

**SPEECH-LANGUAGE THERAPISTS' NEGOTIATION OF  
COMMUNICATION DURING CLINICAL ENGAGEMENT**

**Urisha Naidoo**

Student number: 200304137

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University of KwaZulu-Natal

**Supervisors:**

**Professor Michael Samuel**

**Professor Mershen Pillay**

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## ABSTRACT

Globally, speech-language therapists share similar practice issues with other healthcare professionals with regard to responding to the changing healthcare landscape and the changing nature of practice. In the profession, the speech-language therapist uses his or her communication to facilitate the improvement of his or her client's impaired communication. The therapist further seeks to enhance communication in the delivery of care. Therefore, communication is the core skill that is central to the work of a speech-language therapist. The temporary lens of the study focussed on facilitating an understanding of competences, a discussion on communication as a core and soft skill in the profession, communicative competence in academe and the world of work, as well as theories on communication and competency development. My study explored the participants' experiences of negotiating their communication during clinical engagement. An interpretivist paradigm informed the choice of a case study research methodology. Semi-structured interviews and observations of the participants in practice were conducted. As the speech-language therapists recollected encounters of using communication in their interventions with their clients and their families, their stories were tinged with relived emotions and with reflections on particular events or people. Thus, narrative analysis was conducted to represent and analyse the data. The production of the narratives constituted the first level of analysis. The participants were invited to go through the narratives, and to provide suggestions to reflect their stories better. Although there were unique characteristics to each participant's story, similar nuances resonated through the data set. The data was analysed through a grounded and inductive approach. In the second level of analysis, using cross-case comparison, six factors influencing communication were identified in the eight narratives. Through thematic analysis, the following themes were identified: productive remembering of educational experience, problematising clinical engagement, undervaluing of speech-language therapy, searching for certainty, and moving to comfort. Further to this, antithetical cases (as the atypical cases) were used to validate the initial findings. The thesis of this study was named: The diamond framework: Curriculum of resilience to deal with matters of the 'cut', the 'carat', the 'colour' and the 'clarity' to explore the notion of negotiating communication in clinical practice. Referring to the evaluation of a diamond, these four constructs were considered a metaphor to develop the thesis framework:

- The 'cut' is representative of the 'professional-self': the outward portrayal and usually the first aspect noticeable to others.
- The 'carat' refers to the 'context of practice': the pragmatic space within which the practitioner operates in a social setting.
- The 'colour' refers to the 'affective factors' of the professional self, which refer to unique characteristics of the individual in his or her personal practice.
- The 'clarity' refers to the elements of the personal self, which refers to inner qualities, such as the ability to refract and displace light and engage agentic resources to shine.

This study found that the professional, the contextual, the personal and the affective selves co-influence the negotiation of communication strategies. While looking to the reconceptualisation of the curriculum to inculcate the personal and affective selves of future students in the professional education for specific contextual spaces, there has to be cognisance of the strong hegemonic forces of the profession that are still dominant. Therefore, the ethos of the professional education of speech-language

therapists needs to revisit these ideals and practices of both the profession and the higher education institutions engaged in developing and regulating future professionals.

*Key words:* communication, speech-language therapy, graduate competence, narrative analysis, professional education

## DECLARATION

I, Urisha Naidoo, declare that

1. The research reported in this thesis, except where otherwise indicated, is my original research.
2. This thesis has not been submitted for any degree or examination at any other university.
3. This thesis does not contain other persons' data, pictures, graphs or other information, unless specifically acknowledged as being sourced from other persons.
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6. Please see the Turnitin report (Appendix U).

Signed



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## **DEDICATION**

To my daughter, Surina

Dearest Surina, I hope that this thesis is a source of inspiration for you as you have been an inspiration for me. You make me believe in love, spirituality and the good that there is in this world. I hope that this piece of work helps you believe that whatever your mind can conceive, you can achieve. I love you, now and forever.

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## List of abbreviations

ADHD	attention-deficit hyperactivity disorder
CanMEDS	Canadian Medical Education Directions for Specialists
CAT	communication accommodation theory
CPD	continuing professional development
DOE	Department of Education
DOH	Department of Health
HPCSA	Health Professions Council of South Africa
OT	occupational therapist
NQF	National Qualifications Framework
SAQA	South African Qualifications Authority
SLT	speech-language therapist
APA	American psychological association
ASHA	American-Speech-Language-Hearing Association
CBR	community Based Rehabilitation
CEO	chief Executive Officer
CHC	community health clinic
CHE	Council on Higher Education
HE	higher education
HEI	higher education institution
HIV/AIDS	human immunodeficiency virus/acquired immune deficiency syndrome
LiEP	Language-in-Education Policy
LoLT	Language of Learning and Teaching
PRO	public relations officer
SASLHA	South African Speech-Language and Hearing Association
UKZN	University of KwaZulu-Natal
WHO	World Health Organisation

## **PART ONE: SETTING UP THE STUDY**

This thesis report is organised in three broad parts.

Part One consists of three chapters, which provide details concerning the setting up the study: the context, background, relevant literature, theories and methods for the study. These first three chapters provide the rationale for the research study and the theories that frame the study in a contextualised manner. A detailed plan for data production is presented and substantiated with relevant literature.

Part Two of this thesis comprises four chapters concerned with engaging with the data generated in the field in anticipation of the activation of greater levels of abstraction, which are presented in Part Three.

The three chapters in Part One of the thesis comprise the following:

- Chapter One: The context, background of the study and the outline of the thesis
- Chapter Two: The literature review and theoretical framework
- Chapter Three: The research methodology



## CHAPTER ONE: Scoping the focus on communicative competence within speech-language therapy

### 1.1 Introduction

Communication is at the heart of the agenda of the practice of the profession of speech-language therapy. As practising professionals, speech-language therapists use their own communication to facilitate the improvement of their client's impaired communication. This process of activating alternative patterns of the client's communication is best mediated through the very act of therapeutic communication itself. The care for communication permeates the therapeutic situation (Candlin, 2000; Sarangi & Roberts, 1999). Communicative competence is perhaps regarded as a generic soft skill for all healthcare practitioners to negotiate diagnosis, prognosis and intervention. However, for speech-language therapists, communication is more than just a generic soft skill; it is the *core skill* central to the work of a speech-language therapist. In the profession of speech-language therapy, the challenge is usually regarded as residing within the client (which has activated a pejorative nomenclature, namely a 'client communicative pathology'). As an intervening counterpoint, the speech-language therapist's communication is *assumed* an idealised model of effective communication targeted during the therapy session (Cortazzi & Jin, 2004; Ferguson & Armstrong, 2004). However, is it safe just to accept this *assumption* in the light of the plethora of research suggesting that –

- multiple conceptions of communicative competence abide;
- competing understandings of the cultural worldviews surround communication exist; and
- professional therapists, both novice and experienced, may not necessarily have all the required competences to tackle diverse settings and circumstances of therapeutic contexts?

How are novice therapists activated to embrace these professional responsibilities and competences in their professional higher education (HE) programmes? This research study put the phenomenon of understanding, activating and developing communication in the context of the profession of speech-language therapy under the microscope, using the professional education programme of one selected higher education institution (HEI) as a case study.

## **1.2 Orientation to the chapter**

Chapter One comprises two sections. The first section sets up the context, background and rationale of the study, and concludes by revealing the critical questions of the study. Section Two outlines the focus of each of the chapters of the thesis, providing an overview of the report structure to guide the reader about the logical development across the text.

## **1.3 Section One: The study background**

This section covers the context, background and need for the study. Thereafter, the critical questions are outlined and discussed in relation to the rationale for the study.

### **1.3.1 Context and background**

The speech-language therapy profession could arguably be said to have developed into a field of practice following the demand for tackling speech and audiological impairments derived within the world of war (see Wemmer, 2008). Notably in the European context and the United States of America, therapists were increasingly being sought after to tackle these speech and audiological impairments following the post-war ravages of the devastating First and Second World Wars. Speech-language therapy is thus a war-child deriving its mandates from tackling the global scale of destruction, injustice and dehumanising relations, which incapacitated basic human interaction and communication. Within South Africa (SA), the profession of speech-language therapy could be considered complicit in the combined effect of imperialism and apartheid as the profession historically attended to the needs of a selected privileged population group (Pillay & Kathard, 2015). The profession recruited and educated for most of its existence, dominantly white students who then went on to serve largely white South Africans (Pillay, Kathard, & Samuel, 1997). Communication challenges were believed to be a middle-class preoccupation, and the large population groups of black South Africans were excluded from the focus of this form of therapy. For example, the main beneficiaries of services of speech-language therapy were targeted largely at the middle class, usually white populations, and those who spoke the dominant world languages such as English (Pillay & Kathard, 2015). This happens even within a post-apartheid South Africa, which adheres to the injunction that communication is a basic human right for all people. Section 30 of the Bill of Rights in South Africa states that everyone has the right to use the language and participate in

the culture of their choice (Republic of South Africa, 1996). Surely, this basic human right should apply to access and use of clinical therapeutic engagement as well.

The current SA agenda has officially been directed in its policy rhetoric to resist these hegemonic, Western and largely colonial imperatives. Ndlovu-Gatsheni (2013) reminds us that, although we are beyond colonial administration, we are not beyond coloniality, which has infused into our everyday lives and practices. This can be seen in the demographics of speech-language therapists in the profession, which previously had been predominately white, English and/or Afrikaans-speaking females. Singh et al., (2015) reported that less than 25% of speech-language therapists felt competent in providing services in African languages as well as providing services to culturally and linguistically diverse clients. Additionally, there appears to be an unequal distribution of speech-language therapists within the public and private health sectors with only a small proportion working in the public sector (Pascoe & Norman, 2011) where the majority of the clientele are black African South Africans who are first-language African language speakers and cannot access costly private services.

In South Africa, where language was a means for structural exclusion under apartheid, the work of a speech-language therapist becomes empowering for clients (Mophosho, 2016). Research suggests that there is a need to provide services to the previously under-served groups of individuals within the public health sector. Historically, public facilities and services for such communities were under-resourced and lacking the funding needed to cater to a linguistically diverse environment (Guiberson & Atkins, 2012; Pascoe & Norman, 2011).

The profession of speech-language therapy has to consider how to optimise service provision in a multilingual and multicultural context, to look at improving training outcomes and to improve services to the SA population (Singh et al., 2015). There appears to be limited enunciations of multilingualism and multiculturalism within the profession, and it seems as if 'multilingualism' and 'multiculturalism' are used synonymously with 'race' and 'ethnicity' (Pillay, 2003a). What about other constitutional imperatives related to socioeconomic factors, gender, age and cultural stereotyping, sexual orientation, ability/disability, traditions, beliefs and religion? These ought to be the range of concerns that characterise the focus of professional services in the context of the diverse nature of the communities, especially within a post-apartheid constitutional democracy. However, the profession continues to be

fixated on the issues of ethnicity and language as if only these characteristics define the injustices of the past in South Africa (Pillay, 2003a). This is perhaps understandable, because differences in ethnicity and language between the therapist and client still appear to be the most obvious challenges to communication in the clinical engagement scenario. It is this *difference* that therapists claim to see and hear.

At this point, I find it appropriate to declare my current positionality in this research study. I am a female, South African Indian lecturer in the Discipline of Speech-Language Therapy at the University of KwaZulu-Natal (UKZN) and I am a speech-language therapist by profession. For facilitating an easier understanding of the terms, **speech-language therapy** refers to the profession, while **speech-language therapist** (SLT) refers to the professional. As a relatively recent graduate,<sup>1</sup> I have returned to the higher education environment from the world of practice to become a professional educator of speech-language therapists and researcher.

My involvement with higher education (HE) and the training of Speech-Language Therapy students at UKZN began very early in my career. Since the start of my academic career in 2010, I have always worked very closely with first- and second-year students, which sparked my initial research interests of first-year academic success, which became my master's research. I was interested to know why students entering the world of the HE environment of speech-language therapy did not seem to be able to manage their transition from schooling into academia well enough to succeed, and what the characteristics were of those who were able to do so (Naidoo, 2012). This drew on the inspiration of colleagues who were also assessing the limits of professional education curricula and their focus (Bitzer, 2009; Mbambo, 2008).

My current research focus came about because of my interests in the development of graduate competencies at the exit point of the speech-language therapy curriculum, even in its reformulated renditions. I have decided to interrogate the area of communicative competence because of the implied association of communication being declared pivotal to the profession of speech-language therapy. The provocative questions that I ask, are "Are we, as speech-language therapists, competent communicators?" and "How do we negotiate our communication in practice?" This potentially opens up a reflective appraisal of the kinds of ways in which graduate

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<sup>1</sup> I completed my initial professional education at the end of 2007.

professionals interpret their views about what it means to offer services in relation to the act of speech communication in their clinical interventions (the *focus* of therapy), as well as how they activate communication during their own engagement in the field (the *process* of therapy). This reflective review additionally provides educators of speech-language therapy professionals to review their own communicative engagement with developing professionals as communicators.

### **1.3.2 Rationale for the study**

The feedback received from the world of work through research reports and government initiatives was that graduates from higher education institutions (HEIs) are not well equipped for the world of work (Griesel & Parker, 2009). HEIs however argue that it is not the responsibility of HEIs to ensure that graduates are work-ready. According to Brennan (2014), higher education is about preparing the individual for working life and not for a specific job in the first couple of years after graduation.

It may be argued that higher education is beset by several systemic challenges and therefore do not necessarily have the luxury of attending to matters of 'soft skills' (such as time management, empathy and verbal and written communication) which arguably are seen as best developed in the world of work practice contexts. The implementation of policy frameworks and regulatory mechanisms to steer transformation, the radical restructuring of the HE landscape, the massification of higher education, increased student access, the under-preparedness of students entering higher education – these are matters that contribute to the challenge of an under-focus on ensuring that graduates enter the world of work with expected minimum competencies. This sets up hostile relationships between academe and the world of work when dialogical relationships are not activated.

My argument is that the blame game is not serving a constructive purpose. I believe that the research focus to explore these challenges is being directed by the world of work and activated from higher education. It is perhaps opportune to consider the perspectives of the *graduate*. When graduates entered higher education, they might have heard complaints of being under-prepared, might have experienced growing numbers of students in classes, which took away from the individual and experienced personal adjustments to the space of tertiary-level education. Through all this effort, the individual student is expected to reach his or her targeted exit competences in

order to warrant that he or she graduates. What should be a stimulating time in the young graduate's life at the entry point into the world of work is marred by reports (from within and outside the profession) that he or she is not work-ready. With an already saturated job market in almost every field, but especially within the healthcare system where frozen government posts in South Africa are the norm, one has to wonder what effect the repeated negative interpretations of graduate competences have on the young graduate who possibly had aspirations of helping people, giving back to their communities and contributing to society. I do not wish to lay further blame on any one sector, either ascribing fault to the world of the work sector, or to world of higher education for not activating appropriate graduate competences adequately. Rather I want to explore the *lived experiences of graduates*, the novice and experienced speech-language therapists in order to understand what the negotiations are that they encounter in their everyday practice when using their communication in clinical engagement. My focus is on the influence that these experiences have on their emergent conceptions of being speech-language therapy professionals. The aim was to understand how novice and experienced professionals articulated these lived experiences within the world of work so that this rendition could become a resource for the world of academe to inform the design of their curriculum practices in professional education.

It is a requirement by the Health Professions Council of South Africa (HPCSA) for student speech-language therapists to take an oath at the beginning and at the end of their training. The oath is a mandate guiding the practitioner–client relationship (Mophosho, 2016). Upon completion of their four-year degree, speech-language therapists have to engage in a year-long community service period at an underserved government-owned health facility (see Wranz, 2011). There is an application process whereby the student selects five sites where he or she would like to conduct their community service. The Department of Health (DoH) then assigns the student to a site. Students are employed under the conditions of service as any other healthcare practitioner at a government-owned healthcare facility. After the community service, the speech-language therapist has to source other suitable employment. These are most typically public (government-owned) healthcare facilities, public or private special schools, private practices and non-governmental organisations (NGOs). To gain employment in any of these sectors, the speech-language therapist has to apply for

employment where there are available posts. The typical recruitment processes apply with interviews to determine suitability. If a speech-language therapist decides to start a private practice on his or her own, then he or she will have to follow the procedures and processes stipulated by the HPCSA and the Board of Healthcare Funders. Also available are guidelines by the South African Speech Language and Hearing Association (SASLHA), which are useful but not mandatory. The world of work sites that were included in this thesis were facilities where speech-language therapists are most commonly employed. These are public (government-owned) hospitals, public (special) schools and private practice.

A competency that employers favour highly is communicative competence (Hill, Walkington, & France, 2016). I was interested to know how these early stages of embarking on the journey to becoming a novice professional is experienced and how communicative competence influences defining the nature of the choices that novice professionals make, considering that communication is both the focus of their practice and the means through which they enact their practice. Again, the negotiations of these experiences are understood as potential informative resources for professional education curricula, as well as for sustaining the nature of entry into and continued elaboration within the professional journey.

### **1.3.3 The critical questions**

In order to address the research issues identified above, the following critical questions guided the study:

- What is the nature of communicative competence that is taught and learnt during the initial professional education of speech-language therapists (SLTs)? (the world of academe)
- How do speech-language therapists (SLTs) negotiate communication strategies during clinical engagement within workplace contexts? (the world of work)
- What explains the choices of communication strategies speech-language therapists (SLTs) use during the clinical engagement within workplace contexts? (the world of data, literature, practical, theoretical and philosophical explanations)

## 1.4 Section Two: Outline of the thesis

The thesis is organised in three parts.

### **Part One comprises Chapters One to Three:**

**Chapter One** provides the *background* and *context* and *the rationale* for the study. The chapter elaborates on the phenomenon being studied (i.e. communication used during clinical engagement) within the physical and historical context within which the study was undertaken. The chapter further provides an insight into my ontological positioning in the study and justifies the choice of my topic. The *critical questions* of the study are then presented for the first time.

**Chapter Two** presents the *literature review* and *the theoretical framing* for my study. The literature review spans arguments from the fields of higher education and speech-language therapy. I begin the chapter by discussing the graduate competence argument, focussing specifically on communicative competence. Thereafter I look at how the field of speech-language therapy has negotiated these constructs, and I set up the need for my particular study. The theoretical framing enabled my understanding of the education and training of speech-language therapist within the South African (SA) context and I present two theories from the field of communication, and apply it to speech-language therapy. I also use the Canadian Medical Education Directions for Specialists (CanMEDS) competency framework (Frank, 2005) (see section 2.4.3) to contextualise the phenomenon and the need for the study further. I used a Canadian framework because South Africa and Canada are characterised by a history of colonisation (Penn et al., 2017), which resulted in tiered health systems, a neglect of linguistic and cultural origin and health disparities (Griffiths, Cole, Lee, & Madden, 2016, cited in Penn et al., 2017).

**Chapter Three** is made up of two sections. Section One presents the *research methodology*, which is justified by the relevant literature, as it describes and motivates choices that I have made regarding the research methodology, especially the use of narrative analysis (see section 3.4.1). I provide the biographical profiles of participants (see section 3.3.2) and the instruments for data production (see section 3.3.4). I explain how the research production unfolded as well as how I adhered to the ethical considerations (see section 3.3.5). The challenges experienced during data collection are also discussed (see section 3.3.6). The trustworthiness of the study is presented



and explained in detail (see section 3.3.7). Section Two presents a discussion of how the initial *analysis of the data* was undertaken using narrative analysis.

