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CONTENTS

From the Editors	1	Webwords 29: Ethics and fidelity – <i>Caroline Bowen</i>	22
From the President	2	Speech Pathology in the Asia Pacific Region – Learning from our Neighbours – <i>Lindy McAllister</i>	24
Introducing Ethical Conversations – <i>Louise Brown and Chyrisse Heine</i>	3	Around the Journals – <i>Andrew Whitehouse</i>	25
Ethics in Clinical Decision-making – <i>Belinda Kenny</i>	4	Outside the Square: Making speech pathology computer compatible – <i>Toni Seiler</i>	27
Preschool Teachers and Stuttering: A survey of knowledge, attitudes and referral practices – <i>Brenda Carey, Susan Block, Fiona Ross, Vince Borg and Paul O’Halloran</i>	7	Update on the Australian Aphasia Association – <i>Georgi Laney (National Chairperson) and Matthew Bradley (National Deputy Chairperson)</i>	28
The Early Language Milestone Scale – 2: Part I: Clinical utility – <i>Katherine Osborne</i>	11	My Top 10 Resources – <i>Bronwyn Macey</i>	29
The Early Language Milestone Scale – 2: Part II: Use of ELM-2 and other 0–3 assessment procedures in Australia – <i>Katherine Osborne</i>	14	Review of The Australian Aphasia Guide – <i>Colin F. Cussen</i>	31
Conversation Partner Training – Its Role in Aphasia: A review of the literature – <i>Matthew Bradley and Jacinta Douglas</i>	18	A Consumer Speaks – <i>Steve Pape</i>	33
		Book Reviews	35

FROM THE EDITORS

This is the first issue of *ACQ* for 2008 and we are thrilled to present the first of a series of columns relating to speech pathology in the Asia-Pacific region. This introductory article describes how the column will inform us about the nature of speech pathology work in our region and hopefully stimulate an interesting exchange of ideas. If you have any particular experiences with development and delivery of services in the Asia-Pacific region, please let us know, or contact Lindy McAllister at Charles Sturt University.

In this issue we have peer reviewed articles covering a wide range of topics: ethics in clinical decision making, preschool teachers’ awareness of stuttering; uses of the Early Language Milestone Scale 2; and training of conversation partners for people with aphasia.

The theme for this edition of *ACQ* is “Ethical Practice: Worthy goal or moral obligation.” Our wonderful Carol Bowen, in “Webwords”, has tackled this issue in her familiar, creative, informative and challenging way – a good glass of pinot noir in hand may enhance your appreciation of this column.

Our worthy goal in selecting this theme was to introduce a discussion forum called “Ethical Conversations” on the topic

of Ethics in Speech Pathology. In order to commence this forum, we have presented the key trends and key issues highlighted by Marie Atherton, Senior Advisor Professional Issues for Speech Pathology Australia at the Speech Pathology Australia National Conference in 2007. She raised these points at the start of a workshop and the discussion generated around these and other points will be developed and reported in a book being co-authored by Lindy McAllister (in press).

We will be inviting those who have discussed ethical practice both as a worthy goal and as a moral obligation to address these and other ethical considerations in future issues of *ACQ*. If you have opinions about the points raised below or would like to see discussion of other ethical matters, please contact the editors. We hope that the ensuing discussion will support the ongoing development and awareness of ethical and caring practice of speech pathology in future years.

We thank all retiring editorial committee members for their support of *ACQ* and look forward to announcing the new members of the editorial committee in the next issue.

Louise Brown and Chyrisse Heine

Speech Pathology Week

Sunday 24 August to Saturday 30 August 2008

The theme for this year is ‘Communication – more than just words’

For more information see www.speechpathologyaustralia.org.au



FROM THE PRESIDENT

As I write this, the first 'From the President' for 2008, I can't help reflecting on the speed with which 2007 has flown past. My first year as President was exciting and challenging, full of travel, meetings and learning. During the year I had the opportunity to meet with members at forums and meetings in the Northern Territory, Tasmania, the ACT, Victoria and South Australia, as well as at the National Conference in Sydney. All of these experiences are memorable – memorable for the enthusiasm and commitment shown by members, for the learning which takes place, and for the social contacts made. No one who was at the opening session of the conference will easily forget the keynote address by Dr Christopher Green – a moving, entertaining, thought-provoking address, which had more than one person in the audience in tears.

The Association made progress in many areas during 2007. The decision was made to pursue national registration when the time is ripe. We ran our first lobbying campaign in the lead-up to the federal election – and aim to continue these efforts through 2008. It's a learning process, and we are developing useful skills in the area. We revised and updated a number of policies, and finalised some important projects. Talks around the Mutual Recognition Agreement were held in Copenhagen in July, and we look forward to finalising this revised agreement later in 2008. A strategic planning workshop was held in December, and work continues on the revision of the plan. Look out for the new and improved version in your mailbox soon – if you haven't seen it already!

There have been some significant changes to Council, and we enter 2008 with a number of new councillors in place. Lisa Shaw-Stuart (Vic.), Tania Innes (Tas.), Anna Kwan (NT), Leone Carroll (WA) and Corinne Roberts (NSW) all retired

from Council. All of them have made significant contribution to Council, and all will be missed. But Council goes on, and as we say farewell to one group, we welcome another. Gillian Dickman (Vic.), Natalie Elston (Tas.) and Amanda Dunne (NT) all took up their portfolios with enthusiasm and confidence during 2007. Leone Carroll will be replaced in the Vice President – Communication position by Jacinta Evans (ACT), and Jade Cartwright will take on the position of WA Councillor for 2008 and Beth King is the incoming NSW Councillor.

The staff at National Office, and paid staff in the various branches and positions around Australia, have continued to manage the operations of the Association efficiently and well. Special mention must be made of our CEO, Gail Mulcair, who brings to the position a truly formidable vision and energy, and who plays a crucial role in our lobbying activities. Special mention must also be made of the editors of our quality publications – Sharynne McLeod, Chyrisse Heine and Louise Brown. And of course, we must gratefully acknowledge the many hours of volunteer work contributed by members across the country. The Association is a complex organism, greater than the sum of its parts, but one which requires all parts in order to function.

What lies ahead for 2008? When you read this you will know the outcome of the federal election. Will it affect what happens within the profession, and within our daily lives? Only time will tell. We do know that the Association will continue to represent the interests of its members, to provide quality member services, to actively lobby on behalf of people with communication disorders and to build the profile of the profession. It promises to be another exciting year!

Cori Williams

Reflecting Connections Conference Auckland 25-29 May 2008

Registrations now open – Early Bird Closes 6 April

For the full program listing of all workshops, papers and posters please go to the following website: www.reflectingconnections.co.nz The website also includes further details about the keynote speakers, accommodation options and tourism ideas. The Conference Planning Committee is excited to be providing you with a wonderful program and looks forward to seeing you in Auckland!

Research Paper Submissions – International Journal of Speech-Language Pathology

Speech Pathology Australia will publish the Conference proceedings as a supplementary issue of the International Journal of Speech-Language Pathology. Only the best 7-8 papers will be published. Papers should be no longer than 6,000-7,000 words and follow the author guidelines found at <http://www.informaworld.com/ijslp>.

Therefore, for those of you who submitted a Research Paper, we invite you to submit a manuscript of your paper to the Manuscript Central site <http://mc.manuscriptcentral.com/ta-sl> and clearly indicate that it is to be considered for the Speech Pathology Australia Conference proceedings issue. All submitted papers will be considered for publication. Correspondence regarding the 2008 Conference proceedings should be directed to the editor, Associate Professor Sharynne McLeod email: ijslp@csu.edu.au.

The deadline for manuscript submission is 29 June 2008.

Alternatively, you may wish to submit a manuscript of your work (2,000 words) to ACQuiring Knowledge in Speech Language and Hearing. The author guidelines for ACQ can be found at: <http://www.speechpathologyaustralia.org.au> under publications / ACQ. Manuscripts submitted to ACQ will be considered as a general paper submission.



ETHICAL CONVERSATIONS

Louise Brown and Chyrisse Heine

This is the first of what we hope will be a very stimulating, challenging and informative column focusing on ethical practice. We hope this column will stimulate discussion on the behaviours and thoughts which demonstrate ethical practice in speech pathology and also on the ethical dilemmas which can cause controversy or difficulty for us in the workplace. Marie Atherton, Senior Professional Issues for the Association, will be leading this column.

We are very keen for you to send your responses, comments or queries to her by email so that we can start to present a conversation about real reflections, practices and dilemmas you have raised. Marie will collate your comments and ask people, such as members of the Ethics Board and people who research and write about ethics, to consider and discuss the points raised.

There is an interesting set of documents in the Ethics Roundtable on the American Speech-Language-Hearing Association website (<http://www.asha.org/about/ethics/roundtable/>). This review evolved from a column in the ASHA magazine. Its format focuses largely on the sort of case based ethical dilemmas that make our working lives uncomfortable. There is always more than one commentary provided for each situation reflecting the range of individual interpretations and perspectives.

In this first column, we have reproduced a list of key trends and issues which Marie Atherton, Senior Advisor Professional Issues, presented at the Speech Pathology Australia National Conference in 2007.

Key trends and issues in ethical practice in speech pathology (Atherton, 2007)
Key trends
1. Increased demands of an ageing population <ul style="list-style-type: none"> • Effective use of the limited health dollar • Community care • Long-term care
2. Increased prevalence of chronic disease and disability <ul style="list-style-type: none"> • Increased survival rates • Life-prolonging procedures and technologies • Increased rates of long-term disability
3. Chronic shortage of health workers <ul style="list-style-type: none"> • Difficulty in meeting community needs • Support workers – opportunity or threat? • Delegation and legal liability
4. Increased complexity of clients and settings <ul style="list-style-type: none"> • Prioritisation of services • Waiting lists • Referral onwards
5. Changes in health policy and community expectations <ul style="list-style-type: none"> • Workplace policies • Availability of services closer to home • Better informed consumers

6. Increased emphasis on evidence-based practice <ul style="list-style-type: none"> • Access to relevant facilities • Budget constraints • Maintenance of up-to-date knowledge and skills • “Fit to practice”
7. Extended scope of practice <ul style="list-style-type: none"> • What is our scope of practice? • Governance frameworks • Legal liability
8. Increasing need for non-profession specific skills <ul style="list-style-type: none"> • Prioritisation of workload • Access to training and skills • What is core business for a speech pathologist?
9. Statutory regulation <ul style="list-style-type: none"> • Impact on safety guarantees for consumers • Impact on profession specific regulation – who knows best?
Key issues
1. Changes to speech pathology scope of practice have been extensive over the past 15 years 2. Population demographics are a driving force for change 3. Extended scope of practice by other professionals – is this a threat or an opportunity? 4. Evidence based practice is a priority 5. Compulsory external regulation may be introduced 6. Ethical considerations are complex and far reaching
References
Atherton, M., McAllister, L. & Grant, D. (2007). <i>Emerging issues in ethical practice in speech pathology</i> . Workshop presented at the Speech Pathology Australia National Conference – Sydney. Body, R., & McAllister, L. (in press). <i>Ethics in speech language therapy</i> . London: Wiley & Sons.

This emerging conversation about ethics in speech pathology commences with several questions about these key trends and issues in the list.

1. How do these trends and issues make you feel as you read through the list?
2. Does the list capture some of the key issues in your practice of speech pathology?
3. If so, are there specific examples you can share with us to demonstrate how and why these issues carry an ethical reality for you?
4. Are there key issues or trends which you feel may have been overlooked in this list?

To reply to the questions, to submit new questions or to be added to the list of people interested to respond to topics raised, please contact Marie Atherton at matherton@speechpathologyaustralia.org.au

Visit www.speechpathologyaustralia.org.au

ETHICS IN CLINICAL DECISION-MAKING

Belinda Kenny

This article has been peer-reviewed

Ethics are an integral factor in effective clinical decision-making. While codes of ethics do not provide a recipe for resolving ethical dilemmas, knowledge and open discussion of bioethical principles may facilitate ethical practice in the speech pathology profession. This paper focuses upon some of the ethical issues that may confront speech pathologists in contemporary health care practice and aims to facilitate discussion of ethical practice in the speech pathology profession.

Ethics seek to determine how human actions may be judged right or wrong (Garrett, Baillie & Garrett, 2001). Professional ethics encompass diverse aspects of clinical work including intervention planning, management and outcome evaluation. Furthermore, professional ethics are important when defining professional relationships with clients, carers, managers and the community. While ethical decision-making may be focused towards doing the “right thing”, the complexities of clinical practice may present challenges for a speech pathologist. Unfortunately, it is not always easy to determine the “right thing” when there may be differences between clients’ and professionals’ perspectives of good health care outcomes, quality of life and expectations for standards of care. Clinical decision-making may require speech pathologists to examine “grey areas” in client management where there may be multiple “half right” or “not as bad” options. Consider, for example, the issues encountered by a speech pathologist who is managing the swallowing and communication needs of a young adult diagnosed with a progressive neurological disorder in a community setting. What is a “good” versus harmful outcome for this client?

Professional associations, including Speech Pathology Australia, have developed codes of ethics to guide members’ decision-making towards “right” or “good” actions and outcomes consistent with professional values. Our Code of Ethics identifies five bioethical principles: beneficence/non-maleficence; truth; fairness (justice); autonomy; and professional integrity (Speech Pathology Australia, 2000). Adhering to ethical principles is the hallmark of professional behaviour. To practice ethically, speech pathologists are urged to seek benefit and avoid harm to others, to tell the truth, deal fairly with others, provide accurate information, strive for equality in service provision, respect the rights of our clients to self-determination, maintain competence in our practice, and honour professional commitments (Speech Pathology Australia, 2002). The bioethical principles, described in the Code of Ethics, provide an aspirational guide rather than rigid rules of ethical practice. Thus, speech pathologists must interpret and apply these principles in their individual work settings.

What is an ethical dilemma?

Clinical decision-making often requires a professional to consider more than one ethical principle. An ethical dilemma may arise when there is a conflict among personal and/or professional values, organisational philosophies and expectations for standards of practice. Such conflict poses a problem

in making decisions based on standards of fairness, justice and responsibility (Hinderer & Hinderer, 2001). For example, a speech pathologist may be concerned that providing a client with an accurate diagnosis and prognosis may adversely affect a client’s motivation to participate in a rehabilitation program. The ethical principles of truth, autonomy, beneficence/non-maleficence and professional integrity may be at stake in this dilemma between the client’s “right to know” and the professional’s intention to avoid harm by controlling the content or timing of information. This dilemma may be further complicated if carers request that medical information is withheld from a client. Additionally, conflict may occur between principles of autonomy and beneficence when clients or carers refuse intervention or seek support for quality of life decisions with potentially harmful medical consequences. The client’s right to self-determination is at odds with the professional’s desire to benefit the client by providing evidence based practice.

Further ethical conflict may stem from caseload management policies. Speech pathologists managing large caseloads and long waiting lists may experience ethical conflict between principles of fairness (providing an equal but limited service to many clients) versus beneficence (providing a quality service to a small group while others remain on the waiting list). The caseload management strategy of withdrawing treatment in response to clients’ poor attendance or compliance with home activities is also ethically fraught. Is it fair that Jack, who has a severe language disorder but inconsistently attends treatment sessions, should receive ongoing intervention when there are many clients on the waiting list who may derive significantly more benefit from the service? Will Jack be significantly harmed by withdrawing the limited input and opportunity for change? Do all clients have the same right to a service even though personal circumstances may prevent their full participation? How much responsibility does the service provider need to take in adapting the “one size fits all” model for clients with complex and diverse needs? Resolving ethical dilemmas requires sensitivity to ethical issues, effective reasoning skills, motivation to demonstrate ethical practice and the courage to act upon ethical decisions (Armstrong, Ketz & Owsen 2003; Thorne, 1998).

Difficulties in ethical reasoning

In theory every member of the profession may state “Of course I am ethical!” By being part of a helping profession there is an assumption that our primary intention is to provide a beneficial service to the community. In practice, making an ethical decision is not always simple or straightforward. Why? Professional ethics may conflict with personal ethics or beliefs. Freegard (2006) described this type of dilemma as a conflict of conscience. A professional may have strong beliefs and values regarding the role of families, importance of education, death and dying and these values may be challenged by a client, carer or colleague. Clients may challenge our principles of fairness and professional integrity when the care we offer is influenced by our perception that they have knowingly contributed to their ill health, have a social history that may include criminal activities, domestic violence, or substance abuse. Additionally, clients whose attitudes, behaviours or expectations are perceived as “difficult” may present ethical challenges for the treating professional (Finlay, 1997). Speech

pathologists' conflicts of conscience may subtly affect their preparation, intervention strategies, case management and discharge decisions. For example, speech pathologists working in acute settings may be constantly juggling caseload priorities to manage new referrals. There may be difficulties ensuring that clients with cognitive disorders, clients from culturally and linguistically diverse backgrounds and/or clients with demanding carers receive an equitable service. An English-speaking patient receives a comprehensive communication assessment while the Vietnamese-speaking patient in the bed opposite receives a basic communication screening because it is difficult, time-consuming or expensive to organise for an interpreter to be present. Ethical reasoning requires insight and reflection about the influence of value judgments on clinical decisions and not allowing personal values to negatively impact quality of care. Furthermore, health professionals are challenged to monitor and address the balance between economics of health care and ethical practice (Purtilo, 2000).

When might breaches of ethical principles occur?

Breaches of ethical principles may occur unintentionally when professionals do not consider ethical implications of their actions. A speech pathologist may continue to treat a client, Andrea, whose complex communication disorder requires referral to specialist services. Quality of care is limited by a professional's competence and Andrea is harmed when she does not access the most appropriate services for her communication needs. Breaches of ethics may also occur in regards to client confidentiality. Confidential client information may be disclosed by professionals during conversations in playgrounds, canteens and hospital lifts without consent and without due consideration of the potential for harm.

Conflicts of interest are not always straightforward and may lead to unethical practice (Handelsman, 2006). For example, a speech pathologist employed in a rural community may engage in sporting, religious or social activities with carers and experience challenges in separating personal and professional roles. Handelsman noted that professionals do not always recognise the strings attached to "harmless" invitations and small gifts from clients. Such strings may include expectations regarding the nature or quantity of care provided. Similarly, there may be strings to avoid in professional relationships. For example, a referral agent from a private service expects clients to receive priority or a reciprocal referral arrangement.

Speech pathologists may perceive that their ability to provide an ethical service is constrained by workplace policies and limited resources. For example, in an effort to provide a service with inadequate staffing and resources, speech pathologists may decide to "water down" evidence based interventions. Another difficulty that may be encountered in ethical decision-making is that upholding ethical principles may result in interpersonal conflict. Challenging a team member when they express discriminatory comments in a case conference report, questioning a colleague regarding a management approach that is not evidence based or advocating against policies and procedures that reduce the quality of care provided to clients is professionally and often personally challenging. Does keeping silent, ignoring or avoiding ethical issues erode our professional integrity and make us complicit in attitudes or work practices that may harm some of our clients (Pannbacker, 1998). Resolving ethical dilemmas requires an understanding of our Code of Ethics and the tenacity to actively address dilemmas in ethical practice.

What can speech pathologists do to support ethical work practices?

