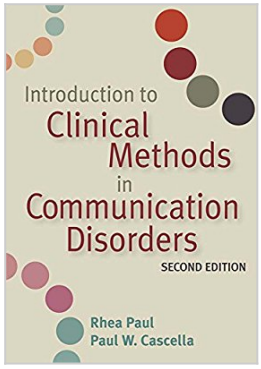

Introduction to Clinical Methods in Communication Disorders

From Paul H. Brookes Publishing Co

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This is the second edition of Introduction to Clinical Methods in Communication Disorders which originally published in 2002. Like the first edition, this textbook guides SLPs through the entire clinical experience, including the process of assessment using a variety of instruments, sampling of communicative behaviors, and planning and implementing interventions. The chapters provide introductory and background information and also address current issues such as multiculturalism and technological advances. The book discusses a wide range of clinical approaches (pull out, consultation, collaboration) in a variety of settings (hospitals, schools, etc.) and shows how they apply across communication disorders. Based on standards mandated by ASHA, this second edition serves as an essential start to mastering the science and art of clinical practice.

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Editorial Review

Review
I will be using the second edition of the Paul book this fall. I'm very pleased that this edition contained the chapter on EBP, as I had to supplement it last year with information from other sources. --Department of Special Education & Communication Disorders, Bridgewater State College

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About the Author
Rhea Paul, Ph.D., received her bachelors degree from Brandeis University in Waltham, Massachusetts, in 1971, her masters degree from Harvard Graduate School of Education in 1975, and her doctorate in communication disorders from the University of Wisconsin-Madison in 1981. Dr. Paul has published more than 60 journal articles and has authored six books. Her research on language development in toddlers with delayed language acquisition was funded by the National Institutes of Health. She has also held grants from the Meyer Memorial Trust, the American Speech-Language-Hearing Association (ASHA) Foundation, the Medical Research Foundation, and the National Association for Autism Research. Dr. Paul has been a fellow of ASHA since 1991 and received the 1996 Editors Award from the American Journal of Speech-Language Pathology. In September 1997, she accepted a joint appointment in the Communication Disorders Department at Southern Connecticut State University and the Child Study Center at Yale University. She spent the summer of 1998 as a visiting professor at the University of Sydney in Australia. Dr. Paul received a Yale Mellon Fellowship for 1998-1999 and the Southern Connecticut State University Faculty Scholar Award for 1999. She was recently awarded an Erskine Fellowship to spend a semester as a visiting scholar at Canterbury University in Christchurch, New Zealand. The second edition of her textbook, Language Disorders from Infancy Through Adolescence: Assessment and Intervention, was published in 2001 by Mosby in St. Louis, Missouri. Dr. Paul has been teaching child language development and disorders courses for 20 years.

Excerpted from Chapter 3 of *Introduction to Clinical Methods in Communication Disorders, Second Edition*, edited by by Rhea Paul, Ph.D., & Paul W. Cascella, Ph.D.

Case Example 1

Darrell is 4 years, 6 months old, but his speech is more like that of a much younger child. His parents report

that he is very difficult to understand and they feel that he is becoming frustrated when he cannot make himself clear. They want him to improve his speech before he begins kindergarten next year.

Case Example 2

Jonah is a 7–year–old and has a severe bilateral sensorineural hearing loss. He uses behind&#ndash;the–ear hearing aids at home and an auditory trainer at school. His school district has referred him for reevaluation of his hearing, speech, and language and to determine whether his amplification equipment continues to be appropriate for him.

Case Example 3

Anna is a seventh–grade student with significant learning disabilities. She received speech and language therapy when she was younger but was dismissed from services in third grade. Although she receives special education assistance with reading and math, her current teacher believes that she needs more help and wonders whether language therapy would be beneficial at this time.

Case Example 4

Marlene is a 50–year–old woman who has had significant difficulty with communication since her stroke 8 months ago. She received speech and language therapy only for a short time, and her family would like her to pursue more therapy now. They believe that she could continue to make improvements in her ability to communicate if she has the appropriate help.