Part Two comprises Chapters Four to Seven:

**Chapter Four** presents the narratives of the first five of my eight participants. These five participants are the *novice* speech-language therapists. I present the narratives according to those participants who were most newly qualified and those who had been in practice for up to three years at the time of this research.

**Chapter Five** presents the second set narratives of the three *experienced* speech-language therapists. The narratives are presented according to the participants who had been in practice between eight to ten years at the time of this research. The comparative analysis of both novice and experienced professionals constituted a means to explore the journey of becoming professional.

**Chapter Six** is the preamble to the second-level analysis and constitutes the *cross-case analysis* of the narratives. Due to the extensive data, this step scrutinised the narratives to explore repeated nuances and recurrences in the data set. This involved further refinement of the data analysis process and shed light on the plethora of factors involved in the negotiation of communication strategies during clinical engagement. Critical question one is answered toward the end of this chapter (see section 6.9).

**Chapter Seven** presents the second level analysis of the narratives. Further refinement of the data allowed for *five main themes* that cut across all the stories to be identified (see section 7.3). An analysis of the *antithetical (atypical) cases* is presented, that is the narratives of participants described as 'outliers'. The term 'outlier' is defined, and justification for this analysis is offered in terms of the two participants selected. I also justify my decision to analyse the data from an alternative perspective based on *credibility* of the research findings. The findings obtained from this level of analysis are described and compared with findings from the previous level (see Chapter Six) to provide a deeper understanding of the phenomenon. Critical question two is answered in this chapter (see section 7.5).

Part Three is made up of Chapters Eight and Nine:

**Chapter Eight** presents the third level of analysis of the data, which was compared and evaluated against *the literature and the initial theoretical framing* in Chapter Two,

which served as a lens to study the data production. The data analysis was organised according to the three constructs of the initial theoretical framing, i.e. communication accommodation theory (which dealt with the curriculum), problematic integration theory (which dealt with clinical practice of the profession) and CanMEDS (which dealt with the policy, systems and the development of competence). This chapter also provides the answer to the third critical question (see section 8.6) and the chapter provides a contribution around the debates on professional education.

**Chapter Nine** culminates this document by way of an elaboration of a *new thesis* based on findings obtained from the successive levels of analysis. The emergent thesis, named ‘The diamond framework: Towards a curriculum of resilience’ is discussed around professional development. The chapter also describes the way in which the current study has pushed boundaries at the methodological, contextual and theoretical levels. Further, a *critical appraisal* of the study is presented and the implications for clinical practice, undergraduate training and education and future research are discussed.

### **1.5 Synthesis of the chapter**

This chapter provided the background, physical and historical contexts and the rationale for the study. It provided an insight into my personal interests in the study. The critical questions were presented. The thesis outline of all the chapters in this study was discussed. Chapter One created the stage for Chapter Two where the literature and theoretical framing for the study are presented.

## CHAPTER TWO: Developing a lens for the study: Frameworks and theories

### 2.1 Introduction

The previous chapter provided a backdrop to the study, by presenting the history of the profession of speech-language therapy and the socio-political landscape within which the profession operates in South Africa in its attempt to alleviate health inequities (Penn et al., 2017) in order to present an argument for the rationale for the study. The present chapter develops a theoretical framing for the study, which also focusses on frameworks from the profession (the *system*), from within higher education (the *professional education* space), and from professional practice (the *operational* context). The focus on graduate competences at the exit point of qualifications is discussed as a key concern of the HE system, especially as professional education makes a contextual contribution to the wider landscape of the profession and its practices.

### 2.2 Orientation to the chapter

This chapter is organised in accordance with the research topic and the critical questions of the study.

I begin with a discussion around understanding competences with particular focus on **graduate competence** and **communicative competence**, followed by a discussion of the importance of this construct in **the profession** of speech-language therapy.

I discuss the discourses in the **world of academe** (higher education) related to **graduate competence**. I further provide evidence and reports from the **world of work** in relation to the concept of graduate competence with reference to the professional **practice** of speech-language therapy.

The temporary lens around the **phenomenon of communication** as well as frameworks discussed in higher education, which influenced the construction of instruments for this study, is then presented.

### 2.3. Section one: Reviewing the literature

This section presents the relevant literature used to explore the phenomenon of the study and to establish the importance for the study.

Firstly, I discuss graduate competencies and, more specifically, the phenomenon of communicative competence.

### 2.3.1 Understanding competences

Hill et al. (2016) explain that there are competencies that are highly favoured by universities. Critical thinking, effective communication, teamwork, inquiry skills, personal values and cross-cultural awareness encompass communicative competence as a graduate competence.

The terms *competence*, *competency* and *attributes* are often used as synonyms in the literature. The choice of the terms is largely dependent on the author's preferences or inclination in his or her field of interest. For example, in healthcare literature, the term *competency* is used while in higher education, the term *competence* is preferred. The former might suggest an emphasis on the ability to engage practice, whilst the latter might be concerned with matters related to the roles and identities of practitioners. In other literature, *competence* (and its plural *competences*) and *competency* (and its plural *competencies*) are used interchangeably (Laher, 2009). This tends to foreground issues of capacities, which theorists claim, entail a range of attributes: ways of *being* (identities), *becoming* (processes of development) and *enacting* (practices) (Laher, 2009). *Competence* tends to be regarded on a more holistic scale, such as whether someone has competence or not, whilst *competency* suggests behavioural dimensions only (Laher, 2009).

Professional competence, as stated by Eraut (1994), comprises attributes such as knowledge, skills and attitudes. However, attributes alone do not constitute competence. The term *attribute* tends to be too atomistic or singular in its form (even in its plural form); hence, the preference for the use of the more comprehensive term *competence* or *professional competence*. The differential preferences of the terms could reveal worldviews of theorists and practitioners as well as their ideologies. For example, in healthcare, there is an inclination to use *competency* rather than *attribute* because of the inherent recurring goal in most of the policy regulatory frameworks of being declared a competent healthcare practitioner. The limitations of the use of the term *competence* are that it can connote a conception of 'having the ability or not having the ability' to conduct practice, i.e. being 'competent'.

In early linguistics research, Chomsky (1965) made a distinction between *competence* and *performance*. Simply put, for Chomsky, *competence* implied idealised capacity or 'knowing', whereas *performance* referred to actual production of language or 'doing'.

This means that a communicator may know the linguistic conventions of an utterance but when the production of the utterance is required, he or she may not produce it as eloquently. I am making an argument here for my choice of using the term *competence* for the purpose of this study while I acknowledge and appreciate the limitations and fluidity of this term.

To narrow the focus of the current study further, I find it necessary to define *communicative competence* in a general sense. To be more specific, in a seminal study, Hymes (1972) defines communicative competence as inherent grammatical competence and the ability to use grammatical competence in a variety of communicative interactions (see Bagarić & Djigunović, 2007). This definition acknowledges the sociolinguistic view to communicative competence, from which the current study drew. To explain this definition further, being communicatively competent implies that the requisite knowledge of being communicatively competent comprises not only the rules for communication, both linguistic and sociolinguistic (Chomsky, 1965), but also the cultural rules and knowledge that form the basis for context and content of communicative events (Saville-Troike & Kleifgen, 1986). Reading, writing, listening, speaking, viewing images, and creating images are all acts of communication. There are many other subtle communication activities. These may be conscious or unconscious, such as facial expressions, gestures and body language (paralinguistic features) (Croft, 2004). The speech-language therapist should have knowledge of and an appreciation for all these elements of communication. Besides monitoring and adapting their own communication, speech-language therapists also have to monitor and assess the communication of the client and/or families through screening, assessment and therapy processes. For the purpose of this study, *communicative competence* was defined as having the appropriate knowledge, skills and attitudes in the linguistic, sociolinguistic and paralinguistic features of communication.

### **2.3.2 Communication as a core and soft skill in speech-language therapy**

For speech-language therapists (SLTs), communication is a central feature of the profession. SLTs are the professionals who assess, diagnose and treat individuals with communication problems. Further to this, SLTs work with families, health professionals and others on how to communicate effectively with people with communication impairments (HPCSA, 2017). SLTs have a blend of skills that equip

them to be able to communicate with clients whose problems range from mildly impaired to severe and/or profound impairment.

The use of communication lies at the core of SLTs' practice, and the tools of diagnosis and intervention are mainly centred on communication methods and approaches (Mophosho, 2016). Figure 2.1 illustrates that **communication** is the subject of intervention, the object that is remediated, and the method of therapy delivery. This recursive patterning of communication as the subject, object and method of practice can be transposed to a phenomenon that biologists Maturana and Varela (1980) describe as *autopoiesis* – which refers to a system capable of reproducing itself. Hence, communication is reproduced in different forms for different purposes – as the impairment, the treatment and the goal of practice.

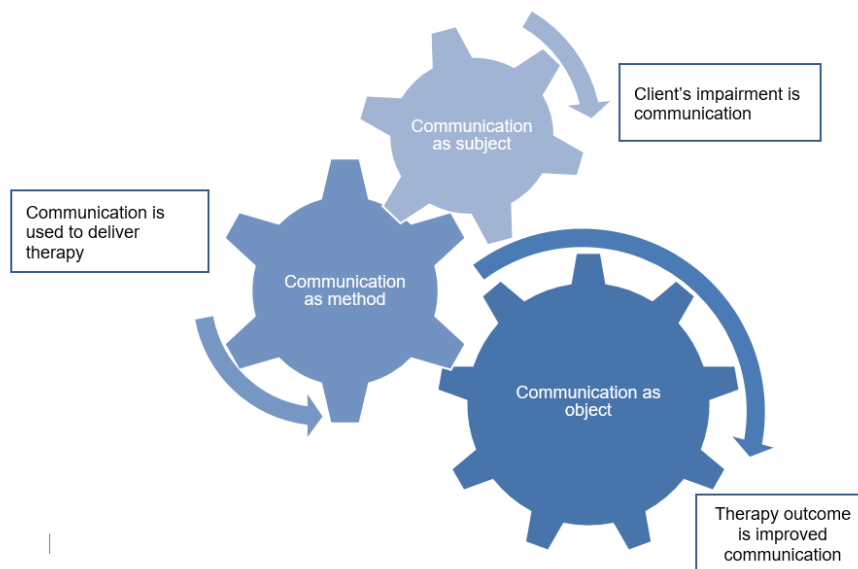


Figure 2.1

*Communication as the subject, method and object of speech-language therapy*

Source: Adaptation of Maturana and Varela's (1980) concept of autopoiesis.

In the profession of speech-language therapy, communication difficulties are seen to rest with the client, and the SLT's communication is assumed to be an idealised model of effective communication (Cortazzi & Jin, 2004; Ferguson & Armstrong, 2004). However, is it safe just to accept such assumption in the light of the plethora of research suggesting that the competence and quality of graduates for the workplace should be explored further? Furthermore, in Figure 2.1, it is indicated that communication is the subject of intervention. At this point, I find it necessary to

emphasise that communication was essentially the phenomenon explored by way of this research.

In the case of paediatric clients, the parent or caregiver stands proxy for the client. The parent or caregiver serves as the prime interlocutor to ensure the success of the practice intervention. The “Clinical Moment”<sup>2</sup> (Pillay, 2003b, p. 4) highlights the nature of our interaction with people who have communication disorders or rather interaction disorders, which entails the negotiating of the client–practitioner relationship. Pillay (2003b) further elaborates the complex interaction and the great deal of activity that takes place in the Clinical Moment and that we need to foreground people who interact amongst these constructs. I wish to extend this notion of the Clinical Moment to clinical engagement to recognise not only the (complex) interaction of people here but also the communication strategies used in these moments. *Clinical engagement* refers to the level of interpersonal involvement during a communicative interaction. A positive engagement is ideally what SLTs want because this builds rapport between themselves and the client. However, not all clinical engagements are positive, especially when considering that the clients have communication pathologies, some of which can result in a complete breakdown in communication. Communication disorders, such as childhood apraxia of speech,<sup>3</sup> cognitive-related communication disorders, stuttering, neurologically acquired communication disorders, attention deficit disorders, voice-related disorders all have the potential to affect clinical engagement drastically and negatively (Simmons-Mackie & Kovarsky, 2009).

This brings me to the issue of whether the above literature mostly focusses on problems during clinical engagement that reside within the client himself or herself. Some research literature (see for instance McAllister, 2005; McAllister, Lincoln, Ferguson, & McAllister, 2006) suggests that there remains a gap in the literature since it does not focus on SLTs who themselves may be experiencing challenges in the communication processes during clinical engagement in the world of work. What could SLTs do or not do to influence the clinical engagement of negotiating their

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<sup>2</sup> Choice of capitalisation of this term is a deliberate argument of the author.

<sup>3</sup> Childhood apraxia of speech is a rare motor speech disorder in which a child has difficulty planning and sequencing the movements required for speech, and difficulty with prosody (rhythm, stress and intonation of speech) (Bowen, 2009).

communication and diagnosis of communication challenges within their practices negatively? Are SLTs competent communicators?

These questions are not simply a matter of understanding the structural and paralinguistic features of interaction but also the (socio)linguistic rules for communication dealing with negotiating cultural systemic patterns surrounding communication practices (which embed matters of power as well as hierarchical and marginalisation issues). If using the autopoietic discussion mentioned previously (see 2.3.2), this would suggest that the 'method' of using communication in service provision might be affected by these sociolinguistic factors, which inadvertently influences the object of improved communication outcomes for the client. Clinical engagement in speech-language therapy in post-apartheid South Africa is infused with layers of multiple language systems: different languages, across different class, gender and race boundaries, across different levels of power structures of alienation and marginalisation. Differences of ideas or conceptions of the communication pathology between SLTs, clients and their families are possibilities.

An example of this would be the cultural understanding around disorders such as cleft lip and palate. There are common belief systems among cultures with regard to the aetiologies of cleft lip and palate, such as that the mother is usually responsible for causing the deformities. The aetiologies could range from the mother's diet during pregnancy to the fact that the pregnant mother looked at a solar eclipse (Loh & Ascoli, 2011). This would entail the SLT to conduct a sociological reading of the cultural and language system and its use in context. When considering the enactment of speech-language therapy during clinical engagement, the SLT has to integrate propositional knowledge, which includes the theoretical tools, negotiating interpersonal interactions between self and the client, considering and integrating the client's culture and background, interests, needs and strengths, all of this while ensuring there are advancements in the client's communicative abilities.

In earlier literature (e.g. Brookshire, 1976), the focus of research was on showing the efficacy of therapy with clients with communication difficulties (i.e. the focus on the pathology) and not actually on the effectiveness of communication used with clients (i.e. the operational nature of therapeutic practice). There is a paucity in literature with regard to SLTs' reflections on practice regarding their own communication strategies and what underpins their choices of selection. It appears that there has been a



reluctance to examine SLTs' own communication whilst transferring pathology (problematics) to their clients (Penn, 2004). Moreover, there is a further paucity in the literature on whether initial professional education of SLTs also addresses these conceptions.

Ferguson and Armstrong (2004, p. 474) raise similar issues in their clinical discussion forum in the *Journal of Language and Communication Disorders* when they introduce the term "speech-language therapists' talk" (SLT talk). They call for critical evaluation in terms of communicative competence, the processes and nature of acculturation that occurs during the first stages of professional development (as a novice student SLT) through to the ongoing development of professional practice (as qualified practising practitioners). Following on from this, the current study explored bringing together the world of academe and the world of work in the way the learning and enactment of communicative competence are transposed from the world of academe to the world of work and to explore the negotiation of strategies that SLTs encounter in clinical practice.

SLTs in South Africa practice in a multilingual and multicultural context. It is the responsibility of SLTs to be knowledgeable about the linguistic and cultural backgrounds of their clients and to provide culturally and linguistically appropriate services.

Section 30 of the Bill of Rights in South Africa states that everyone has the right to use the language and participate in the culture of his or her choice (Republic of South Africa, 1996). The National Language Policy Framework (see Department of Arts & Culture, 2003), which was approved by government in 2003 promotes the equitable use of the 11 official languages in the country to ensure redress of the previously marginalised official indigenous languages and to promote good language management for efficient public service administration to meet an individual's expectations and needs (Mophosho, 2016). The HPCSA ethical guidelines (see HPCSA, 2008a), Batho Pele principles (see Republic of South Africa, 1997), and the Patient's Rights Charter (see HPCSA, 2008b) are just some of the policies and statements that underpin SLTs' professional and ethical practice.

Even in the United States of America, where English is dominantly the language of public interactions and sometimes argued to be spoken by the majority of the

population, there is controversy of whether English should be recognised as the official language of the country (Crystal, 2012). The situation in South Africa is also complex as English is spoken as a first language by a minority in the country, even though it is regarded as the passport to better life opportunities. The multilingual and multicultural context means that South African SLTs face challenges in practice, which relate not only to matters of varying individual interpretations of language usage (the substance of communication), but also to specific language itself (the form of the communication), which might be the targeted choice for negotiating the clinical engagement.

Nevertheless, clients cannot be simply referred to SLTs who match the language preferences of the client. According to Mdlalo, Flack, and Joubert (2016), the average SLT in South Africa is still predominantly either an English- or Afrikaans-speaking woman who is not competent in an African language. With the dearth of SLTs who speak all African languages in the SA context, the probability is high in terms of speech-language therapy caseloads consisting of clients who speak languages other than that of the SLT, whether the SLTs are bilingual or multilingual (Mophosho, 2016). This consequently adds an additional layer of choices and strategies for communication in the clinical engagement between the SLT and the client.

In the development of the field, speech-language therapy has established its roots from other fields, such as medicine, psychology, education and sociology (Beecham, 2002). A brief explanation about the history of the profession (more broadly in a generic overview, as well as within the specific context of South Africa) seems to be appropriate at this point.

The conception of 'speech disorders' can be traced back in the literature to Mesopotamian times when medical conditions were reported to have associated communication problems (Duchan, 2002). Clients who were diagnosed as medically unfit were also frequently noticed to present with a lack of stable communicative patterns of speech. As patients were deemed 'medically unfit', this consequently created medical roots of communication pathology as a field. It is not surprising therefore that one of the earliest academic books on speech disorders was written by an American medical doctor, Samuel Potter, in 1882 (Duchan, 2002) consolidating a conjoining of medicine and communication pathology, which had developed over a long time. Dr Potter was a stutterer, which thus sparked his interest in the area. He provided a general classification of speech disorders according to three sub-groups:

- **alalia**, which referred to motor speech disorders as a result of cerebral lesions;
- **paralalia**, which referred to articulation disorders; and
- **dyslalia**, which referred to stuttering (Duchan, 2002).

However, communication pathologies are known to span over much more than these speech disorders identified above.

As an aftermath of World War 2 (1938–1945), therapists were increasingly being sought after to tackle the perceived relationships between post-war injuries (which included head injuries) and impairments of speech and language abilities. Noise-induced hearing losses as a result of ammunition used made the rehabilitation process more difficult. The audiological component to the then speech and hearing therapy profession was born from the realisation of the critical relationship between hearing and speech and language abilities.

Further to this, discoveries were made by neurologists regarding brain impairment and language behaviour, which helped them corroborate this association further. Muriel E. Morley (1957) was one of the first individuals with a speech pathology background who considered language and articulation disorders from the range of activities of an SLT (Paul & Norbury, 2012). Morley further provided definitions to assist with the differentiation between language and articulation disorders. Mykleburst (1954, cited in Paul & Norbury, 2012) contributed to the field of 'language pathology' by looking at the consequences of oral language disorders in the acquisition of literacy skills. Hence, the role of the SLT was established in written language.