The complexity of ethical decision-making indicates that there is a need for professional support and guidance for clinicians in this area. The first step in forming an ethical decision is to identify when a clinical issue involves ethical principles. Is a client's well-being or autonomy threatened by the nature or actions of a service provider? Are the ethical principles of truth and professional integrity at stake in an interdisciplinary team conflict? Will proposed models of service delivery provide fair and just distribution of speech pathology resources to all members of the community? Sensitivity towards ethical issues may facilitate speech pathologists' management of ethical dilemmas and reduce breaches of ethics. Clearly, ethical sensitivity is based upon knowledge of the Code of Ethics and reflection upon ethical issues in everyday practice.

The second step is to actively incorporate ethics in decision-making by carefully considering how ethical principles may be applied during problem-solving and managing professional issues. Open discussion of ethical issues and support for professionals who are managing ethical issues in the workplace during case discussions and mentoring will support ethical practice. Two approaches that may support speech pathologists' application of codes of ethics are ethics of care and narrative ethics. An ethics of care approach (Gilligan, 1982) emphasises the importance of the rights of patients and their families to participate in health care decisions that involve ethical dilemmas. Benefit and harm are determined according to the family's perceptions of health and well-being and the individual's social and physical environment. Narrative ethics focuses upon the professional community during ethical decision-making (Benner, 1991). According to a narrative approach, speech pathologists are part of moral communities whose members influence others by appealing to mutually recognised values and use those same values to refine understanding, extend consensus and eliminate ethical conflict (Nelson, 2002). The narrative approach emphasises the need for professionals to share their ethical concerns and discuss their strategies for managing ethical dilemmas. An ethical story may include the context of the dilemma, the history of the clients involved, perspectives of different stakeholders in the dilemma, and discussion and analysis of options available and potential outcomes. By sharing ethical stories, speech pathologists may clarify expectations for ethical practice in a rapidly changing health care environment. Finally, considering outcomes of decision-making from an ethical perspective may reinforce the need to develop policies and procedures that protect ethical principles and the rights of clients to receive a service governed by beneficence, truth, autonomy, fairness and professional integrity.

References

- Armstrong, B., Ketz, J.E., & Owsen, D. (2003). Ethics education in accounting: moving toward ethical motivation and ethical behaviour. *Journal of Accounting Education*, 21, 1–16.
- Benner, P. (1991). The role of experience, narrative and community in skilled ethical comportment. *Advanced Nursing Science*, 14, 1–21.
- Finlay, L. (1997). Good patients and bad patients: how occupational therapists view their patients. *British Journal of Occupational Therapy*, 60 (10), 440–446.
- Freegard, H. (Ed.) (2006). *Making ethical decisions* (pp. 66–92). Melbourne: Thomson.
- Garrett, T. M., Baillie, H. W., & Garrett, R. M. (Eds.) (2001). Ethics, professional ethics, and health care ethics. *Health care*

ethics. Principles and problems (4th ed.) (pp. 1–28). Upper Saddle River, New Jersey: Prentice Hall.

Gilligan, C. (1982). *In a different voice: Psychological theory and women's development*. London: Harvard University Press.

Handelsman, J. (2006, 17 Jan.). Recognising when strings are attached. *The ASHA Leader*, 11 (1), 18.

Hinderer, D. E., & Hinderer, S. R. (Eds.) (2001). Ethics: What, why, and why now? In *A multidisciplinary approach to health care ethics* (pp. 3–21). Mountain View, CA: Mayfield.

Nelson, H. L. (2002). Context: backward, sideways, and forward. In R. Charon & M. Montello (Eds.), *Stories matter: The role of narrative in medical ethics* (pp. 39–48). New York: Routledge.

Pannacker, M. (1998). Whistleblowing in speech- language pathology. *American Journal of Speech-Language Pathology*, 7 (4), 18-24.

Purtilo, R. B. (2000). A time to harvest, a time to sow: Ethics for a shifting landscape. *Physical Therapy*, 80 (11), 112–1120.

Speech Pathology Australia. (2000). *Code of ethics*. Melbourne: Speech Pathology Association of Australia Limited.

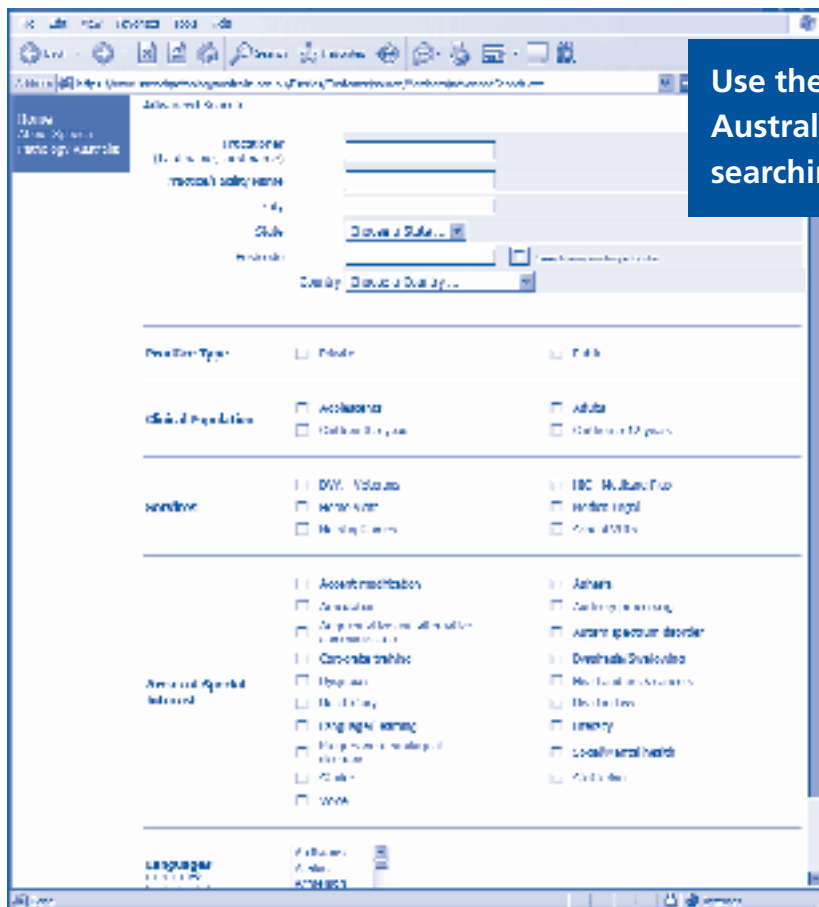
Speech Pathology Australia. (2002). *Ethics education package*. Melbourne: Speech Pathology Association of Australia Limited.

Thorne, L. (1998). The role of virtue in auditors' ethical decision making: An integration of cognitive-developmental and virtue-ethics perspectives. *Research on Accounting Ethics*, 4, 291–308.

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www.speechpathologyaustralia.org.au

The online Speech Pathology Australia National Database holds information on all our members, both private and public speech pathologists, Australia wide. If you are looking for a speech pathologists in your local area, it is as simply as entering your Postcode, and ticking the 'Search surrounding suburbs' box.

Speech Pathology Australia members are encouraged to keep their practice information up-to-date as much as possible either via your online 'User Profile' or by contacting National Office. The information you submitted at the time of renewing your membership is entered into the Database. This information will be available online unless you have indicated 'I do not want these details used for public referrals, private practice directory listings or online searches'

Remember this referral information is both a service to the public and a benefit to the marketing of your own practice/ services.

PRESCHOOL TEACHERS AND STUTTERING

A survey of knowledge, attitudes and referral practices

Brenda Carey, Susan Block, Fiona Ross, Vince Borg and Paul O'Halloran

This article has been peer-reviewed

Correct identification of stuttering in the preschool years is a vital step in preventing stuttering from becoming a chronic and debilitating condition. Evidence exists to show that early stuttering can be treated effectively using the Lidcombe Program. Preschool teachers of 4-year-old children are in an ideal position to detect stuttering and refer children for assessment and treatment. In this study, preschool teachers were surveyed (survey response rate: 63%) to identify knowledge of stuttering, understanding of treatment and recovery, reactions to children who stutter, and referral patterns. Results showed that preschool teachers had a good understanding of how to manage a child who stutters. While most were aware of the need for referral, they were unclear about the best time to refer. It is recommended that speech pathologists liaise with preschool teachers more closely and disseminate up-to-date information about stuttering in young children more regularly. A recent initiative by speech pathology students in the School of Human Communication Sciences at La Trobe University is described as an example of one way to present this information.

Keywords:

preschool teachers,
preschool-age children,
questionnaire,
stuttering,
teachers

Stuttering is a disorder affecting approximately 1% of the population. In preschool-aged children the incidence is even higher (Craig, Hancock, Tran, Craig, & Peters, 2002; Mansson, 2000). The Lidcombe Program of early stuttering intervention is a treatment that is both effective and efficacious (Jones, Onslow, Harrison, & Packman, 2000; Jones, Onslow, Packman, et al. 2005). Further, as the evidence base for the Lidcombe Program grows, it is apparent that there may be no time at which a child is more responsive to stuttering treatment than in the preschool years. Treatment in these years takes less time, is less complex and results in generalisation of fluency more automatically than in later years (e.g., Adams, 1984; Bloodstein, 1987; Yairi & Ambrose, 2005).

Eliminating stuttering in early childhood prevents the condition from continuing into adulthood. It may also prevent the development of a range of potentially negative consequences – social, emotional, behavioural and educational (Craig, 1990; Langevin, Bortnick, Hammer, & Weibe, 1998; Menzies, Onslow, & Packman, 1999; Onslow, Harrison, & Jones, 1993). It is therefore paramount that effective treatment occurs in preschool years. Indeed early intervention for stuttering is

time and cost effective and “liberates children from a lifetime of frustration and embarrassment about speech” (Onslow, cited in Packman & Lincoln, 1996, p. 45).

The identification or detection of stuttering in the preschool years is a vital first step in preventing stuttering from becoming a chronic and debilitating condition, persisting into adolescence and adulthood. While early stuttering is often first identified by parents, preschool teachers may also play a vital role in this identification. Following identification of early stuttering, early referral can occur. The significance of the role of preschool teachers includes:

- contact with children at the age at which stuttering onset is most frequent (Andrews et al., 1983)
- interaction with children over an extended period of time, providing the opportunity to observe representative samples of their speech
- education in early childhood development, including normal speech and language
- contact with most preschool-aged children in the community.

The aims of the project were to investigate preschool teachers' knowledge of stuttering, understanding of treatment and recovery, reactions to children who stutter, and referral patterns. This information would establish whether there is a need for further education of preschool teachers by speech pathologists about early stuttering identification and management; if so, providing it to this group of early childhood professionals would enhance the likelihood of timely intervention for preschool age children who stutter.

Method

Questionnaire

A questionnaire was designed to obtain a range of information relating to early stuttering from preschool teachers:

- who to refer
- when to refer
- general information (i.e., reactions to and needs of children who stutter, causes of stuttering)
- how to refer.

The first section contained seven items relating to consistency and severity of stuttering, age of the child and the child's awareness of their stuttering. The second section consisted of nine items and sought information about timing of referral, perceptions of natural recovery and preschool teachers' views of the effectiveness of early treatment for stuttering. The third section consisted of 18 items and addressed teacher management of and interaction with children who stutter. It also included questions relating to their knowledge and attitudes about stuttering. The final section contained 8 items including demographic information about the experience teachers had with children who have stuttered, speech pathologists and referral procedures. The average time taken to complete the questionnaire was 15 minutes.

Pilot study

A pilot study was undertaken to trial the questionnaire. Feedback was provided by 10 preschool teachers who worked within three municipalities in Melbourne. Feedback was analysed and modifications to the wording and structure of some questionnaire items were made. Results of the pilot were not included in the final analysis.

The sample

Preschool teachers conducting programs for 4-year-old children were targeted as respondents. In Melbourne most children attend a 4-year-old preschool in a variety of venues, formats or locations (e.g., kindergarten, childcare centre). This would be the final opportunity for children who stutter to be identified and referred by education professionals prior to commencing school. One hundred preschools with 4-year-old children were randomly selected from a list of Melbourne metropolitan preschool centres supplied by the Department of Human Services. The questionnaire was sent to the preschool teachers with an accompanying letter that outlined the study, explained the reasons for the survey, and invited participation of the preschool teacher. The Dillman Survey Method (Dillman, 1983) was employed to maximise response rate. This specifies a method of response to non-respondents via follow-up letters and prompts. All questionnaires and responses were numerically coded to ensure confidentiality.

Respondents

A total of 63 preschool teachers responded to the questionnaire. The response rate (63%) was fewer than was expected using the survey method employed (Dillman, 1983). However, the questionnaires were distributed just prior to the end-of-year break and higher than usual workloads may have affected the response rate. Despite being a slightly lower response rate than anticipated, 63 responses provide useful information from which to make preliminary interpretations.

Data analysis

Participants were asked to respond to questions either using a 5-point Likert scale (where 1 = strongly agree, 2 = agree, 3 = neutral/not sure, 4 = disagree, and 5 = strongly disagree) or a 3-point categorical scale (yes, no, or unsure). Means, medians and standard deviations were calculated for all questions that were rated using the 5-point scale. However, for the purpose of clarity, means and standard deviations were used to summarise and interpret responses to questions using the 5-point scale. This was based on the fact that means are the preferred measure of central tendency when data tend to be relatively normally distributed (Keppel, 1991). Evidence of normality with the present data set was provided by a visual inspection of histograms produced in the SPSS output, the fact that means and medians for each question were comparable, and that the level of variability for each question was relatively low (Tabachnick & Fidell, 2001). Given the use of the 5-point scale for the present study, means between 1 and 2.5 were consistent with some form of agreement with the questionnaire item and those between 3.5 and 5 were consistent with some form of disagreement with the questionnaire item. Percentages were used to summarise data for the items on the questionnaire that used the 3-point categorical scale. Trends for each of the major topic areas for the survey need to be read in conjunction with general characteristics of the sample.

Results

Sample characteristics

The average number of years that teachers had been teaching at preschool was 13.6 years ($SD = 9.3$). Teachers reported on the number of preschool children who stuttered that they had encountered. The average number of such children encountered was 6 students ($SD = 7.0$). Approximately 19% (11 of 57) of teachers reported they had not had a child who stuttered in their classroom.

General knowledge and beliefs about stuttering

Responses to the 18 questions that assessed general knowledge and beliefs about stuttering suggested that preschool teachers typically have a reasonable level of general knowledge about stuttering and generally hold some suitable beliefs about the condition. Respondents showed appropriate agreement to two items: *teachers need to exercise patience in teaching and correcting children who stutter* ($M = 2.48, SD = 1.12$) and *children who stutter can perform as well academically as other children* ($M = 1.56, SD = 0.71$). Further, there was appropriate disagreement with seven of the items pertaining to practices to employ with children who stutter such as: *helpful for teacher to complete words that the child is experiencing pronounced dysfluency* ($M = 4.00, SD = 0.82$); *good policy for teachers to ask children to repeat stuttered words until they can speak fluently* ($M = 4.13, SD = 0.81$); and *advisable for teachers to suggest that children who stutter avoid certain speaking situations* ($M = 3.95, SD = 0.82$). Further, teachers showed appropriate disagreement with items that assessed knowledge about stuttering and child development such as: *stuttering can never be completely cured* ($M = 3.83, SD = 0.87$); *children who stutter are emotionally different* ($M = 4.03, SD = 0.88$); and *children are more likely to develop a stutter if they are learning two languages* ($M = 4.00, SD = 0.92$). Finally, given that teachers were unsure about important areas pertaining to the etiology of stuttering: *stuttering runs in families* ($M = 3.06, SD = 0.76$) and *stuttering occurs as a result of a specific incident* ($M = 3.29, SD = 0.80$), it appears that teachers require further knowledge in this area. There were also some examples of incorrect knowledge including respondents agreeing that *it is helpful to advise child to slow down his/her speech* ($M = 2.03, SD = 0.80$) and respondents disagreeing that *most children will grow out of it* ($M = 3.73, SD = 0.85$).

When to refer for stuttering treatment

Preschool teachers disagreed appropriately with four of the nine questions that related to when to refer for stuttering. Specifically, disagreement with four items pertaining to age of the child (*to benefit from therapy it is best to wait until the child is aware of stuttering* ($M = 4.11, SD = 0.93$), *best to see whether a child grows out of stuttering rather than refer to a speech pathologist* ($M = 4.05, SD = 0.77$), and *a school-aged child would benefit more from a speech pathologist than a preschool aged child* ($M = 4.11, SD = 0.65$)) suggested that teachers correctly recognised that it is important not to wait to refer children for treatment. As well, teachers correctly recognised that therapy for children who stutter is important (*I don't think therapy for children who stutter is very effective* ($M = 4.24, SD = 0.77$)). However uncertainty with several items suggested that teachers would benefit from more knowledge about the effect of age on treatment effectiveness (*stuttering responds to treatment of all ages, to the same extent* ($M = 3.37, SD = 0.77$) and *treatment for stuttering is most effective when children are of pre-school age* ($M = 2.60, SD = 1.71$)). It is of concern however, that while the majority held

appropriate views, 21% of respondents were unsure whether to refer a child for treatment or to wait until the child was older. Additionally, 44% were unsure whether drawing attention to the stutter would only make it worse.

Who to refer for stuttering treatment

Disagreement with three of the seven items that assessed who to refer to treatment for stuttering suggested some appropriate knowledge. Teachers recognised that it is important not to ignore stuttering in preschool children (*is it best to ignore stuttering in a preschool child* ($M = 4.35$, $SD = 0.94$)), that whether a child recognises his or her own stuttering should have no bearing on whether they are referred to a speech pathologist (*a child who seems unaware of his/her stuttering should not be referred to a speech pathologist* ($M = 4.19$, $SD = 0.76$)), and the ability to be able to sing or recite a poem fluently should not prevent referral (*if a child sings or recites a poem fluently, s/he does not require speech pathology* ($M = 3.94$, $SD = 0.74$)). However consistent with several items in the 'when to refer' category, teachers were unsure about the effect of age on appropriate referral (*every stuttering preschool child should be referred to a speech pathologist* ($M = 2.60$, $SD = 1.20$) and *a child who is under 3 years is too young to be referred to a speech pathologist* ($M = 3.29$, $SD = 1.02$)).

How to refer for stuttering treatment

The majority of preschool teachers correctly recognised that a medical referral is not required for a speech pathologist (79.4%). Responses to two items suggest that teachers are not receiving up-to-date information about stuttering in preschoolers. Specifically, only 20% of teachers received information about stuttering in preschoolers from speech pathologists or other sources in the last 5 years. Also, almost 20% of teachers who had had experience of a child who stutters had not had experience with a speech pathologist who treats children who stutter. However, 77.8% of teachers reported that they were aware of a procedure for referral in their workplace. Similarly, most (92%) teachers would refer children who were stuttering to a speech pathologist. The remaining respondents would refer to a preschool field officer (14.3%), followed by a paediatrician (11.1%) and psychologist (3.2%).

Additional information was provided by the respondents in the form of general comments. Most comments related to concerns regarding long waiting lists for access to speech

pathology services and access to affordable services. There were many requests for additional speech pathology services (*"almost impossible to refer to a speech pathologist as the waiting list in my area is years and need more resources as referrals can take up to 6 months"*) and updated information on stuttering in preschoolers.

