Beukelman, D.R., & Mirenda, P. (2005). *Augmentative and alternative communication: Supporting adults and children with complex communication needs*. Baltimore, MD: Brookes Publishing.
- Williams, M.B., Krezman, C., & McNaughton, D. (2008). Reach for the stars: Five principles for the next 25 years of AAC. *Augmentative and Alternative Communication*, 24 (3), 194–206.

1. Also known as CAUS – Communication Aid Users Society <http://www.caus.com.au/>
2. Communication support worker (CSW): CSWs are specifically trained to understand a range of communication methods and devices, and support and/relay communication from a person with little or no speech to another person (Communication Rights Australia)

**Barbara Solarsh** works at the Communication Resource Centre, Scope, and for the Bendigo Health Regional Communication Service. She has worked extensively in the field of disability in community-based settings, both in rural South Africa and in regional Australia, and has been involved in multi-professional student training. She has a strong interest in the ethics of sustainable interventions in underresourced areas. **Meredith Allan** is a person who uses Augmentative and Alternative Communication (AAC). Meredith is one of the very few AAC users in Australia in the full-time open employment workforce. She was a member of the Speech Pathology Australia Ethics Board from 2002 to 2008.

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# Paediatric private practice

## Illawarra speech pathologists in private practice

**WE ARE SPEECH PATHOLOGISTS WHO WORK** independently in private practice in the Illawarra and Shoalhaven regions of the south coast of NSW. We meet four times a year to share information on clinical matters, practice news, professional development and clinical resources.



### 1. Digital recorder

(suggested by Jenny Adams)

Devices such as the Sony 1GB Digital Notetaker USB are available from Dick Smith ([www.dse.com.au](http://www.dse.com.au)).

I use a digital voice recorder with an inbuilt microphone. There are various models available; for example, the JNC USB 350. It has 5 hours of memory that is organised in a series of folders. Recorded data can be stored on a computer and played through the computer speakers.

The recorder is helpful to supplement written notes when assessing a number of children in a limited time, such as at a kindergarten screening, or when testing for research. Language samples, test responses and clinical observations can be recorded and analysed at a later date. In the clinic I use my digital recorder as a(n):

- *motivator for eliciting speech and language*: children love to press the buttons to record and play back their voices.
- *reward for multiple-sentence memory*: the child imitates and then learns to say a sequence of sentences using action picture cues (may be a four- or five-part narrative, recount or procedure). The picture cues are turned face-down one by one as the child rehearses and memorises the sequence of sentences several times, finally being able to say all the sentences without any pictures to help. When the child can say all the sentences with no errors, he can record himself and listen back to his “perfect

story” or, for an older child, his “speech”.

- *memory support in a writing task*: students with weak sentence memory and poor spelling and writing skills generate a sentence, rehearse it and then record it. They can then replay the recording as many times as necessary so that they can write the sentence down.
- *alternative response method for poor writers*: students can plan a piece of writing and say it from the notes. Once they have composed a “speech” in this way, they record it. The parent may scribe this speech to be handed in as a written text, or the student’s own recorder can be taken to school to be marked by the teacher as a verbal text rather than a written one.
- *memory support when teaching note-taking, summarising and paraphrasing*: I read a passage to the student and record it as I read. The student replays the recording and takes notes, stopping the recording after each piece of key information to make a note of it. The student replays the recording again if necessary to fill out the notes, stopping and starting as needed. The student retells the information in their own words by referring to their notes; this summary is recorded. The student can listen to the original passage and then their own retelling and analyse how well they did. As the student’s note-taking skills improve, only one replay is allowed and gradually fewer or no stops are allowed.



## 2. Guess Where?

(suggested by Jenny Adams)

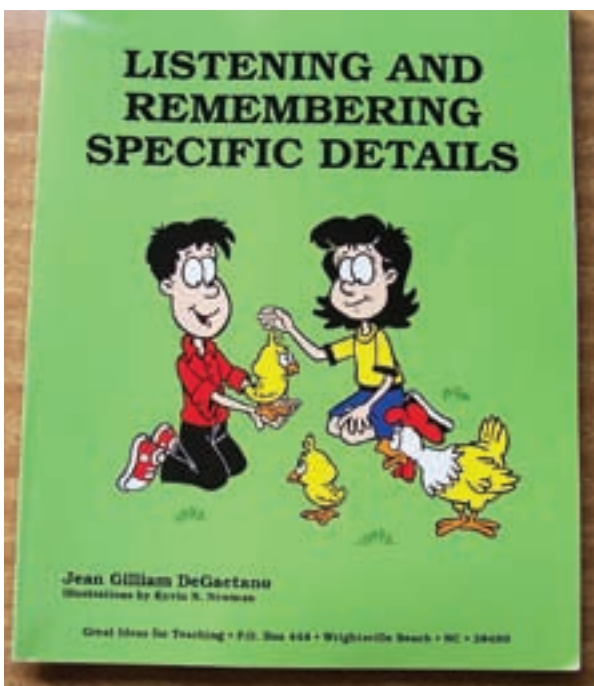
By Milton Bradley. Available from Toyworld and other games retail outlets.



*Guess Where?* is similar to the old favourite *Guess Who?*, but I find *Guess Where?* is more useful for speech pathology purposes. It consists of four identical houses (the same six rooms are repeated top and bottom) and four identical families (with six people and two pets in each). I use it in the same way I use other barrier games. Children can follow directions or give directions to set the people and pets up in the houses and then check to see if the two scenes match. It is useful for teaching question forms, prepositions and various grammatical morphemes, and can be adapted for a variety of articulation goals. The kids love inserting the people into the slots in the various rooms and I love it because I can get two lots of responses by repeating my task with two sets of families.