In terms of the SA perspective, Professor P. de Villiers Pienaar (regarded as the founding father of the speech-language therapy practice in South Africa [see Swanepoel, 2006]) who completed his doctoral studies in Germany, instituted a professional two-year diploma qualification in logopaedics (another name for speech therapy) at the University of the Witwatersrand, and the first cohort graduated in 1938 (Swanepoel, 2006). Logopaedia is the study of speech defects, which over time came to be regarded as the foundational roots of speech-language therapy in South Africa, although logopaedics was quite a narrow scope. After a few short years, the depth and breadth of this emerging profession were realised, especially due to the post-war influence, and the two-year diploma was extended to a four-year professional degree in 1948 (Swanepoel, 2006). Positions for SLTs began to open in public education and

healthcare sectors, which led to the establishment of the profession in public and private contexts (Swanepoel, 2006); however, serving the minority of white South Africans, thus shaping the history of speech-language therapy in the way it has come to be.

The above discussion has highlighted the development of the profession of speech-language therapy. It has been elucidated how the profession came to be responsible for the rehabilitation of communication impairments in the fields of healthcare and education. It was necessary to delve into a discussion around how communication features so prominently in the profession as communication are at the core of the profession. The current study explored how SLTs negotiate their communication in the world of work and the way the Speech-Language Therapy curriculum could prepare graduates to deliver appropriate services to clients.

### **2.3.3 Bringing HE in South Africa into focus**

Paradigm shifts internationally and more so nationally in terms of creating formal access to allow for a greater number of students to attend HEIs have been termed 'massification of higher education'. Massification of HE came about in post-apartheid South Africa when universities in the country were put under severe pressure to produce graduates in greater numbers and to respond to government's commitment to create an equitable society (Blunt, 2008). In HE policy and institutions, there has been an intended shift move away from an elitist view of access for students to a 'massified' system of HE where large numbers of students from diverse backgrounds attend HEIs (Naidoo, 2012). The focus on the competencies of graduates could be under the spotlight possibly due to:

- the massification of HE;
- increased access to students wanting to pursue further education;
- the competitive and often saturated world of work;
- the diversification of the world of work; and
- the flexibility and diversification of skills that graduates ideally should possess.

Increased student access to HE has not translated into increased student success (Mngomezulu & Ramrathan, 2015). Despite government bursaries and other forms of financial assistance, a substantial number of students fail to complete their degrees in minimum time, or drop out of programmes completely (Council on Higher Education

[CHE], 2014). There are varied explanations for this statement; however, most findings indicate that the poor throughput rate is largely accounted for by students from the previously marginalised population, for whom access has been enhanced (Mngomezulu & Ramrathan, 2015). To gain formal access as a student at a university does not imply that the student possesses the knowledge or cultural capital with which to succeed at university. Morrow (2007, p. 11) uses the term “epistemological access”, which responds to a political need to democratise access to HE in South Africa. Morrow (2007) further argues that the agency of the learner is necessary for educational access and, hence, educational achievement.

There has been a plethora of research focussing on student success and student attrition from HE (Akoojee & Nkomo, 2007; CHE, 2013; Letseka & Maile, 2008). Academic success (or educational achievement) has been defined by Jones, Coetzee, Bailey, and Wickham (2008) as the student’s ability to progress through the intended course of study and adequately complete the course within the minimum allocated time. The research foci on academic success have been to understand this concept in quantitative terms, such as graduate outputs, throughputs and student dropouts instead of more enduring ideas such as professional development, competence development and social justice. There is considerable pressure on universities to monitor throughput and graduate outputs of students, as there are financial consequences for the institution as well as for the student (Basson, 2006). In South Africa, a funding framework for higher education was introduced in 2004 (Department of Higher Education and Training [DHET], 2012), closely linking funding to student success and throughput (Essack et al., 2009). Therefore, it is conceivable that those students who attain academic success and go on to graduate should then be considered to have the necessary epistemic access to succeed in higher education. However, reports from the world of work are that graduates from HEIs are not well equipped for the world of work (Griesel & Parker, 2009). The focus of the current study was not to criticise the current practice of graduates but to explore and understand how graduates negotiate their work contexts, i.e. clinical engagement and the communicative competence of SLTs.

### **2.3.4 ‘Communicating’ between the worlds of academe and work**

At this point, I want to use Schramm’s (1954) model of communication to explain the interface or relationship between higher education or universities (the academic world)

and the labour market (world of work). The articulation (communication) between higher education and employment in the workplace has been the focus of government initiatives for many years (Griesel & Parker, 2009).

Wilbur Schramm (1954) reconstructed a model of communication<sup>4</sup> to account for the dynamic process that occurs in the encoding of the sender's message and the decoding by the receiver of a signal (Croft, 2004). Schramm's contribution was the added level of feedback between the sender and receiver. This allows for interaction, which is the foundation on which communication is built. However, Maturana and Poerksen (2004) explain that this understanding of communication is too simplistic, as it portrays a recursive and flowing manner. It is agreed that the communication process is a complex one, and the communication model has been and continues to be reconstructed to account for situations of misunderstandings and divergent thinking between conversational partners. Hence, the 'problematics' of communication is added to account for this dynamic.

Figure 2.2 presents an adapted version of this communication model using the key concepts of this study according to the metaphor of the sender–receiver as in the communication model.

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<sup>4</sup> One of the earliest recorded communication models is attributed to ancient Greek philosopher Aristotle, whose model incorporated a few elements such as a speaker, message and listener (Croft, 2004).

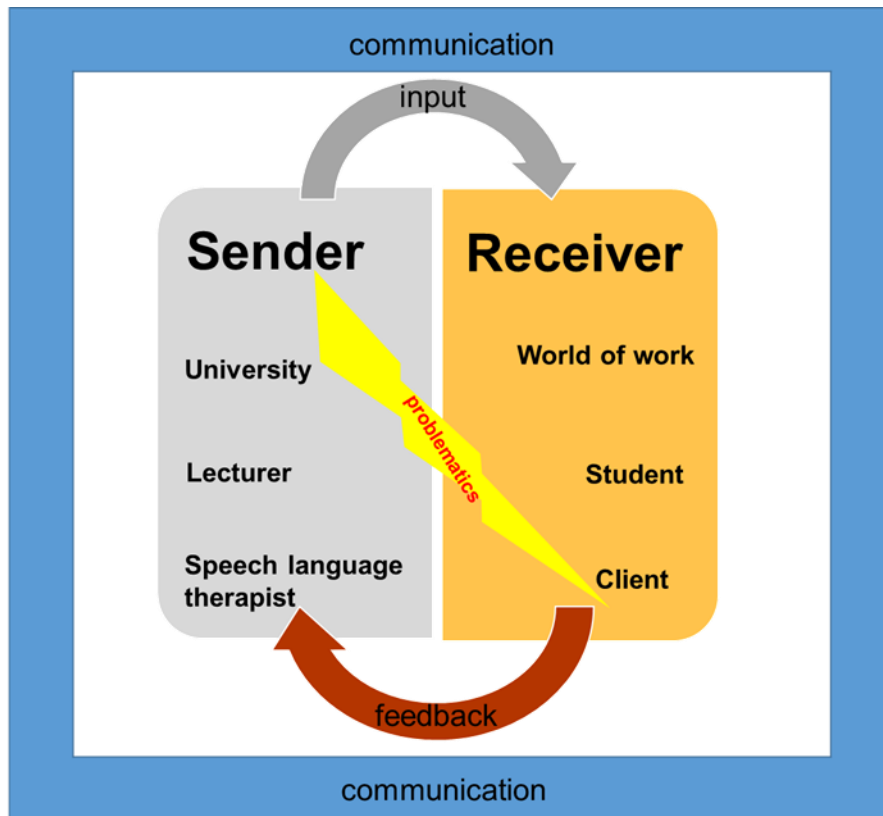


Figure 2.2

*Adapted model of communication illustrating the key constructs of the research study.*  
 Source: Schramm (1954).

The sender (university) sends out the stimulus (graduates who possess competences) to the receiver (the world of work). The feedback that has been received in research done by McCowan, Reilly, and Steven (2014) is that the world of work has concerns regarding the preparedness of graduates for the workplace. The purpose of the current study was to explore this communication chain of the sender (the Discipline of Speech-Language Therapy at UKZN) sending the graduate (with communicative competence) into the world of work. To complete this model chain, the results of the current study are intended to provide feedback to the undergraduate Speech-Language Therapy curriculum at UKZN.

### **2.3.5 Academe and communicative competence**

Graduate competence has become an important research agenda in higher education internationally. This reflects the growing interest that graduate competence has received in recent years. This shift is engendering debate around the world about the

role of HEIs in producing employable graduates to feed national prosperity in the emerging knowledge economy (Hill et al., 2016).

Many different institutions and authorities, including regulatory bodies responsible for establishing national qualification frameworks and standards of practice, have interpreted the concept of communicative competence. The HPCSA document on the regulations relating to the undergraduate curricula and professional examinations in Speech-Language Therapy (2012) suggests that the communication of a practitioner needs to include the following:

- being able to form positive therapeutic relationships;
- motivating clients and their families in therapy;
- being aware of and responding to nonverbal cues from clients;
- engaging with other professionals about the client to facilitate holistic care for the client; and
- being linguistically and culturally competent as well.

Communicative competence should be a critical cross-field outcome of any programme registered with the South African Qualifications Authority (SAQA). Therefore, while communication skills or strategies are not explicitly taught in the undergraduate curriculum in a single module, these competences could be taught implicitly by being embedded in the structure of the curriculum, as is currently done at UKZN. All speech-language therapy clinical sessions at UKZN are pre-planned with input from the clinical supervisors (lecturers) who then also supervise (observe) the sessions. I would describe the entire educational experience as 'sanitised' or 'safe' so that no harm may come to the client, student clinician or clinical supervisor. I would also like to iterate here that 'safe' practice is necessary. Clinical practice becomes problematic when this is expected as the only means of enactment of therapy in the world of academe by the student clinician who may show resistance to limited involvement from his or her supervisor. I am arguing that there should be a space where the student clinician can establish his or her own communicative competence in practice.

Guidelines for clinical practice for SLTs are provided by the HPCSA's minimum standards for training (HPCSA, 2012) as well as the scope of the practice document (HPCSA, 2017), and the SAQA exit level outcomes for professional programmes (SAQA, 2000). Communicative competence is a critical cross-field outcome of any



SAQA-registered programme. However, there remains uncertainty about communicative competence when entering the world of work. My focus in this study was to explore how SLTs negotiate their communication in the world of work, and to explore how graduates negotiate their communication in the world of work. UKZN was used as a space to allow me to theorise the phenomenon of communicative competence and how it could be activated as a valuable and contested notion within the everyday world of work. This was an opportunity to explore how the HE curriculum relates to the wider social environment in the reconnection between the world of academe and the world of work.

The American Speech and Hearing Association (ASHA) is the largest professional association in the world for SLTs, and is committed to empowering and supporting SLTs through advancing science, setting standards and fostering excellence in professional practice, as stated in their mission statement (ASHA, n.d.). ASHA is the leading association in the profession because of its long-standing history, having been established in 1925. According to ASHA's (2016) Code of Ethics, SLTs are obligated to provide culturally and linguistically appropriate services to their clients, regardless of the practitioner's personal culture, practice setting or caseload demographics. The HPCSA exit-level outcomes require that the graduate be able to practice safely, competently and independently (HPCSA, 2012).

Gravett (2012) speaks about the theory–practice divide as it pertains to initial teacher education and early teaching practice. This argument draws parallels to the current study in that the initial professional education of speech-language therapy students involves theoretical and practical exposure. In the Discipline of Speech-Language Therapy at UKZN, the curriculum is structured over a four-year programme, with clinical practice beginning in the second year of study. Hence, the discipline operates according to a translation of theory-to-practice approach (applied science conception), which implies that the theoretical modules supply the content and theory, which the students then apply to clinical practice at different sites (Gravett, 2012). However, this still does not explain how SLTs come to develop communicative competence, as this is not formally taught in the curriculum. Korthagen and Kessels (1999, p. 7) wrote about a practical wisdom approach, originally an Aristotelian term, “*phronesis*”, which focusses mainly on the development of practical reasoning. This relates to choosing the appropriate behaviour for a particular situation (Gravett, 2012). In speech-

language therapy, this is often referred to as 'clinical reasoning' or 'clinical discretion', in other words, to know what to say, how to say it and when. At universities, the dominant mode of professional development tends to involve a transfer of knowledge from the knower (the teacher or the lecturer) to the recipient (the student). We (lecturers) usually categorise and compartmentalise the theory into manageable units of analysis. We then emphasise the need to link abstract theory with pragmatic practice (Gravett, Petersen, & Petker, 2014). In an article about professional development of teachers, Samuel (2009) explains that this is falsely understood to be a simple process, usually consisting of the transference of skills to execute classroom pedagogy or classroom management.

Further, Samuel (2009) explains that novice teachers need to be exposed to this wide range of knowledges, both 'public or propositional' and 'private or craft knowledge' varieties in order to affect any deep conception of professional growth. However, many formal curriculum models for teacher development tend to operate consciously to provide only the former propositional knowledge with limited attention to the more enduring 'craft knowledge' dimension. For deep professional development, both public or propositional knowledge as well as private knowledges are needed, as seen in Figure 2.3. This latter knowledge is presumed to be activated in the workplace learning initiatives where students are placed into practice sites to activate the dialogical relationship between public and private knowledges. Samuel (2009) regards the role of mentors to activate such dialogue as pivotal to early professional growth. I extend this debate to the profession of speech-language therapy and contend that something similar needs to be done when looking at the development of communicative competence for novice therapists in both the world of academe and the world of work.

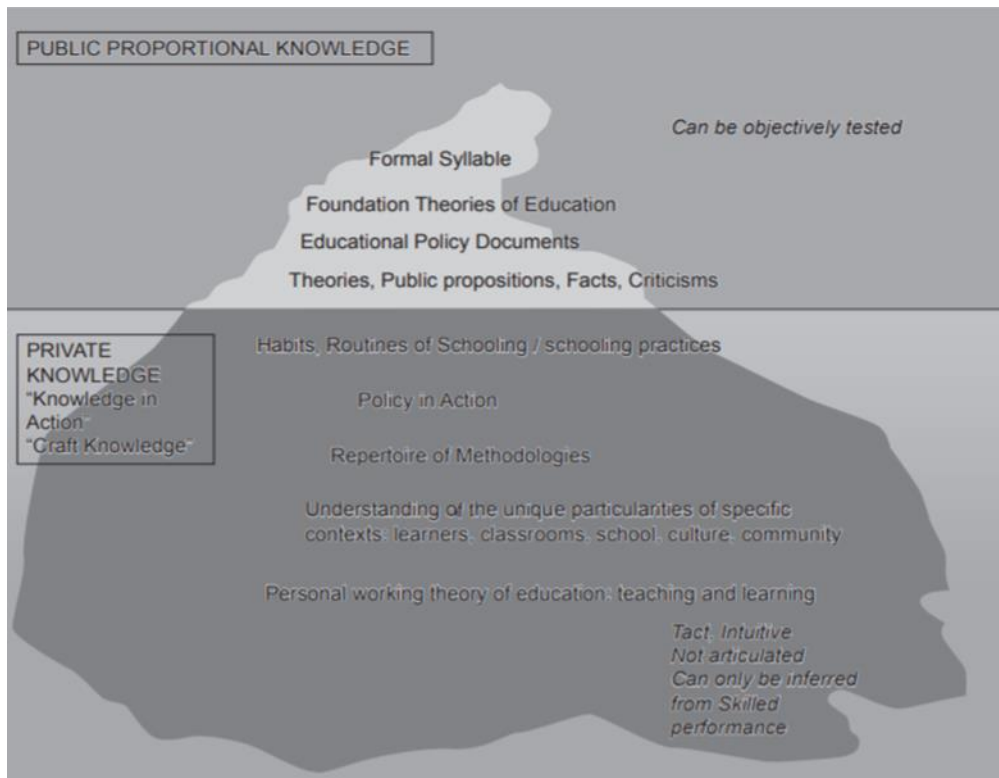


Figure 2.3

*The iceberg principle of knowledge*

Source: Samuel (2009, p. 746).

Most speech-language therapy clinical sessions at UKZN are pre-planned with input from the clinical supervisors (lecturers) who then also supervise (observe) the practical therapy sessions in clinical settings (such settings comprise simulated therapy sessions, in-patient campus-based programmes in clinics and/or off-campus real-life clinical settings). If pre-planning is not possible in sites, such as acute care hospitals, supervisors are available to assist with planning and preparation. I would describe the entire educational experience as 'safe' where priority is directed so that no harm may come to the client or to the practitioner. The practitioner therefore operates within a space of certainty. My criticism is whether there is enough space in this setup for the practitioner to grow independently in order to embrace the uncertainties of clinical practice.

The gradual weaning off (as part of the agenda of creating autonomous professionals making independent judgements) of the high levels of support once offered at university is also a matter of concern during the early stages of professional development. The added pressure with which novice graduates have to deal is the

matter of independent handling of the contexts beyond the kind of idealised settings discussed within the formal university training sites on a daily basis.

Within the undergraduate curriculum in the Discipline of Speech-Language Therapy, students are first offered theory-based modules, which cover the propositional content of the subject. This precedes clinical-based modules in the following semester or year where students are expected to engage in clinical practice as a practical component to the theoretical content; hence, an enactment of theory taught and facilitated. An acculturation process into the discourses and jargon used in the profession takes place at theoretical level when students engage in the theory modules and a practice level during their clinical practice modules. The clinical practice modules are a type of service learning where the student clinicians work with actual clients under the supervision of their clinical supervisors. This takes place from the second year of study until their final year. In terms of curriculum design, it would appear that the theory module followed by the clinical practice might be the most logical way to ensure that professional education is able to facilitate the students' transference of the propositional content to a clinical context, which ought to mimic the real working world. Practically, however, this may not be the realisation as there are contextual and social differences in students, and training opportunities that may not result in the same experience and to same extent for all students.