Table 1 presents a summary of the items most indicative of a need for further information by speech pathologists.

Discussion

This study identified preschool teachers' knowledge of stuttering, understanding of treatment and recovery, reactions to children who stutter, and referral patterns. Teachers typically had a reasonable level of general knowledge about stuttering and held beliefs about the condition that were consistent with current understandings of stuttering. They demonstrated awareness of how to interact with a child who stutters but were unsure about the etiology of stuttering. It may be argued that while the cause of stuttering is unknown to the speech pathology profession, it is reasonable for confusion about etiology to exist. Of concern, however, is how firmly held beliefs about the etiology of stuttering may lead to incorrect assumptions about stuttering, for example, the belief that stuttering results from a specific incident. It would appear that further information would help to clarify some misconceptions.

Teachers showed awareness that treatment was important for young stuttering children. However, while most thought that treatment should not be delayed into the school years, they were not aware why this was the case. Disturbingly, a number of respondents felt that stuttering treatment in the preschool years was ineffective or early referral was not appropriate. Clearly, there is a need to inform teachers of the reason for early referral so that more children are able to benefit from treatment when it is most effective. Their uncertainty about the effect of age on appropriate referral should be addressed with information.

Teachers are confident about the referral process. What is of concern is the lack of liaison and information from speech pathologists that preschool teachers report. A number of explanations exist. One possibility is that speech pathologists are indeed failing to liaise with preschool teachers. Alternatively, preschool children referred by preschool teachers are not being treated for their stuttering during their preschool years due to long waiting periods. Either of these explanations is of significant concern and future investigations of preschool referrals and outcomes could produce valuable information.

Additionally, it is important to acknowledge that many children start to stutter at 3 years of age. Consequently, preschool teachers of 3-year-old children may also need to be targeted for the provision of additional information about stuttering.

In summary, this investigation revealed that most preschool teachers have a good understanding of how to manage a child who stutters. They recognise that speech pathologists are the appropriate professionals to assess and treat stuttering. There are indications that most are aware of the need for referral; however, they are unclear about the appropriate age for referral. Their enthusiasm for more information about stuttering is encouraging and indicates awareness of their need for further knowledge.

Recommendations

- Further information should be provided to preschool teachers initially during their undergraduate education and later at professional development opportunities

Item	Mean, standard deviation
Stuttering runs in families	$M = 3.06$, $SD = .76$
Stuttering occurs as a result of a specific incident	$M = 3.29$, $SD = .80$
Most children will grow out of it	$M = 3.73$, $SD = .85$
Every child who is stuttering requires referral	$M = 2.60$, $SD = 1.20$
A child under 3 years is too young for referral	$M = 3.29$, $SD = 1.02$
Treatment is equally beneficial at all ages	$M = 3.37$, $SD = .77$
Treatment is most effective in preschool years	$M = 2.60$, $SD = 1.70$

- Increased liaison with preschool teachers – speech pathologists should directly contact preschool teachers in their area and disseminate up-to-date information about stuttering in young children.
- The speech pathology profession should utilise the results of this questionnaire to more fully investigate the need for increased preschool services for young children who stutter.
- The speech pathology profession should foster ongoing collaboration with preschool teachers as they indicate they would be responsive advocates in support of lobbying for increased service provision.

Outcome

A preliminary attempt to address the request for more information has already been made by final year (2006) speech pathology students at the School of Human Communication Sciences at La Trobe University. These students developed and distributed an information package to preschool teachers in Victoria (<http://www.latrobe.edu.au/hcs/projects/preschoolstuttering/index.html>). It contains a PowerPoint slide show for preschool teachers and downloadable information brochures for teachers and parents of young children who stutter.

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References

- Adams, M. (1984). The differential assessment and direct treatment of stuttering. In J. Costello (Ed.), *Speech disorders in children: Recent advances* (pp. 261–290). San Diego, CA: College-Hill Press.
- Andrews, G., Craig, A., Feyer, A. M., Hoddinott, S., Howie, P., & Neilson, M. (1983). Stuttering: A review of research findings and theories circa 1982. *Journal of Speech and Hearing Disorders*, 48, 226–246.
- Bloodstein, O. (1987). *A handbook on stuttering* (4th ed.). Chicago, IL: National Easter Seal Society.
- Craig, A. (1990). An investigation into the relationship between anxiety and stuttering. *Journal of Speech & Hearing Disorders*, 55(2), 290–294.
- Craig, A., Hancock, K., Tran, Y., Craig, M., & Peters, K. (2002). Epidemiology of stuttering in the community across the entire life span. *Journal of Speech Language and Hearing Research*, 45(6), 1097–1105.

Dillman, D. A. (1983). Mail and other self-administered questionnaires. In P. B. Rossi, J. D. Wright & A. R. Anderson (Eds.), *Handbook of survey research* (pp. 359–377). Orlando, FL: Academic Press.

Jones, M., Onslow, M., Harrison, E., & Packman, A. (2000). Treating stuttering in young children: Predicting treatment time in the Lidcombe Program. *Journal of Speech Language and Hearing Research*, 43(6), 1440–1450.

Jones, M., Onslow, M., Packman, A., Williams, S., Ormond, T., Schwarz, I., et al. (2005). Randomised controlled trial of the Lidcombe programme of early stuttering intervention. *British Medical Journal*, 331(7518), 659–661.

Keppel, G. (1991). *Design and analysis: A researcher's handbook*. Englewood Cliffs, NJ: Prentice Hall.

Langevin, M., Bortnick, K., Hammer, T., & Weibe, E. (1998). Teasing/bullying experienced by children who stutter: Towards development of a questionnaire. *Contemporary Issues in Communication Science and Disorders*, 25, 12–24.

Mansson, H. (2000). Childhood stuttering: Incidence and development. *Journal of Fluency Disorders*, 25(1), 47–57.

Menzies, R. G., Onslow, M., & Packman, A. (1999). Anxiety and stuttering: Exploring a complex relationship. *American Journal of Speech-Language Pathology*, 8(1), 3–10.

Onslow, M., Harrison, E., & Jones, A. (1993). *Early stuttering: Onset, treatment and recovery*. Paper presented at the Annual Conference of the Australian Association of Speech and Hearing, Darwin, Australia.

Packman, A., & Lincoln, M. (1996). Early stuttering and the Vmodel. *Australian Journal of Human Communication Disorders*, 24(1), 45–54.

Tabachnick, B. G., & Fidell, L. S. (2001). *Using multivariate statistics* (4 ed.). Boston: Allyn and Bacon.

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

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THE EARLY LANGUAGE MILESTONE SCALE – 2

Part I: Clinical utility

Katherine Osborne

This article has been peer-reviewed

Part 1 of this paper describes the clinical utility of the Early Language Milestone Scale-2 (ELM-2), an assessment tool for identifying speech and language delay in the 0–3 year population. The ELM-2 was published 15 years ago, is standardised, quick to administer, easy to score and relatively inexpensive; however, it seems that few practising clinicians have heard of it. This paper describes the author's use of the ELM-2 as part of formal assessment in private practice and as a screening instrument administered to 74 toddlers at an early childhood centre. Part 2 explores Australian clinicians' awareness of the ELM-2 and the assessment tools they are using with this age group.

Keywords:

0–3 year language assessment,
ELM-2,
screening

"Speech and language development is a useful indicator of a child's overall development and cognitive ability and is related to school success. Identification of children at risk for developmental delay may lead to intervention services and family assistance at a young age, when chances for improvement are best" (Nelson, Nygren, Walker, & Panoscha, 2006, p. 1). This was the thinking of a local school and its early childhood centre that asked the author to screen the speech and language skills of its children ranging in age from 16 months to 5 years. The Preschool Language Assessment Instrument – 2 (PLAI-2) (Blank, Rose and Berlin, 2003) was selected to screen children in the upper age bracket of 3–5 years, as part of the school's Language For Learning program which focused on children's ability to cope with questioning levels. The Early Language Milestone Scale – Second Edition (ELM-2) (Coplan, 1993) was selected for use with 16-month – 3-year-olds, for a number of reasons including its brevity, ease of administration, cost effectiveness and standardisation.

In 2004, when the author began using the ELM-2, data began to emerge regarding its usefulness not just as a screening tool but also as part of formal language assessment. It is the aim of this paper to discuss the clinical utility of ELM-2 as a screener administered to 74 toddlers at the early childhood centre and as part of formal assessment in the author's private practice.

Background

The ELM-2 is a quick, standardised test of language development from birth to 3 years and speech intelligibility from 18 months – 4 years. The ELM-2 is not intended as a substitute for formal assessment, but its author asserts it is able to identify and quantify language delay. It can be administered by professionals other than speech pathologists as it was

designed to be used by examiners of varying degrees of knowledge about language development.

The Early Language Milestone Scale (ELM) was first published in 1983 in the United States of America (Coplan, 1983). It was developed by James Coplan, MD due to his dissatisfaction with the language portion of the Denver Developmental Screening Test commonly used by paediatricians at the time. The ELM was designed as a screening test with a pass/fail scoring procedure. In 1987 it was expanded to include a speech intelligibility question. To extend the range of the ELM, a second edition was published in 1993 (Coplan, 1993). This included a more complex scoring system for giving detailed information about a child's language development, and with standard scores and percentiles to assist with determining eligibility for support services. The new scoring procedure was also intended for monitoring progress and for research. Items taken from the literature on language development and from Coplan's own experience were "selected

based on their presumed significance as markers of linguistic development and ease of administration" (Coplan, Gleason, Ryan, Burke, & Williams, 1982, p. 678). Items are similar to those on previous language scales including the Receptive-Expressive Emergent Language Scale (Bzoch & League, 1971), the Bayley Scales of Infant Development (Bayley, 1969), and the Preschool Language Scale (Zimmerman, Steiner & Pond, 1979; 2002).

Language skills are assessed using 43 items in 3 sections, Auditory receptive, Auditory expressive, and Visual. The speech intelligibility component is

part of the Auditory expressive section and is a forced choice question about how much of the child's speech a stranger can understand. All responses are recorded on a single record form.

Test users can choose one of two scoring procedures. The first is a pass/fail procedure. For this procedure it is not necessary to administer all items, only those at or slightly below the child's chronological age. These are items that have been successfully completed by more than 90% of children the same age. The child is required to pass three consecutive items to achieve a basal level score. This scoring method is recommended for screening large low-risk populations and "has been set to flag the slowest 10% of children with respect age at acquisition of each item on the Scale ... this is based on an estimated 8–12% prevalence of language disability in preschool populations" (Coplan, 1993, p. 70).

The second scoring system is a point-score procedure with basals and ceilings. A raw score is converted to a percentile and standard score equivalent. This method is intended for use with populations at risk of developmental delay and has a 5% cut-off for failing items. The point-score method reflects a child's total performance rather than penalising the child for a single critical item failure as in the pass/fail procedure. The point-score method yields a global language score which if below the 5th percentile warns of a significant language delay.

Items are marked as to whether they can be administered by case history, incidental observation or direct testing. Twenty-three items are elicited by history or observation, 11 by history, observation or direct testing, and 9 items that can only be administered by direct testing. A kit of materials is provided.



Katherine Osborne

The ELM-2 was standardised on 191 typically developing children attending private paediatricians or attending a paediatric clinic of a university-based medical centre in New York. Eighty percent were middle-class private patients and 20% had low socioeconomic status. Eighty percent of children were white. Non-white children were evenly divided across private and clinic groups. Cross-sectional data were obtained on the children ranging in age from 0–36 months (96 males, 95 females). Clinicians may question the validity of Coplan’s standardisation sample in view of assertions made by McCauley and Swisher (1984) that subgroups should be 100 or more for norms to be reliable and stable. Clinicians may also have some reservations about the age of the ELM -2, given that using tests with norms older than ten years are not considered technically adequate according to Salvia and Ysseldyke (1988).

Nevertheless, the ELM-2 has been shown to have reasonable reliability based on the .90 figure considered to be the minimum standard of reliability (McCauley & Swisher, 1984; Salvia & Ysseldyke, 1988). The ELM-2 has 96% test retest reliability for the pass/fail method and a range from .77 to .94 reliability for the point-score method (Coplan, 1993). Interrater reliability is high for both scoring methods (.98 for pass/fail method; .93–.99 for point-score method).

A number of validation studies have been carried out which indicate reasonable to good validity. Table 1 enumerates these studies.

However, contrary to these validation reports, the New York State Department of Health (2006) in its Clinical Practice Guideline reported the ELM (Coplan, 1983) to have poor ability to identify expressive language delay in 24-month-old children (low sensitivity) but moderately good ability to identify normal expressive language in 24-month-old children (moderately high specificity).

Screening

In an early childhood centre

The author has been using the ELM-2 since 2004 to screen the language skills of 16 months – 3 years in a local early

childhood centre. Group leaders familiar with the children were questioned to satisfy the history items, while parents were contacted if the group leader was uncertain. This was sometimes necessary in the case of reticent communicators. The author administered the direct testing items.

To date, 74 children have been screened (42 females, 32 males). Of these 15 failed the ELM-2 which represents 20%. This figure would seem high in view of the prevalence of children with speech and language disorders reported in the normal population estimated to be 10–14% (SPAA, 2003) and even more so in relation to the 8% that remain after many spontaneously resolve by 4 years of age (Eadie et al., 2006). However, despite this seemingly high percentage of toddlers failing the ELM-2, all were referred to local speech pathologists. The author did not treat any of the identified children for ethical reasons. Of the fifteen, 10 chose to attend formal speech–language assessments, and all commenced intervention. The 5 who failed the ELM-2 but who did not seek further language assessment were described as very immature in all areas of development by their group leaders. Parents chose to accept strategies for language development at home and reviews were scheduled.

Five children were referred to specialists including paediatricians and a developmental assessment team, comprising a medical practitioner, physiotherapist and occupational therapist. The author met with parents of children who were borderline or failed to discuss strategies for language development. The author also worked with group leaders and their toddler groups demonstrating language stimulation strategies and activities.

For the purposes of the early childhood centre, the ELM-2 was used to determine the status of children’s language skills, support group leaders’ suspicions and identify children with speech and language delay, thereby enabling early and informed referral for specialist services.

In private practice

The ELM-2 has so far been used with 14 children (aged 25–46 months) in the author’s private practice. The brevity of the

Table 1 Validation studies

Author	Scoring	Subjects	Results
Black et al., 1988	Pass/fail	High risk (n=48)	83% sensitivity, 100% specificity; re BSID & REEL <2 years of age
Bzoch, League & Brown, 2003	Point score	N = 36	Moderate to high correlation with REEL – 3
Coplan & Gleason, 1990	Point score	Low risk (n=50)	R = .51 – .66, p < .0001; re SBIS; PPVT; ITPA
Coplan et al., 1982	Pass/fail	High risk (n = 119)	97% sensitivity, 93% specificity, 94% PPV, 96% NPV; re BSID, PPVT, REEL, PLS, SBIS
Satish et al., 1988	Pass/fail	High risk (n = 117)	Very strong relationship with performance on the BSID at 18 months. Passing the ELM <18 months has good correlation with future performance on the BSID
Walker, Gugenheim, Downs, & Northern et al., 1989	Pass/fail	Low risk (n= 657)	100% sensitivity, 68% specificity, 67% PPV, 100% NPV; re SICD 13–36 months

Sensitivity = percentage of persons with language difficulties correctly identified as having language difficulties; specificity = percentage of persons with normal language correctly identified as having normal language; PPV = positive predictive value; NPV = negative predictive value; r = product-moment correlation co-efficient; p = probability of obtaining results by chance; TESTS: SICD = Sequenced Inventory of Communication Development (Hendrick, Prather & Tobin, 1984); BSID = Bayley Scales of Infant Development (Bayley, 1969); REEL = Receptive and Expressive Emergent Language Test (Bzoch & League, 1971); SBIS = Stanford Binet Intelligence Scale (Terman & Merrill, 1973); PPVT = Peabody Picture Vocabulary Test (Dunn & Dunn, 1981); ITPA = Illinois Test of Psycholinguistic Abilities (Kirk, McCarthy & Kirk, 1969); PLS = Preschool Language Scale (Zimmerman, Steiner & Pond, 1979)

ELM-2 means the nature of the communication disorder and its severity can be established quickly without prolonging the initial assessment. This is especially useful when meeting with very active toddlers with short attention spans. The ELM-2 has also been useful as a quick screen of expressive language ability. While thirteen of the children referred for expressive language difficulties failed the expressive section of the ELM-2, the one child who passed had been referred for speech difficulties so the ELM-2 was efficient for expressive language screening.

The test form itself, while visually dense, helps emphasise to parents the importance of critical milestones for early language development – for example, black bands on the test form indicate when 90% of children have mastered particular milestone. The Visual section of the ELM-2 has been helpful in identifying children with autism as it contains items such as imitating gesture games and response to facial expressions. Two children with percentiles less than two were admitted into special education facilities on the suspicion of autistic spectrum disorder and two were admitted with speech-language impairment. Coplan (1993) asserts that the ELM-2 can assist in distinguishing language disorder from intellectual impairment and autism spectrum disorder, and adds that though the test is not “definitive for specific developmental disabilities ... patterns of failure may suggest a specific developmental diagnosis” p. 77). Formal developmental testing should then be carried out.

Regarding the auditory receptive section of the ELM-2, six children passed this section. Of these, it has been possible to test two with either the PLS-4 (Zimmerman, Steiner & Pond, 2002) or the PLAI-2 (Blank, Rose & Berlin, 2003) soon after. Though this is a small sample, age-appropriate receptive language functioning was confirmed.

Conclusions

Despite some reservations concerning sample size and age of test norms, the author has been using the ELM-2 since 2004 and has confidence this test, especially in the hands of a speech pathologist, will correctly identify normally developing children and those with speech and language delays. Without extensive knowledge about early language development, other professionals may need some guidance though the manual instructions are specific.

For the author’s purposes which have so far included screening toddlers 18 months – 3 years in an early childhood centre (using the pass/fail method) and as part of formal assessment of high-risk toddlers (using the point-score method), the ELM-2 has proven to be a useful and valid procedure for this population.

References

- Bayley, N. (1969). *Bayley scales of infant development*. New York: Psychological Corporation.
- Black, M. B., Freeland, C. A. B., Nair, P., Rubin, J. S., & Hutcheson, J. J. (1988). Language screening for infants prone to otitis media. *Journal of Pediatric Psychology*, 13, 423–433.
- Blank, M., Rose, S. A., & Berlin, L. J. (2003). *The Preschool Language Assessment Instrument-2*. Austin, TX: PRO-ED.
- Bzoch K. R., & League, R. 1971. *Receptive-Expressive Emergent Language Test*. Austin, TX: PRO-ED.
- Bzoch, K., League, R., & Brown, V. (2003) *Receptive and Expressive Emergent Language Test* (3rd ed.; REEL-3). Austin, TX: PRO-ED.
- Coplan, J. (1983). *Early Language Milestone Scale*. Tulsa, OK: Modern Education Corp.
- Coplan, J. (1993). *Early Language Milestone Scale* (2nd ed.). Austin, TX: PRO-ED.

Coplan, J., & Gleason, J. R. (1990). Quantifying language development from birth to three years using the early language milestone scale. *Pediatrics*, 86, 963–971.