## 3. Listening and Remembering Specific Details

(suggested by Bronwyn Bryceson)



By Jean Gilliam DeGaetano. Available from Brainstorm Educational and Special Needs Resources ([www.brainstormed.com.au](http://www.brainstormed.com.au)).

I use many of the “Great Ideas for Teaching” resources. *Listening and Remembering Specific Details* is especially effective in teaching children to listen actively, since the children are told, before having the paragraph read to them, what questions they will be asked after the story is finished. Once they become used to the format of these activities, I find that their capacity to listen for and remember details improves over time.

## 4. PM books

(suggested by Bronwyn Bryceson)

PM Starters. Available from Cengage Learning ([www.primary.cengage.com.au](http://www.primary.cengage.com.au)).



The books from the “PM Library” are early readers that contain attractive colour photographs. I use them as a means of encouraging children to use various grammatical forms repetitively. I recommend that parents borrow early readers like these from the library to share with young children with comprehension difficulties. Readers are repetitive and short, and I find that by listening to these books, children can learn to enjoy being read to.

## 5. Wooden Marble Tower

(suggested by Bronwyn Bryceson)

Marble towers such as the 60-piece Rolliblock Marble Run are available from iQ Toys ([www.iqtoys.com.au](http://www.iqtoys.com.au)).

If there is any chance of coaxing an unwilling child to speak in the clinic, then this marble tower, ordinary though it appears, will do the job. There is something very appealing about watching the marbles drop from level to level; even young babies like to watch and their older siblings ask to see it again weeks after they have first seen it. The towers used to be in the Oxfam catalogue (they are made in India) but are no longer included. However, I believe that if anyone was interested in requesting, along with their colleagues, seven or eight of the towers, then Oxfam might import them specially.



## 6. Traffic Lights

(suggested by Hilary Cleator)

Custom-designed/made to order by Technical Aid to the Disabled ([www.technicalaidnsw.org.au](http://www.technicalaidnsw.org.au))

"Go!" "Stop!" "Careful!" I use a set of miniature traffic lights to give instant and eye-catching visual feedback during all manner of clinical tasks (e.g., speech and language therapy; phonological awareness activities). If the lights turn green, a child knows they have done well; amber is a cue to think more carefully about their response; and if the lights turn red it's definitely time to stop, think and maybe try again. At first I used the traffic lights during specific therapy tasks, but I have found children enjoy playing with the controls and operating the lights themselves (they are child-proof). The lights often act as an "ice-breaker", especially for those who are shy during the first clinical contact. As the child becomes absorbed in manipulating the lights in the context of a game involving toys such as cars, trains, fire engines and pedestrians, they usually start communicating in whatever way they can. The battery-powered lights are 13 cm high and 4 cm wide.

## 7. My First Picture Pairs

(suggested by Katherine Gorrie)



By DK Games. Available from Learning Ladder ([www.learningladder.com.au](http://www.learningladder.com.au)).

*My First Picture Pairs* is an invaluable resource with innumerable uses. I use these pictures every day for language stimulation, posting, matching, picture identification, following directions, auditory discrimination and visual memory development. The pictures are of everyday common objects on a plain white background and are just the right size for little hands.

## 8. Bunny Hop

(suggested by Alex Holliday)

By Educational Insights. Available from Amazon ([www.amazon.com](http://www.amazon.com)).

In the game *Bunny Hop*, 20 bunnies of four different colours are hiding in a carrot patch. Children need to help the farmers catch the bunnies in a game of luck and memory. Some of the chosen bunnies will jump high out of their holes, while others stay put. The winner is the first person to collect at least one bunny of each colour. This is the one game that my clients keep coming back to – children of all ages love it.



## 9. Animalia Frieze

(suggested by Ros Neilson)

By Graeme Base (Viking). Available from Mosaic Resources ([www.mosaicresources.com.au](http://www.mosaicresources.com.au)).



In my waiting room I have a long frieze that is a reproduction of Graeme Base's marvellously illustrated alphabet picture book, *Animalia*. The frieze keeps parents and adults entertained in a most productive way. Parents do often need to be told that the point of the pictures is not just to read the alliterative tongue twisters on each page, and children do need to be told that the game is not just to find the little boy hidden in each of the illustrations. The book, rather, provides hours of intriguing practice with word-finding and vocabulary building as one works out what the alliterative reference is for each of the detailed images on each page. Once parents and children are familiar with the frieze, they often ask to borrow my copy of the book – I have picked up several copies over the years, and am happy to share the pleasure with them.

## 10. Caroline Bowen's Phonological Therapy Listserv

(suggested by Ros Neilson)

To sign up, go to <http://health.groups.yahoo.com/group/phonologicaltherapy/>.

Caroline Bowen's Phonological Therapy listserv provides a positively exhilarating experience of what can happen in terms of communicating and networking in this day of the world wide web. People from all over the world contribute to the discussions on a range of clinical problems relating to phonology – including the top researchers in the field, experienced professionals, and ordinary plodding professionals or students who sometimes ask the simple questions that all of us really wanted to ask but didn't have the courage. Caroline Bowen herself is very generous with specific bits of advice, constructive comments and practical suggestions, and the listserv has a "Files" storage area that contains a treasure trove of resources. The interchanges occasionally get heated, but everything is well moderated and things get politely smoothed out in the end. The listserv is free for speech pathologists and other professionals to join, and is priceless in terms of value.