In discussing how teachers learn and develop, Hammerness et al. (2005) argue that the knowledge, skills and attitudes (competence) for optimal practice are not fully developed in initial professional education. This is where the role of continuing professional development (CPD) facilitates the lifelong learning in which a professional needs to engage. Therefore, contemporary theory and research related to a professional's learning and development emphasise the importance of and need for professionals to continue learning throughout their practice. In South Africa, CPD activities are mandatory for health professionals to engage in annually as stipulated by the HPCSA to facilitate ongoing learning and skills development. Dreyfus and Dreyfus (1986, cited in Eraut, 2009) provide a model of progression (Table 2.1) and the development of expertise through a set of stages. The set of stages begins with the **novice** at level 1 (possibly at student level) who rigidly adheres to taught rules from their initial professional education. The **advanced beginner** is someone who has some prior experience. The advanced beginner level is succeeded by the **competent**

**level** (possibly at final-year level or graduate level) where the professional is adaptable to situations and conscious of deliberate planning. The penultimate level is the **proficient level** where the professional is able to see situations holistically and decision-making is less laboured than during the previous levels. The final level is the **expert level** where the professional no longer relies on rules or guidelines and where he or she has an intuitive grasp of situations based on deep tacit understanding, possibly due to prolonged engagement in the field. Table 2.1

Summary of the Dreyfus model of progression of professional development

Level 1	<p><b>Novice</b></p> <p>Rigid adherence to taught rules or plans</p> <p>Little situational perception</p> <p>No discretionary judgement</p>
Level 2	<p><b>Advanced beginner</b></p> <p>Guidelines for action based on attributes or aspects and characteristics of situations recognisable only after some prior experience</p> <p>Situational perception still limited</p> <p>All attributes and aspects are treated separately and given equal importance</p>
Level 3	<p><b>Competent</b></p> <p>Coping with crowdedness</p> <p>Now sees actions at least partially in terms of longer-term goals</p> <p>Conscious deliberate planning</p> <p>Standardised and routinised procedures</p>
Level 4	<p><b>Proficient</b></p> <p>Sees situation holistically rather than in terms of aspects</p> <p>Sees what is most important in a situation</p> <p>Perceives deviations from the normal pattern</p> <p>Decision-making is less laboured</p> <p>Uses maxims for guidance, whose meaning varies according to the situation</p>
Level 5	<p><b>Expert</b></p> <p>No longer relies on rules, guidelines or maxims</p> <p>Intuitive grasp of situation based on deep tacit understanding</p> <p>Analytic approaches used only in novel situations, when problems occur or when justifying conclusions</p> <p>Vision of what is possible</p>

Source: Dreyfus and Dreyfus (1986, cited in Eraut, 2009, p. 3)

According to Eraut (2009), levels 1 to 3 of the model show the development of situational recognition and understanding, and of standard routines that enable one to

cope with crowded busy contexts. It is conceivable to think that over time, the explicit rules and guidelines so essential at the novice level gradually become superfluous, until they are eventually abandoned when simple activities become more automatic, and more complex activities are subjected to deliberation at the 'competent' stage, but may not be treated very analytically unless analysis is specifically required (Eraut, 2009). When applied to clinical practice in speech-language therapy, I am in agreement with Freeman (2004) who argues that if we can validly ascertain key competences in clinical interactions, at different levels of initial professional education, then we will have more grounded ways of sign-posting students' development of these generic skills (communicative competence).

### **2.3.6 The world of work and communicative competence**

In the medical profession, empirical research on doctor–patient communication has been identified as problematic, with implications related to reduction in healthcare or intervention effectiveness through a lack of patient compliance and misunderstandings resulting in re-admissions (Frankel, 2001; McNeillis, 2001). The manner in which a healthcare professional communicates information to a patient is as important as the information being communicated (Yasmeen, 2013). Without effective communication skills on the part of the SLT, client situations will not be appreciated, client desires will not be understood, common ground with the client and families about priority issues will not be reached, and shared decision-making about best courses of action will not occur (King, Servais, Bolack, Shephard, & Willoughby, 2012). This will inadvertently influence the diagnosis and treatment outcomes for clients and their families.

SLTs globally share similar practice issues with other healthcare professionals with regard to responding to the changing healthcare landscape and the changing nature of practice as well as seeking to enhance communication in the delivery of care (Candlin 2000; Sarangi & Roberts, 1999).

The changing healthcare context of the 21<sup>st</sup> century has highlighted the gaps in health systems and has alluded to new graduates being 'ill equipped' for the world of work largely due to static, fragmented and outdated curricula (Frenk et al., 2010). Frenk et al. (2010) discuss the dynamic interaction between the education system, the health system, and the mutual power that both systems have in the production and

development of adequate numbers of health professionals and the appropriate type of healthcare workers for the labour market.

A study conducted by Khan, Knight, and Esterhuizen (2009) explored the perceptions and attitudes of SLTs, audiologists, occupational therapists and physiotherapists doing community service in KwaZulu-Natal. Of significance, participants reported concerns regarding communication difficulties experienced during service delivery with regard to cross-linguistic communication. Around the same time, Penn, Mupawose, and Stein (2009) reported findings indicating that speech-language therapy graduates experienced challenges in dealing with linguistic diversity. It is clear that healthcare professionals experience communication difficulties with their clients, mostly due to cross-linguistic reasons; hence, cross-linguistic communication difficulties seem to get attention for research purposes possibly due to the overt communication breakdown that occurs. The question, however, is whether there will be further facilitators or inhibitors to communication if we move beyond these common (however no less important) challenges and delve deeper into encounters between SLTs and their clients.

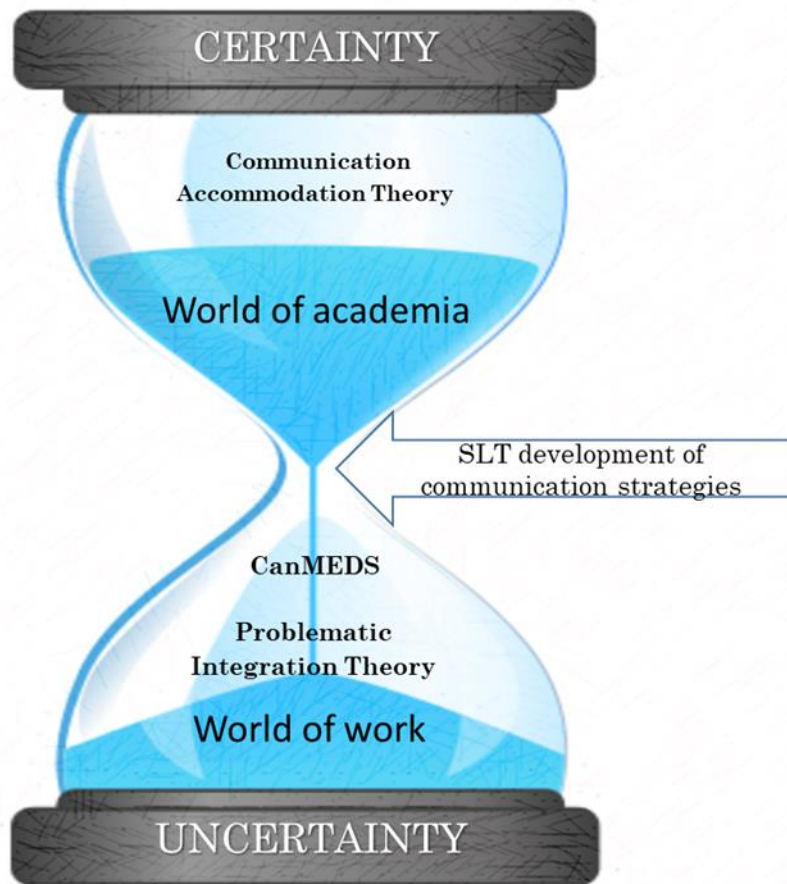


Figure 2.4

*Conceptual framework of communicative competence during clinical engagement*

Source: Author's compilation.

The intersecting concepts that will constitute the literature review are presented in a conceptual framework (Figure 2.4). The purpose of this diagram is to orientate the reader to the terminology used below in the discussion in section two and to facilitate coherence in terms of the critical questions of the study.

## **2.4 Section two: Engaging the theories**

The two communication theories, which have framed this study, are the communication accommodation theory (CAT) as well as the problematic integration theory (PIT). As part of the theoretical framing of the study, I wanted to use the two constructs of 'certainty' and 'uncertainty' to theorise how our communication is negotiated by SLTs in the world of work. I do not propose that the constructs are in contention with each other. In the world of work, people are faced with moments of



certainty (preparedness through education and training in the world of academe) as well as moments of uncertainty (where tacit or private knowledge is used). The two theories (CAT and PIT) were chosen to show how prepared (certain) and spontaneous (uncertain) engagements or situations can yield different experiences and draw on different skills. From an HE perspective, which was discussed earlier (see section 2.3.5), the CanMEDS competency framework (see Frank, 2005) and specifically the 'communicator' competency will be layered further onto the theoretical lens for the study. The metaphor of an hourglass is used here to illustrate the theories in order to discuss the notion of the development of competence in which a professional engages over time.

I discuss each of these theories as it relates to the phenomenon of communication, especially within clinical engagement in the field of speech-language therapy.

#### **2.4.1 The communication accommodation theory (CAT)**

This theory provides a framework aimed at predicting and explaining many of the adjustments individuals create, maintain or decrease during interaction with communication partners (Giles & Ogay, 2007). The theory proposes that there are two strategies during communicative interaction that facilitate the communicative exchange, i.e. convergence and divergence (Giles & Ogay, 2007). In clinical engagement in speech-language therapy, both strategies are often used to achieve successful communication with clients. I discuss these two strategies using the background of a typical speech-language therapy clinical scenario. *Convergence* is a strategy where individuals adapt their communicative behaviours in terms of the *linguistic features* (rate of speech, accent), *paralinguistic* features (pauses, length of utterances) and *nonverbal features* (smiling, eye contact, gazing) (Giles & Ogay, 2007). Individuals may adapt all three levels of communicative behaviours or just one. The effort of adaptation of an otherwise typical communicative style is regarded as accommodation of the other communicative partner. This strategy is important for maintenance of topics in everyday interaction; however, it becomes even more important in the field of speech-language therapy where the comfort level of the client is of importance in order for intervention to be beneficial. This means that the SLT engages in this strategy by assessing and observing the client's communicative behaviours and matching some of these to establish some similarity. One such example would be when an SLT converses with a person who stutters. The SLT would

typically slow down his or her rate of speech when speaking to a person who stutters to model to the client the appropriate rate of speech that he or she should be using to alleviate anxiety and stuttering moments.

Conversely, the strategy of *divergence* emphasises the difference in communication styles between the conversational partners. Application of this strategy to the clinical environment would be demonstrated when the SLT engages with a client in a phonological process. The SLT would want to draw the client's attention to the difference between the client's production of the target word and the target that the SLT models. For example a typical communicative exchange for this scenario would be:

Client: That is a wed car.

Therapist: Yes, that is a red [emphasis on /r/] car. Red is my favourite colour. Do you like the colour red?

In this scenario, it was important for the SLT to highlight to the client that there was a difference in their productions. By emphasising this difference, the clinician would expect the client to listen to the target and reflect on the clinician's production.

Practitioners or clients may accommodate each other by taking into account others' conversational needs and the power or role relations of the individuals in the interaction. Those traditionally perceived as having greater power between the conversational partners tend to be accommodated more in a conversation than those with less power (Giles, 2008, cited in Bylund, Petersen, & Cameron, 2012).

CAT has had limited application in healthcare engagements between practitioners and clients, let alone application to SLTs as professionals who seldom have had the opportunity to engage with this through deep study and reflection. The gap I wanted to explore in the profession of speech-language therapy was to bring the world of academe and the world of work in dialogue with each other. The evaluation that I am making is that there appears to be a strong technician focus in how the curriculum is enacted with regard to the development of communicative competence across healthcare disciplines. This does not leave much space for creativity and innovation when teaching the 'soft skills', such as communication, which paradoxically happens to be the core skill in the profession of speech-language therapy. This therefore

provided an opportunity for the current research to explore this communication theory further during clinical engagements in the field of communication pathology.

From my involvement as an HE educator and after reviewing the literature, I argue that the SLTs' initial professional education is loosely based – knowingly or unknowingly – on the principles of the CAT where students are taught about the convergence and divergence of communication in negotiating their communication with their clients. Hence, in Figure 2.4, this theory (CAT) is positioned at the upper level of the hourglass as it relates more specifically to the academic world of SLTs. During their initial professional education, student SLTs are acculturated into the profession. They are taught about human communication disorders, and their clinical education involves the therapeutic intervention of clients with these communication disorders. During this clinical engagement, the students have to accommodate their conversational partners through convergent and divergent strategies, as the constructs of the CAT explained above. One could argue that this is a general skill of communication; however, during clinical engagement, convergence and divergence constitute a purposeful act with intention, motivation and reason supporting it. The question is what happens when communicative engagements encounter problematics and accommodations have been exhausted. To respond to this, I introduce the second communication theory as another lens to my theoretical framing.

#### **2.4.2 Problematic integration theory**

The problematic integration theory (PIT) is a sociological theory of uncertainty and communication that examines how we make meaning of information and experiences and how we deal with uncertainty (Babrow, 2007). The PIT suggests that communication creates conceptions of our world (Babrow, 2001). Healthcare professionals, like other professionals working with diversity and/or acculturation and/or illness, face issues surrounding uncertainty, although they may or may not be directly aware of it. Unlike dominant theories of the health sciences, this uncertainty theory suggested by Babrow (2007) hints that the healthcare practitioner is often confronted by not being able to know the client's impairment or diagnosis and/or whether the client requires therapy definitively and precisely. However, as a mark of professionalism, in front of the client or colleagues or to validate their years of training, overt public manifestations of certainty are paraded. This lends an air of professionalism that suggests the worth of the professional health practitioner.

However, the PIT suggests that the clinical engagement is infused with the process of using communicative strategies to identify and resolve problems of uncertainty. Communication is thought to be essential to the construction, management and resolution of uncertainty (Babrow, 2001). Communication in the clinical setting may thus be considered not as aiming to resolve clients' problems, but perhaps rather as negotiating to mask practitioner uncertainty since it is expected that the professional therapist is required (conventionally) to demonstrate confidence and certainty. Professionals are expected to appear as solvers as problems.

It remains to be determined whether uncertainty is regarded only in terms of therapeutic clinical engagement of propositional knowledge. Uncertainty relates to the communicative experience and the sociological issues related to linguistic and cultural differences that may be encountered. The healthcare practitioner has to negotiate all of these key components of clinical engagement. When engaging in the authentic world of everyday practices in clinical settings, the novice is faced with much uncertainty. The question of uncertainty in healthcare has to be raised on many levels: culturally, socially, linguistically, personally and from a professional practice point of view. The current model of speech-language therapy (Sampaio, 2014) focusses on the health condition or disability, which can never be purely quantified, but has been admitted as a state of the client's strengths and weaknesses, i.e. relational well-being. It is within this realm of certainty and uncertainty that the practitioner practices. Uncertainty also lies in the diversity of clients, whom the practitioner encounters in practice. Graduates may not be proficient in languages that are needed to carry out effective therapy. This extends the earlier narrow conceptions of communicative competence, which were confined to matters of fluency and accuracy of speech acts only. 'Effective' therapy offerings seem to be concerned with the appropriate enactment or 'delivery' of therapy and not actually the content. For example, if the client and therapist speak the same language then the clinical engagement would be considered (incorrectly) as 'effective' therapy. There is a (negative) concern when there is a mismatch of languages between the client and the therapist, such as an underlying assumption that there should always be a linguistic match. According to the International Organization for Migration (2011, cited in Hyter, 2014), more people than ever are living outside their 'home' areas. Hyter (2014) further explains that these people travel with their own worldviews and beliefs about health, wellness and

disability; therefore, SLTs need to be aware of these diverse worldviews for the purpose of clinical practice.

Uncertainty has often been linked to negative connotations because much research on the concept of uncertainty had focussed exclusively on how and why people reduce uncertainty – possibly because uncertainty is viewed as threatening (Brashers, 2007). However, at other times, many see uncertainty as positive, because it allows people to maintain hope and optimism (Brashers, 2007). Learning to manage uncertainty is an important life skill (Brashers, 2007). The manner in which SLTs (novice and experienced) deal with matters of uncertainty using communicative competence to integrate the problematics of clinical engagement and engage matters of uncertainty, will be the thread that will run through this thesis.

### **2.4.3 The Canadian Medical Education Directions for Specialists (CanMEDS) competency framework**

The CanMEDS competency framework (Frank, 2005), depicted in Figure 2.5, was developed to respond to the healthcare needs of the new millennium, which has seen dynamic societal forces that have influenced the practice of medicine and healthcare in the past decade (Frank, 2004). The concerns with the new healthcare environment include increased patient consumerism, medical information on the internet, policy and government regulations (Frank, 2004). The CanMEDS competency framework is an initiative to improve patient care by health professionals in the world of work. Its focus is on articulating a comprehensive definition of the competencies needed for medical education and practice (Frank, 2005).

According to the CanMEDS competency framework, communicators are healthcare practitioners who effectively facilitate carer–patient relationships and the dynamic exchanges that occur before, during and after intervention. Locally the Medical and Dental Board of the HPCSA adapted the CanMEDS framework to identify the core competencies that health professionals should possess (Van Heerden, 2012). Included in the core competencies of the framework is communicative competence, which refers to both verbal or oral and written communicative competencies (Frank, 2004). The HPCSA is the statutory body, which governs all healthcare professional activities under the Health Professions Act 56 of 1974 (HPCSA, 2006). This Act clearly defines the scope of practice of each profession it mandates. The growing interests in

competency development of students in healthcare are in response to the Lancet Commission on Education of Health Professionals for the 21<sup>st</sup> century (Frenk et al., 2010; Van Schalkwyk, Louw, & Du Plooy, 2014). Although applied to the medical and dental professions in South Africa, at the time of this research, the adoption of the CanMEDS competency framework (Frank, 2005) has not yet been applied to the other professional boards of the HPCSA, including the Speech Language and Hearing Professions Board. The Canadian context also draws some parallels with South Africa because of the history of colonialisation that both countries have experienced (Penn et al., 2017), which resulted in tiered health systems, a neglect of linguistic and cultural origin, and health disparities (Griffiths, Cole, Lee, & Madden, 2016, cited in Penn et al., 2017). Further to this, both countries have experienced migration-related issues, destabilisation and democratic order. Hence, it was decided to explore this framework in this study on the profession of speech-language therapy in the South African context.

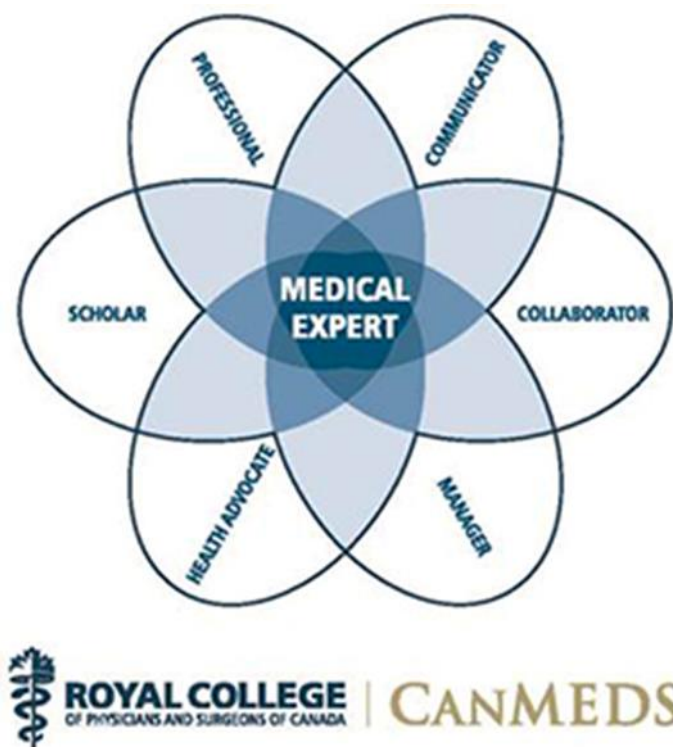


Figure 2.5

*The Canadian Medical Education Directions for Specialists (CanMEDS) competency framework*

Source: Visual source: <http://www.royalcollege.ca/rcsite/documents/dialogue/dialogue-15-5-e>

The CanMEDS competency framework provides the idealistic representation of core and enabling competencies that health practitioners should develop during the time of training and all through their practice. It is a type of benchmark, which has been adopted and adapted by the HPCSA in 2012 as a means of looking at the development of professional competences (S.Y. Essack, personal communication, October 14, 2014). My criticism of the framework is that it is too idealistic in that all of the said competencies within the framework are positioned to suggest that each can be taught. One could argue that there is much propositional knowledge, which the students and novice graduates have to negotiate to concern themselves further with this craft or personal knowledge or 'soft' skills of being a competent communicator. As an SLT, communication forms the solar plexus of practice. It is the subject, object and method of intervention. Hence, it is worthwhile to explore the negotiations of communication that SLTs encounter in everyday practice with their clients. The end goal of speech-language therapy service provision should be on the enhancement and improvement of a client's communication impairment (Simmons-Mackie & Damico, 2010); hence, the client's communication is at the centre of practice. It is through the SLT's communication that therapy is enacted and shifts in the client's communication are achieved.