Coplan, J., & Gleason, J. R., Ryan, R., Burke, M. G., & Williams, M. L. (1982). Validation of an early language milestone scale in a high risk population. *Pediatrics*, 70(5), 677–683.

Dunn, L., & Dunn, L. M. (1981). *The Peabody picture vocabulary test – revised*. Circle Pines, MN: American Guidance Service.

Eadie, R., Reilly, S., Bavin, E., Wake, M., Williams, J., Prior, M., Bretherton, L., & Barrett, Y. (2006). *Predictors of language development from 0–2 years: Data from the Early Language in Victoria Study (ELVs)*. Paper presented at SPAA Conference, Fremantle, WA.

Hendrick, D.L., Prather, E.M., & Tobin, A.E. (1984). *Sequenced inventory of communication development*. Seattle: University of Washington Press.

Kirk, S.A., McCarthy, J.J., & Kirk, W.D. (1969). *Illinois test of psycholinguistic abilities* (rev.ed.) Champaign: University of Illinois Press.

McCauley, R. J., & Swisher, L. (1984). Psychometric review of language and articulation tests for preschool children. *Journal of Speech and Hearing Disorders*, 49, 34–42.

Nelson, H. D., Nygren, P., Walker, M., & Panoscha, M. D. (2006). Screening for speech and language delay in preschool children: systematic evidence review for the US Preventive Services Task Force. *Paediatrics* 117(2)(February): e 298–319. Retrieved 6 September 2006 from <http://www.ahrq.gov/clinic/uspstf06/speech/speechrev.htm>

New York State Department of Health Info for Providers. (2006). *Assessment methods for young children with communication disorders: screening tests for communication disorders*. Retrieved 6 September 2006 from http://www.health.state.ny.us/community/infants_children/early_intervention/disorders

Salvia, J., & Ysseldyke, J. (1988). *Assessment in special and remedial education* (4th ed.). Boston: Houghton Mifflin.

Satish, M., McQuiston, S., Denner, J., Mueller, J., Urrutia, J., Elshafie, S., & Peters, L. (1988). Developmental testing 1. Correlation of early language milestone scale (ELM) at varying ages with Bayley. *Pediatric Research*, 23 (4 part 2) Abstract No. 1519455A.

Speech Pathology Association Australia. (2003). *Language, literacy and the role of the speech pathologist*, Briefing paper 3. Melbourne: Author.

Terman, L.D., & Merrill, M.A. (1973). *Stanford Binet Intelligence Scale*. Boston, Houghton – Mifflin.

Walker, D., Gugenheim, S., Downs, M., & Northern, J. (1989). Early language milestone scale and language screening of young children. *Pediatrics*, 83(2) (February), 284–288.

Zimmerman, I. L., Steiner, V. G., & Pond, R. E. (1979). *Preschool Language Scale*. Columbus, OH: Charles E. Merrill.

Zimmerman, I. L., Steiner, V. G., & Pond, R. E. (2002). *Preschool Language Scale – Fourth edition*. The Psychological Corporation, 19500 Bulverde Road, San Antonio, TX.

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THE EARLY LANGUAGE MILESTONE SCALE – 2

Part II: Use of ELM-2 and other 0–3 assessment procedures in Australia

Katherine Osborne

This article has been peer-reviewed

This paper explores Australian clinicians' awareness of the Early Language Milestone Scale - 2 and assessment tools currently being used with 0–3 year olds. In Part 1, the author described the clinical utility of the ELM-2 for screening and assessment purposes and discussed its weaknesses. The ELM-2 is one of many tools for identifying language delay in the 0–3 year population. However, it seems that it is rarely used in Australian clinics. This paper presents the findings from an electronic survey completed by 72 speech pathologists across Australia. Clinicians' familiarity with the ELM-2, preferences for assessment tools and reasons for selection of these tools are presented.

Keywords:

assessment,
early language screening,
survey

There is evidence of a significant need to improve early identification of children who are likely to require special education at school age (Wetherby & Prizant, 2002). Indeed, in the United States, "identification of children with communication disorders prior to school entry is a requirement of law" (Sturner, Layton, Evans, Heller, Funk, & Machon, 1994, p. 1). Early language milestones are an extremely sensitive indicator of developmental status (Coplan, Gleason, Ryan, Burke & Williams, 1982; Wetherby & Prizant, 2001). The Early Language Milestone Scale – 2 (ELM-2) (Coplan, 1993) is one such tool that assesses the child's acquisition of early language milestones from birth to 3 years of age. There are 43 items in 3 sections: Auditory receptive (referring to listening comprehension), Auditory expressive (encompassing both speech intelligibility and expressive language) and Visual (including pre-linguistic and linguistic behaviours). The test takes no more than 10 minutes to administer and all responses are recorded on a single form.

The ELM-2 can be used by examiners other than speech pathologists and was originally developed for use by paediatricians. Item instructions in the manual are specific and must be adhered to, as changing them can alter the meaning of questions asked of parents. For most items there are explanations and clarifications of terminology for examiners with limited in-depth knowledge of early language development.

Twenty-three items are elicited by history or observation, 11 by history, observation or direct testing, and nine items that can only be administered by direct testing. A kit of materials is provided. The ELM-2 can be used to screen large populations, to assess children at risk for developmental delay and as a research tool for monitoring speech and language development.

There are two scoring procedures depending on the population being tested: a point-score method yielding percentiles and standard scores, and a pass/fail score method for screening large low-risk populations.

Despite its small standardisation sample (191 children), the ELM-2 has been shown to have "reasonable to good" retest and inter-rater reliability (Coplan, 1993) and validity (Black, Freeland, Nair, Rubin & Hutcheson, 1988; Bzoch, League, & Brown, 2003; Coplan et al., 1982; Coplan and Gleason, 1990; Satish, McQuiston, Dennler, Mueller, Urrutia, Elshafie & Peters, 1988; Walker, Gugenheim, Downs, & Northern, 1989).

Though the ELM-2 is standardised, quick, easy to administer and score, and is cost effective (< \$1.50 per test form), it appears to be an assessment tool rarely used in Australian clinics. Why? Is it because it is considered too old, because it has been written by someone outside the profession or has it been competing with other early assessment procedures? Are clinicians simply not aware of its existence? What are clinicians using with the 0–3 year age group? What are clinician's expectations of assessment procedures with under 3-year-olds?

It is the aim of this paper to answer the following questions: Are clinicians aware of the ELM-2? What assessment tools are clinicians using? What reasons do clinicians give for their choices of assessment tools?



Katherine Osborne

Method

To answer these questions, the author surveyed speech pathologists across Australia. Surveys were distributed electronically to 122 clinicians. Potential participants working in private practice, hospitals and health centres were identified from Speech Pathology Australia's email lists of participants who attended the 2006 and 2007 national conferences. Local speech pathologists were also sent surveys.

A letter of invitation and a 10-question survey was electronically distributed to clinicians. Seven yes/no and three open-ended questions asked whether clinicians had heard of the ELM-2 or its predecessor, The Early Language Milestone Scale (ELM) (Coplan, 1983), had used either of these tests, or were aware of any reports positive or negative concerning them. Clinicians were asked to list assessments they used with 0–3 year olds, describe which assessments they liked and provide reasons. Clinicians were asked whether they were happy with the procedures they were using and lastly whether they would be interested in knowing more about the ELM-2.

Results

Awareness of the ELM-2

Seventy-two questionnaires were returned: Qld: 29; NSW:18; Vic.: 17; WA: 6; NT: 1; ACT: 1; SA: 0; Tas.: 0. Less than 20% (11/72) of surveyed participants reported awareness of the ELM-2 or its predecessor, and only 2 clinicians (2%) reported having used the ELM-2. One clinician reported being aware of both positive and negative reports concerning the ELM-2.

Table 1: Assessment tools for 0–3-year-olds

Assessment tool	% Participants using tool
Preschool Language Scale – 3 (Zimmerman, Steiner, & Pond, 1992) and Preschool Language Scale – 4 (Zimmerman, Steiner, & Pond, 2002)	55%
Rossetti Infant Toddler Language Scale (Rossetti, 1990)	45%
Self-formulated checklists	36%
Receptive - Expressive Emergent Language Scale (Bzock & League, 1971)	30%
Macarthur Communicative Developmental Inventories (Fenson et al., 1993)	16%
Reynell Developmental Language Scales 2nd ed. (Reynell & Huntley, 1985)	13%
Meeting Street School – Language Development Scale (Lieberman, 1974)	5%
Hawaii Early Learning Profile: HELP (Toland, Crock & Goff, 1992)	5%
Communication and Symbolic Behaviour Scales Developmental Profile (Wetherby & Prizant, 2002)	5%
Symbolic Play Test (Lowe & Costello, 1976)	4%
Clinical Evaluation of Language Fundamentals – P (Wiig, Secord, & Semel, 2006)	2%
Batelle Developmental Inventory 2nd ed.– Communication Domain (Newborg, 2004)	1%
ASQ: Ages and Stages Questionnaire (Squires, Bricker & Twombly, 2002)	1%
It Takes Two to Talk (Manolson, 1992)	1%
TAIT Analysis (Tait, 1987)	1%
Language Development Survey (Rescorla, 1989)	1%
Preverbal Communication Schedule (Kiernan & Reid 1987)	1%
Ward Infant Language Screening Test, Assessment, Acceleration & Remediation (Ward, 1992)	1%
Blades (Sherwood, 2003)	1%
Functional Assessment of Communication Skills (Ulliana & Mitchell, 1996)	1%
The Bureau Auditory Comprehension Test (Rosenthal, 1969)	1%
From Birth to Five – Children’s Developmental Progress (Sheridan, Sharma & Frost, 1997)	1%

Language assessment tools being used

Forty-three percent of clinicians reported making clinical judgements based on informal clinical observations, language sampling and case history as well as some form of formal assessment. Table 1 lists the formal assessment procedures clinicians reported using and the percentage of clinicians using them.

Table 2 sets out clinicians’ positive and negative comments about some of the language assessments they currently use. This information is useful when deciding on an assessment tool to use. Each tool described has points to recommend it depending on the clinician’s reason for testing, the age of the child and the nature of the child’s difficulties.

Clinicians’ satisfaction with procedures in use

Twenty-nine percent (21/72) stated they were not happy with the assessment instruments they were currently using. Almost one-third (23/72) reported being happy with their current assessment tools but said they would like to know what else is available, while 26% (19/72) stated they were happy with their current procedures. Twelve respondents (9/72) did not comment.

There was considerable variation in the type of comments made by clinicians regarding what they were looking for in a 0–3 year assessment tool. Comments included general statements about wanting “something better” to more specific statements such as wanting a “functional” or “play-based

procedure” or “with capacity for parent input”. Some clinicians wanted a tool “other early childhood professionals could use” while others stated the need for a “predictive screening tool” and a “normed screener”.

Discussion

This paper sought to investigate Australian clinicians’ awareness of the ELM-2 and table their preferences for assessment tools with 0–3 year olds. Results from the survey show there is little awareness of the ELM-2 among Australian speech pathologists. One can only speculate the reasons for this, and they may include the fact that James Coplan, the test’s author, is outside the profession of speech pathology, which may lead to a perceived lack in credibility. Perhaps clinicians were content with the Rossetti or PLS-3 both published a few years before the second edition of the ELM-2, and therefore had no need to explore another assessment tool. Perhaps it was simply a marketing oversight.

A wide range of procedures are being used by Australian clinicians, with 82% of clinicians using one of three tools or a combination of these – Preschool Language Scale-4, Rossetti Infant Toddler Language Scale or the Receptive Expressive Emergent Language Scale. A large number of assessment tools are used by a relatively small number of clinicians, e.g., Macarthur Communicative Developmental Inventories, Communication and Symbolic Behaviour Scales, Ages and Stages Questionnaire, Language Development Survey. This may

Table 2. Clinicians’ comments about assessment tools

Preschool Language Scale – 3	<i>Positive:</i> less flipping from book to toy compared with the PLS-4; easy to administer <i>Negative:</i> less useful for 0–12 months
Preschool Language Scale – 4	<i>Positive:</i> observational; good basis for discussion; easy to administer and score; quick and doesn’t rely on parent report; play component useful; familiar with it; standardised; good for early receptive and expressive language; as a screen for younger; vocabulary checklist gives an idea of the cross section of words being used <i>Negative:</i> too constrictive and structured; can be very disjointed in administration; expensive score forms (\$10.30 each!); difficult with Indigenous population; toy sections difficult to administer and score
Receptive and Expressive Emergent Language Scale - 3	<i>Positive:</i> gives standard score to help determine severity; good basis for discussion with parent; easy; gives a snapshot; for children who are difficult to assess; predictive of language delay in < 12 months <i>Negative:</i> not useful for identifying areas for intervention: doesn’t take in the child as a whole
Macarthur Communicative Development Inventory	<i>Positive:</i> easy to administer and score; qualitative idea of semantic level; reliable as a parent report instrument <i>Negative:</i> not so happy with the norms; database beyond vocabulary understanding too thin
Rossetti Infant Toddler Language Scale	<i>Positive:</i> good for planning clinical intervention goals; increases parent awareness of different modes of early communication; comprehensive including information about pragmatics, attachment and play; easy to administer and doesn’t rely on child compliance; straightforward and gives narrow age brackets; good for parent interviewing; clear; parent friendly; option of a parent questionnaire; used for long-term research with special needs; its in the clinic; am used to it <i>Negative:</i> takes a while to administer
Hawaii Early Learning Profile	<i>Positive:</i> very visual and quick within multidisciplinary assessments
Pre-verbal communication schedule	<i>Positive:</i> good for very discrete behaviours
Meeting Street School – Language Development Scale	<i>Positive:</i> used for screening <i>Negative:</i> not normed
Communication and Symbolic Behaviour Scales	<i>Positive:</i> for research, enabled us to validate parent report to clinician observation

simply reflect clinicians’ awareness of what is available or may reflect a limitation of this study as all Australian states were not equally represented in the survey.

The list of assessment tools (table 2) may increase clinicians’ awareness and access to tools available for < 3 year olds. Practical comments made by respondents (table 3) may be useful for the 29% of clinicians who stated they were not happy with their current assessment tools. It is worth knowing that some of the tools listed are easily accessible either via the internet (e.g., Wetherby and Prizant’s 2001 Communication and Symbolic Behaviour Scales Developmental Profile; Infant/Toddler Checklist) or in a journal article as in the case of Rescorla’s Language Development Survey (Rescorla, 1989).

It is interesting to note the number of clinicians using self-formulated checklists. Perhaps this reflects dissatisfaction with single instruments, and the need therefore to combine elements from different assessment tools to meet clinicians’ needs, or this may reflect funding limitations. Some clinicians commented on the cost of assessment tools, particularly test forms.

The many reasons clinicians gave for their choices of assessment tools indicates that a range of tools is necessary to account for client factors, reasons for testing, clinician preferences, and accessibility to parents. No single assessment instrument is comprehensive enough to cover all factors. Indeed, most clinicians (73%) reported using more than one procedure.

For the majority of clinicians who expressed interest in knowing more about the ELM-2, part 1 of this paper may be

of interest. In this, the clinical utility of the ELM-2 is discussed as a screener and as part of a formal assessment.

Conclusions

Given the relatively small number of clinicians surveyed, this paper could be seen as a pilot for a more representative study of Australian clinicians about their early language assessment practices. However, results from this survey reveal that though there are numerous assessment tools available for use with 0–3 year olds, almost a third of surveyed clinicians indicated they were not happy with their current assessment/s. Perhaps there is a need to circulate more effectively the wealth of information that is available, both in terms of assessment tools and comments from those who have used them. This investigation may help to inform clinicians regarding the range and nature of assessment tools available.

Few Australian clinicians reported awareness of the ELM-2, an assessment tool which the author has been using since 2004 for screening and as part of formal assessment. Clinicians can refer to part 1 for a comprehensive discussion of the strengths and limitations of this test.

References

Black, M. B., Freeland, C. A. B., Nair, P., Rubin, J. S., & Hutcheson, J. J. (1988). Language screening for infants prone to otitis media. *Journal of Pediatric Psychology, 13*, 423–433.

Bzoch K. R., & League, R. 1971. *Receptive-Expressive Emergent Language Scale*. Baltimore, MD: University Park Press.

Bzoch, K., League, R., & Brown, V. (2003) *Receptive and Expressive Emergent Language Test* (3rd ed.; REEL-3). Austin, TX: PRO-ED.

Coplan, J. (1983). *Early Language Milestone Scale*. Tulsa, OK: Modern Education Corp.

Coplan, J. (1993). *Early Language Milestone Scale* (2nd ed.). Austin, TX: PRO-ED.

Coplan, J., & Gleason, J. R. (1990). Quantifying language development from birth to three years using the early language milestone scale. *Pediatrics*, 86, 963-971.

Coplan, J., & Gleason, J. R., Ryan, R., Burke, M. G., & Williams, M. L. (1982). Validation of an early language milestone scale in a high risk population. *Pediatrics*, 70(5), 677-683.

Fenson, L., Dale, P., Reznick, J., Thal, D., Bates, E., Hartung, J., Pethnick, S., & Reilly, J. (1993). *Macarthur Communicative Developmental Inventories*. San Diego, CA: Singular Publication.

Kiernan, C., & Reid, B. (1987). *Preverbal communication schedule*. London, England: NFER-Nelson.

Lieberman, E. (1974). *The Meeting Street School - Language Development Scale 0 - 3 years*. Meeting Street School. Providence: Rhode Island.

Lowe, M. & Costello, A.J. (1976). *The Symbolic Play Test*. London, England: NFER-Nelson.

Manolson, A. 1992. *It takes two to talk*. Toronto, Ontario: The Hanen Centre.

Newborg, J. (2004). *Batelle Developmental Inventory*, 2nd ed. Itasca, IL: Thomas Nelson.

Parks, S. (1992). *Hawaii Early Learning Profile (HELP)*. Palo Alto, CA: Vort Corporation.

Rescorla, L. (1989). The Language Development Survey: A screening tool for delayed language in toddlers. *Journal of Speech and Hearing Disorders*, 54(November), 587-599.

Reynell, J., and Huntley, M. (1985). *Reynell Developmental Language Scales* (Rev. ed.). Windsor, England. NFER - Nelson.

Rosenthal, L. (1969). *Bureau Auditory Comprehension Test*. Sydney: Bureau of Maternal and Child Health, NSW Department of Health.

Rossetti, L. (1990). *Rossetti Infant - Toddler Language Scale*. East Moline IL: Linguisystems.

Satish, M., McQuiston, S., Dennler, J., Mueller, J., Urrutia, J., Elshafie, S., & Peters, L. (1988). Developmental testing 1. Correlation of Early Language Milestone Scale (ELM) at varying ages with Bayley. *Pediatric Research*, 23 (4 pt. 2), Abstract No. 1519 455A.

Sheridan, M. D., Sharma, A., Frost, M. (1997). *From birth to five: - Children's developmental progress*, 2nd ed. Routledge: UK.

Sherwood, M. (2003). BLADES 1. Master class, Hobart National SPAA Conference.

Sturner, R.A., Layton, T.L., Evans, A.W., Heller, J.H., Funk, S.G, & Machon, M.W. (1994). Preschool speech and language screening: A review of currently available tests. *American Journal of Speech - Language Pathology*, 3 (January) 25-36.