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# Around the Journals

## Families' perceptions of EIBI intervention for their child with autism

Grindle, C.F., Kovshoff, H., Hastings, R.P., & Remington, B. (2009). Families' perceptions of home-based early intensive behavioural intervention for their child with autism. *Journal of Autism and Developmental Disorders*, 39, 42–56.

Nicole Watts Pappas

This study investigated the experiences of parents of children with autism who were receiving early intensive behavioural intervention (EIBI). The article assumes prior knowledge of the background philosophy and structure of EIBI, which involves frequent, lengthy intervention sessions conducted within the home by a team of trained therapists. Due to the home-based and intensive nature of the program, it has the potential to be disruptive for families.

A semi-structured interview format was used to interview 53 parents (31 mothers and 22 fathers) whose children had been receiving EIBI for two years or more. The parents were asked about their experiences with the program and their perceptions of its positive and/or negative impact on their child and family life. Content analysis was used to identify common themes in the experiences of the parents.

The investigators found that the majority of parents interviewed felt that their child had benefited from the program and had seen improvements in language and communication skills, social skills, and play skills. Many parents also perceived benefits for themselves such as free time when the child was receiving intervention and more support in the home environment. However, the parents also reported negative aspects of the program such as a feeling of intrusion in their home, unanticipated time required to prepare materials for sessions, and problems recruiting and maintaining therapists. A third of the parents reported disappointment with the outcomes of the intervention. While all of the parents interviewed felt that their relationship with their child had improved as a result of the program, a third of the parents indicated that their relationship with their spouse had deteriorated during the same time period. Similarly, while some parents felt that sibling relationships improved as a result of the intervention, others felt that their other children were given less attention as a result of the program.

Overall, the majority of parents indicated that they would recommend EIBI to other parents of children with autism. The authors concluded that EIBI could be made easier for families by more consistent funding from health authorities and support to manage the therapists providing the training. They also recommended that families be given more information at the beginning of the program regarding anticipated outcomes and expectations of family involvement.

## The impact of background television on parent-child interaction

Kirkorian, H.L., Pempek, T.A., Murphy, L.A., Schmidt, M.E., & Anderson, D.R. (2009). The impact of background television on parent-child interaction. *Child Development*, 80(5), 1350–1359.

Marleen Westerveld

This study investigated the impact of background television on the quality and the quantity of the interaction between

parents and their toddlers. A total of 51, mainly Caucasian children participated: 17 one-year-olds, 16 two-year-olds, and 18 three-year-olds. Although there was an even gender distribution among the children, only 2 of the 51 parents were fathers. All parents had obtained at least a high school diploma.

The study involved observing the children and their parents during a 1-hour free play session in a laboratory playroom. For half of that time, the television was switched on showing a parent-selected adult-directed program. The other half of the time, the television was switched off. Sessions were videotaped and coded at 10-second intervals for: 1) parent verbal behaviours, including who initiated the interaction, 2) child utterances (social or self-directed), 3) parent and child responsiveness, and 4) parent involvement. In addition, the sessions were coded at 3-second intervals for the level of parent involvement.

Results from this experiment showed a significant effect of television on parent verbal interaction, with the parents talking less to their children when the television was on. With respect to parent involvement, parents spent less time being actively involved with their child when the television was switched on and, as expected, the amount of time being actively involved with their child reduced over the hour. Child responsiveness increased with age, with the three-year-olds showing a higher responsiveness than the one-year-olds. Interestingly, there was no effect of the television condition on the child responsiveness measure.

In summary, background television affected both the quantity and the quality of the parent-child interactions. The authors conclude that future studies should investigate the impact of background television showing children's programs and should replicate the current study in the children's homes. Regardless, the findings from this study confirm previous research demonstrating the negative effects of television exposure for very young children on their overall development.

## Quality of life of children 2–3 years after cochlear implantation

Huttunen, K., Rimmanen, S., Vikman, S., Virokannas, N., Sorri, M., Archbold, S., & Lutman, M.E. (2009). Parent's views on the quality of life of their children 2–3 years after cochlear implantation. *International Journal of Pediatric Otorhinolaryngology*, 73, 1786–1794.

Marleen Westerveld

This study investigated the impact of cochlear implantation on a range of quality of life factors in 36 Finnish children (17 boys, 19 girls) and their families 2–3 years after unilateral implantation. Most of the children (86%) had a bilateral prelingual profound hearing impairment (i.e., average hearing threshold of best ear > 95dB across 0.5–4 kHz). Thirteen of the children demonstrated difficulties in other areas of development, such as visual impairment, specific language impairment, or motor difficulties. All families spoke Finnish as their native language. Mean age of implantation was 3;5 years (range 2;3 to 12;3 years). At the time of the study, children were aged between 3 and 15 years (mean age 5 years), and used speech (n = 24), speech and signs (n = 8) or Finnish sign language (n = 4) as their main means of communication.

All parents filled out a validated questionnaire containing 74 statements followed by a 5-point Likert scale. Questions covered issues such as communication, general functioning, self-reliance, well-being and happiness, social relationships and education. Two themes related to the family and included effects of implantation and supporting the child. In addition Categories of Auditory Performance (CAP) were scored by the child's speech therapist. The CAP is "an index describing the highest typical level of functional hearing in everyday life".