## **2.5 Synthesis of the chapter**

Chapter Two started with a discussion regarding facilitation of an understanding of graduate competence and communicative competence. Thereafter a discussion was presented on how SLTs come to develop communicative competence during initial professional education. The chapter then delved into the world of work and the enactment of communicative competence, analysing how central communication is to the profession of speech-language therapy. The chapter further foregrounded the communication between the worlds of academe and work in which the model of communication was adapted to augment the argument presented. The concept of clinical engagement was recognised as the complex interaction of people and the communication strategies used in these moments. Finally, two communication theories were presented according to their relevance to the study. I argued that the principles of CAT underpin the initial professional education of SLTs. SLTs are taught about accommodating their communication partner through constructs of convergence and divergence. However when accommodations have been exhausted, the PIT finds

its place in clinical engagement to assist in negotiating the uncertainty of the communication. The PIT was discussed in relation to how professionals make meaning of information and experiences and the way they deal with uncertainty during clinical interactions. It was through these lenses of communication theories that I explored the data to explain the complexities that exist during clinical engagement and communicative encounters between the SLTs and their clients.



## **CHAPTER THREE: Engaging the field**

### **3.1 Introduction**

In the previous chapter, a review of the relevant literature was presented and the conceptual framework discussed. The literature provided me with insight into potential research approaches to explore deeper the experiences of SLTs as they negotiate their communication in the world of work and reflect on the world of academe. In this chapter, I discuss the choices made in conducting the fieldwork of the study and the issues faced before, during and after entering the field. The lens constructed at the end of the last chapter provided the basis for the design of the research instruments for my study.

### **3.2 Orientation to the chapter**

This chapter is divided into two sections. In Section One, I discuss the data methods, the data production plan and the issues around ethics and trustworthiness. In Section Two, I present a description of how the data analysis was engaged and the decisions that led to using narratives to represent the data.

### **3.3 Section One: Research methodology**

This qualitative study explored the negotiation of communication strategies of SLTs in the world of work. The study was situated within an interpretivist paradigm to explore the multiple realities of the participants, which provided varied insights into the phenomenon under study, namely communication used during clinical engagement.

#### **3.3.1 Genre of inquiry**

The study was most suited for a single-case study design, which is an intensive description and analysis of a phenomenon, social unit or system bounded by time or place (Berg, 2004; Creswell, 2007). The case under study was the negotiation of communication of SLTs. This was a single-case study involving UKZN as the site of context for the case (Creswell, 2007). South Africa is at greater risk for severe health conditions due to the burden disease profile of the country linked to HIV/AIDS, poverty and low literacy levels, which increase the risk for communication disorders (Popich, 2003). Van der Linde et al., (2016) report a high prevalence of communication delay in an SA primary context thus highlighting the need and an important role for SLTs. UKZN is the only institution offering initial professional education to SLTs in the

province of KwaZulu-Natal; hence, the Discipline of Speech-Language Therapy at UKZN was chosen as the case. Multiple individuals were selected for the study as well as multiple sources of data (e.g. interviews and observations, which will be discussed later in the chapter – see 3.3.4). These units allowed me to explore the case using cross-case comparisons (Gustafsson, 2017). I adopted a narrative methodology to capture the complexity of the participants' lived experiences and to add an extra layer to the data representation and analysis process. I also wanted to represent the participants' experiences as creatively as possible. Hence, a narrative methodology was used during the initial stages of data analysis. The data was subjected to narrative analysis as I studied the cases of the participants while they told their stories to provide complex and multiple meanings of their experiences. I detailed the levels of coherence, consistencies and contradictions within and between the data sets. The narrativising of the data is discussed in 3.4.1.

### **3.3.2 Research sampling**

Purposive sampling was used because I attempted to select information-rich cases from different contexts with participants on either end of the level of experience spectrum. I also used a maximum variation strategy to represent diverse cases and differentiation representative of the field to display multiple perspectives about the case (Bloomberg & Volpe, 2012; Flick, 2014). This was done to yield insight into the phenomenon (i.e. communication used during clinical engagement) from varying perspectives (Bloomberg & Volpe, 2012). I identified their work context with respect to the sector in which they were employed (health, education, private practice), type of facility (government, public or private). I also considered their language background, race, gender, level of experience (newly qualified, i.e. 0–3 years of experienced, or experienced with 8 years or more of experience). Newly qualified or novice SLTs and experienced SLTs were purposefully chosen to explore the negotiation of communication strategies across the experience spectrum as well as to facilitate cross-case comparisons between participants. One prospective participant who was a novice SLTs was not included in the study, as gatekeeper permission was not granted due to clashes with work commitments. See Table 3.1 for the biographical descriptors of participants who participated in the study.

The criteria for the selection of the participants were as follows:

- **Newly qualified SLTs:**
  - all participants had to be registered with the HPCSA;
  - all participants had to have between 0 and 3 years of experience in the world of work; and
  - as this was a case study at UKZN comprising speech-language therapy graduates, all participants had to have completed their undergraduate education at the university.
  
- **Experienced SLTs:**
  - all participants had to be registered with the HPCSA;
  - all participants had to have > 8 years of experience in the world of work; and
  - as this was a case study at UKZN comprising speech-language therapy graduates, all participants had to have completed their undergraduate education at the university.

Eight SLTs who graduated from UKZN participated in the study. They are named in order of most recently qualified to most experienced and will be ordered in this manner for the rest of the study unless otherwise stated: Sharon, Carl, Lynn, Stephanie, Zandi, Amelia, Mbali and Halima. Each participant was included based on the variation to the participant set that they offered in terms of gender, race, language, experience and work context, which added to the richness of the data.

The participants comprised seven females and one male. Male SLTs are scarce in South Africa, and this has been a historical phenomenon in this country with speech-language therapy being known as a female-dominated profession. The participants had 1 to 15 years of experience among them. At the time of the study, the participants were either employed in public (government) or private settings in urban and rural areas in KwaZulu-Natal. The location of the work contexts emerged as an interesting factor in terms of medium of language instruction in therapy and ideas regarding sociological and cultural background. I was interested in exploring in which way and how these factors influenced or did not influence the SLT's communication in these contexts.

Table 3.1

*Biographical information of participants*

Participant	Gender	Newly qualified OR Experienced	Context	Public OR Private	Race	First language
Sharon	Female	Newly qualified	Hospital	Public	White	Afrikaans
Carl	Male	Newly qualified	Hospital	Public	Indian	English
Lynn	Female	Newly qualified	Hospital	Public	Coloured	English
Stephanie	Female	Newly qualified	Private practice	Private	White	English
Zandi	Female	Newly qualified	Hospital	Public	Black African	isiZulu
Amelia	Female	Experienced	Special school	Public	Indian	English
Mbali	Female	Experienced	Hospital	Public	Black African	isiZulu
Halima	Female	Experienced	Special school	Public	Indian	English

**3.3.3. Research process**

The research process comprised a step-by-step order of events that took place to conduct the study. This constituted part of the audit trail, which spoke to the confirmability component of the trustworthiness of the study (Lincoln & Guba, 1985).

**3.3.3.1 Ethical clearance and gatekeeper permission**

The research process began by completing an on-line ethics course and obtaining certification (Appendix A) to proceed with an application for ethical clearance from the university committee (see ethical clearance document in Appendix B).

Simultaneously to this, I obtained gatekeeper permission from the DoH (Appendix C), school principals (Appendix D) and the private practice manager (Appendix E) as the university ethics committee required this permission before issuing clearance for the study.

Once ethical clearance and gatekeeper permission had been obtained I then requested gatekeeper permission from the individual hospitals within the DoH (see Appendix F). I contacted the chief executive officers (CEOs) of the institutions and explained my study to them. I did not encounter any resistance from them verbally. However, I found that I had to send a number of formal requests in order to obtain written confirmation of their permission.

### ***3.3.3.2 Initial contact with participants***

At first, I contacted the participants telephonically to introduce my study. Once they had agreed verbally to participate I thanked them for their interest and explained the specific details of the study, such as the logistical arrangements that would need to be made. I made my requests known from the start regarding interview space, consent to audio and video recording, and identification of a client whom I could observe, to act as a mediator between the client and/or parents/caregivers in soliciting their permission. I then forwarded the informed consent document (Appendix G) outlining all the details of the research to the participants (SLTs). The participants agreed to receive the letters to clients and/or their families prior to my visit via email. The informed consent form for adult clients (Appendix H) was sent to willing adult clients who were able to understand the content of the form. If the adults were unable to consent or if minors were the clients, then the declaration of consent from the caregiver or parent form was to be completed (Appendix I). In the case of minors, the verbal assent script for paediatric clients was to be read out to the client prior to the data collection by the researcher (Appendix J). The SLTs were assured that all information would be kept confidential, that they could refrain from providing information where they deemed it necessary and that they could withdraw from the study at any point. They were also told that the transcripts and narratives would be sent to them at a later stage for member checking (Loh, 2013). Once all information had been clarified, SLTs were asked to sign the informed consent document, which would serve as a binding contract of consent to participation.

### ***3.3.3.3 Entering the field for data production***

Once I had established contact with my participants and had gained access to the hospitals, schools and private practice, I was ready to enter the field for data production. I set up a schedule of dates and times on which I would go to each participant for their planning as well as my own. This helped with the overall organisation of data production and it prepared the participants to know how much time I intended spending with them so that they could accommodate me better in their schedules.

### **3.3.4 Data production**

Data production for the main study took place over five months, from November 2015 to March 2016. Table 3.2 presents the data production plan that was amended after the pilot study. As could be anticipated there were delays and unforeseen events that took place during this time, which did not necessarily affect the time but did affect the logistical planning within this time. The duration of interviews and observations varied among participants, which was dependent on their availability and schedules and the attention span and willingness of their clients during my observation.

Table 3.2

Data production plan for the main study

	Critical question	Why is the data being collected?	Data sources and location	How often will data be collected?	How will the data be collected?
DESCRIPTIVE QUESTION	1. What is the nature of communicative competence that is taught and learnt during the initial professional education of speech-language therapists (SLTs)? (the world of academe)	To explore the communication strategies used in the world of work that were taught to the SLTs during their initial professional education.	The participants were interviewed and video recorded for later discussion and observation of the strategies used. The data was collected from the participants' natural environment, which was their place of work as this is typically where therapy takes place.	The pre- and post-observation interviews were done once off. The clinical engagement with the client was video recorded. This constituted the observation data, which was recorded once and was viewed multiple times to verify initial observations made and to optimise the narratives with authenticity.	Verbal pre- and post-observation interviews were conducted where I used an interview schedule loosely to guide the discussion. The observation data was collected through video recording and was later played back to participants after the video had been uploaded to a laptop to facilitate viewing.
INTERPRETATIVE QUESTION	2. How do SLTs negotiate communication strategies during clinical engagement within workplace contexts? [ <i>the world of work</i> ]	To explore how SLTs negotiate communication strategies during clinical engagement in the workplace.	SLTs were observed and interviewed at their work sites. Participants from varied work contexts were purposively chosen to participate in the study. Race, gender and language background were the criteria used in the selection of the participants as this is one way of reflecting diversity especially in terms of communication.	The pre-observation interview was conducted first. The SLTs were observed during clinical engagement with a client of their choice. The clinical sessions were video recorded. The post-observation interview was done using the video data to assist recall of events.	Data was gathered at the workplaces of the participants. All preliminary permissions were obtained (e.g. from the Department of Health, Department of Education, hospital managers, practice managers, principals, SLTs and clients).

THEORETICAL QUESTION

3. What explains SLTs' choices of communication strategies during the clinical engagement within workplace settings?  
*[the world of data, literature, practical, theoretical and philosophical explanations]*

To determine how SLTs use communication strategies within the workplace during clinical engagement. To interpret the explanations offered by the SLTs of themselves, their views about their initial professional education, or from other sources of influence, from theoretical understandings or literature regarding their choices of communication strategies.

SLTs were observed and interviewed at their work sites. Participants from varied work contexts were purposively chosen to participate in the study. Race, gender and language background were the criteria used in the selection of the participants as this is one way of reflecting diversity especially in terms of communication.

The pre-observation interview was conducted first. The SLTs were observed during clinical engagement with a client of their choice. The clinical sessions were video recorded. The post-observation interview was done using the video data from the clinical session to assist recall of events.

Verbal pre- and post-observation interviews were conducted where I used an interview schedule loosely to guide the discussion. The observation data was collected through video recording and was later played back to participants after the video had been uploaded to a laptop to facilitate viewing.



### ***3.3.4.1 Conducting the pilot study***

The pilot study was conducted prior to the main study. It was conducted with two SLTs: one who was newly qualified and working in a private school setting and the other who was experienced and working in a public hospital setting. The pilot study offered more benefit to me other than the 'testing' of my data collection tools. As the data collector, I found that I needed the experience to practice this new role that I had. Was I researching up? Was I researching down? I really was not sure. My dress code was not something that I anticipated to affect the data production process; however, I found that it did. I discussed the first participant's aloofness with my supervisors and other colleagues in a formal forum and realised that this was possibly due to the following: me being an outsider (a lecturer at the university and not a therapist in the field), my usual professional dress code as well as the nature of questions that I asked that may have been intimidating to the participant. I adapted to a more casual approach. I tried to show my genuine interest in conversation where I attempted to suspend judgement and modulated my tone of voice to be more conducive to listening and relinquishing control and power in this interaction. Kvale (1996, p. 20) offers, "the research interview is characterised by a methodological awareness of question forms, a focus on the dynamics of interaction between interviewer and interviewee, and a critical attention to what is said". I followed these guidelines in my mind. However, I did not let my agenda interfere with the flow of the conversation. Once I had suspended control of the researcher in me, I found that the participants were more comfortable with my presence and in conversing with me. This was more evident in the second pilot study.

#### ***3.3.4.1.1 Piloting the pre-observation interview***

The pilot studies revealed a number of issues with the pre-observation interview schedule (Appendix K) that I had not anticipated. My interview techniques and probing were found to be problematic. I believed that if I had my list of questions in a well-thought-of manner that the participant would generate a flowing and coherent narrative. However, I soon realised that this was not the case. I found that participants were distracted by my piece of paper (the interview schedule) so I put that away. I did not need a script; I just let the conversation take its course. Furthermore, the participants were not familiar with the types of questions that I were asking so their answers were based on short-term recall, such as something that had happened that week or even earlier in the day. This required more probing in order to generate deeper

introspect. I generated a mind map of the interview schedule so that I could vividly recall the questions or issues that I wanted to discuss in a more user-friendly manner (diagrammatically) (see Appendix L).

#### *3.3.4.1.2 Piloting the observation schedule (Appendix M)*

I sat in the first observation session between the SLT (participant) and the client even though I video recorded the session. The video was meant to be a backup of my observations. However, I found that my presence affected the participant as well as the client with whom she was working. Also distracting was the video camera set up. The first issue was simple enough to work around. I decided to leave the camera in the room but I would not be present during the session. The second issue of concealing the camera was difficult. The camera was positioned behind the client so that they were not in view of this. I decided to desensitise the participant by including the camera in the pre-observation interview so that he or she could become comfortable with a camera present. The second pilot study participant reported that she soon forgot about the camera being in the room. I recorded this on the observation schedule retrospectively once I was able to view the video recordings. I gave the participant a break between the session with the client and the post-observation interview. I used this time to scan the video and make notes to pick out behaviours on which I wanted to elaborate during the post-observation interview.

#### *3.3.4.1.3 Piloting the post-observation interview*

The post-observation interview schedule (Appendix N) was actually a type of stimulated recall interview. The pilot study following the observation interview highlighted the need for me to review quickly the videos of the session that occurred. I needed to be technologically 'savvy' so as not to waste time uploading the videos onto my laptop. I had practised this beforehand as this was important. During the second pilot study, I developed more competence with handling the equipment and navigating through the video. The stimulated recall interview schedule needed to be amended and was seemingly shorter than the pre-observation schedule as I could pre-empt all of the questions that I wanted to ask because these were based on the observation. However, by the end of the second pilot study, I had decided to follow my temporary lens loosely from my review of the literature in the form of a mind map with the questions that I wanted to ask. This focussed on the general impressions and

reflections of the session, instances of communication accommodation on the part of the SLT in the session, instances of uncertainties or problematics and reflections thereof (see Appendix O).

### **3.3.4.2 Conducting the main study**

Once the pilot studies had been conducted, I reflected on the entire process and referred to my journal notes to plan the way forward to the main study. Table 3.2 outlined the data production plan that was followed. The data sources and methods were aligned to the critical questions of the study.

As mentioned previously, the plan for data production was developed in line with the critical questions for the study. The tools were chosen with the intention of how best to produce the data. The data collection tools were revised for the main study based on the outcomes of the pilot study.

The phenomenon of the study was the negotiation of communication strategies in the world of work of the speech-language therapist. The speech-language therapy sessions were video recorded, and were later viewed. This formed the observation component of the study. In addition, interviews were conducted before and after the videoed therapy sessions. The videos were used as a stimulus to help participants recall particular incidents in the therapy session that they wanted to discuss or on which they wanted to elaborate (Mackey & Gass, 2005). Field notes in the form of my research journal were also used to augment the data. Thus several data sources were helpful for triangulation purposes and in generating the narratives for each participant, which will be discussed later in the chapter (see section 3.3.7.1.2).

#### *3.3.4.2.1 The pre-observation interview schedule (Appendices K and L)*

This interview was the first contact that I had with the participants for the purposes of data production. Although discussed telephonically and via email, we still briefly discussed the purpose of the study and the amount of time that we needed to collect the data (Creswell, 2007). Although I was familiar with all participants, time was still spent on building rapport and developing a trusting relationship.

The pre-observation interview took an average of 45 minutes. A few participants were comfortable to speak for longer periods. However, some appeared anxious about the upcoming video recorded (observation) session with their clients and seemed more

comfortable in the post-observation interview. The interviews were audio and video recorded, which would have also affected their feelings of uneasiness, even though they gave their permission for this to happen. As discussed earlier, the interview schedule was refined and reorganised after the pilot study to be more illustrative and diagrammatic so that I could visualise it and navigate through the conversation without being dependent on the schedule. A complete pre-observation transcript can be found as Appendix M.

#### *3.3.4.2.2 The observation (Appendix N)*

Non-participant observations were carried out in the typical workspaces of the participants within each context. Each participant needed a 30–45-minute time slot for his or her therapy session with the client.

Jacob (1988) states that human ethology is one of the distinct traditions of qualitative research. Human ethology involves the detailed observations and descriptions of behaviour in natural settings (Jacob, 1988). The term originated in the study of animal behaviour. In the current study, qualitative ethology was used for exploring the interactions between the practitioners and the clients using the video-recorded (observation) data (Bottorff & Varcoe, 1995). This ethological approach involved the study of the participants' behaviour in their natural environments. The opportunity of watching the participants in their professional role and in their natural environments gave me insight into how they communicated during therapy.

The observation data added another lens on communication, especially non-verbal communication. It provided depth and evidence of the sentiments expressed in the pre-observation interview and it gave me insight into what to probe for in the post-observation interview. The conversation between the SLT and the client was transcribed to augment the observational data. In cases where the language used in the session was different from English, an interpreter was employed. The data was transcribed in the language spoken and then translated into English so that I could read and code the data.