Squires, J., Bricker, D., & Twombly, E. (2002) *Ages and Stages Questionnaire: Social Emotional*. Baltimore, Maryland: Brooke Publishing Co.

Tait, M. (1987). TAIT analysis. *Journal of British Association of Teachers of the Deaf*, 11 (5).

Toland, S., Crock, R., & Goff, H. (1992) *Hawaii Early Learning Profile*. Vort Corporation. Palo Alto, CA.

Ulliana, L., & Mitchell, R. (1996). *The Functional Assessment of Comprehension Skills (F.A.C.S.)*. Module 1, Autism and related disorders. Speech Pathology Australia Conference, Canberra.

Walker, D., Gugenheim, S., Downs, M., & Northern, J. (1989). Early language milestone scale and language screening of young children. *Pediatrics*, 83(2) (February), 284-288.

Ward, S. (1992). Ward Infant Language Screening Test Instrument, Assessment, Acceleration and Remediation. *European Journal of Disorders of Communication*, 27, 1. www.nfer-nelson.co.uk

Wetherby, A., & Prizant, B. (2001). *Communication and symbolic behaviour developmental profile: Infant/toddler checklist*. Baltimore, MD: Paul H. Brookes publishing Co.

Wetherby, A., & Prizant, B. (2002). *Communication and Symbolic Behaviour Scales*. Baltimore, MD: Paul H. Brookes Publishing Co.

Wiig, E., Secord, W., & Semel, E. (2006). *Clinical evaluation of language fundamentals preschool - (2nd ed.)*. London: Harcourt.

Zimmermann, J., Steiner, V., & Pond, R. (1992). *Preschool Language Scale - 3*. San Antonio, TX: The Psychological Corporation.

Zimmerman, I. L., Steiner, V. G., & Pond, R. E. (2002). *Preschool Language Scale* (Rev. ed.). San Antonio, TX: The Psychological Corporation.

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CONVERSATION PARTNER TRAINING – ITS ROLE IN APHASIA

A review of the literature

Matthew Bradley and Jacinta Douglas

This article has been peer-reviewed

Conversation and conversation partner training is receiving increasing attention in aphasia research and clinical settings. To date, most aphasia research has focused on language impairment. Recently, however, there is increasing research addressing activity, participation and well-being in aphasia including research undertaken in the area of conversation partner training. Many variables need to be considered when exploring conversation partner training, including the theoretical approach, types of recipient and amount of training. This article provides a review of 19 conversation partner training studies and also draws upon relevant supporting literature. Study designs are explored and their results and limitations discussed.

Keywords:

aphasia,
dysphasia,
conversation,
supported conversation,
partner training

A growing literature has focused on conversation between people with aphasia and others as a collaborative effort. It recognises communication as vital to relationships, psychosocial well-being, life participation and quality of life (Cranfill, Simmons-Mackie, and Kearns, 2005). Rather than being viewed in isolation, the person with aphasia is treated as a “social unit” with those people with whom s/he interacts (Kagan, 1998a). Lyon et al. (1997) add that “focusing solely on clinical repair of language in the adult having aphasia is not sufficient to remediate that totality of what aphasia is” (p. 694).

The increased appreciation of conversation within aphasiology is reflected in the growing practice of incorporating conversation partner training (CPT) within therapy. Conversing with a person with aphasia requires considerable skill and expertise (Kagan & Gailey, 1993). Parr and Byng (1998) comment that even highly experienced clinicians may have difficulty conversing with people with aphasia.

Although conversational skills can appear deceptively simple when used by an experienced partner, implementing skills to support people with language impairment is not necessarily intuitive (Parr & Byng, 1998). Thus guidelines for training may not be readily transparent.

Conversation partner training appears to have the potential to lessen the impact of language impairment and to support increased life participation and well-being for people with aphasia; however, research is required to determine its efficacy and those factors which influence its success.

Conversation partner training studies

Despite a growing interest in and use of conversation partner training within the aphasiology field, relatively few studies have addressed it directly. An article by Simmons, Kearns and Potechin in 1987 was one of the first to investigate spousal training. It was not until nearly a decade later that other conversation partner training studies emerged in the literature. A total of 19 studies are included in this review.

The studies could broadly be separated into three categories with respect to the model underpinning their intervention: 1) “multi-modality communication training” (term adapted from Hickey, Bourgeois, and Olswang, 2004), 2) conversation analysis and 3) experiential learning. Although an attempt was made to categorise the 19 studies into the three defined approaches, many of them drew on various approaches making classification difficult.

Multi-modality communication training

Multi-modality communication training is based on training a range of general transferable strategies and skills to break down the communication barrier. It incorporates non-verbal strategies and resources and mainly targets communication partners of people with moderate-severe language impairment. A variety of applications exist within this framework with two examples being Supported conversation for adults with aphasia™ (SCA) (Kagan, 1998a) and John Lyon’s communication partners approach (Lyon et al., 1997).

Conversation analysis

Conversation analysis (CA) is a “procedure for the study of interaction... which uses a naturalistic, observation-based approach to study actual verbal and non-verbal behaviour” (Lock & Wilkinson, 2006). It focuses on how people construct conversations collaboratively; turns and sequences, repair, topic; and use of both language and non-verbal behaviour.

CA is a multistage process involving: (a) data collection, (b) transcription of data (verbal and non-verbal data), (c) analysis. Additional steps in using CA in conversation partner training involve feedback to the participants and behaviour modification.

Experiential learning

The experiential learning model is based on learning through experience. In experiential learning, learning occurs with repetition, practice and incorporation of specific feedback from experienced persons. Learning is promoted through critical self-reflection on experiences (Purdy & Hindenlang, 2005).

Comparison of approaches

While these three approaches all address conversation training differently, the emphasis on the collaborative nature of conversation and the interdependency between the person with aphasia and the conversation partner unify them. Multi-

modality communication training appears more appropriate for people whose language is more severely impaired than the other two approaches. The generic skills as taught in the multi-modality communication approach lend themselves to being used with a variety of partners with aphasia. Thus, it may be more appropriate in training unfamiliar communication partners, such as volunteers and health professionals, who are likely to engage with multiple partners with aphasia. Experiential learning and conversation analysis are tailored to individual participants and less transferable, thus suiting familial partners.

Participants

Characterisation of the participants in the studies largely focused on those with aphasia rather than their conversation partners and generally there was more detailed information on the former. Nonetheless, studies varied in the information (amount and type) provided about the participants with aphasia.

There is a significant range in time post-onset of aphasia with predominance for people who had lived with aphasia for at least a year. Two studies worked with people who acquired their aphasia less than 6 weeks earlier (Lesser & Algar, 1995; Correll, van Steenbrugge, and Scholten, 2004). The age of people with aphasia varied widely, ranging from 36 to 80 years.

In 12 of the 19 studies, the conversation partners were family members and the majority were either a spouse or partner. Of the remaining 7 studies, one included a spouse and two volunteers (Lyon, 1996), one involved two friends who worked as a triad with their friend with aphasia (Lesser & Algar, 1995), and another involved training sixth-year medical students in taking case histories (Legg et al., 2005). Conversation partners in the final 4 studies were volunteers and in 3 of these the volunteers were described as inexperienced.

Intervention

There was much variability in the intervention undertaken within the studies reviewed. Studies were differentiated in terms of whether the intervention was conducted within individual dyads or within a group setting.

Eleven of the studies provided intervention individually/within the dyad. Six worked within a group setting and the remaining two provided a combined approach.

There was also substantial variability in the amount of intervention provided. The intervention ranged from one 4-hour training session in multi-modality training (Legg, Young, and Bryer, 2005) in a group setting through to 41 sessions of individual input in a criteria-based program (Simmons et al., 1987).

The location was commented on by several authors but many (10) did not state where the intervention took place. One study (Correll et al., 2004) took place in an inpatient rehabilitation setting; one took place in a nursing home setting (Hickey et al., 2004), while others were conducted in clinical settings, the participants' homes and in the community.

Study design

As in other areas of aphasia therapy research, there is a predominance of single case design in the form of individual case studies and multiple single case studies. These two categories account for 16 of the 19 studies reviewed.

There were two randomised control trials (RCT). Kagan, Black, Duchan, Simmons-Mackie, and Square, (2001)

compared the success of training 20 volunteers in SCA compared to 20 controls who received no training in SCA. The authors noted that their study technically applied quasi-randomisation as changes to group allocation were made because of transport issues. The other RCT was conducted by Legg et al. (2005) and involved comparing the success of 11 sixth-year medical students trained in SCA versus 10 controls who received traditional "medical education" about aphasia.

There were two quasi-experimental group designs within the studies reviewed. Rayner and Marshall (2005) included eight volunteers who received no training but completed the same questionnaires as the experimental group on two occasions. Lyon et al. (1997) included three participants who received no intervention compared with 7 who did. Table 1 provides information about the study designs and sample sizes of each of the reviewed studies.

Table 1. Study designs and sample sizes

Study design (No.)	Studies	Sample size
RCT (2)	Kagan et al. (2001)	40 dyads <i>Controls=20</i>
	Legg et al. (2005)	21 dyads <i>Controls=10</i>
Quasi-experimental group (2)	Lyon et al. (1997)	10 dyads
	Rayner & Marshall (2003)	6 dyads
Multiple single case study (9)	Purdy & Hindenlang (2005)	10 dyads
	Sorin-Peters (2004)	5 dyads
	Boles (1997)	4 dyads
	Booth & Swabey (1999)	4 dyads
	Cunningham & Ward (2003)	4 dyads
	Correll et al. (2004)	2 dyads
	Hickey et al. (2004)	2 dyads
	Hopper et al. (2002)	2 dyads
	Lesser & Algar (1995)	2 dyads (incl. 1 triad)
Single case study (6)	Boles (1998)	1 dyad
	Booth & Perkins (1999)	1 dyad
	Lyon (1996)	1 triad
	Simmons et al. (1987)	1 dyad
	Turner & Whitworth (2006b)	1 dyad
	Wilkinson et al. (1998)	1 dyad

Results and limitations

Reflecting the diversity of approaches and interventions of the conversation partner training studies are similarly diverse approaches taken to measuring the outcomes. Measures were applied variously to either or both of the conversational partners (those with aphasia and those without). Outcome measures included: traditional impairment-based language measures; those addressing psychosocial consequences; measures looking at the application of conversational skills within interactions (both transactional and interactional);

conversation analysis measures; and perception measures addressing issues of attitudes and knowledge.

As Turner and Whitworth (2006a) note in their review article, "That CPT interventions can be effective is not disputed. However, the measurement of such effectiveness needs scrutiny and for whom these interventions work remains largely unknown".

Collectively, the studies demonstrated the effectiveness of conversation partner training. Seven of the studies incorporated statistical analyses. All studies involving statistical analysis resulted in clinically significant results, though several also included results on some outcome measures that did not reach significance. All other studies showed positive trends or changes.

The strength of the findings must also be considered within the context of the research quality of the studies. While all the studies demonstrate successful outcomes, there are several limitations relating to methodological rigour which need to be considered.

As Douglas, Brown, and Barry (2004) highlight,

The limitations of randomised controlled trials for examining the effectiveness of aphasia therapy has been well documented and much discussed among aphasiologists. The heterogeneity of aphasia and the resulting individual treatment supports the use of single case study methodology to establish an evidence base for aphasia therapy (p. 39).

Nevertheless, small sample sizes and heterogeneity of participants limit the generalisability of the findings of these studies (Hickey et al., 2004).

The lack of details about the intervention in some studies limits their potential to be replicated. All of the studies provide explicit detail about the amount of intervention undertaken; however, many fail to make the nature of the intervention explicit for the reader. Almost all studies compared treatment versus no treatment and it may have proven useful to compare treatment types. Only the Legg et al. (2005) study compared interventions; they compared training in supported conversation versus provision of theoretical information about aphasia as per the existing medical student training syllabus.

Attributing the outcomes to the interventions also needs to be done with caution. Failure to establish stable baselines prior to commencement of intervention was apparent across many of the studies. Only six studies provided multiple measures at baseline (Boles, 1997; Boles, 1998; Correll et al., 2004; Cunningham and Ward, 2003; Hickey et al., 2004; Simmons et al., 1987). Although changes were evident on outcome measures in all of the studies, the lack of control of, or indeed reference to, extraneous variables such as environmental and personal factors means concluding the change is solely as a result of a treatment effect is tenuous.

With respect to the evaluation of success, several issues arise. Many of the studies used informal measures or descriptive results only (Lyon, 1996; Correll et al., 2004). Purdy and Hindenlang (2005) acknowledge their crude scoring system was a concern. The variety of tools employed and areas evaluated render comparisons across studies difficult. Reliability and validity must also be questioned, with less than half of those studies reviewed (8 of 19) including a discussion about reliability and even fewer commenting on validity. Few studies included evaluations undertaken by blind assessors or considered the impact of "observers' paradox" described by Booth and Swabey (1999) where performance is skewed by the act of videotaping (a recording method used by many of the studies).

Numerous authors who investigated conversation analysis commented on the time commitment required to transcribe and analyse the data (Boles, 1997; Booth and Swabey, 1999). It is not only the time commitment required but also the expertise required to apply it reliably. This phenomenon is not limited to CA but extends to all the approaches employed.

A limitation not peculiar to the study of aphasia, and one noted by numerous authors (Boles, 1997; Kagan et al., 2001) in their discussions, was the lack of follow-up and consideration to maintenance. Lyon et al. (1997) did evaluate outcomes 6 months post-intervention though this was completed using informal outcome measures only. Simmons et al. (1987) provided 1-month follow-up evaluation, while others provided no follow-up. Closely aligned with this issue is that of generalisation.

Partner training has primarily addressed intimate (familial) partners and volunteers. Given one's social network is comprised of people in many other roles, it would be beneficial to consider the application of conversation partner training for other conversation partner groups such as friends.

Future directions

Although the evidence is limited, the research findings to date provide some support for the benefits of conversation partner training. A future aim should include developing a systematic approach to the study of conversation partner training accounting for the weaknesses in methodology that were discussed above. This aim mirrors that which is required in many other areas of speech and language research.

References

- Boles, L. (1997). Conversation analysis as a dependent measure in communication therapy with four individuals with aphasia. *Asia Pacific Journal of Speech, Language and Hearing*, 2, 43–61.
- Boles, L. (1998). Conversation discourse analysis as a method for evaluating progress in aphasia: A case report. *Journal of Communication Disorders*, 31, 261–274.
- Booth, S., & Perkins, L. (1999). The use of conversation analysis to guide individualized advice to carers and evaluate changes in aphasia: A case study. *Aphasiology*, 13, 283–303.
- Booth, S., & Swabey, D. (1999). Group training in communication skills for carers of adults with aphasia. *International Journal of Language & Communication Disorders*, 34, 291–310.
- Correll, A., van Steenbrugge, W., & Scholten, I. (2004). Communication between severely aphasic adults and partners. *ACQ – Acquiring Knowledge in Speech, Language and Hearing*, 6, 93–96.
- Cranfill, T., Simmons-Mackie, N., & Kearns, K. (2005). CAC Classic: Preface to "Treatment of aphasia through family member training". *Aphasiology*, 19, 577–581.
- Cunningham, R., & Ward, C. (2003). Evaluation of a training programme to facilitate conversation between people with aphasia and their partners. *Aphasiology*, 17, 687–707.
- Douglas, J., Brown, L., & Barry, S. (2004). The evidence base for the treatment of aphasia after stroke. In S. Reilly, J. Douglas and J. Oates (Eds.), *Evidence Based Practice in Speech Pathology* (pp. 37–58). London: Whurr Publishing.
- Hickey, E., Bourgeois, M., & Olswang, L. (2004). Effects of training volunteers to converse with nursing home residents with aphasia. *Aphasiology*, 18, 625–637.
- Hopper, T., Holland, A., & Rewega, M. (2002). Conversational coaching: Treatment outcomes and future directions. *Aphasiology*, 16, 745–761.
- Kagan, A. (1998a). Supported conversation for adults with aphasia: Methods and resources for training conversation partners. *Aphasiology*, 12, 816–830.

Kagan, A., Black, S., Duchan, J., Simmons-Mackie, N., & Square, P. (2001). Training volunteers as conversation partners using "supported conversation for adults with aphasia" (SCA): A controlled trial. *Journal of Speech, Language & Hearing Research, 44*, 924–638.

Kagan, A., & Gailey, G. (1993). Functional is not enough. In A. Holland and M. Forbes (Eds), *Aphasia treatment: World perspectives* (pp. 199–225). London: Chapman & Hall.

Legg, C., Young, L., & Bryer, A. (2005). Training sixth-year medical students in obtaining case-history information from adults with aphasia. *Aphasiology, 20*, 559–575.

Lesser, R., & Algar, L. (1995). Towards combining the cognitive neuropsychological and the pragmatic in aphasia therapy. *Neuropsychological Rehabilitation, 5*, 67–92.

Lock, S. and Wilkinson, R. (2006) *SPPARC Workshop Manual*.

Lyon, J. (1996) Optimizing communication and participation in life for aphasic adults and their primary caregivers in natural settings: a use model for treatment. In G. Wallace (Ed.), *Adult aphasia rehabilitation* (pp. 137–160). Boston: Butterworth-Heinemann.

Lyon, J., Cariski, D., Keisler, L., Rosenbek, J., Levine, R., & Kumpula, J., Ryff, C., Coyne, S., & Blanc, M. (1997). Communication partners: Enhancing participation in life and communication for adults with aphasia in natural settings. *Aphasiology, 11*, 693–708.

Parr, S., & Byng, S. (1998). Breaking new ground in familiar territory: A comment on "Supported conversation for adults with aphasia", by Aura Kagan. *Aphasiology, 12*, 847–850.

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

Rayner, H., & Marshall, J. (2003). Training volunteers as conversation partners for people with aphasia. *International Journal of Language & Communication Disorders, 38*, 149–164.

Simmons, N., Kearns, K., & Potechin, G. (1987). Treatment of aphasia through family member training. In R. Brookshire (Ed.), *Clinical Aphasiology Conference Proceedings* (pp. 106–116). Minneapolis: BRK.

Sorin-Peters, R. (2004). The evaluation of a learner-centred training programme for spouses of adults with chronic aphasia

using qualitative case study methodology. *Aphasiology, 18*, 951–975.

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

Turner, S., & Whitworth, A. (2006b). Clinicians' perceptions of candidacy for conversation partner training in aphasia: How do we select candidates for therapy and do we get it right?. *Aphasiology, 20*, 616–643.

Wilkinson, R., Bryan, K., Lock, S., Bayley, K., Maxim, J., Bruce, C., Edmundson, A., & Moir, D. (1998). Therapy using conversation analysis: helping couples adapt to aphasia in conversation. *International Journal of Language & Communication Disorders, 33*(Suppl.), 144–149.

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WEBWORDS 29

Ethics and fidelity

Caroline Bowen

You may have heard that *Webwords* loves an incognito long weekend away: the change of scene, the new experiences, the chance to reflect and renew. The delicious anonymity that might allow you to challenge someone's sexist, racist or ageist opinions without having to worry about therapeutic neutrality, and the chance to use your pet cockroach to eat free in restaurants.