Results indicated that, in general, parents were happy with their family's quality of life following implantation. Parents reported, in line with their expectations, improvement in social relations, communication, and general functioning with the help of hearing, as well as improved self-reliance of their child. Importantly, parents' perceptions were consistent with the CAP scores awarded by their child's speech therapists. For example, there were high correlations between the parents' views of their child's communication ability and the child's overall CAP score. Significant correlations were also found between some background factors and questionnaire subscale scores. For example, children with additional problems scored lower in education, and children with higher speech recognition scores achieved higher scores on the communication and education subscales. In summary, the authors expressed their satisfaction with the ability of the questionnaire in examining a wide range of quality of life factors in families of children who received cochlear implants. For more information about the questionnaire the reader is referred to: <http://www.earfoundation.org.uk/research/questionnaires.html>.

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### **Twenty-year follow-up of children with and without speech-language impairments**

Johnson, C., Beitchman, J., & Brownlie, E. (2010). Twenty-year follow-up of children with and without speech-language impairments: Family, educational, occupational and quality of life outcomes. *American Journal of Speech-Language Pathology*, 19, 51–65.

**Nicole Watts Pappas**

Speech pathologists do not often have the opportunity to work with individual children until they reach adulthood. Thus, our knowledge of the long-term outcomes for children with speech-language delays cannot usually be based on clinical experience. This study provides important information about outcomes for children with speech-language delays in a range of areas and would be of use to clinicians to share both with families and policy-makers. The study followed 244 people with ( $n = 112$ ) and without ( $n = 134$ ) speech-language impairment. Assessments were conducted at 5, 12, 19, and finally 25 years of age. At each assessment, data were collected in communicative, cognitive, academic, behavioural, and psychosocial domains. This article reported specifically on the 25th year follow-up assessments. Prediction analyses were used to determine what factors may have predicted family, educational, occupational and quality of life outcomes at age 25.

The results of the study indicated that the young people with language impairment or speech-language impairment presented with poorer outcomes in communication, cognitive/academic, educational attainment, and occupational status than the participants without language impairment. Speech impairment (which included participants with a history of speech, fluency or voice disorders) without concomitant language impairment was not associated with any significantly poorer outcomes. The prediction analyses revealed that language impairment was a significant predictor for only one of the outcomes investigated – occupational socioeconomic status (SES). Educational attainment and early parenthood (children before the age of 25 years) were better predicted by early family SES, teacher-rated child behaviour problems, performance intellectual quotient (IQ) and later reading scores. Interestingly, quality of life outcomes were found to be unrelated to a history of language impairment. The

participants with speech-language impairment were found to have similar quality of life scores to the control group. Quality of life was found to be more strongly associated with good relationships with family and friends than with IQ, language abilities, educational attainment, or occupational SES.

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### **Shared decision-making interventions for people with mental health conditions**

Duncan, E., Best, C., & Hagen, S. (2010). Shared decision making interventions for people with mental health conditions. *Cochrane Database of Systematic Reviews* 2010, Issue 1. Art. no.: CD007297. DOI: 10.1002/14651858.CD007297.pub2.

**Andrea Murray**

With one in four people being diagnosed with a mental health condition during their life course, international health care policy has increasingly adopted a partnership model of mental health care. It is now recognised that consumers should be central in contributing to intervention plans, with health improvement being viewed more often in terms of recovery rather than just symptom relief. According to Jacobson (2001), in a recovery model of care, the professional relinquishes full control and gives more control to the consumer. This shift in emphasis necessitates significant collaboration between health care providers, consumers, and their families. Shared decision-making (SDM) is a partnership approach whereby both health care providers and consumers reach a "shared decision" regarding treatment which incorporates both consumer preferences and practitioner responsibility, and which must be agreed to by both parties (Charles, 1997).

This comprehensive Cochrane review gives a clear definition and description of SDM and outlines the difference between a "shared decision-making model", and "informed decision-making" and "professional as agent" models. The review's objective was to explore and examine the effectiveness of SDM on a range of outcomes in mental health interventions. These included patient satisfaction, clinical outcomes, and health service outcomes. Randomised controlled trials, quasi-randomised controlled trials, controlled before-and-after studies, and interrupted time series studies were included in the review with information accessed via all reputable databases, online trial registers, and bibliographies of relevant papers. Three papers describing two studies, one conducted by Hamann (2006) and one by Loh (2007) ultimately met the selection criteria of the review and formed the basis for analysis. Although neither study demonstrated that SDM had a significant impact on clinical outcomes, Loh's study showed a statistically significant increase in levels of consumer satisfaction. Twenty-three other studies are referred to in the review but these were excluded from analysis as the effects of SDM intervention could not be isolated due to the complex and multi-faceted nature of patient care. The review concluded that SDM was not harmful to consumers but that there was insufficient evidence to indicate that SDM was effective in the long term. The need for further research was highlighted.

Of clinical interest to practitioners working in health or in mental health is the description of the criteria for shared decision-making and the features of SDM as outlined by Charles (1997). The review also refers to a decision aid used in research studies by Hamann (2006) and Loh (2007). This is a tool utilised by consumers and health care providers and is designed to support the decision-making process. Information on past treatment, consumer preferences, and treatment options is recorded and then referred to during planning meetings. With current service delivery moving increasingly toward consumer-inclusive practice, the review provides professionals with food for thought regarding their own models of practice.

*Note:* Please visit <http://www.thecochranelibrary.com> for a full copy of the report including the references.