Case Example 5

Richard, 62 years old, recently underwent a total laryngectomy. He would like to learn to use esophageal speech.

Case Example 6

Thomas is a 27–year–old with a history of severe stuttering. He feels that his speech disorder is interfering with his ability to advance in his career.

The six individuals described previously all appear to have a communication disorder, but they have little else in common. You have been asked to evaluate and make recommendations for these individuals. How will you provide an appropriate assessment for each of these potential clients given the large differences in their problems and the varied assessment protocols that will be necessary to complete the task competently? These examples are provided not to overwhelm the beginning clinician, but to illustrate the breadth of the field of communication disorders. As different as the clients described previously may seem, they are but a sample of the variety of ages, functional levels, and types of disorders to which you will be exposed during training and later in practice. How is it possible to competently assess such a range of problems?

Despite the fact that the needs of these clients are indeed diverse, as are the assessment instruments you will use, there are some general principles that apply. This chapter introduces you to these general principles that guide the process of assessing any communication disorder and provides examples of assessment tools for a variety of communication disorders.

When you hear the word assessment, you may think of testing, but the two terms are not really the same. Testing is only one part of assessment. **Assessment** is the process of collecting and interpreting relevant data for clinical decisionmaking. The process includes a series of problem–solving activities to assist in making decisions that will result in effective management and intervention for clients with communication disorders. In this chapter, the terms **diagnostic, evaluation,** and assessment are used interchangeably to denote the

problemsolving and descriptive process.

Various approaches to assessment in communication disorders have been described in the literature. One approach, derived from the medical model, makes a distinction between **appraisal** and **diagnosis** (e.g., Darley, 1991; Peterson & Marquardt, 1994). Appraisal is seen as the collection of both quantitative and qualitative data about the client. Diagnosis involves interpretation of these data in order to decide whether a problem exists and then differentiating the problem from other similar problems (i.e., **differential diagnosis**). In a medical model, emphasis is also put on identification of possible causes (i.e., **etiology**) and maintaining factors. Another approach is what Miller (1978) and Paul (2001) described as a **descriptive–developmental model** of assessment. In this orientation, the two phases are less distinct. Emphasis is placed on description of the client's present communication behaviors rather than on causal factors or categorization of the disorder. Tomblin (2000) also described a **systems model** of assessment. This model stresses the importance of the family and the cultural context in which the client must function. In this model, there is much emphasis on including the client's significant others in the assessment process to get information about the dynamics of the communication problem. There is a great deal of overlap among the various approaches, and there is no one correct model. For example, use of the descriptive–developmental model certainly does not preclude family involvement or consideration of the client's cultural background. It is more a question of relative emphasis. The specific model (or combination of models) to be used will depend on the philosophical orientation of the clinician, the setting, and the type of communication problem demonstrated by the client. For example, clinicians who work in medical settings may be more likely than other clinicians to perform assessments that fit the appraisal and diagnosis model. Clinicians who work primarily in educational settings may find the descriptivedevelopmental approach more useful.

No matter which setting you work in, you will be involved with professionals from other disciplines. Teaming and collaboration among professionals is recognized as the best practice for meeting the needs of clients with a variety of disabilities. Various models of teaming are used in the assessment process, including **multidisciplinary, interdisciplinary,** and **transdisciplinary.** Regardless of the model used, remember that the client and the family are partners in the assessment process; that is, they are critical team members.