The following information was recorded on the observation schedules:

- observer information;
- participant characteristics;
- client characteristics;

- verbal characteristics of the clinician-client interaction;
- nonverbal characteristics of the clinician-client interaction; and
- instructional artefacts and/or stimuli used.

The observation schedule was developed using the speech acts theory (Searle, Kiefer & Bierwisch, 1980) which includes the illocutionary, perlocutionary and locutionary speech acts). This was used to address the verbal clinician-client interaction. Nonverbal communication or the paralinguistic features of the interaction were coded using the elements of kinesics (body movements), haptics (touch) and proxemics (spatial boundaries) (Duck & McMahan, 2010), as well as my experience as a clinician in the field of speech-language therapy (type of instructional method, types of elicitation methods and instructional artefacts or stimuli used). The raw data was processed through an inductive process of coding the transcripts and incorporating notes made in my researcher's journal. Categories were then established. Themes that were developed underwent several revisions. The themes were then aggregated to generate the building blocks for establishing the analysis of the raw data. See Appendix N for the observation schedule used in the study. For the analysis, the raw data was processed through an inductive process of coding the transcripts and incorporating notes made in my researcher's journal. Categories were then established. Themes that were developed underwent several revisions. The themes were then aggregated to generate the building blocks for establishing the analysis of the raw data. See Appendix O for an example of a completed observation schedule and see Appendix P for a completed observation transcript of the clinical session as it was coded according to the observation schedule.

#### *3.3.4.2.3 The post-observation interview (Appendices Q and R)*

Stimulated recall interviews, or the post-observation interviews (as I have referred to it in the study) can be viewed as a subset of introspective research methods, which access participants' reflections on mental processes, which have their origins in philosophy and psychology (Rowe, 2009). One advantage of this approach is that stimulated recall data allows participants to explain their decision-making (Fox-Turnbull, 2009). One limitation to stimulated recall is that recall procedures should occur as soon as possible after the task has been completed (Fox-Turnbull, 2009). Most of the stimulated recall interviews were conducted on the same day of the video observations to mitigate this limitation. I found it useful to conduct the post-observation

interview on the same day of the observation but after a short break. In some cases, due to time constraints on the part of the participants, I had to conduct the post-observation interview on another day. This gave the participants and myself time to reflect on what had happened during the session. Unfortunately, the time that elapsed between the observations and the post-observation interview sometimes affected participant recall in terms of reasons behind decisions made in the session. The video stimuli were useful in this recall. At the time of the post-observation interview, participants were more relaxed and comfortable with the research process. I briefed the participants on the purpose of this interview and we set a time frame of how long the interview would take, bearing in mind that it was almost at the end of the day in some cases. For most participants, the interview lasted approximately 30 minutes. The interview was again audio and video recorded. The participants reported that this interview was less stressful for them due to their prior experience in the pre-observation interview. The post-observation interview schedule was developed as a mind map to facilitate better flow of the conversation (see Appendix R). This interview gave me a good understanding of the world of work issues that the participants faced. Refer to Appendix S for an example of a completed post-observation schedule.

#### ***3.3.2.4 Data management and storage***

The data collected during the fieldwork was organised by transcribing verbal data and recording observation data onto the observation schedule (Appendix N). All electronic data was stored on my external hard drive in password-protected files with no access allowed to anyone other than myself. Each participant was allocated a different folder where all data pertinent to that individual was indexed and stored. This made for easier management of individual participants' data when constructing the narratives. All printed and written records were filed and stored in a secure and locked cabinet on the UKZN Westville Campus, in the Discipline of Speech-Language Therapy, in my office. These written records will be kept for a minimum of five years. All non-essential documents will be destroyed and discarded after the five years of storage.

#### **3.3.5 Ethical issues**

To adhere to the ethical principles of anonymity and confidentiality, I completed an online ethics courses mandated by UKZN (Appendix A). The research proposal was prepared and submitted to the Humanities and Social Sciences Research Ethics

Committee for ethical clearance for the study. Simultaneously gatekeeper permission was sought from the KwaZulu-Natal Department of Health in order to access SLTs employed in public health facilities in the province, school principals and practice managers for those employed in the private practice context. Prior to conducting the research, ethical considerations, such as informed consent (verbal and written), guarantees of confidentiality, beneficence and non-maleficence were discussed with all participants (Cohen, Manion & Morrison, 2013; Henning, Gravett, & Van Rensburg, 2005). The SLTs were provided with detailed information of the purpose, aims, their involvement in the research and what the data would be used for. This information comprised the recording of data (audio recorders and video recorders) as well as the storage of such data.

The participants' names were withheld through every stage of the research and they were given pseudonyms as it was the responsibility of the researcher to protect their identity. Although not direct participants, the clients with whom the SLTs interacted during the observation were asked for their permission (Appendices H, I and J) to be part of the study and to be video and audio recorded. In the case of minors or special populations whose literacy was affected, verbal assent was requested and parents and/or caregivers were asked for permission on their behalf (Appendix J).

Cautionary measures were taken to store the data and other research-related records in a secure manner to ensure that nobody other than myself as the researcher had access to this material.

### **3.3.6 Challenges experienced during data collection**

It was difficult to manage the data collection process because of conflict in work schedules between the researcher and the participants. Often walk-in clients or other work duties interfered with the flow of the interview and observation process and in one instance, the observation had to be rescheduled on another day. This affected the rapport already established between the researcher and the participant.

Gatekeeper permission was another limiting factor to the timeous arrangement of the pre-data collection process. The university ethics committee often requires gatekeeper permission prior to issuing ethical clearance for the study while gatekeepers of institutions are reluctant to provide permission without the formalisation by the

university of the ethical clearance. Hence, both processes had to occur simultaneously, which resulted in extra time being required to facilitate this process.

### **3.3.7 Issues of trustworthiness**

In seeking to establish the trustworthiness of a qualitative study, Lincoln and Guba (1985) use the terms 'credibility', 'transferability', 'dependability' and 'confirmability'. The guidelines provided by Lincoln and Guba (1985) were used here.

#### **3.3.7.1 Credibility**

Credibility relates to how congruent the research findings are to reality (Merriam, 1998). Prolonged engagement, triangulation, peer debriefing, negative case analysis and member checking were all conducted to ensure that the credibility of the study data was achieved.

##### *3.3.7.1.1 Prolonged engagement*

I had professional relationships with all of the participants prior to the research process; therefore, engaging with them was relatively effortless and easy-going. I engaged and maintained contact with the participants prior to, during and after the data production period, which spanned a period of two years. This allowed time for reflection for myself as well as for the participants, for refinement of the data and to improve the quality of data production.

##### *3.3.7.1.2 Triangulation*

I gathered data from multiple sources through different data production methods over time, i.e. pre-observation interviews, video-recorded observation data and post-observation interviews. In doing so, I was able to get a fuller and richer picture of the phenomenon under study.

##### *3.3.7.1.3 Peer debriefing*

I engaged with a number of peers during the research process, mostly during the transcription process, the data representation and the analysis. Fellow doctoral students as well as well-established researchers were all involved in evaluating the processes that I followed. This challenged me throughout the process, which improved my skills as a qualitative researcher. It made me engage reflexively with the data and in this way, enhanced the credibility of the study.



#### *3.3.7.1.4 Negative case analysis*

The negative case analysis or the search for 'atypical' cases or the 'outliers' in this study involved searching for and discussing elements of the data that did not support or appear to contradict patterns or explanations that were emerging from the data analysis (Miles & Huberman, 1994). Two cases or participant narratives were identified to cross-check and validate the data analysis process (see section 7.4).

#### *3.3.7.1.5 Member checking*

Throughout the data production process, I used member checking in its various forms to ensure that it was the personal truth of the participants that I was capturing (Loh, 2013):

- While I conducted the interviews, I synthesised key points at certain times in order to check that my interpretation of the data was consistent with what the participants were saying.
- While transcribing the recorded data, I checked for accuracy of the actual words that had been said.
- I sent through the transcripts and the narratives to the participants for member checking. Feedback from these checks was incorporated in the final versions of the narratives.

### **3.3.7.2 Transferability**

This refers to how 'transferable' the research findings are to other contexts (Firestone, 1993). Although transferability is not the imperative of qualitative research, the reader uses his or judgement to determine how he or she can relate to the research findings of the study.

#### *3.3.7.2.1 Thick description*

Thick descriptions of the empirical data were presented in the narratives of the participants in the description of the context, participants' feelings, actions and experiences. The thick descriptions are important as they allow the reader into the world of the participant to understand the data better.

### **3.3.7.3 Dependability**

To ensure that the study can be repeated in the future, I provide a detailed breakdown of the research process as well as the data production plan in Table 3.2. This speaks

to the replicability of the research methodology. It is important to be as detailed as possible so that future research can build on the current study. There has also been extensive discussion with my peers in the PhD cohort programme and I invited their comments regarding the research design. A critical appraisal of the study is offered in Chapter Nine.

#### **3.3.7.4 Confirmability**

Confirmability is the qualitative researcher's comparable concern to objectivity within the positivist paradigm (Shenton, 2004). The audit trail followed, triangulation of data sources and researcher reflexivity all speak to the issue of confirmability.

##### *3.3.7.4.1 Audit trail*

This was done by providing a comprehensive research procedure protocol, which clearly outlined the processes followed when conducting this research. The decisions made in managing the data were outlined in section 3.3.2.4 for the purposes of transparency in documenting the data management process.

##### *3.3.7.4.2 Triangulation*

The purpose of triangulation was to reduce the effect of researcher bias (Shenton, 2004). A key feature for confirmability is the researcher's awareness and the extent to which the researcher admits own predispositions (Miles & Huberman, 1994). To this effect, I have declared my positionality in conducting this research study. There were multiple data sources with which triangulation had been achieved.

##### *3.3.7.4.3 Reflexivity*

Researcher reflexivity was maintained throughout the study by being cognisant of personal biases and ways of thinking through the data production levels and in the data analysis. My concern was centred on how the presentation of my findings would suit my readers. I attempted to make this thesis as reader-friendly as possible. I reflected on my position as a researcher from an ontological and epistemological perspective. I was always guided by my critical questions, which guided me through these stages.

#### **3.3.8 Summary of the data production process**

Figure 3.1 below provides a diagrammatic representation of the data production process to facilitate readability and transparency of the process.

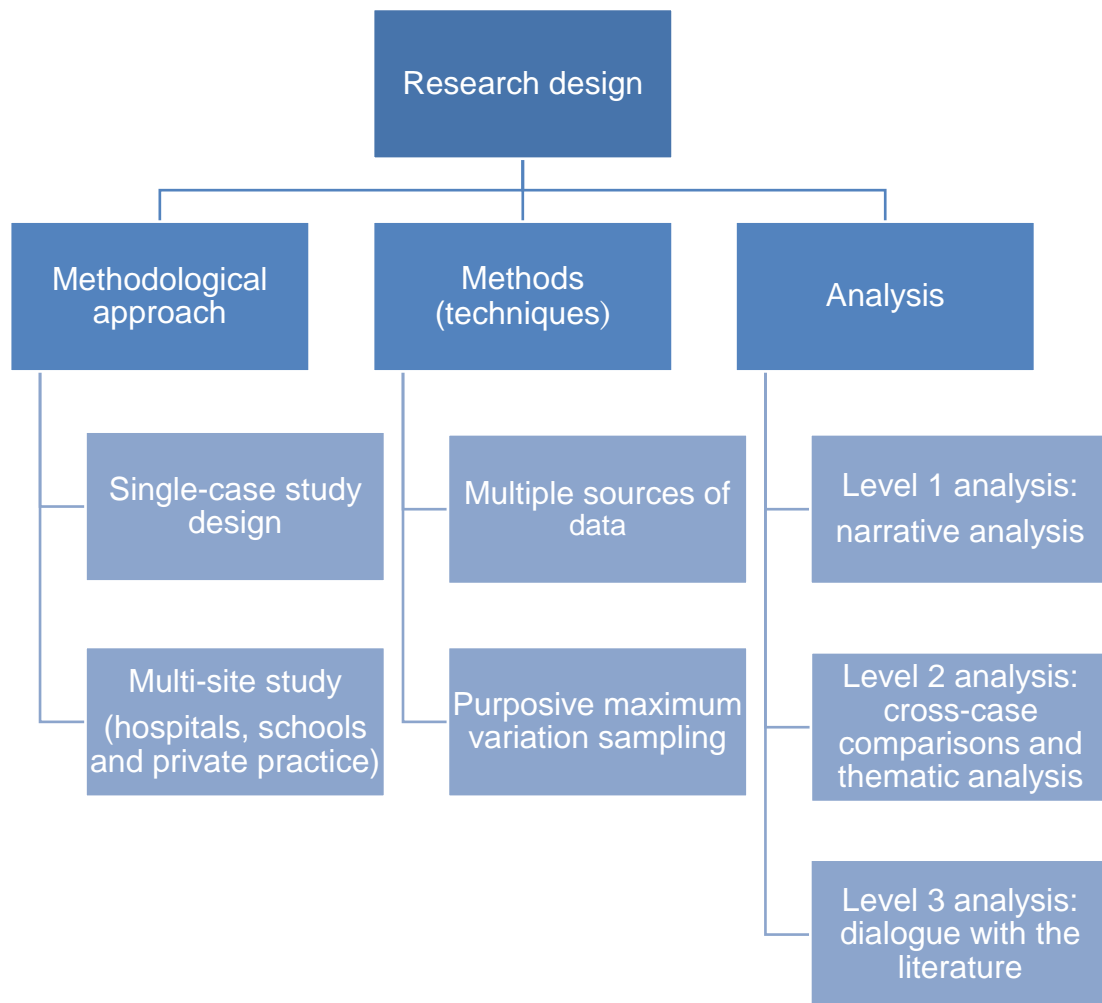


Figure 3.1

*Diagrammatic representation of the data production process*

Source: Author's compilation.

### **3.4 Section Two: Methods of analysing empirical data**

In this section, I discuss the phases of data analysis that I conducted comprising three levels:

Level 1 analysis: Once the interviews had been transcribed and the observation schedules completed, I engaged in writing the storied narratives, which formed the narrative analysis.

Level 2 analysis: I carried out the cross-case comparisons of narratives where the themes that emerged in level 1 were analysed to identify similarities and differences.

Level 3 analysis: This involved the in-depth analysis of the themes and cases that were theorised.

Although the processes followed might be represented in a linear and clinical manner, the enactment of the process was far from such sterility. There were several iterations of revisions to the narratives based on renegotiations with participants. The themes extracted from the data also went through several renegotiations.

Figure 3.1 presents the steps followed in the data analysis process, which made up the analytical strategy.

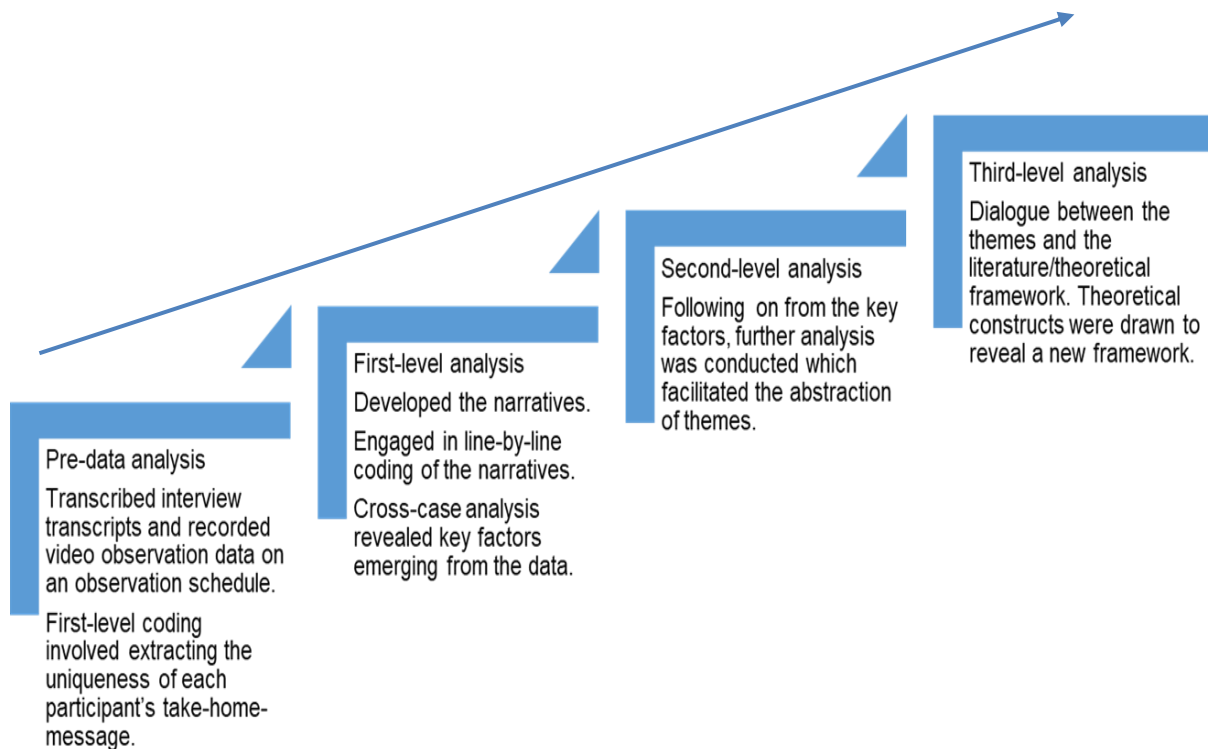


Figure 3.2

*Data analytical strategy followed in the research study*

Source: Author's compilation.

### 3.4.1 Level 1: Narrative analysis

There were several steps within this level that formed the groundwork for the higher levels of analysis. While producing the interview transcripts, I had the chance to familiarise myself with the data.

Once all interview transcripts and observation schedules had been completed I began reading and re-reading them to immerse myself in the data (Braun & Clark, 2006).

Once immersed in the data I realised the dearth of information I had obtained. I turned to narrative analysis as it served the following purposes for me:

- It was a data management mechanism to form coherence among the variety of sources and the volume of data in order to produce a coherent whole.
- It served as an interesting representational device for the data gathered. This form of narrative representation is not commonly used in the field of speech-language pathology and even more especially so when representing SLTs as participants.
- It allowed me to represent the data in a systematic manner to facilitate cross-case comparisons as the next level of data analysis. Each narrative followed a plot to compose the data into a coherent story.
- It also facilitated a telling of the participants' stories of their experiences in practice in an interesting manner.

I used Polkinghorne's (1995) notions of narrative analysis. Narrative researchers solicit events and happenings as data and use narrative analysis procedures to study the stories (Polkinghorne, 2007). I considered this the first instance of coding. I read and worked through each participant's data set and extracted a core 'take-home message' for each participant. This then became the focal point of the narrative to provide a story structure.