On the other hand you may not have heard that the quietly philanthropic group, the *Benevolent Friends of Webwords*, shares this passion for undercover work. A typical Friend is a conference tragic or CPD enthusiast, works furtively and alone, and travels the land developing illicit hoards of toiletries, pens, jotters, coffees, teas and sugars, sewing kits, shoe wipes, *Do Not Disturb* and *Make Up My Room Now Please* signs, coasters, and other collectables – to donate to charity, naturally.

The hospitality and the travel industries know a thing or two about such benevolent work, and are unappreciative, classifying it among the top three travel taboos: lying, cheating and stealing.

Chains

Tackling stealing with wry humour the Holiday Inn chain won an industry award by holding an annual Towel Amnesty Day when each guest was issued with a retro green-striped towel with a tiny message that read: 100% Cotton 100% Guilt-free 100% Yours.

Hoteliers have not come up with a funny way of dealing with patrons' propensity to nick lamps, irons, faxes, modems, bathmats and flat screen monitors, or to drink the Evian from the mini-bar and replace it with tap water. Tap water! That's bad. Even the Benevolent Friends would not rationalise *that* as a form of recycling and would not be caught doing it. But we can only wonder what twisted logic they would apply, or the conduct they would advise, in the following situation.

BYO ethics

Tired and hungry after a long flight, you and your budget-conscious companion check into an exclusive country hotel around 7:30 p.m., soon realising that the culinary extravaganza downstairs is seriously expensive. But wait! There is a moderately famous, good value BYO Italian in the next block. That's tempting. The only thing is, the sleepy town's bottle shop closed at seven. You've both noticed a very nice Pinot Noir gracing the mini-bar – three times the price you would normally pay for the same excellent drop. What now? Do you have a dry night, do you tick the box so that you will have to pay for the expensive bottle, or do you take the bottle to Antonello's without ticking the box and replace it with a well-

priced bottle of the same thing from the local retailer next day? You can easily manage that before the guy comes around to restock the fridge. No probs. No one will be any the wiser, and after all, a red is a red is a red, right?

So what *is* the dilemma? And if there is a dilemma, what *kind* is it? Legal? Moral? Ethical? Are you thinking that you could live with your conscience for doing it but would not want the embarrassment of being caught? Are you justifying your cunning plan along the lines that if the mini-bar prices were remotely reasonable you would not be driven to extremes? That in fact you are not made of money and have a perfect *right* to economise and that it is the hotel's *fault* that you are guilt-tripping. Moreover, they deserve creative guest-behaviour if they persist in overpricing the grog *and* serving horrible meals to hideous music. Or are you thinking there is no dilemma, but a decision to be made: a choice to be taken from three obvious options. One, we pay top price for the Pinot and quaff it with gusto with our \$16 Gnocchetti Cimbri with Leeks, Pancetta, and Cauliflower; two, we have the pancetta and cauli without bothering with wine tonight and be better organised with a legitimate BYO bottle by tomorrow; or three, we proceed with the money-saving deception. Choices, choices.

Certain principles

The **Speech Pathology Australia Code of Ethics**¹ reminds us that we do not have any choice when it comes to our fundamental professional responsibility to observe the highest standards of integrity and ethical principles. It does not say look for the loopholes or choose your standards, or regard ethical practice as a worthy but unobtainable goal that only a total goody two shoes could live up to. Not at all. Instead it sets out our moral obligation to follow a series of principles when we strive to make ethical decisions.

Our code's first principle is that of beneficence and non-maleficence. We seek to benefit others through our activities; and we also seek to prevent harm, and not to knowingly cause harm or make mischief. Principle two is truth: we tell the truth. The third is fairness and justice: we provide accurate information, we strive for equal access to services, and we deal fairly with everyone with whom we come in contact. Number four is autonomy: we respect the rights of our clients to self-determination and autonomy. And five is professional integrity or fidelity: we are respectful and courteous, we are competent and follow the association's Code of Ethics, and we keep promises and honour our commitments to clients, colleagues and professional organisations.

Clearly our Code of Ethics was not written with the quaffing quandary in mind. But let's have a go anyway. One: we embrace an opportunity, take the Pinot, replace it next day,

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and beneficence is upheld: the restaurant and the bottle shop have benefited and no harm has befallen the hotel. Two: we tell no lies. The waiter does not ask us where Pinot came from, the bottle shop salesperson does not query our purchase, and when the mini-bar guy comes we tell him the truth: we don't need a new bottle. Three: there has been no disrespect. Four: fairness has been served. We pay a fair price for a fair drop. And five: that's professional integrity or fidelity, remember? We don't have to worry about that just now, do we? – after all, it's an incognito weekend away and we are not acting in our professional capacities.

Steadfast

If you have the space and time to think about them, on a peaceful weekend away, for example, each of the key words denoting the five principles can evoke deep reflection. It is interesting, even inspiring, to consider the import of words like beneficence, truth, fairness, justice, autonomy, respect, honour, integrity and fidelity. That final word is possibly the most intriguing – a pleasantly antiquated, graceful one, associated with ideas of allegiance, fealty and loyalty – that means faithfulness to obligations or to duties, or to observances. And it meshes so exquisitely with its close relation, "integrity" with its message of steadfast adherence to a strict moral or ethical code.

Some time during a reflective long weekend away Webwords made some important decisions. She sent the

cockroach back to his people, abandoned all thoughts of wining and dining scams, and made a note to have a stern chat to the Friends about their hunting and gathering activities. She confided later that she could not honestly ascribe these decisions to newfound insights into the meanings of fidelity and integrity. No, she insisted, it was something about the word steadfast. Webwords wanted to be steadfast: to be steady, firmly loyal, constant, unswerving, trustworthy and true to herself. By thinking about it, it had become clear to her that ethical conduct was not simply a worthy goal or a moral obligation specifically related to our practice as professionals. It was not to be abandoned on the weekends when professional hats were removed, or manipulated for our own purposes when it suited. Rather, ethical conduct was for all the time. It was a way of being. I felt so proud of her, and said so.

She smiled happily, placed two Antonello's coasters on the table between us, and said, "Good". Her mischievous eyes twinkled, "Now, if you pass me the Pinot Noir we can drink to that". And we did.

Link

1. <http://www.speechpathologyaustralia.org.au/Content.aspx?p=19>

Webwords 29 is at <http://speech-language-therapy.com/webwords29.htm> with just one live link this time, to the Speech Pathology Australia Code of Ethics.



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SPEECH PATHOLOGY IN THE ASIA PACIFIC REGION – LEARNING FROM OUR NEIGHBOURS

Lindy McAllister

Most Australian speech pathologists would say they know a reasonable amount about the profession of speech pathology in Australia. But how much do we know about the profession of speech pathology in other countries in the Asia-Pacific region of which we are a part? There is much we could learn from the practice of speech pathology in our region, but some countries do not have a journal for the dissemination of information and research. Others do publish journals and hold regular conferences, but these are rarely accessed by the majority of Australian speech pathologists. This column aims to provide a means for Australian speech pathologists to learn about speech pathology in the Asia-Pacific region.

Speech pathology exists in many forms in the Asia-Pacific region. For example, there are formalised speech pathology professions in several countries including New Zealand, Malaysia, Singapore, Hong Kong, the Philippines, Japan, India, and Sri Lanka. In addition, speech pathology services are delivered by volunteers in a host of other countries including Indonesia, Cambodia, Vietnam, Fiji, Bangladesh, and Nepal. These volunteers may be affiliated with government agencies such as Australian Volunteers International or the Australian Youth Ambassador Development Program, a range of non-government organisations such as Rotary International or church-based charities, or universities offering international placements. Furthermore, services labelled as speech pathology are sometimes delivered by medical or educational personnel. For example, I can think of examples in Vietnam and Nepal, two countries without formalised speech pathology services, where nurses, paediatricians or teachers who have done short courses in speech therapy offered by aid organisations in-country or overseas, run “speech therapy programs” in children’s hospitals or community-based rehabilitation centres. The growing demand for speech pathology services in our regions offers many opportunities for Australian speech pathologists to get involved in the development and delivery of speech pathology services, as witnessed by the interest in Speech Pathology Australia’s new Member Network of Speech Pathologists in Developing Countries.

The history of the speech pathology profession in neighbouring countries is of interest to us. In some countries, the profession has grown from services offered initially in schools; in others, especially in developing countries, the profession has started and often remains in medical settings. In some countries, the profession developed from speech pathology-educated ex-pats lobbying for the establishment of training courses and expanded services. In other countries, the develop-

ment of the profession has been more organic, growing from a need recognised by local health professionals.

Regardless of the origins of the profession in neighbouring countries, we in Australia have much to learn. All countries in our region are grappling with how to provide speech pathology services to multilingual, multicultural populations. Many could be said to be further ahead of the profession in

Australia in developing culturally appropriate assessment tools and therapy resources. Several countries are creatively engaged in developing “whole of population” services and reaching out to underserved communities.

We aim to make this column a regular feature in the ACQ over the next few years. Speech pathology associations or individuals in the Asia-Pacific region will be invited to contribute columns which can inform us about the history of the profession, the current size and scope of practice of the profession, research and resource development, recent achievements of the profession and current challenges and needs of the profession in their country.



Lindy McAllister

Lindy McAllister has a long standing professional interest in the Asia Pacific region. As Associate Professor of Speech Pathology at Charles Sturt University she initiated the Carrick Institute award winning Vietnam fieldwork program for allied health students. She is also an external examiner for the speech language therapy courses at the National University of Malaysia, Kelanya University in Sri Lanka, and Auckland University in New Zealand. While President of Speech Pathology Australia she sought to develop closer links with our sister associations in the Asia Pacific region, and more recently helped initiate the Member Network for Speech Pathologists in Developing Countries. Lindy believes there is much we can learn from the speech pathology profession in our region.

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AROUND THE JOURNALS

Andrew Whitehouse

Behaviour problems in children with language impairment

Van Daal, J., Verhoeven, L. & van Balkom, H. (2007). Behaviour problems in children with language impairment. *Journal of Child Psychology and Psychiatry*, 48, 1139–1147.

There is a well-established association between language impairment and childhood behavioural problems. Behavioural difficulties fall into two broad categories. Externalising problems relate to a child's outward behaviour and reflect a child negatively acting on the external environment (e.g., aggression, delinquency), while internalising problems relate to behaviours that are directed inward (e.g., withdrawal, anxiety, low self-esteem). The current study sought to investigate the presence of internalising and externalising behaviours in children with language impairment, and to determine whether these behaviours are related to any specific pattern of speech/language deficit.

The sample was 71 five-year-old children recruited from schools around the Netherlands that specialise in the education of children with language impairment. Children were given a battery of standardised psychometric tests assessing various aspects of language ability. Parents of the children completed the Child Behaviour Checklist (CBCL) – a questionnaire assessing various non-adaptive behaviours.

As expected, the bulk of the children performed poorly on the language tasks. Similarly, there was a high level of reported behavioural disturbances, with around 40% of children scoring in the "clinical" (impaired) or "borderline" (near-impaired) range on the CBCL. The most frequently reported internalising problems were somatic complaints and withdrawn behaviours, while externalising problems were most commonly exhibited in the form of aggression. Internalising and externalising behaviours tended to occur to the same extent in this sample of children.

Further analyses found that internalising problems (anxiety/depression and withdrawn behaviours) were most commonly seen in those children with phonological or semantic deficits. Externalising problems, on the other hand, were related to phonological problems only. Speech problems appeared to carry the least risk for any form of behavioural problem.

These findings highlight the importance of gauging both language and behavioural abilities at initial assessment.

Development of a scale that predicts long-term dysphagia progress

Han, T. R., Paik, N-J, Park, J-W., & Kwon, B. S., (2008). The prediction of persistent dysphagia beyond 6 months after stroke. *Dysphagia*, 23(1), 59–64.

This paper reports the development of the Videofluoroscopic Dysphagia Scale (VDS), an instrument designed to provide an objective prediction of long-term persistent dysphagia after stroke.

Eighty-three participants with dysphagia underwent a videofluoroscopic swallowing examination upon their admission to a rehabilitation unit (on average, 40 days post-stroke). Participants received a standard swallowing assessment, where they were asked to ingest 2ml and 5ml of diluted

barium, curd-type yoghurt and boiled rice. At the same time, a physiatrist who is a specialist in physical medicine and rehabilitation completed the VDS, a checklist that measures swallowing performance along 14 parameters of ability (e.g., lip closure, mastication, laryngeal elevation).

The swallowing ability of the participants was reassessed with videofluoroscopy 6-months later (on average, 183 days post-stroke). The researchers examined the relation between the 14 parameters of swallowing ability observed at initial assessment and the presence of subglottic aspiration at the 6-month follow-up assessment. Based on the predictive power of the different parameters, a scoring system for the VDS was formulated (total score = 100). The parameters that best predicted aspiration at follow-up (i.e., poor tongue-to-palate, laryngeal elevation, coating of the pharyngeal wall, pharyngeal transit time, aspiration) were given greater weighting towards the total score, while those parameters that showed relatively weak predictive power (lip closure, apraxia) had a reduced contribution. The scoring system is outlined below:

1. Lip closure (intact = 0; inadequate = 2; none = 4)
2. Bolus formation (intact = 0; inadequate = 3; none = 6)
3. Mastication (intact = 0; inadequate = 4; none = 8)
4. Apraxia (none = 0; mild = 1.5; moderate = 3; severe = 4.5)
5. Tongue-to-palate contact (intact = 0; inadequate = 5; none = 10)
6. Premature bolus loss (none = 0; <10% = 1.5; 10-50% = 3; >50% = 4.5)
7. Oral transit time (≤ 1.5 seconds = 0; >1.5 seconds = 3)
8. Triggering of pharyngeal swallow (normal = 0; delayed = 4.5)
9. Vallecular residue (none = 0; <10% = 2; 10-50% = 4; >50% = 6)
10. Laryngeal elevation (normal = 0; delayed = 9)
11. Pyriform sinus residue (none = 0; <10% = 4.5; 10-50% = 9; >50% = 13.5)
12. Coating of pharyngeal wall (no = 0; yes = 9)
13. Pharyngeal transit time (≤ 1 second = 0; >1 second = 6)
14. Aspiration (none = 0; supraglottic penetration = 6; subglottic aspiration = 12)

Further analysis indicated that a cut-off score of 47 or above shows optimal sensitivity and specificity for long-term dysphagia prediction, i.e., those who score 47 or above at initial assessment are most at risk for long-term dysphagia.

Genetic overlap between SLI and autism?

Whitehouse, A. J. O., Barry, J. G., & Bishop, D. V. M. (2007). The broader language phenotype of autism: A comparison with Specific Language Impairment. *Journal of Child Psychology and Psychiatry*, 48, 822–830.

In the recent years, evidence that autism and specific language impairment may share a common underlying genetic cause has been accumulating. One of the strongest pieces of evidence is that relatives of individuals with autism often show language impairments similar to that experienced by individuals with SLI. This study investigated the idea of a common genetic cause for autism and SLI, by comparing the language functioning of parents of children with SLI and parents of children with autism. If there is a shared genetic liability for the two disorders, then it was expected that the

two parent groups would show a similar profile of communication abilities and disabilities.

The study recruited three parent groups: 30 parents of children with autism, 30 parents of children with SLI, and 30 parents of typically developing children. The participants were administered a range of linguistic, memory and literacy tasks, as well as a checklist that examined pragmatic language ability.

Both the autism and SLI parent groups were found to have communicative deficits – a result that once again highlights the genetic component of both disorders. However, the two groups displayed a different pattern of communicative abilities and disabilities. The parents of children with SLI performed poorly on the linguistic, memory and literacy tasks, but showed no difficulties with pragmatic language. The reverse was true for the autism parent group: they had good performance on the linguistic, memory and literacy tasks, but experienced difficulties with some aspects of pragmatic language. The “double dissociation” between linguistic performance and social communication ability suggests that SLI and autism may result from a different underlying genetic cause.

Syntactic processing in aphasia

Caplan, D., Waters, G., DeDe, G., Michaud, J., & Reddy, A. (2007). A study of syntactic processing in aphasia I:

Behavioural (psycholinguistic) aspects. *Brain and Language*, 101, 103–150.

This study examined syntactic comprehension in a large group of patients with aphasia secondary to left hemisphere stroke. The authors sought to investigate two main views of why aphasic individuals have difficulties with syntactic comprehension. The first view suggests that these impairments result from specific deficits in parsing, while the second view maintains that a reduction in cognitive resources disrupts comprehension.

Forty-two participants with aphasia and 25 healthy adults completed five tests of syntactic processing. Cognitive load – the number of mental operations required to successfully complete a task – increased across the various tests. The behavioural data was then subject to individual and group data analysis.

As expected, general proficiency in the tasks was reduced for the patients with aphasia compared to the healthy adults. There was considerable variability in the performance of the aphasic patients, and, for the most part, these individuals did not show a stable pattern of errors for any task. However, there was a trend for the aphasic group to make more errors in syntactic processing as the cognitive load increased. This finding supports the view that syntactic comprehension is impaired because there is a reduction in cognitive resources available to process multiple mental operations.

Speech Pathology Australia National Employment Register is now available on the website www.speechpathologyaustralia.org.au

This member-only service assists speech pathologists to find employment.

Members seeking employment can choose to have their contact details uploaded onto the website or alternatively view the list of vacant positions on the ‘Job Board’.

Employers can choose to advertise vacant speech pathology positions on the ‘Job Board’ which members can then access and apply for.

This free of charge service aims to assist members seeking employment.

We would also recommend you seek other sources when looking for employment.

Forms for completion can be downloaded from the website if you wish to use this service at any time in the future.

For more information see the Association’s website or contact National Office.

OUTSIDE THE SQUARE

Making speech pathology computer compatible

Toni Seiler

I never thought I'd be in Boston, USA, on the Dynavox/Mayer-Johnson stand at a huge ASHA conference, marketing speech pathology software we have developed! As a new graduate, 34 years ago, I actually avoided the complexity of the emerging technologies. But now I enjoy the challenge of producing software that makes our role as speech pathologists increasingly hassle-free and efficient.

How did all this start? A combination of circumstance, the need for engaging materials when starting private practice, and simply being "game to have a go" meant our small group spent hours, weeks, months, and years, excitedly discussing games and activities over our trusty white board. It certainly helped that my partner and husband, Rob, loves the challenge of computer programming, and also that our colleague, Anna Breakell, is one of those creative and artistic therapists who can scribble, while in therapy sessions, drawings good enough to file as permanent resources. Our vision was to use what was then an emerging technology, the Internet, to provide speech pathologists with resources from wherever they were working.



Toni Seiler



Some reflections. As a speech pathologist I've observed with interest the understanding that must develop in the process of designing software. We estimate that it took our group easily 2 years to achieve a comfortable "common language". Luckily we are all very good friends, and we weren't paying for our programmer's time!

The world of speech pathology is about as far away from "computer talk" as you could imagine. Rob had to grapple with our "non-rule based" games. Speech pathologists regularly modify tasks in a variety of ways to suit client performance. We make instant choices about vocabulary selection, and we may even have to adjust the goals of a task. The computer, on the other hand, must follow concrete, rule-based actions – it knows no subtlety. Rob had to absorb notions about the sorts of variables that a speech pathologist might want to consider. He also started to understand the varying nature of our clients. Many clients can't cope with such things as visual overload and excessive choice, or need off-screen prompting.