# Speech pathology resources

McFarland, D. H. (2009). *Netter's atlas of anatomy for speech, swallowing, and hearing*. St Louis, MO: Mosby Elsevier. ISBN: 978 0 323 05656 4; pp. 261; A\$100.80; [www.elsevier.com.au](http://www.elsevier.com.au)

Annabel Grant



This first edition text brings together Netter's rich full-colour illustrations of the structures associated with speech, language, and hearing. The text is divided into an introduction section, followed by five chapters (the respiratory, phonatory, articulatory, auditory, and nervous systems). There is also a companion website (evolve learning system). The introduction section gives a succinct

overview of the terminology and vocabulary required prior to beginning a study in anatomy. Descriptions of planes and sections, spatial relationships, and anatomical movements are backed up with illustrations in which highlighted terms are used to draw attention to relevant concepts.

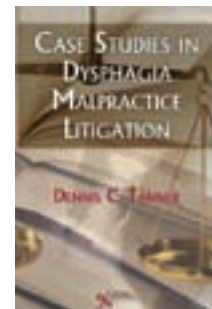
What follows are over 200 pages of detailed colour illustrations and corresponding anatomical and physiological information. The atlas format means that for many of the illustrations, the corresponding text is on the facing page for quick reference. The respiratory, phonatory, and articulatory system sections have summary tables for the relevant muscle origins, insertions, actions, and innervations. The final section on the nervous system summarises the cranial nerves that are significant to speech, mastication/swallowing, and hearing.

This text would be particularly beneficial for undergraduate students and their instructors, given the potential for enhanced learning with the companion website. Instructors will find the PowerPoint images ready for download a quick way to enhance their teaching. The high quality video clips show cadaver dissections of the head, neck, chest, and abdomen with a commentary to help identify the structures as they appear.

The book was shown to undergraduate students in speech-language pathology who recently completed a course in anatomy and physiology. They commented that the book was certainly "aesthetically pleasing". The students felt that the atlas wouldn't replace their current anatomy textbook which had more detailed explanations of physiology compared to the bullet pointed information in the atlas. The final negative aspect was that they felt the soft cover format may not be sturdy enough for student life. Students will benefit from the resources on the evolve website, however, where they can view video clips of cadaver dissections, watch animated clips, view the image collection, download self-test questions, and complete labelling exercises to further develop their understanding. In summary, clinicians or researchers would likely find the text a useful and valuable reference.

Tanner, D. (2008). *Case studies in dysphagia: Malpractice litigation*; Oxfordshire, Plural Publishing. ISBN 978 159 756 325 3; pp. 109; US\$59.95; [www.pluralpublishing.com](http://www.pluralpublishing.com)

Asher Peet



This book addresses an area of increasing concern to the dysphagia clinician – the possibility of being a target for litigation during your practice. Dennis C. Tanner, a professor of health sciences in Speech-Language Sciences and Technology at Northern Arizona University, who has extensive clinical and academic experience, writes of his knowledge in this field. The volume contains an overview of swallowing and dysphagia, issues in dysphagia malpractice litigation, the experience of the expert witness, and case studies of real life litigation.

The benefits of this text are that it presents an interesting insight into the way that malpractice suits are carried out. It presents the positions of both the plaintiff and the defence in an easy-to-understand format with good use of tables and summaries. The reader therefore gains an understanding of the "preponderance of evidence" that a defendant must provide. That is, that they have acted appropriately, within commonly accepted standards of competent practice. It also enables the clinician to be forewarned about issues that are commonly targeted as being inadequate in clinical practice, and how a court or an expert witness may view these.

The book does have limitations, however. One of these is that it is of somewhat limited applicability to an Australian practitioner, being based on knowledge of the US legal system, and US standards of practice. ASHA guidelines are heavily quoted, as the legal system demands criteria of commonly accepted practice on which to judge a practitioner's actions. The US also differs in the registration of the speech pathology profession, and the ability to become a "board-recognised specialist in swallowing disorders" (although it is highlighted that holding these qualifications in no way proves that you have acted within standards of practice for the purpose of a case).

Another limitation is that the overview of swallowing and dysphagia is somewhat simplistic. While it must be acknowledged that the book has been written in accessible language so that a range of health professionals may benefit, there is some information that I must consider inadequate or misleading. Some examples are: "*Silent aspiration* occurs when there is pooling of food or liquid anywhere in the pharynxes but usually at the level of the pyriform sinuses or the vallecula" (italics in original, p. 11); "Aspiration occurs when the patient inspires during or following the swallow" (p. 11). In one case, it is also stated that placement of a gastric tube would have "eliminated the potential for aspiration or choking", which does not allow for the possibility of aspiration of colonised saliva, bodily secretions or refluxed

stomach contents (p. 55). When speaking of tracheotomies, Tanner also recommends the performance of a dye test to “check” the cuff’s protection against aspiration of food and drink, which is in contrast to the extensive literature that disputes the validity of blue dye testing.

The book also lacks discussion of the difficult ethical questions surrounding oral versus non-oral feeding. The cases discussed involve relatively clear situations of alleged inadequate assessment, documentation and information handover, and have very little mention of the challenging quality of life issues that commonly occur in dysphagia management. There is no acknowledgement of a “grey area” of a right or wrong decision, whether ethically or clinically.

Overall, I would not consider this book to be an extensive source of knowledge for dysphagia management, but it is a useful resource to make your everyday clinical practice more litigation aware.

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**Bews, S. (2009). *Child talk: Strategies for stimulating your child’s language*. Brisbane: Child Talk. ISBN 978-0-646-51690-5; A\$24.95; [www.childtalk.com.au](http://www.childtalk.com.au)**

Rachael Logan



*Child Talk* was developed by Soraya Bews as an educational tool to teach parents how to stimulate their children’s language skills. The package, containing both a workbook and an instructional DVD, outlines seven language stimulation techniques as well as a brief summary of normal language development from birth to five years.