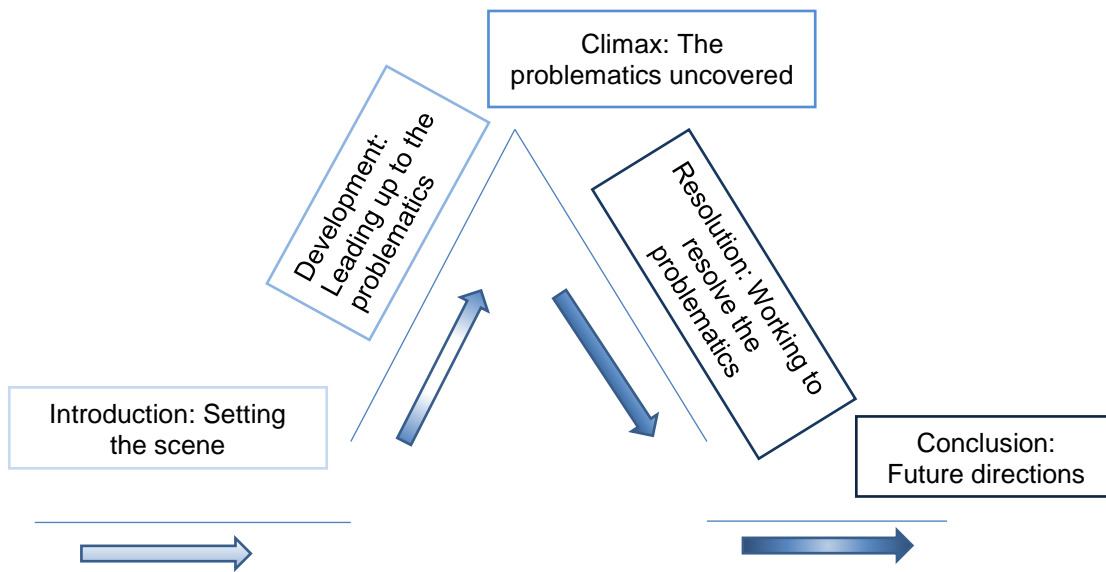


Figure 3.3

*The plot development for the narratives*

Source: Adaptation of Freytag's pyramid (1893, cited in Rolfe, Jones, & Wallace, 2010).

The narratives were produced using creative writing and short story writing techniques whereby I supplemented the detail with verbatim extracts to authenticate the narratives further and to enhance the credibility of the analysis. An adaptation of Freytag's pyramid (1893, cited in Rolfe, Jones, & Wallace, 2010) for plot development was used to construct the narratives as shown in Figure 3.3. This began with the setting of the scene and the introduction of the main protagonists in the story, followed by the development of the plot, the climax where the problematics were heightened, the resolution of the problematics and finally the conclusion. Each of the narratives followed a simple structure. This was a deliberate choice as it aided the comparability of the narratives while doing cross-case comparisons (Chapter Six, section 6.3). The narratives went through several (about four) revisions of each as the stories became more focussed and my story-telling skills developed.

A concern was the truth-value in the construction of narratives and when using multiple data sources (Gustafsson, 2017; Loh, 2013). It was my task to remain true to the

personal truth of the participants (Loh, 2013). Therefore, verbatim phrases were used as often as possible and the member checking process became very important.

Although verbatim quotes were used, the construction of the narrative was an interpretive act, which means that different levels of interpretation were used for different data sources. For example, the visual data required some degree of interpretation from the researcher. I verified these interpretations with the participants. The interpretations were further contextualised with the tone of voice of the participant, and the content of what was said through the audio and video recordings.

A key issue during the construction of the narratives was that of voice, as this choice must be a purposeful act (Polkinghorne, 2005). I chose first-person narrative, and I acknowledge both its value and limitations. I found that first-person narrative allowed the participant's reality to be expressed better as I felt that this form of narration was more authentic to the participant as he participant was the central feature. I acknowledge that the voice of the researcher was muted but only for a short while. The power of first-person stories allowed my participants and myself to have a voice and it helped break the us–them divide between researcher and participants (Ely, 2007). Thick description of the context was an important factor for me to consider, especially if the reader might not have had exposure to SA public (government-owned) hospitals and schools. Therefore, the adjectives that were needed had to be accurately descriptive without a negative connotation as I had to be careful not to be disrespectful of the context.

According to Dubois and Gadde (2002), the researcher constructs the narrative according to an interpretation of the phenomenon. Not all the data elements can be included; therefore, it is left to the researcher to refine the plot. It is for this reason that the researcher is an active participant in the research process and the construction of the narratives are left vulnerable to the perceptions, biases and worldview of the researcher as much as the participants. More appropriately, it could be argued that narratives are co-produced by both the input of the participants and the levels of interpretation of the researcher. This is the reason why, where possible, member checking of initial narrative constructions is conducted by the participants themselves before further levels of research analysis. However, in this study this process of co-construction was mediated through a referring back of the raw data transcriptions of the interviews so that the participants had recourse to refine the propositional content

of the data recorded in written form. It is recognised that this negotiation between the researcher and researched is usually resisted within the traditional empirical positivistic research paradigms that suggests that the researcher should not ‘tamper with truth they are gathering’. Within an interpretivist paradigm within which this study was conducted, the role of both the researcher and the researched and their meaning making is the very focus of the exploration.

The ethical principles of anonymity and privacy of the participants had to be respected throughout the research process. However, the narrative record making constituted a process of revealing within the thick descriptions of the nuances of each specific narrative record. This ran the risk that when attributes were ascribed to a particular story it posed difficult to conceal the participants’ identity so that the participants did not become recognisable. This was especially a concern within a relatively small professional community such as speech-language therapy. Specific attention was therefore given to how the individual’s personal biographies and contexts could be anonymised and confidentiality adhered to in the construction of the narratives.

### **3.4.2 Level 2: Cross-case comparisons and thematic analysis**

Once all the narratives had been completed, I moved on to the analysis of the narratives using line-by-line coding (Braun & Clark, 2006). As a qualitative researcher, I inductively coded the data and tried not to let personal biases interfere with the coding process (Flick, 2014). I was however, cognisant of the a priori categories from my theoretical framework. This, together with the critical questions of the study, helped guide me to identify six factors that influence the negotiation of communication strategies of SLTs during clinical engagement. These factors were policy, student training and continued learning, world of work context, cultural and power matters between SLTs and families and the client, the practitioner’s experience of speech-language therapy, and cross-linguistic–cross-cultural communication. I used the verbatim quotes from the participants to augment and support my comments. I developed commentary boxes after discussing each of the factors. In these synthetic commentaries, I succinctly brought to the fore the ‘take-home message’ for the reader. Thereafter, I inputted these commentaries into a table in line with the literature review concepts and the theories and frameworks from the theoretical frameworks so that I could abstract themes further. This process required several attempts and many



consultations with supervisors and peers before I was satisfied with the themes that had been produced.

Once I did this, I found that I could 'sit above the data' and I could generate themes from the narrative data. I engaged in deep analysis of the themes where I could identify specific situations and circumstances that affected the individuals. This allowed me to explore the resonances and dissonances across the narratives in relation to the phenomenon I was studying. The themes that I generated were:

- productive remembering of the educational experience;
- problematising clinical engagement;
- undervaluing of speech-language therapy;
- searching for certainty; and
- moving to comfort

There were two cases that deviated from the pattern of data findings (see section 7.4) Often referred to as 'negative cases', the outlier data is often considered a valuable strategy for assessing the credibility or validity of qualitative research claims (Denzin & Lincoln, 2011). The term 'outliers' has traditionally been associated with the positivist orientation, however I wish to reappropriate the term in this qualitative study to consider the negative or deviant cases in my research.

Please refer to Appendix T for an example of the Level 2 analysis process.

### **3.4.3 Level 3: Dialogue with the literature and theoretical framework**

Theorising is an iterative skill that requires intuitive and creative ways of thinking (Sonday, 2016). This third level of analysis comprised a process of taking the data through greater levels of abstraction, which facilitated the extension of existing theories and coining of new terms to develop a new framework to understand the phenomenon being studied better. The theorising process began by selecting theories that made up my temporary theoretical lens, which influenced the theorising of the research methods and design. Theorising around the constructs of uncertainty in the world of academe and in the world of work led to implications for clinical practice and future research. Through this sense-making processes that drew on interpretivism and philosophy, new constructs relevant to the study started emerging.

### **3.5 Synthesis of the chapter**

This chapter provided a detailed description of the research methodology. A case study methodology was used to illustrate the phenomenon of communicative competence as it is enacted in the world of work of SLTs. The participant sample comprised eight purposively selected participants. Three data collection tools were used, i.e. the pre-observation interview schedule, the observation schedule, and the post-observation interview schedule. The data was analysed using narrative analysis as the first level of data analysis. A discussion around the development of the narratives and the coherence between the data methods and narrative analysis was presented.

## **PART TWO: WORKING WITH THE DATA**

Part One of the thesis comprising Chapters One, Two and Three was concerned with the setting up the study where the context, background, relevant literature and theories and methods for the study were presented. Part Two of this thesis consists of the next four chapters concerned with working with the data generated in the fieldwork as I prepared to engage in greater levels of analytical abstraction.

The four chapters of Part Two are the following:

- Chapter Four: The narrative analysis of the novice SLTs
- Chapter Five: The narrative analysis of the experienced SLTs
- Chapter Six: Cross-case comparisons
- Chapter Seven: Working toward an evaluative analysis.

## **CHAPTER FOUR: Narrativising novice professionals**

### **4.1 Introduction**

This chapter presents the first set of the participants' stories. The stories come from participants who were novice (newly qualified) SLTs from a variety of contexts, i.e. public hospitals, a public special school and an urban-based private practice. This chapter constitutes the five stories of Sharon, Carl, Lynn, Stephanie and Zandi.

### **4.2 Orientation to the chapter**

Each story reflects a description of the participant's world of work. The stories were written in the first-person narrative form. The choice of first-person narration was discussed in Chapter Three of the thesis. Matters relating to the validation process of member checking of the narratives with the participants were also discussed in Chapter Three. The biography of the story-teller is alluded to as they explain how they negotiate their communication strategies during clinical engagement in the world of work while reflexively reflecting on their initial professional education (undergraduate education at UKZN).

The narratives have been set in a particular order from the most newly qualified to the more experienced SLTs in the way they negotiate their communication in practice. The narratives in Chapter Four begin with Sharon who was a newly qualified community service SLT in a government (public) hospital and concludes with Zandi who was an SLT with three years of experience in a government (public) hospital. Carl and Stephanie were newly qualified SLTs who were placed in between the continuum of experiences of novice to experienced. Please note that all quotations are reproduced verbatim and unedited.

### 4.3 Sharon: It starts with the community

“We both, his mum and I, enjoyed that excitement.”

Sharon was a novice SLT, and a bilingual Afrikaans–English-speaking white female. She completed her community service at a rural public health facility. At the time of this research, she was employed at a large public healthcare facility.

My journey to work usually winds its way from my middle-class urban apartment outwards into the rural village of Gamalakhe, my vehicle winding its way through the crowd of eager street vendors plying their trade on both sides of my closed windows. Then, I meander through the livestock grazing on semi-lifeless grass, across the field where a distinct clinic emerges in full view. I walk into the building greeted by a line of clients outside my office. Down a ramp, through two doors and there I am on the threshold. I pass through a portal into a more sanitised space. The morning noises fade in the distance.

The setting is clinical ... everything is white ... the walls, the bed sheets, the curtains, even the therapists. A sign greets me in English, “Welcome to the rehabilitation department. Physiotherapy. Occupational Therapy. Speech Therapy.” That’s me, the (community service) speech therapist. I have only been here for a short while but it feels like a lifetime. My clients too perhaps, have this stretched view of time: days fade into weeks, and weeks into months, hopefully awaiting some treatment for their condition. My university training had not prepared me for these repetitive sessions of therapy. A thousand times over and over again: intervention, recommendations, non-compliance with my intervention, no results. Nothing happens. My head hangs low: I thought I came here to make a difference, but nothing happens. Today I didn’t even feel like coming to work. But I was glad that I did because I saw a client that I am quite fond of.

He was a little boy who has cerebral palsy (CP).<sup>5</sup> Why was CP so prevalent in this area, I wondered? He communicated in IsiZulu and English but at a basic level. Unfortunately, Mbongeni [the client] does not seem to connect into the world surrounding him. Words do not matter to him. I thought of drawing on the profound power of touch. Hand-over-hand facilitation is a technique that we learnt at university. As the name implies, the therapist places her hand over the client’s to help guide their attention and focus. However, I think that it is really more of an instinctive act. Touch, that is firm but gentle, and deliberate, but nurturing. Touch is how children learn and it is how they learn that I care about them. He let me hold his hand today. I think that he was beginning to trust me. I showed his mother what to do at home, but she seemed not to be interested. Maybe the repetitive course of therapy had his mum waning. She’s a young mum. She had to drop out of school because

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<sup>5</sup> Cerebral palsy is primarily a disorder of movement and posture (Sankar & Mundkur, 2005).

she fell pregnant with Mbongeni. I think that she did not really want this pregnancy even before she knew that he was going to be born with CP. She looked so lost. I didn't know what went through her head. I invited her to ask questions which she promptly declined. She was just fourteen years old when Mbongeni was born. Sadly, teenage pregnancy and young, unprepared mothers are so common here in the community. The mother said that Mbongeni's dad has no relationship with him. I doubt whether she even told him. It has been very disturbing to see such young girls having babies who they cannot take care of and many of whom have special needs. If she returns with him next month, I will get the security guard to translate my English into her home language so that my words are broken down for her to understand. This will take time and effort, but if I want my message to get across as best as possible, it is worth investing in.

I referred Mbongeni and his mum to the educational psychologist for school placement and other issues and the psychologist for counselling. Unfortunately I have not heard back from the psychologists and they have not acknowledged my referral. I just feel this is a system that's failed. While I was a student a qualified therapist told me that working for the government can make a person lazy. You don't need to show progress with your clients and you will still get paid at the end of each month. So why bother? I have a problem with this thinking.

I have tried learning more isiZulu because I felt that if I spoke isiZulu then maybe the clients will listen to me more and they will see that I am serious about helping them. But sometimes when I speak isiZulu, it just doesn't click with some people and I think that it is because of who I am. I am a white, bilingual Afrikaans–English-speaking female. Maybe it is a cultural issue; however, there are clients who do appreciate me trying. We need to try and help each other. But most of them just stared at me trying to speak isiZulu. But to know isiZulu will only help me only some of the time. There are eleven official languages in South Africa and many others too. What kind of multilingual do I need to be to be a competent speech therapist?

Communication is my tool. I didn't realise this when I was at university, or at least it was not made explicit to me. This whole idea would have probably been too abstract for us students at that time. Our focus was more on practical side of things: tell me what standardised tests I would need, what stimuli or toys are best, what was the general set up of the hospital and how far away it was from home. We wanted facts and tangible answers. Then you get here, to the real world, and then you realise that it's not about any of those things at all. It's just about being able to help a parent or the client. I can do a session now and not have any of the stuff that I had at varsity. I know back then I did not want to think about how communication was the method and the subject of my intervention. Now, I often would sit in a session and just talk. Sometimes I want to get an understanding of what the problem is and how I can try and fix it. Then there are those cases where you have to make the clients aware that it might not be able to be fixed. I also want determine

how much they understand. This can only be done by talking to them and asking them questions.

When I do the cerebral palsy group session with the mothers, I stress the importance of stimulating their babies every day. The expressions on their faces tell me whether they understand or not. I see that there are those mothers who realise, may be for the first time that their child is going to be like this forever, and then there are those who are nonchalant possibly because they do not understand or they do not care. This disinterested behaviour has really bothered me. Such behaviour was observed at a day-care facility that the rehab team went to recently. There were children with ADHD<sup>6</sup> and cognitive impairment and the caregivers<sup>7</sup> seemed disconnected from what I was suggesting for them to do. The children just lay on the floor, not being turned, not being stimulated. I could not hold my tongue. “Why aren’t you helping them I asked?” I think my disbelief came through my voice even though I tried to control my emotions. The caregivers looked at me blankly, “But they are dumb, why must we do anything with them?” As a therapist, I had to be composed and professional even though I wanted to scream. I calmly chastised, “Even though they’re not normal like other children, they still have a brain that needs to be stimulated.” I proceeded to show them what they could do. “Even though their bodies are not working, they still have a mind, and that mind needs to be stimulated to see things, hear things, even though the body isn’t doing anything.” They seemed unmoved. I felt like I wasted my time. I think it comes back to a cultural issue with the caregivers, their level of education and their understanding.

Not all clinical interactions are as such. There is one client that I will always remember. He was the only client that I had actually discharged from therapy. He was a four-year-old and he wasn’t communicating when he first came through for speech therapy. Maybe, he had one word, maybe. This was just the start of the challenges because his mum didn’t understand much English and there was no interpreter in the community clinic. I thought of asking one of the nurses, but they are always complaining of being understaffed. It was just me, the client and my broken isiZulu connecting us. I hoped that this was enough because that was all I had. His mum needed feedback and guidance on what to do at home. The only way I was going to achieve this was through demonstration with her and with the child while we played.

“You must watch now. This is what we’re looking for,” I said to the mum.

I would point out what she needed to encourage at home. We tried to understand each other. Somewhere between her broken English and my broken Zulu we connected. I think

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<sup>6</sup> ADHD is the abbreviation and colloquial term for attention-deficit hyperactivity disorder, which is a persistent pattern of inattention and/or hyperactivity–impulsivity that interferes with functioning or development (American Psychiatric Association [APA], 2018).

<sup>7</sup> ‘Caregivers’ refer to carers of a patient (in this situation the children at the day-care facility) who are not necessarily the parents nor family.

it was after a few sessions that the little boy was able to come to me and ask me for a toy. We both, his mum and I enjoyed that excitement. I think that was the first time that I truly believed in speech therapy and I know so did his mum. He progressed to learn more words and speak in sentences. I did not understand everything that he said but he would talk to me in his language and I would try and catch one or two words and I'll try and reciprocate. The community needed more mums like her, so I encouraged her to tell all of her friends who have children about speech and language stimulation.

"If you see a child who isn't talking, you tell the mum what to do."

The only way that we were going to reach the community is through others. He was discharged about two months ago when he was able to communicate with me in sentences. I felt success there and so did the little boy and his mum. It made me feel good. Not every case or every day is like that but for that moment, it felt good.

I knew that this feeling could not last forever and it did not. A few days later there was a baby with hydrocephalus<sup>8</sup> who came in for therapy. He had feeding difficulties and was at risk of aspiration pneumonia.<sup>9</sup> His mum needed to follow my advice because there was the potential that the baby could die. I don't think she understood the severity of his problem or the importance of therapy just to keep him well because she would just bring the child to me. She appeared completely disconnected. Her body language suggested "here, do what you need to do with him". She did not actually say that, but then again she never did say anything. She would just sit on the chair. I invited her to join us a few times but she declined. She was also a young mum, probably of school-going age. I used an interpreter to communicate with her because she stared blankly back at me. To me, it just seemed that this mum didn't care. If the child dies, the child dies. I find that with the younger mothers. I am not sure if it is that they do not care or if it is something else. I needed to be sure that she understood what I was saying so I used an interpreter which did not help with our interaction but at least I knew she understood. It is easier when you are talking to somebody in your own language.

Just then I thought about a conversation that I had with the community service occupational therapist once.

"Do you ever think about last year when you were just a student," I asked her.

"Sometimes I do. It seems like a really long time ago doesn't it?" said Janine [community service occupational therapist]. She went on to say that I was able to adapt to the context so effortlessly whenever the rehabilitation team goes out into the community".

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<sup>8</sup> Hydrocephalus is an excessive accumulation of cerebrospinal fluid (CSF) within the head caused by a disturbance of formation, flow or absorption (Pople, 2002)

<sup>9</sup> Aspiration pneumonia is a term that refers to pulmonary abnormalities following abnormal entry of endogenous or exogenous substances in the lower airways (Ferri, 2014).



"I think UKZN equipped us with problem solving and clinical skills. We were placed in a community and the tutors weren't there all the time," I said.

"At my university we did not have the same learning opportunities like that. This is my first time working in a rural community," said Janine.