As speech pathologists we had to become more intimately aware of the nature of a computer – the positives and the negatives. One obvious limitation is that you "can't see" where your activities are. In the real world, if you can't find a particular game you can quickly search your bag or spot it on the shelf. But in the computer, it's filed away ... somewhere.

So, defining the structure of the program was the first step. Another example is a mathematical consideration. In many clinical activities we want items shuffled to prevent clients using rote recall. But do we want the computer to do true "random" presentation? True randomisation means that you may rarely or never see a particular item, or the same one might appear three times in a row – not what you want in therapy.

The computer has many positive aspects. It can instantly retrieve and present varied material, whereas a printed page will always present material in the same order and has to be laboriously reproduced. With the click of a mouse, you can move from one task to another. Feedback can be instantaneous and specific. In all, there is no "paper shuffle" in a therapy session and minimal need for carrying heavy resources when they're computerised. And of course "colour and movement" are much more easily achieved on a computer than in conventional paper-based materials.

The personal and professional outcomes have been wide ranging. My professional development has become more focused, and yet encompasses a wider range of topics, to enable current advances to be reflected in the software. In addition to the development (the fun part), I have had to become involved in packaging, marketing, sales and product support – the more down-to-earth aspects of producing software. And we've also become aware of the time it takes to turn an idea into a completed product.

And I have had some very interesting discussions about how computer software is best incorporated into clinical practice. Do we want "computer scores" to be the sole measure of progress, or do we value our ability to observe and interpret the other non-scorable facets of a client's response? Do we want the "computer to do it all", or is it better for skill development to happen within an interactive human language session? We need to refine the "common language" between software designers and speech pathologists. This will enable us to harness the positive aspects of computer software, while maintaining the unique understanding of client processing and interaction that speech pathology training gives us.

Toni Seiler completed a BSpTher at the University of Queensland in 1973, and an MSSpPath at Ithaca College, New York, USA in 1981. From 1975–84, Toni did a combination of travelling, having children, working and studying, in Canada, Malaysia, and the United States. She has worked in education departments, a centre for children with multiple and developmental delays, and adult rehabilitation settings. Toni currently has a private practice and develops software in Bairnsdale, Victoria.

UPDATE ON THE AUSTRALIAN APHASIA ASSOCIATION

Georgi Laney (National Chairperson) and Matthew Bradley (National Deputy Chairperson)

The Australian Aphasia Association Incorporated (AAA) was founded in 2000 by Professor Linda Worrall of the University of Queensland in collaboration with people with aphasia and family members (Linda's contribution has since been recognised through her appointment as the inaugural life member of the AAA). The AAA was formed in response to limited support offered to people with aphasia and the recognition that significant achievements could be made by working collectively.

It took some time before the AAA had a significant presence outside of Brisbane where its foundations lay. Indeed the logistics of consolidating an incorporated national entity (with respect to legal, financial and logistical considerations) is proving to be extremely challenging and time-consuming. Nevertheless, the AAA has made an invaluable contribution to the aphasia community and plans to continue to do so. This commitment is impressive because AAA has very limited financial resources (it receives no government funding and few donations) and the association's activities are undertaken by a relatively small number of volunteers.

Each year has witnessed an increase in membership numbers. As of 31 October 2007, the AAA has 320 members with members concentrated in Queensland, New South Wales and Victoria. We have also seen a steady increase in the number of hits to our website and enquiries, via our email and phone service.

In addition to producing *The Australian Aphasia Guide*, which you can read about in this issue of *ACQ*, the AAA has been involved in numerous other activities aimed at supporting people with aphasia and their families. Significant have been the AAA national conferences. There have now been a total of six national conferences which have grown from strength to strength. The conferences are held every two years – the next one, titled *Not Just A Phase Ya Go Through. Let's Talk about Aphasia!*, will be held in Brisbane on 29–30 September 2008. The conference will be held immediately prior to the Aphasiology Symposium of Australia, also to be held in Brisbane – an example of the Australian aphasia community working together.

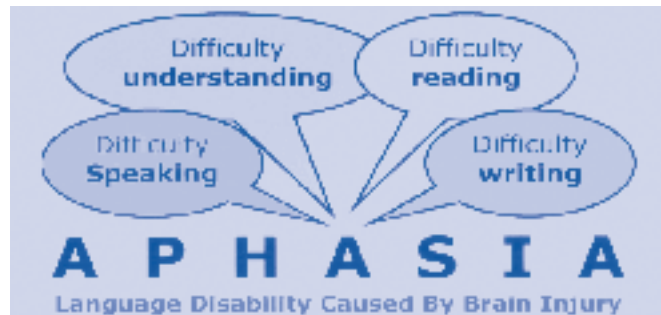
Significant too has been the development of an aphasia logo. Many within the aphasia community lament the lack of public awareness of the condition. The development of a colourful, simple logo allows the branding of aphasia in this fast-paced age where easily identifying a "product" is so important. The logo will form the basis of our advertising, public awareness and merchandising campaigns.

The Aphasia Link (the newsletter of the AAA) continues to be a forum for updating the aphasia community and is instrumental in fostering an "informed community". It is only when a community is informed that it can truly influence and affect change. Increasing numbers of contributions are coming

from a variety of people with aphasia who are sharing their experience and knowledge.

The AAA in collaboration with the Talkback Association For Aphasia Inc. (based in South Australia) has voted to establish an Australian Aphasia Awareness Day ("Wednesday Without Words"). It will be held on the first Wednesday of September each year, to be launched 3 September 2008. It will provide an opportunity to highlight aphasia and improve community awareness.

The AAA is striving to address the continuing challenges which confront it. Of importance is ensuring that the association meets the needs, and is inclusive, of people with aphasia (of all severity). This has proven difficult particularly at a national level where the complexities of legal, financial and logistical issues dominate discussion. We are seeing people with aphasia now becoming involved more locally. They are well represented on the 2008 National Conference Organising Committee and on the Victorian Branch of the AAA. The AAA is in the process of establishing an expert reference panel (of people with aphasia). This group will be consulted for their opinion on matters which will affect people with aphasia.



Another challenge is how the AAA can best work with other relevant organisations (such as the various state stroke associations, the Talkback Association) to maximise our effectiveness. This is not easy given our limited resources (both fiscal and human resources) but is necessary if the association is to make a significant contribution in supporting the Australian aphasia community.

Despite the challenges it faces, the AAA is determined to continue to support people with aphasia and their families by building on the achievements already made. If you would like to learn more about the AAA or if you are interested in becoming involved please contact us (contact details on our website www.aphasia.org.au).

Georgi Laney is the National Chairperson of the AAA and **Matthew Bradley** is the National Deputy Chairperson.

Visit www.speechpathologyaustralia.org.au



MY TOP 10 RESOURCES

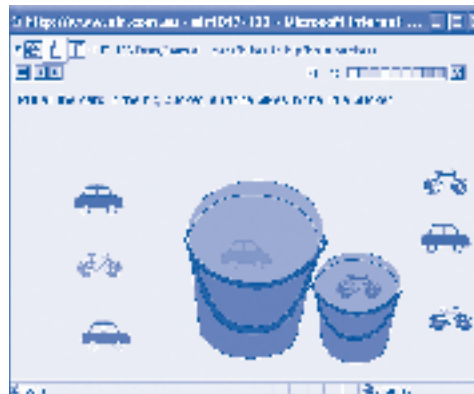
Bronwyn Macey

CanDo4Kids – Townsend House is a 133-year-old organisation based in Adelaide that supports South Australian children with sensory impairments. Launched in 2005 the speech pathology department is a quite recent addition to the services offered. It currently employs two full-time speech pathologists to provide services for children with hearing impairments, vision impairments and auditory processing disorder. Therapy resources can vary substantially between these different client groups depending on the severity of the impairment and, of course, age of the child. However, some resources are used across the board.

In 2006 I commenced a 3-year training regime to become certified as an auditory-verbal therapist. Since early 2007 my caseload has become entirely children with hearing impairments, predominantly under the age of 6 years, so while I have tried to provide a list of therapy resources that are used across the different impairment categories, my focus is on resources for hearing impairment therapy.

boards, and barrier games. The possibilities with this software are only limited by your imagination (and of course IT skills) (www.mayer-johnson.com).

3 eLr



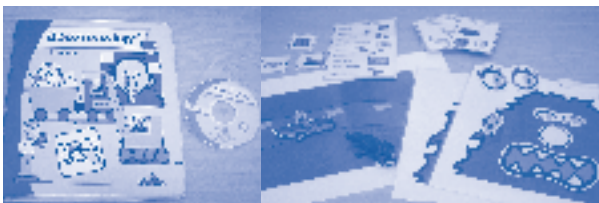
Another computer program, eLr (Extra-Language Resources) is an internet-based program clinicians can subscribe to; it provides access to a comprehensive assortment of on-screen activities for targeting different aspects of listening, speech and language. Although incorporation into a therapy sessions takes a little extra time and a laptop, the children are highly motivated to participate in these bright and colourful click and/or drag games. Again, the application of each game is restricted only by the clinician's creativity. A particular asset of having a subscription is the ability of the clinician to prescribe homework activities for the parent to practise with their child at home. With a home connection to the internet, parents can sign in as guests and access the particular activities selected by the therapist. These games also assist hand-eye coordination and the use of a mouse. We have had children as young as 3 years of age use these activities successfully (ELR Software Pty Ltd – www.elr.com.au).

1 People



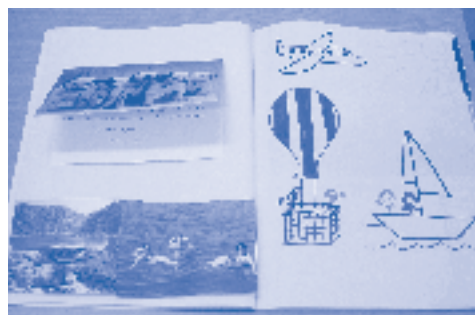
A whole family (including grandma and grandpa) of manipulable people is invaluable in my therapy. They are a great tool across the age span to begin with body parts, clothing, and verbs early on, and progress to pragmatic judgement and role-playing at school age. I really like little wooden people with wire bodies as they can be bent into great action postures.

2 Boardmaker



Boardmaker is a computer program produced by Mayer-Johnson which allows the clinician to tailor therapy resources for the client at the click of a few buttons. I use it to make simple games (with specifically selected vocabulary) such as bingo, memory and go fish, as well as schedule boards, nursery rhyme story

3 Experiences books (scrapbook)



I have integrated using experiences books into my therapy recently, which is brilliant for targeting discourse level language but is also great for embedding speech targets. The child is given a scrapbook in which they are required to draw pictures or paste photos or other items in order to help them recount an experience

they had in the time period since the last therapy session. Drawing is great but it's also exciting for the children to glue in movie ticket stubs, birthday cards, or sports day ribbons, etc. It is particularly good for targeting past tense language. It ensures a parent-child language activity is completed at home as I ask to see what they've been up to at the beginning of every session. Sometimes we draw what we've done for the therapy session so the child can go home and tell the other parent about it. I also have my own experiences book that I draw and glue pictures in to steer the child towards a certain therapy goal. For example, a picture of a visit to the beach can target beach vocabulary, irregular past tense verbs (swam, ran, rode, etc.), or even word initial /b/ or word final "ch". I have even had parents own an experiences book to help model past tense discourse. The children take great pride in their book (providing increased motivation) which they can share with extended family and friends.

5 Digital camera

A picture is worth a thousand words (and language structures) and children love to look at pictures of themselves. In fact, they seem to enjoy looking at photos of just about anything familiar from their plate and spoon, to their bedroom or even their favourite shoes. With digital camera technology children can now see the snapshot immediately after it has been taken, making the task of the photography itself a language activity in addition to the activities designed once the shots are in printed form. With parental permission, the pictures of a role-play activity of one child can make up the picture sequencing cards for another child.

6 Box of everyday objects (shoe, sock, cup, toothbrush, spoon, ball, hat etc.)

Working with little ones, a box of common objects is surprisingly useful for bringing everyday life into the therapy room. The items enable targeting of phrases related to everyday routines at the therapy table. Our therapy requires parental participation during the session and follow-up at home so theoretically all items inside must be found in any typical household.

7 Colourful, empty bags and boxes



From my auditory-verbal training, I found it is of utmost importance that auditory input always precedes the visual. Therefore on top of generating intrigue, cute and interesting boxes and bags make the presentation of a therapy item fun.

8 My singing voice

There is no such thing as too much singing for any child and this is especially true for children with a

sensory impairment. The fact that my singing voice is not high quality is actually an asset too. If my voice was world class my therapy partners, the parents, would never feel confident about using theirs. Even children with hearing impairments are drawn to the suprasegmentals of singing very early on in the development of audition and listening, so any singing, with or without actions or props should be exploited.

9 Wind-up toys



The array of wind-up toys available is enormous, from swimming Nemo fish and flipping monkeys, to a coin-stealing dog hiding inside his doghouse. Again highly motivating, these toys are handy for targeting tenses. Children can be required to predict what each toy might do, comment on what it is doing while in action, and then review exactly what each toy did. They are also great therapy savers to divert a child's attention if they become unsettled.

10 Orchard Games



While we only have a small collection of Orchard games, there is an enormous variety available, and the ones we do have get used very frequently. These colourful, interactive games are quite durable and very adaptable. Some examples are:

- Washing Machine: great for clothing vocabulary as well as wet/dry, clean/dirty, and in/out concepts. The cards can be used in conjunction with the machine or as snap or memory cards.
- Greedy Gorilla: This game is good for teaching manners as every time the gorilla burps (when you feed him a junk food card), everyone must say "Pardon" or "Excuse me." It is also great for food and drink vocabulary, categories (vegetables, dessert, drinks, fruit), and healthy versus unhealthy foods.
- Shopping List: This is a particular favourite. It can target food and shopping vocabulary but I have also used the Boardmaker software program to create shopping lists of items targeting a particular speech sound. Instead of shopping for toothpaste and apples we might go shopping for a sheep, a shell, a shoe and a shower (Orchard Toys – www.orchardtoys.com).

REVIEW OF THE AUSTRALIAN APHASIA GUIDE

Colin F. Cussen

***The Australian aphasia guide*, by Angela Berens together with Georgi Laney, Tanya Rose and Tami Howe; St Lucia, Qld: Australian Aphasia Association Inc.; 144 pages, \$20. Available from the Australian Aphasia Association Inc.**

I was asked to do this review last week! I've been worrying about it ever since. A bit like Angela who "won this challenge", as noted in beginning this work. I think that Angela's preface spells out the reasons for the book – "to promote aphasia at every chance I have and to help people like me who are living with aphasia" (p. 1).

Too often in life I have met many people who wonder why someone hasn't done something to solve a problem. When I have suggested that they might put their hand to the plough and get the solution moving, they shy clear with many and various reasons. But then, I have often found that if I begin to get things moving, I have had many respond by offering their assistance. Thus the work was still done – only more circuitously! That then gives others heart to see to solving problems. This might seem to be in a perfect world – because it sometimes doesn't happen!

So, we must express our thanks to Angela for initiating and, with the assistance of many others, getting it off the ground. That thanks comes from me also as a person who needed help as well.

On 30 November 2005 – just 20 months ago – I had a massive stroke.

I had had a shower and just dried myself as I was preparing to go to All Saints' Church, Wickham Tce in Brisbane to say the midday mass for the Feast of St Andrew. You see, I am a priest – Anglican brand – and had retired in April 2001.

Because of my good health I was of use in parishes. I had only been in hospital twice – the last time was 27 years before!

In my retirement my wife and I had moved into a townhouse in Stanley Tce, Toowong. On 29 June we eventually moved into a house in Taringa because of my wife's problems of walking up and down the staircase in the townhouse.

Five months after that shift I was stricken by a stroke and spent the next 12 weeks in St Andrew's Hospital. When I came out of hospital there was much intervention on the medical side to see that I was in a safe environment. I knew that no way in the world would I have been able to go back to a three-story townhouse. So, what we had done for my wife was actually done for me!

The whole cost of the hospitalisation plus the continuing rehabilitation after hospital were fully paid for (apart from \$250) by my health insurance. For years I couldn't see the benefit paying large sums of money for private insurance. Now I knew why!

So began many more months of continuing rehabilitation. My wife had been given time off from her teaching position from the end of November till mid-July 2006. It was fully paid leave which she had accumulated over many years. The benefit of being honest paid off!

I joined the University of Queensland's continuing research work, which made it possible to continue to improve my memory.

I have continued twice weekly going to the Wesley Hospital swimming pool for hydrotherapy. Very tiring but well worthwhile. Every day sees improvement in my well-being.

I had to learn to drive again – or, at least, go through training with RACQ. I don't drive everywhere. I had got used to being chauffeured! But also, realistically, I felt very unsure about driving. It's only now after 8 months that I have a measure of confidence in driving.

As a person who has gone through these experiences I found *The Australian Aphasia Guide* exceptionally informative, interesting and helpful.



Colin Cussen with his wife

The book is divided into 2 major divisions: the book itself has 8 chapters; and the service directory which is organised under 6 headings. Then there are 4 pages of symbols of common needs. The important thing about this book is that it is colour-coded. That is a great teaching method. Not only is the book colour-coded, but each chapter in itself is also colour-coded.

In the index, the page references for the chapters are numbered and colour-coded. One doesn't have to look for the chapters by numbers – you'll find them by their colours: cyan, orange, dark green, blue, purple, light green, etc.

What is aphasia?

If I had been asked on 30 November, 2005, I would have pleaded ignorance! *Now* it is a different story. I have much fun when people ask me what organisations I belong to or what I'm doing at UQ. 'Oh, I belong to an aphasiac group.' *A what?!!!*

So you can see there is still much work to do to educate people about aphasia.

This book has made a valuable start on this work. In case you the reader of this article don't know what aphasia is, here it is: "Aphasia is a language difficulty caused by injury to the brain. It affects communication: to understand words, to speak, to read, to spell, to write, to gesture and to use numbers" (p. 12).

As we are well aware, this may affect everyday communication, relationships and everyday living (p. 14). Aphasia affects different people in different ways. I know that – I had *twelve weeks* in hospital learning to communicate and walk again! *But* there is one consolation which will give the reader much hope – "Aphasia does not affect intelligence" (p. 14).

The rest of the initial chapter is devoted to extending and explaining meanings: What causes aphasia? What is a stroke? There are other terms that are associated with aphasia, e.g., dyspraxia, dysphasia, etc.

Then there are the multifarious questions (pp. 20–28) which arise:

- Can aphasia be cured?
- Can it be temporary?
- How long will recovery take?
- Why can't I find the words?
- Why do I swear now when I rarely did before my stroke?
- Why does the wrong word come out of my mouth?
- Why am I so tired?
- Why do the words make sense to me but not to others?
- Why can't I spell any more?
- Why do I repeat the same words?
- Why can I look at the time but can't tell the person what the time is?
- Why can't I remember names?
- Why have I lost my memory?

These are *real* questions asked by *real* people in the *real* world. I *know*! I can see myself going through most of those!

The rest of the chapters in the first section deal with important areas in the patient's life.