The workbook allows the parents to keep a record of their attempts at using each of the seven strategies outlined in the DVD. Helpful questions encourage parents to look at how their child responded to the parents’ attempts, as well as how they themselves felt about trying each of the strategies.

The DVD begins with an outline of normal language development and includes examples of children at various ages modelling the typical language skills expected. It then explains each of the seven language stimulation strategies. At the end of each explanation, a parent–child interaction is shown, where the parent models the specific strategy.

Some of the strategies have been given names that may be confusing for parents to remember, such as “Easy easy commentator” (parallel talk) and “Easy easy you” (self-talk) but the techniques themselves are outlined clearly. Other strategies are clearly obvious such as “Add a word” (expansions) and “This or that” (choice questioning).

Overall the package, in my opinion, is a thorough and helpful tool, with explanations of language stimulation strategies reinforced with a model from a parent–child interaction.

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**Leupold, N.E., & Sciuabba, J.J. (2008). *Meeting the challenges of oral and head and neck cancer: A survivor’s guide*. San Diego, CA: Plural Publishing. ISBN-13: 978-1-59756-239-3 (soft bound); pp. 217; US\$24.99; available from Plural Publishing.**

Toni Dalzell

The book contains eleven chapters with contributions from a range of health professions including dental, medical, surgical, allied health and nursing. Some chapters also include information from other professionals, such as an attorney, as well as caregivers, survivors and those involved

in support groups and other foundations. A diverse range of topics are covered and the book provides some excellent information on subjects such as treatment, swallowing, nutrition and oral and skin care.

The book is a useful resource for patients and caregivers as well as health professionals; however, some chapters are more patient-friendly than others. For example, the opening chapter provides extensive information pertaining to anatomy, which could be overwhelming for the layperson, whereas chapter 4 provides an excellent, easy-to-follow overview of chemotherapy treatment.

Throughout the book, the reader is directed to useful websites, associations and resources. Although some of these are universal, many of them are not applicable outside of the USA, making the book less useful to readers based away from America. However, these could still provide a guide for those readers who were interested in researching more local providers.

In particular, the final chapter provides extensive tables devoted to products and therapies for overcoming side effects, including those suggested by cancer survivors.

Chapter 9 can be ignored, as it deals with US insurance issues and social security disability benefits. The legal and website information in chapter 10 too is not applicable to a non-American audience but the rest of the chapter includes good information regarding clinical trials.

The chapter on communication and swallowing (chapter 7), by Bonnie Martin-Harris and Julie Blair, provides a good overview of the basic anatomy and function of the structures involved in speech and swallowing. They succinctly and simply describe the ways in which these mechanisms may be affected by the tumour and/or the actual treatment of the cancer. Early speech pathology involvement is promoted and possible assessment and treatment options are discussed.

Conversely, there are some sweeping generalisations in chapter 2 regarding the progression of swallow function post surgery that may not be accurate for all patients. This chapter also implies that a surgical puncture and speaking valve is part of all laryngectomy procedures, whereas some patients are not suitable for this option. Otherwise, the information contained in chapter 2 is very informative for those unfamiliar with treatment planning and surgical intervention procedures.

Overall, the book is easy to read and it does provide valuable information across a range of topics on oral and head and neck cancer, with many of the chapters being well referenced. It is strongly directed toward an American audience but it does promote a multi-disciplinary approach and encourages the patient to become strongly involved in their treatment planning and care.

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**Sataloff, R.T. (Ed.). (2006). *Vocal health and pedagogy. Volume II: Advanced assessment and treatment* (2nd ed.). San Diego, CA: Plural Publishing. ISBN 978 1 59756 087 1 (paperback); pp. 339; US\$55; available from Plural Publishing.**

Jenni Oates

Robert Sataloff’s classic text, *Professional Voice: The Science and Art of Clinical Care*, originally published in 1991,



is now in its third edition and has grown to a massive 106 chapters. This tome is costly and may be a little overwhelming for students, clinicians, professional voice users and their teachers. It is therefore fortunate that Dr Sataloff has made some of the content more accessible by publishing the companion text, *Vocal Health and Pedagogy*. This text is published as two volumes, with volume II focusing on a wide range of health and environmental influences on the voice as well as assessment and rehabilitation approaches. Volume II is now in its second edition.

Following an introductory chapter that provides an overview of common benign vocal pathologies and their non-surgical management, much of the remainder of this book outlines medical, psychological and environmental contributors to vocal dysfunction. Most of the expected contributing factors such as allergy, respiratory conditions, endocrine conditions, emotional problems, medications, and vocal misuse are discussed. Several less commonly discussed influences on the voice are also included: bodily injuries, sleep problems, artificial smokes, pollutants, and seating arrangements for vocalists and instrumentalists. There are no chapters that focus specifically on assessment of the voice, but voice evaluation information is scattered throughout the book and the appendices provide invaluable history questionnaires for singers and other occupational voice users. The final section of this text focuses on vocal rehabilitation. Several chapters outline the role of speech pathologists, medical specialists and singing and acting voice specialists in managing professional voice users with vocal injury. Again, topics that are not often discussed in depth are included: voice rest, exercise physiology, and the use public speaking training for people with injured voices. In accord with Dr Sataloff's well-known expertise, considerable attention is given to the role of medications in the management of professional voice users.