Before we can proceed further, several concepts that are important to the diagnostic process must be discussed. The World Health Organization (WHO) has developed a framework for considering health and disability through the International Classification of Functioning, Disability and Health (ICF; WHO, 2001). In ICF, disability and functioning are viewed as outcomes of interactions between health conditions (disorders, diseases, injuries) and contextual factors. Contextual factors include environmental factors (e.g., architectural barriers, social attitudes) as well as personal factors (e.g., age, education, profession). These factors and their interaction influence how the individual experiences a disability. In this framework, functioning is identified at three levels: at the level of the body or body part, at the level of the whole person, and at the level of the whole person in a social context. Disability involves a dysfunction at one or more of these same three levels: **impairments** are problems in body function or structure (such as aphasia following a stroke); **activity limitations** are difficulties experienced by an individual in executing one or more activities (such as difficulty producing speech); and **participation restrictions** are problems an individual may experience in involvement in life situations (such as the inability to converse with family). Although it may seem that we should be able to infer activity limitations and participation restrictions from a known impairment, this is not always the case. This can be illustrated in the case example of Richard, the man who underwent a total laryngectomy. Consider two different scenarios: first, that Richard is a computer programmer by profession, and second, that Richard is a trial attorney by profession. Although Richard's obvious activity limitation (inability to communicate by using speech), which is secondary to the impairment (laryngectomy resulting in a structural change to the body), is the same in both cases, the degree of participation restriction relative to his career may be quite different. In the first scenario, Richard may very well be able to continue his career with minor adaptations and compensations. Resuming his career in the

second scenario might be more difficult and would most likely require major adaptation and compensation. Knowledge of the impairment is important in describing prognosis and determining an optimal intervention strategy. In Richard's case we know that, barring other medical problems, his status should be stable, and we make prognostic statements and intervention recommendations based on that knowledge. In other cases, with individuals who have neurological impairments known to be degenerative, it is equally important to be familiar with the associated symptoms in order to make appropriate prognostic statements and intervention recommendations. Thus, these issues of disability and functioning must be considered in a comprehensive assessment.

As you develop your clinical skills, keep in mind that assessment, like all types of clinical decision–making, should be undertaken with an evidence–based orientation. The American Speech–Language–Hearing Association (ASHA) has affirmed the importance of **evidence–based practice (EBP),** in which speechlanguage pathologists (SLPs) and audiologists use current high quality researchbased evidence in concert with clinician expertise and client preferences and values to make decisions (ASHA, 2005) (see Chapter 7 for a more in–depth discussion.). By applying EBP criteria, you will be able to choose maximally informative and cost–effective assessment protocols, form valid interpretations from the results, and make meaningful recommendations for treatment.

PURPOSES OF ASSESSMENT

Assessments are completed for various purposes. Understanding the purpose or goal of the assessment is important because it will affect the types of instruments and protocols chosen. The most common reasons for assessment described in this chapter are based on the works of Miller (1978, 1983) and Paul (2001).

Screening

Screening involves the collection of data to decide whether there is a strong likelihood that an individual does or does not have a problem that will require more in–depth assessment. Screening has its roots in medical practices used to identify those who are at risk for a particular disease or disorder (Salvia & Ysseldyke, 1998). Rather than yielding scores, screening results are generally described *as pass* or *fail* based on a predetermined **cut–off score.** A fail will typically result in a referral for more intensive follow–up assessment. You may be familiar with some common uses of screening. Most school districts screen children before they enter kindergarten in a number of areas including speech, language, readiness skills, hearing, and vision. Children who fail one or more of these screenings are referred for further evaluation. Another example is universal newborn hearing screening, now required by 38 states. Examples of frequently used screening procedures in communication disorders are provided in Table 3.1. As Paul (2001) pointed out, it is not always necessary to use a test published as a screening instrument. Any standardized test that samples the relevant areas efficiently and meets certain psychometric criteria can be used.

Screening is also an important component of comprehensive communication assessments. In addition to addressing the presenting concerns, it is important to screen other aspects of speech, language, and communication as well as selected collateral areas. You will see how screening procedures are included into the assessment of Darrell, the 4–year–old whose speech sounds immature. Most likely, you will decide to assess articulation and language skills in depth using several different instruments, both formal and informal. You will also need to screen other areas, however, such as fluency, voice, hearing, and the oral mechanism in order to determine the possibility that a problem in these areas is also contributing to the concerns that Darrell's parents have described. In addition, you may need to get information about related areas such as play and cognitive skills. These areas will be discussed in more detail later in the chapter. If the examiner suspects any problems in these areas, more in–depth evaluation should follow.

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