- Chapter 2 – How does aphasia alter lives?
- Chapter 3 – Speech therapists and the Australian Aphasia Association (AAA)
- Chapter 4 – Caring for people with aphasia and how it affects families
- Chapter 5 – What helps people with aphasia to communicate and participate in everyday life
- Chapter 6 – Other services of help
- Chapter 7 – Financial support and return to work
- Chapter 8 – Driving and transport

Some of these are longer than others and a couple are reasonably short – for instance, chapter 2 is 15 pages long, while chapters 7 and 8 are each five pages. Irrespective of length, each chapter is vitally important.

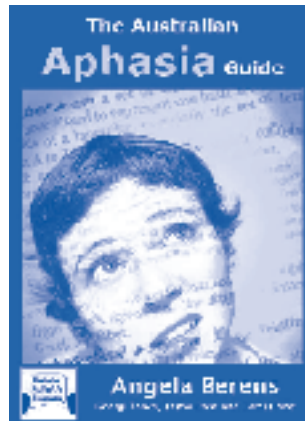
From a male perspective I felt totally deprived when I could not drive, let alone being allowed to! So, for me chapter 8 made wonderful reading – what the law says and how I can get permission to drive. To make the matter worse, I turned 75 and so the driving law came into play where before you turn 75, you have to have a medical certificate! I got my driver's licence (except motor bike!) back in September 2006.

That provided legal driving and the beginning of rebuilding self-confidence.

Let us look at chapter 5

As an example, let us look at chapter 5. This chapter, which I found particularly interesting, deals with that important part of ordinary life – *how* do I live my life *if* I can't communicate?

What helps people with aphasia to communicate and participate in everyday life?



Angela Berens

I *know* this problem, having gone from a person who spoke unintelligible English to a person who could make intelligible sounds and then to a person who *knew* what he wanted to say, but had to find more circuitous ways of saying it. I still have a problem remembering who some people are. *How blest are people who have a wife! Or husband, or someone who loves them.*

Chapter 5 is divided into 3 sections:

- strategies for the person with aphasia
- strategies for other people
- tips for communicating with the person with aphasia.

I personally recognise *now* some of these strategies. Yesterday, when talking to the lady next door as I was watering for 20 minutes, I could not remember the names of shrubs which I am saving in the drought. As I write this, it dawns on me that I have to ask my wife! Will do when she gets home!

Each of these strategies is spelt out, illustrated by words from real people. I am not afraid to tell people I can't remember. HELP!! All it requires of me is to recognise my need – and tell people!

There are important strategies for those who are the recipients of the conversation – all summed up by an old Latin tag, *festina lente* (hasten slowly)!

The last 2 pages of the chapter deal summarily with Do's and Don'ts. I think these are common suggestions, but still are useful.

Part 2 of the book

I noted early in this review that there were 2 parts in this book. The second part consists of 39 pages. Why is this section so important? It contains:

- definitions of professional words
- details on reference books
- state and inter-state contacts, containing *all* media links including websites and email addresses
- listings of worldwide information centres in Great Britain, USA, and Canada
- lists of statewide centres for aged care and for carer services.

Wherever you may live, particularly if you live in the country, there are 1800 numbers. Use these to give you a beginning point. All *you* have to do is get in touch!

Conclusion

I think that all who have access to this book will recognise that Angela has discovered that "living with aphasia has been the *hardest thing* I have ever had to deal with" and "though I accepted my circumstances, I am still *finding new challenges* to help me improve" (p. 97). How true those words are! How true that "when I take one step back, I know that in the near future I will make two steps forward."

For me I have taken on light work. Last Sunday I said two masses and preached a sermon which my wife said was more than passable! But then having read the words for a friend in chapter 5, I wonder was she just being positive! She says, No!

It has always been my philosophy of life – as it also was Angela's – not to worry about the past. We learn from that in order to apply it to today and tomorrow.

Lastly, I end with thanks to my wife, Deirdre, and my children, Paul, Philip, Catherine and Michael, and their families for their love and for being there to help Deirdre during my initial illness and continuing life towards recovery.

God bless you all!

Correspondence to:

Colin Cussen

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A CONSUMER SPEAKS

Steve Pape

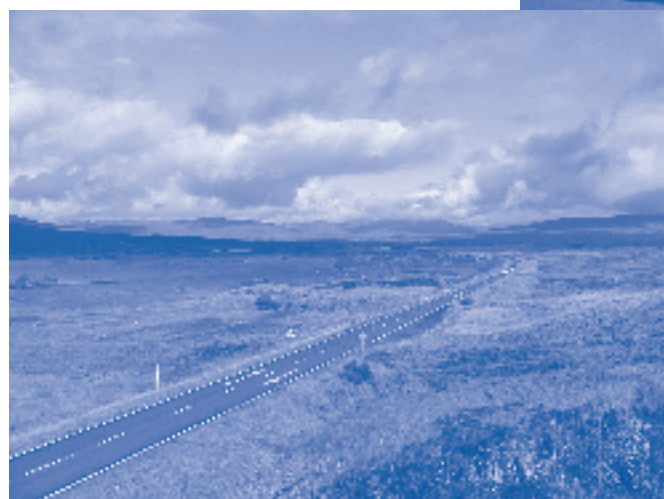
I awoke from my coma after several weeks in hospital; I remember thinking to myself, what on earth was I doing here.

I was on a motorbiking holiday in Scotland when I lost control and crashed. I had died on the roadside as a result of my injuries. Luckily for me, I was in a group other riders, some of whom were off duty policemen and in the first car to happen upon the crash was a nurse on her way to work. When the ambulance arrived and I was stabilised, I was taken to the nearest hospital specialising in neurological injuries, which was Ninewells Hospital in Dundee, 45 miles away.

I had broken only my ankle on the initial impact and the rest of my injuries were related to being thrown around like a rag doll. My helmet was shattered like an eggshell and this gave the doctors their biggest worry – it was obvious that I had sustained a head injury.

My accident and coma had taken me back to zero; I was like a newborn baby in an adult's body. I had thirty years of life experience ahead of me to relearn.

Physically, my recovery was progressing very well and all my body needed was time to heal itself. Mentally, my problems were only just beginning and I realised that there would



be many problems ahead. People think I'm joking when I tell them how badly damaged I was, but because there are no bandages or physical disabilities people assumed I was fully recovered.

Because of the head injury I had sustained, speech therapy was included as part of my rehabilitation program. The speech therapy was teaching me how to regain control of all the different systems used for speech, with various breathing and oro-facial exercises I was progressing well with my speech. I left hospital with a slight speech problem, so Carol (my wife) and I made some outpatient appointments to continue with the speech therapy. It was at home, away from hospital that I realised how much of a problem I still had. In hospital, the

doctors and nurses are used to dealing with head injuries and speech problems, but out in the big wide world it's a totally different story. Carol and I had a long journey ahead of us, I still couldn't control my tone of voice very well and I still needed to work on my breathing. Every day with Carol's help, I performed my exercises to build up my lungs and throat, and to control my tone of voice. I had to mentally force myself to listen to what I was saying and how I was speaking, and if it didn't sound right to me then I would correct myself to make it sound correct. I spoke to people in the manner and tone of voice that I would like to be talked to; this was the rule I made for myself to follow when speaking. Talking to old age pensioners helped, because for them to understand me I had to enunciate clearly; this helped tremendously with controlling my voice and tone.

My speech was progressing well until I started work. As I mentioned earlier, because there were no visible injuries or bandages people assumed I was fully recovered. What people couldn't understand is that my brain was still damaged and working hard to heal itself. In hospital and at home I didn't have to think about much – the biggest decision I had to make was what to have for lunch, so I didn't have to strain myself or do any hard thinking. In the months before I went back to work both Carol and I thought that I was doing remarkable well with my recovery. Physically, I was back to normal because I'd been exercising daily and mentally. I was coping well with

my day-to-day life, but what we couldn't foresee was that for the several months I only had to think about what to watch on TV and what to have for lunch.

In the work environment, it was totally different, and having to make decisions that had consequences put a great strain on me. Within a couple of hours each day my head started to feel like it was filling up with cotton wool. Tiredness became a problem. When I was tired, I became short-tempered and communicating became even more difficult. This really affected my speech: because I was thinking so hard on my work, it felt like I had no more brain capacity to use for speech, so communicating with my work colleagues really became a problem.

It was at this point that my work colleagues and I started to see things differently. I wasn't aware that my brain still



needed a great amount of time to recover from the crash. With me concentrating so hard on work, my speech started to suffer, and the worse my speech became the more difficult it was for me to communicate with my work colleagues, and I was becoming the focus of everyone's attention. Whenever I slurred my words or had problems speaking to my work colleagues, I was immediately made fun of and called names. I was becoming known as the 'The gibbering idiot'. As you can imagine, with these types of comments from my work colleagues, my confidence took a nose-dive and quickly hit rock bottom. This type of attention went on for several months, and it resulted in me developing a slight stutter and I also started to have problems finding the right words in my head to use when speaking. I had to get the words right in my head first before I spoke, or a load of rubbish would pour out without making any sense. My problems at work were rapidly having an effect on Carol and me. The more my work colleagues focused on me to make fun of, the worse my problems became with my speech, and unfortunately I started to take my frustrations out on Carol. Carol had been by my side from the moment she arrived at the hospital only hours after I was admitted to hospital. I knew she didn't deserve this type of behaviour so we both sat down one night and discussed our next move with my recovery. We both agreed that a lot of my problems were down [due?] to my lack of confidence and my work environment. At work I was reminded every day that I had a speech problem and as you can imagine this didn't help me at all.

I needed to change my working environment, and the only decisive way to do this was to seek out new employment. It was a very hard decision to make; I had loved my job, and had worked very hard to become a studio manager. With resentment from both my colleagues and me, I knew that there was no future for me where I was. Making the decision to leave and find a new job was difficult enough because at this moment in time I had no confidence in myself at all, although I had a strong sense of the person I was before the crash, and I wanted to be that person again. Starting a new job with a new work environment was one of the best things that ever happened to me. The change in my personality was almost instant, and my new work colleagues accepted me for who I was. I could just be myself and not feel like I had to live up to people's expectations. My confidence in myself was growing and my speech and control of my tone of voice improved rapidly. Although to this day I still have some small problems, these problems are so small that they aren't even noticeable to most people. Unfortunately, I'm just too hard on myself and I notice that I still have problems.

There tends to be a misconception that life after a brain injury is all doom and gloom. I must admit that the first year after the accident was really difficult although we received a lot of support from the various therapists at the rehab unit and from Headway, the organisation supporting brain injury sufferers and their families. I also wrote *Stepped Off* – a book about my journey back to health, accompanied with a website (<http://www.steppedoff.co.uk>). The aim is to help others going through a similar experience, although no two accidents and no two brain injuries are the same.



BOOK REVIEWS

Berens, A., Laney, G., Rose, T., & Howe, T. (2006). *The Australian aphasia guide*. St Lucia, Qld: Australian Aphasia Association Inc.; no ISBN, 144 pages, \$20. Available from the Australian Aphasia Association Inc.

Deborah Hersh

It is abundantly clear to anyone reading this book that it has been written from the heart, a "labour of love" according Georgi Laney in her introduction. The first author, Angela Berens, writes from the perspective of someone living with aphasia following a burst aneurysm at the age of 27. She, like many other people with aphasia, had little information in her early days post-stroke and little guidance in finding out what supports were available to her and her family. These experiences contributed to her drive to be completely involved in the production of this book, the first comprehensive Australian information book on aphasia written for people with aphasia, as well as their families, friends, carers and those with whom they are in contact in the community. Most notably, this book is carefully presented to be "aphasia-friendly", to be accessible to people with aphasia. Its third and fourth authors, Tanya Rose and Tami Howe, have researched and published on accessibility, particularly in relation to written information and their contribution is apparent (Worrall et al., 2007). Each of the eight chapters plus the additional sections (references, service directory and communication charts) are colour-coded, including colour strips down the sides of the pages, for easy access. The print is clear and larger than usual, and key words and phrases are emboldened. Certain sections are boxed, some information is listed using bullet points and there are relevant pictures, photographs and symbols used throughout. The writing style is clear, uses short sentences, and there is conscious use of paragraphs and clear space to make most pages reasonably easy on the eye.

The eight chapters explain what aphasia is, how it affects people's lives, what speech therapy and the AAA have to offer, the impact of aphasia on families and carers, strategies to assist communication, other sources of help, financial support and return to work, and finally driving and transport. Not only do these chapters include sensible, clear information, but they also are interspersed with quotes from people with aphasia which give the advice a very personal touch. The service directory is useful, not only including contact details for Australian aphasia supports and Speech Pathology Australia contacts, but also listing international websites of interest, national aged care and carer contacts, communication aids and assistive technology contacts, independent living centres, stroke and brain injury supports and transport information.

Aphasia is such an isolating and disempowering condition and a lack of accessible information simply compounds the problems that people face in coping with it. No one book can ever please every reader entirely – one gentleman with aphasia complained to me that it would not fit in his pocket! But this book is proving very popular and obviously fills a need. Ideally it (and indeed, membership of the AAA) should be actively promoted by speech pathologists for each person they meet with aphasia. This book should answer many of the questions that people with aphasia, and those touched by it,

have. It should also help address their isolation, as Angela Berens writes in her conclusion: "it is reassuring that you are not alone" (p. 98). I hope it continues to be circulated widely and offered as a standard resource.

Reference

Worrall, L., Rose, T., Howe, T., McKenna, K., & Hickson, L. (2007). Developing an evidence-base for accessibility for people with aphasia. *Aphasiology*, 21, 124–136.

Forsyth, Kate (author) & Street, Rosalie (illustrator). (2007) *I am*. Sydney: Macmillan Australia; ISBN 978 14050 38096 6; 24 pages (hbk), \$19.95.

Simone Lees



I am, by author Kate Forsyth and illustrator Rosalie Street, is a story about Tim, who is 4¾ years old, and likes to do many interesting and imaginative things each day including swimming like a hammerhead shark, playing knights and making magic potions out of his mum's shampoo!

Kate wrote the story for her 4-year-old son, who was struggling to use correct pronouns, in particular "I". The book provides various "I" phrases throughout the story, including "I like", "I love", "I can", as well as "I am" and "I'm". The book is being sold as an "excellent guide for parents to help their children overcome the difficulty of using pronouns".

The story is lyrical and flows well when read aloud. There are no repetitive phrases or rhyming passages though, so young "readers" would find anticipating the text difficult, at least initially. The vocabulary and phrasing is also advanced in parts, given the intended audience of 3–5 year olds, with phrases such as "wallowing hippo", "blows bubbles on her feet", "with swords drawn" and "claps her hands with glee" featuring within the more straightforward text. These provide excellent language enrichment opportunities, but perhaps detract from the main purpose of the book.

The illustrations by artist Rosalie Street are delightful. They are brightly coloured and have plenty of detail. Unfortunately, the illustrations do not consistently link to the more advanced vocabulary and descriptions presented in the text, which makes teaching words such as "spider monkey" and "snail slime" more difficult. The illustrations do, however, provide a solid source of material for discussion and language stimulation more generally.

The book would be a useful tool to provide "bombardment" of the pronoun "I", and certainly the illustrations lend themselves to discussion about what "I like", "I can do", and "I think". For a RRP of \$19.95, the book would be a handy resource to lend to parents of children who are struggling to acquire this pronoun and need some extra exposure, using the natural context of joint book reading.

De La Bedoyere, C. & Lowry, C. (2007). *School start. Programmes for language and sound awareness.* Brackley, UK: Speechmark. £33.99 / US\$61.25.

Chryssie Heine

Although originally based on work by SLPs, this resource is primarily aimed at school staff, specifically teachers, school aids/teaching assistants working with 4–5-year-old children. It consists of 4 parts: an introduction, group session sheets, resource templates and program delivery templates.

The book begins with an 11-page introduction which provides information regarding a proposed timeline for the program, how the group sessions should be run, the possible team members involved in the delivery of the program, brief details regarding the implementation of the program (including meetings, the use of checklist and the need for evaluation) and software requirements for use of the CD-ROM.

Part 2 is an extensive compilation of group session sheets targeting language (30 sessions are provided) and sound awareness (30 sessions are provided). Each sheet outlines the learning objectives, activities to be completed and resources to be used. Spaces are available for noting children's progress.

An example of a plan for a group session is:

- Learning objective (four are provided), e.g., To work as part of a group, taking turns and sharing.
- Activities (four are provided), e.g., A toy is passed around the circle. When the bell rings, whoever is holding the toy says his name.
- Resources: A number of options are provided, e.g. Toy such as teddy, doll or puppet.

Part 3 contains the resource templates which are selected weekly, to correspond to the resources identified in the target week. Resource templates vary and include:

- Pictures (e.g., for week 1, eight pictures of everyday objects are provided)
- Yes/No cut-outs
- Filling in the missing part (e.g., for week 18, the resource is the outline of a boy)
- Sentence lists (e.g., for week 19, a two word sentence is 'He jumped')

Templates are large black and white, easily identifiable, pictures and/or written words or sentences.

Part 4 contains the program delivery templates which include checklists, tips for conducting the programs and teacher handouts.

For SLPs, this program would be a valuable, quick resource to use as an adjunct to therapy or as a program to recommend for teachers to use to promote children's language and sound awareness skills.

On the practical side, this program is spiral bound with a soft attractive cover. A CD-ROM is provided to aid replication.

Overall, this resource is easy to use, provides valuable instruction material for 4–5-year-olds, is well structured and well presented.

Love, E., & Reilly, S. (2006). *Story talk: An oral story telling kit.* Camberwell, Vic.: Speech and Language Products. \$49.50 (including GST).

Ruth Nicholls and Jemma Skeat

Story Talk is designed to promote oral narrative skills, including knowledge and use of story grammar, planning and sequencing, understanding of causality and vocabulary. The kit (which comes in a carry case) includes some magnetic shapes, brief instructions and two figurines ('Smiley', a character to be used in stories, and 'Story Star', a soft toy to support turn-taking). There is also a CD containing an electronic manual (PDF of 77 pages), which includes instructions, activities, story starters, black-line masters, awards, prompt cards and photographs.

Story Talk would be suitable for use with junior and middle primary school age children. For older primary school or early secondary school students, some elements of the kit could be utilised with modification (e.g., exclusion of the figurines). Although designed to promote oral storytelling, this kit may also be useful to support the development of written narrative skills with older primary school children. The CD includes a variety of activity ideas suitable for working with individuals or small groups. The various elements (e.g., figurines, magnetic shapes and pictures) support multiple learning styles.

Our impression was that this resource requires careful thought and time to prepare, prior to use. In order to select appropriate activities and materials, clinicians need to read through the lengthy electronic manual, which we found difficult to navigate on the computer screen. Other materials, such as the magnetic shapes (to support story sequence/grammar), would require pre-teaching in order for children to understand what each shape represents.

The pictures provided on the CD are in colour and lose some detail if printed in black and white. We also wondered how much of a story some of the pictures would trigger (e.g., notice board, ATM, choosing an electrical cord). We were not particularly taken with the 'Smiley' figurine although young children may find 'Smiley' more engaging than we did.

Story Talk brings together various elements to support oral storytelling such as pictures, activity ideas and 'characters' and may provide fresh ideas for those who work in this area. However, many of the elements are available in other resources and *Story Talk* may not provide anything new for some clinicians. While the kit is not expensive at \$49.50, clinicians may need to factor in the costs of printing the manual and colour pictures.

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