Thirty-two authors have contributed to this text, all of whom are experts in one or more of the fields of otolaryngology, general medicine, speech-language pathology, singing and acting voice pedagogy, nursing, dietetics, kinesiology, exercise physiology, voice science, audiology, industrial hygiene and engineering. Dr Sataloff has written or co-authored 19 of the 25 chapters and has edited the entire volume, thus ensuring consistency of writing style and level of complexity throughout. This is a remarkable achievement considering the large number of professionals who have contributed. The common risks of publishing a book with so many authors from different fields have been largely avoided. However, there is some redundancy between chapters and there is sometimes lack of cohesion from chapter to chapter. Further, some chapters are so brief that they cannot do justice to the topic and some cite only a small number of supporting references. Nevertheless, this text contains a wealth of valuable and practical information and advice for speech pathologists, voice and singing teachers, professional voice users and students. Its focus on the special needs of performers and other occupational voice users is particularly welcome.

## Reference

Sataloff, R.T. (Ed.). (2005). *Professional voice: The science and art of clinical care* (3rd ed.). San Diego, CA: Plural Publishing.

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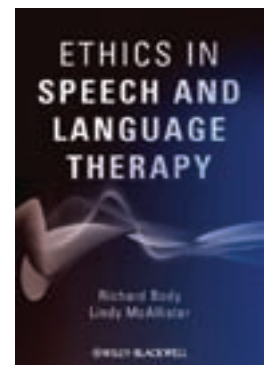
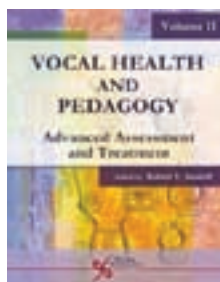
Body, R., & McAllister, L. (2009). *Ethics in speech and language therapy*, West Sussex, UK: John Wiley & Sons Ltd. ISBN 978 0 470 05888 6; pp. 204; A\$ 77.95; available from [www.wiley.com/wiley-blackwell](http://www.wiley.com/wiley-blackwell)

Nerina Scarinci

Teaching and applying ethics in speech pathology practice is one of the more challenging aspects of academic training and clinical practice. Why? Because there are no right or wrong answers, no black and white view of ethical dilemmas. The newly released book *Ethics in Speech and Language Therapy* presents an alternative approach to thinking about ethical dilemmas and fills a recognised void in this area. As both a clinician and teacher in the area of ethical issues, I eagerly read this book in search of future teaching applications and of course, for my own clinical interest. I was not disappointed. What makes this book stand out from the crowd is its unique approach to understanding and appreciating the complexity of ethical dilemmas, and the authors' refusal to conform to the long-held bioethical view of ethics.

The introductory chapters outline a theoretical and historical framework to inform the discussion and application of the ethical scenarios presented later in the book. The authors review the literature in this area, providing a comprehensive background to ethical conduct in the field of speech pathology. In addition to the commonly applied ethical principles of autonomy, non-maleficence, beneficence, and justice, Body and McAllister present readers with a number of alternative approaches to consider when tackling ethical dilemmas. The advantages and disadvantages of each approach are analysed and discussed, offering much food for thought to readers.

After the introductory chapters, a series of case examples is presented, followed by commentaries from two specialists in the field. The authors then provide a stimulating discussion of the key issues identified by the experts. These ethical case examples are broken up into a number of different areas of clinical practice, including dysphagia, intellectual and sensory impairment, acquired communication disorders, paediatric speech and language disorders, ageing, and service provision and management, making the book an easy reference guide for clinicians working and teaching in specialist areas. Although the application of case studies is a commonly used approach in books written about ethics, the inclusion of case examples followed by two independent commentaries represents a unique approach to discussing ethical issues. Each of the commentators sets out a different reaction to the case examples, which was encouraged by the authors who chose to give limited direction to the commentators on how to tackle the task. This very decision not to interfere with the style of the commentaries provides for interesting reading and clearly illustrates the diverse perspectives speech pathologists take when confronted with an ethical dilemma. It is this diversity in approaches highlighted by the case studies which makes the book special. The use of a range of narrative techniques to set out each scenario (e.g., through email exchanges between two speech pathologists, through a letter of complaint to a speech pathology department) produces an additional dimension to the ethical scenarios. In addition, rather than attempting to illustrate just one ethical dilemma in each example, each scenario offers readers an abundance of ethical dilemmas to debate and discuss. This approach is not only congruent



with the day-to-day occurrence of ethical scenarios, but also enables readers to carefully analyse each scenario, identifying a plethora of ethical issues. The book concludes by identifying and discussing the common themes reflected in each of the case examples and by highlighting emerging themes in the field of speech pathology ethics.

Overall, the book is an easy read, written in a style of language that keeps the reader engaged and in anticipation

of what's to come. The book's ability to demonstrate the everyday realities of ethical dilemmas for speech pathologists makes it a useful reference for not only the speech pathology profession, including clinicians, and students and educators in speech pathology educational programs, but also for other health professionals. It would be an appropriate text for any speech pathology program, as well as a stimulating read and must-have resource for any speech pathology department.

## Introducing the *ACQ* Committee 2010-2012



### **Jade Cartwright**

Jade graduated from Curtin University in 2000 and has focused her clinical career on neurorehabilitation and neurogenic communication disorders. She is currently completing her PhD part time in the area of primary progressive aphasia and working as a lecturer at Curtin University.



### **Deborah Hersh**

Deborah, PhD, has over 20 years of clinical and research experience in Speech Pathology in the UK and Australia. She has presented and published in the areas of discharge practice, professional client relationships, clinical ethics, group work for chronic aphasia and goal setting in therapy. Deborah started the Talkback Group Program for Aphasia in 1995 and established the Talkback Association for Aphasia Inc. in 1999. She is a Fellow of Speech Pathology Australia and a senior lecturer in Speech Pathology at Edith Cowan University in Perth.



### **Natalie Ciccone**

Natalie holds a Bachelor of Speech and Hearing Science (Hons) from Curtin University of Technology and a Doctor of Philosophy (Human Communication Science) from Curtin University of Technology. She is currently employed as a lecturer within the Speech Pathology programme at Edith Cowan University in Perth. Natalie's main area of research interest lies in working with adults with aphasia post stroke, particularly in issues of treatment effectiveness, such as timing, intensity and nature of intervention in acquired communication disorders and applying theoretical knowledge to improve treatment outcomes.



### **Suze L  itao**

Suze has a PhD in Speech Pathology. She is lecturing in Clinical Sciences at Curtin University, and interested in a wide range of clinical, ethical and professional issues in assessment and intervention.



### **Mary Claessen**

Mary is a Speech Pathologist and is currently completing a PhD at Curtin University in the area of phonological processing skills of children with Specific Language Impairment. Mary has been lecturing at Curtin University since 2002 and presently teaches in the areas of language analysis, phonology, ethical issues in Speech Pathology and evidence-based practice. Her focus is on teaching students to become clinical scientists and in bridging the gap between theory and practice.



### **Andrea Murray**

Andrea (BA logopaedics from the University of Pretoria, Grad Dip Mental Health, QUT) has worked in Child and Youth Mental Health for the last 14 years and been actively involved in the development and implementation of the Future Families Infant Mental Health program, Childrens Health Services, Queensland. Andrea has a passion for working with families, with a particular interest in enhancing the relationship between parents and their young children. She is also passionate about taking mental health into speech pathology and speech pathology into mental health so loves to provide training and workshops and to develop new models of service delivery including the formation of partnerships across services.



### **Julia Day**

Julia holds a Bachelor degree in Speech Pathology and a Masters degree in Teaching (primary). She is currently working for the National Acoustic Laboratories on a longitudinal study measuring outcomes for children with hearing impairment (Longitudinal Outcomes for Children with Hearing Impairment - LOCHI). Julia is interested in the phonological development of children with hearing loss and also the issue of data quality in longitudinal research.



### **Kyriaki (Kerry) Ttofari Eecen**

Kerry works part-time at the Murdoch Childrens Research Institute while finalising her PhD thesis. Her interests include the areas of speech sound development and disorders, stuttering and literacy. Kerry is also interested in longitudinal research, and issues of assessment and classification.

# ACQ notes to authors

*ACQuiring Knowledge in Speech, Language and Hearing* is a major publication of Speech Pathology Australia and provides a professional forum for members of the Association. Material may include articles on research, specific professional topics and issues of value to the practising clinician, comments and reports from the President and others, general information on trends and developments, letters to the Editor and information on resources. Each issue of ACQ aims to contain a range of material that appeals to a broad membership base.

ACQ is published three times each year, in March, July and November.

Issue	Copy deadline (peer review)	Copy deadline (non-peer review)	Theme*
March 2011	3 August 2010	15 October 2010	Language Disorders
July 2011	6 December 2010	15 February 2011	TBA
November 2011	15 April 2011	1 July 2011	TBA

\* articles on other topics are also welcome

## General

Material submitted must be your original work. Any direct quotations or material used from other sources must be credited in full. If copyright clearance is required to use material included in your article, please supply evidence that this has been obtained.

With rare exceptions, we do not publish material that has already been published.

Articles will be checked by a copy editor to ensure consistent presentation and standard of English.

## Length

Articles should not usually exceed 2500 words (including tables and references). This is equivalent to approximately 11 double-spaced pages. Longer articles may be accepted, at the discretion of the editors.

## Format

The article should be submitted electronically via email (as an attachment). One hard copy and a copy on disk (preferably in Microsoft Word) is required if the article contains symbols (e.g., phonetic font).

The title page should contain the title of the article, the author's name, profession, employer, contact phone number and correspondence address, as well as a maximum of five key words or phrases for indexing.

The format must be double spaced with 2.5 cm margins, in a serif face (such as Times or Courier), each page numbered sequentially.

CDs must be clearly marked with file name, author's name and program used, including version number and whether PC or Macintosh (e.g., MS Word 2007 IBM). Each table or figure must be in a separate file on the disk. Do not incorporate figures or tables within the text of the article. Formatting must be kept to a minimum. Do not use tabs, bold or other highlighting of the text. References must appear at the end of the article. The first line of each paragraph should be indented. Do not right justify the text. Use one space after punctuation, including full stops. Double quotes should be used.

## Peer review

Articles submitted to ACQ may undergo a double blind peer review process if: (a) requested by the author(s), or (b) requested by the editor.

If peer review is requested, the article will be sent to two reviewers. The authors will be provided with information from the review process and will be invited to revise and resubmit their work if this is indicated. The sentence "This article was peer reviewed" will appear after the title for all peer reviewed articles.

## Style

Clear and concise writing is best. Use short sentences and paragraphs and plain English.

Reproduce any quotations exactly as they appear in the original and provide the page number(s) for the pages you have quoted from.

References, which should be kept to a minimum, should follow the American Psychological Association (APA 5th ed.) style.

The title should be kept as short as possible (maximum 80 characters).

Headings should be short. Within the article a maximum of two levels of headings should be used. For first level headings use all capitals, centred with one line space above and one line space below. For second level headings use a capital letter for the first letter of the first word only, centred with one line space above and one line space below.

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