My student memories are still fresh and I know most of my colleagues and I did not want to see the multilingual clients. Our concerns were short-term as we were worried that our grades would be affected. We never did think about how our years in practice and our service delivery could be affected. I suppose I could work with an interpreter, but we don't have one at the hospital and the people who are can help you do it voluntarily. I feel terrible to ask them all the time because I don't want to impose on them and they have other jobs. It's usually the security guards and some of the nurses who are willing to help. At the risk of sounding ungrateful, sometimes I wonder what they are thinking because it seems they too don't believe in my interventions and recommendations. I wondered whether my urgency was coming across in their translations. There is also lots of work that goes into working with an interpreter. I have to think about how you are going to explain it to the interpreter, and then how the interpreter is going to explain it to them. It's easier when somebody explains in your own language, but when it's somebody coming from a different language, you have to think about it. I get worried, there is a risk involved in miscommunication.

There is a need for a permanent speech therapist here in this clinical setting. At first, I thought that person was me, but as the months go by, I do not think so. This place is limiting my learning. What, after all, is the client getting out of the session as well? When I graduated from UKZN I left wanting to make a difference. I am not so sure that I have achieved that yet.

In a few short months, I will be transferred to a larger public hospital where I will join more experienced speech-language therapists. I have renewed hope for my experiences there and I will have the company of another colleague. Perhaps a change in the micro-system of the environment is what I will need.

#### 4.4 Carl: The white coat

“Perhaps they thought that because I was an Indian man in a white ‘doctor’s coat’ that I didn’t fit in the rehab department.”

Carl was a novice SLT, and an English-speaking Indian male. He served his community service at a rural public hospital. Following that, he moved to an urban private hospital.

When I arrived that first day to start my community service<sup>10</sup> at the public hospital, I think staff there thought I was lost. My attempt at isiZulu was very poor when I asked for the rehabilitation department. They quizzically looked at me and pointed in the direction of derelict park homes. Perhaps they thought that because I was an Indian man in a white ‘doctor’s coat’ that I didn’t fit in the rehab department. I was met with even more surprised faces when I introduced myself as the new speech-language therapist. I received such a hostile welcome. I could feel their prying question: what is this man doing here? Men in health were usually doctors, pharmacists or physiotherapists! I know that male speech-language therapists were not common, and I felt their dismissal of me as someone who could offer anything worthwhile. My office was a tiny space in a park house adjacent to the hospital building, which I had to share with the (community service) occupational therapist. The last time that the hospital had a speech therapist was about 7 years ago. I had anticipated the mammoth task ahead of me in setting up services again. I felt like I was thrown in the deep end and was expected to swim.

There were no referrals coming through because of the absence in service for such a long time. I had to actively promote speech therapy services to doctors and nursing staff. I visited each ward, and explained to the doctors exactly what I do. Then I ended up printing out posters and sticking it on the noticeboard because they were still not referring clients to me as should be the case. I then decided to live up to the expectation of ‘being a man in healthcare’. I put on my white coat, a paediatric stethoscope around my neck and I walked around with an air of purpose. The white coat, the one that the doctors also used, was my suit of armour as I navigated through wards and the corridors of the hospital. The rate of referrals got better over time; however, my strategy was still something that I had to keep at.

This facade I paraded, unfortunately, did not work with everyone. Mr Khumalo, an isiZulu-speaking male client was one of these people. I vividly recall my sessions with him and the sense of discomfort that I felt. Firstly, he did not want to accept that he needed speech therapy. It felt like an emasculating experience for him. Perhaps it was a cultural thing.

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<sup>10</sup> Community service of speech-language therapists is compulsory for a full calendar year. This is a policy from the SA DoH ensuring service provision to largely underdeveloped areas, especially rural areas in South Africa (Wranz, 2011).

When I approached his bed in the ward he furiously shook his head. “Angifuni,<sup>11</sup>” he muttered. “Sawubona,<sup>12</sup> Mr Khumalo. I am here to help you with your speaking”. I decided that I would first have a general conversation with him and then move into the session. I needed to try just ten to fifteen minutes with him, just to show the doctors that I responded to their referral, and that I, at least, tried with an unwilling client. He looked at me as if to say, “I am a man: why are you making me say ‘ah’? What is wrong with you?” I said, “That’s alright, if you don’t want this today, it’s fine, I’ll come back and do it some other time.” With that I left and I decided to see him the next day. I thought that I would give him time to think about therapy. He never really did change his mind.

Mr Khumalo got me questioning, “Was I a good communicator?” I am not sure. I know that I was not 100% perfect. When I was at university, I felt that communication – and my communication specifically – was really important. It was something that I had to monitor and work at. When I arrived for work in the real world, I saw these clients, and I felt that there could be something more that I could do. I felt somewhat helpless because I’m just doing speech therapy and this was not solving the overall problems that they had. I felt that speech therapy was helpful, it was effective, but was it enough? I knew that once the doctor got involved that he took precedence over me. This spoke to how other people think about us, as therapists in the hospital. I felt that they thought I am just part of the rehabilitation department, so I was not that important. However, I felt like I had to persevere to prove that speech therapy did help and it did make a difference.

I went into the kitchen to quench my thirst. It had been a blistering hot day without any relief from a fan or air conditioner.

“Hey, speechie,” called Kamini, the physiotherapist. “The university called us earlier today and they wanted to speak to you”.

“Oh, what about?” I asked.

“Something about them wanting to send the third-year students here for a site visit,” said Kamini.

“That would be nice. But I am only a community service therapist; they will most probably come with their lecturer, right? I remember that when I was in third year, we went to a hospital in preparation for the upcoming clinical block. It was nice to see the space that you would be working in and the clients that you would see. I think that the context creates the communication,” I replied.

“Yes, it will be a good opportunity for them,” Kamini said.

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<sup>11</sup> ‘Angifuni’ is an isiZulu word, which translates to ‘I do not want (to)’ in English.

<sup>12</sup> ‘Sawubona’ is an isiZulu word, which translates to ‘hello’ in English.

“The only way, in my opinion that students can develop communicative competence is with practicals and doing more of that. I think the length or duration of the clinical module, the practical part of it will determine their competence,” I offered.

“Hands-on experience is the only form of experience is what we say in the physiotherapy world,” laughed Kamini.

I chuckled, “You know when I was a student I really wanted the opportunity to watch a session from start to finish by a qualified therapist so that I know what is to be expected. I still would love to do this. I feel that what we got in terms of guidance was very much on a surface level at university. It was not in depth. For example, something that still bothers me now, is how could I modify and implement my therapy to suit different ages and cultural groups. Like with an isiZulu client, I would like to know what their cultural beliefs about their conditions are and their norms of speech and language development. What do they learn first, as opposed to an English-speaking person? Do they learn shapes, colours and numbers as English speakers do, or are we imposing Eurocentric ideas on them? This really does trouble me. How can I work in this context without knowing?”

“I am not sure,” Kamini replied, “I do know though that you will figure it out.”

I never really did.

Looking out the large frameless window at the Sandton<sup>13</sup> skyline, about eight months since my days at the public hospital, I made my decision: I cannot work in that setting because I just did not feel a fit there. I stand here now, clad in my white coat and my stethoscope draped around my neck: I am content with my position here in a private urban hospital.

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<sup>13</sup> Sandton is a suburb in Johannesburg, South Africa.

## 4.5 Lynn: The blood splatters

“These were real people with real problems.”

Lynn was a novice SLT, and an English-speaking coloured female. She worked in an urban public hospital. At the time of this research, she was still enjoying her work there.

The red blood splatters directed my path on my way into the hospital that blistering summer morning. The gore ends at the entrance of the trauma unit. Other colleagues casually walked past and through this mess. It had only been a year and 2 months that I had been out in the real working world. Perhaps over a length of time one can become immune to this sight. As I entered the hospital I heard a group of nurses speaking in isiZulu and from my limited knowledge of the language, I could only gather just a bit that it was about the blood splatters outside. My headband kept my curly hair away from my face as perspiration ran down. The waiting room of the speech therapy department was full of tired parents and fussy children waiting for their turn to see me. I tried to muster a genuine smile. After all, I was glad that so many of them had kept to their appointments. The windows did not open and there were no fans or air conditioning in the department. I was sure to hear during the course of the day, the clients' and their families' stories of how dependent on public transport they were, and also how many could not afford the rising costs of transport. I was also sure to hear their silent complaints about the systems here at the hospital: they dread the long queues simply to collect the hospital files. I was aware that coming for therapy either for themselves or for their loved ones meant getting time off work or arranging for care for the other children at home, which may have its own financial implications. It seemed like much sacrifice for a 45-minute session once or twice a month. These were real people with real problems but I was glad that they were there to see me.

Restless in his bed in the paediatric ward staring out the window at the ocean, Dre acknowledged me approaching but looked away when I greeted him. His mum was with him. “Hi mum, do you remember me? I am the speech therapist. I met with you the other day.” Half acknowledging my presence, she greeted and continued typing out something on her mobile phone. When I had met her previously she had quite a negative description of her son. She said that he doesn't listen and is badly behaved. However, my initial observations gave me a sense that he was much better than what his mother made him out to be. I had a vague idea of the little boy that I was going to meet. All the nurses said, was that he doesn't speak too well. He was willing to follow me into the therapy room and engage in light conversation. However, the session quickly turned. Beads of perspiration settled on my upper lip and on my brow as I watch Dre quietly slip in and out of lucidity. My heart racing, I waited to see for any more signs. I had never seen anyone having a seizure before. I only knew of the textbook version of epilepsy and what was unfolding in front of me was different because there was no shaking or frothing at the mouth. The

nurses mentioned that he had seizures but I didn't think that it would happen in my session. He then became quiet and dropped his head. These few minutes felt like hours until he finally came around. I could see that he didn't understand me when I asked him a few questions. He slowly regained his composure. I communicated with him in simple sentences; I had to repeat myself frequently. I contorted and twisted my face to see if he would react. Would a smile work? Something eventually caught his attention. It was one of the toys that I brought along. As the session progressed, I could tell that this little boy wanted to communicate with me. I felt that he appreciated me trying my best to communicate with him at his level. I think he was enjoying the attention that I gave him in this 45 minutes that I have been sitting with him. It was the little things, like helping him to tie his shorts tighter or that I let him sit on my lap.

The session turned again. He clenched his fists and slamming them onto the table he then lunged forward toward me. He muttered something under his breath and screamed "No, no!" I just glossed over this and did not give a reaction although I was deeply concerned.

He kept fidgeting with the ties of his shorts, twisting and rolling it up. He then repeatedly tapped the table with his hands. He could not seem to sit still. But why was I expecting him, a young lad, to do so? If somebody is not well behaved or if they are hyperactive, there is that great possibility that they do not take in what they hear the first time. I repeated most of what I said because of the look of confusion that he gave me in those moments of silence. It was in those moments that I think he had the seizures. After a while, he got up again and ran around the room. This happened at least three times in the session. I felt uneasy and afraid. Whenever I thought a seizure came about, I wrapped my arms around him thinking that he may fall over. I think I needed to discuss this with the nurses or the doctor and I needed to do my own research. I was reluctant because of what I might find out.

I returned to the speech therapy department to find one of my clients, Kito, waiting there with his dad. Kito and his family spoke Swahili as their home language. However, his dad was able to understand a little bit of English. I previously asked his dad to write down important Swahili words or phrases for me. He was kind enough to teach me pronunciations of words that I could use in the session. This was not always very successful because I did not have background information on the language itself, so the accent, specific sounds in a language and other linguistic features were not things I was familiar with. The school-going clients, like Kito have not been so problematic because most of them go to English-medium schools so they know some English. The foreigners with their little ones or the elderly clients posed the greatest challenge because of the lack of interpreters for the languages that they speak. There were many foreigners in the area because it was a business hub to find jobs and start shops. These clients were Swahili, Amharic, Shona and Lingala speakers. There are some local clients who also speak Afrikaans, which isn't very common here. Thankfully, most of them do have the broken

English and we are able to communicate. However, I am not sure about 100% effective service delivery then. Sometimes I think it would be easier if I could speak and understand multiple languages.

Practice in the real world is much more difficult from the time when I was a student at university. Back at university, we had our supervisors there to offer advice or problem solve with and for us. I think that I needed to be thrown in the deep end back then. They needed to task me with everything that I would have been expected to do in the world of work like setting the appointments and advocating for services. I needed to learn how to adapt my communication for these different tasks. Building a good rapport with parents and the clients was something that was drummed into my head by my clinical supervisors. I suppose that building a relationship of trust would help in the long term.

I realised this when I did an initial assessment on a bilingual client, Thuli. Her mum was concerned about her child. Sensing her increased anxiety as the seconds went by, I decided to reassure her by speaking with Thuli's mum. I explained Thuli's condition, suggesting behaviours that she might have noticed at home. She was quite astonished by how much I knew, and how I was able to communicate this to her using every day experiences. I think she was particularly grateful because I could relate to the situation with my knowledge. I felt satisfaction too that my communication was successful in this case.

There have been a few instances where I felt that I was not a successful communicator. One of my biggest problems in my workplace is the language barrier between me and my clients and the lack of interpreters. The PRO [public relations officer] at the hospital sometimes assists in sourcing an interpreter from the PRO but this requires forward planning in notifying his office, finding someone who is available and waiting for his reply. Many of my clients are walk-ins and it is not fair to make them wait for an indefinite amount of time because of a language barrier. This is when I use a colleague or other staff members like the nursing sisters, depending on availability. However colleagues are not willing to help a lot of the time. It can become so difficult. Sometimes I don't want to go and ask. I rather try and to communicate with clients. I try and learn the main words in a language and it could possibly help me in a session. It involves lots of visual input. There are those cases when the interpreters that are available may not be suitable for the clients because of the language difference. Most of the interpreters can help with the Zulu-English language barrier. Even then I am not always able to guarantee that I am providing a 100% service delivery. But then what do I do in situations where clients and their families speak Swahili, Amharic, French or Lingala?

I wanted to stay here at this hospital for a while longer. I felt that there is a lot more that I needed to learn and will learn. I will probably die never knowing all the strategies of how to communicate with clients. I think at some point I will be equipped with the skills and will communicate successfully at most if not all sessions with my clients and will learn to adapt

and problem solve more ... more ... allowing it to flow and be more easily done. While I was in the middle of my thought my phone rang. It was the nurse from the male medical ward. There was a patient referred for speech therapy. He sustained a traumatic brain injury and was brought in this morning. The blood splatters at the entrance of the hospital were his.



## 4.6 Stephanie: Therapy is not a pill

“How do I explain to her that speech and language problems are not fixable with a pill?”

Stephanie is a novice SLT, and an English-speaking white female. She served her community service at a rural public health facility and subsequently moved to an urban private practice. At the time of this research, she was still enjoying her work there.

Setting up a private practice as a speech-language therapist is oftentimes considered a major career aspiration for many. I should consider myself lucky then that I am newly qualified therapist who started working in the private sector a few months ago. I am a white, English-speaking therapist and most of my client-base is all English-speaking so I had not encountered problems with language differences in this context. My typical day includes visits to some of Durban's most elite schools to do therapy and then to the private hospital for the afternoon appointments. My caseload had comprised of children with speech, language and learning problems. My clients and their au pairs or parents usually wait for me in our plush waiting room. The fish tank a major attraction for the children.

I had found that some of the parents in private practice see me as a young person, much younger than them. I felt this when they looked at me, “Can this person really be doing therapy with my kid?” I've never heard them articulate this though, so it might be all in my head. However, during my community service last year in a rural community I never really got this feeling. Everyone out there on the South African border with Mozambique were so appreciative: they just took what you said and just held onto it. I was one of just a few non-black healthcare providers. I could not speak isiZulu, yet the parents seemed to be grateful for whatever I could offer. They would come back every month always with a big smile; moreover, they listened to me. I have felt sometimes in private practice that parents don't appreciate what you say to them because they have often ignored what I have said. The worlds of urban private practice and that of rural community service areas were really different just based on the attitudes of parents and clients toward therapy.

I saw Mrs Williams in the waiting room and I said hello more out of surprise than an actual greeting. I hadn't expected to see her or her son again for therapy because of our previous session when I had got the sense that she did not believe that her son had a speech problem. She brought him into therapy saying that the teachers said that he needs to be in therapy. The teachers report to the parents that their child has a particular difficulty and then they make the referrals to me. After many emails to be parents, they usually come through reluctantly just to keep the teachers quiet I would imagine. It seems like many just subscribe to therapy out of duress. I think that the problem might be the stigma of therapy. The stigma that there is something wrong with their child. Perhaps Mrs Williams also does not want other people finding out that Seth saw me for therapy. Little Seth was quite cheeky

in the session: what we now label as 'strong-willed'. He did not want to listen to me in the previous session and I was still unsure of how to get him to engage in the session without making him upset. I felt that there was a certain amount of pressure with the short amount of time that I had to work with him. Also Mrs Williams kept asking how long would therapy take. I knew that she knew that it was only a half-an-hour session but her tone gave me the impression that she meant the entire duration of therapy. I told her that I don't want to put pressure on Seth in therapy and that we go according to his pace. But maybe in private practice, you need to be rigid and time-bound. How do I explain to her that speech and language problems are not fixable with a pill? This did put a little bit of pressure on me but no matter how much I have been badgered for a time frame, I have never said to a parent, "I'll fix your child in a month," because I don't think that is fair to the child or me. I wanted to say to Mrs Williams, "I am a professional; I know what I am doing. Just give me some time."

I think that the client's progress also came down to the homework component of therapy. Seth had forgotten his homework book again this week. This was the third week in a row. I think that they must have lost it. I phoned Mrs Williams and sent her messages to remind them but they still forgot it. I doubt that he had done the homework but they still came for therapy which bugged me a little bit. How was Mrs Williams willing to pay so much money for therapy, but she was not willing to follow up with my recommendations in the home environment? It seemed counterproductive to me. This was a big frustration of mine. However, there were those times when there are those kids and parents who do not do the homework or the parents had not discussed their child's progress with me. I offered Mrs Williams to sit in the session because I wanted her to see how I work with Seth so that she may have been motivated to do the same with him at home. I think she got a little bit defensive and afforded an excuse. She didn't want to come into the session. She suggested that we wait for a week or two then she will come and watch. She never did come to watch him. I have really battled to understand this. Perhaps she felt that since she is paying for therapy, that it was solely my responsibility to help the little boy. I thought that maybe I should be more forceful in getting parents to come in, but I don't know yet where that line was. It was so difficult to see the child that is struggling and the parents didn't see that or don't want to see that, when you know that they could help them at home.

In private practice there has been this real emphasis on making the parents happy. I really could not say anything because I had to keep my client numbers consistent or else the practice manager<sup>14</sup> would have asked me to source more clients in order to keep an adequate caseload. There was a therapy contract that Mrs Williams signed that clearly stated that homework is a big part of therapy. I did not understand how she expected to

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<sup>14</sup> A private practice manager is someone who oversees the day-to-day operations of the private practice (R. Sewgambar, personal communication, September 18, 2017).

see progress when I see Seth for half an hour once a week. Perhaps she had been very busy and could not do the homework. Perhaps she needed more reminders.

These reminders had me thinking that it appeared that there was a lot more communication in private practice with the parents: emails, phone calls and letters about the child's progress. By comparison when I was engaged in community service last year in a rural setting, there was not as much dialogue with the parents probably because parents there did not have access to cell phones and emails. I also saw the rural parents only once a month rather than once a week as I do in the private schools/practice. I think my community service year was a little more difficult also because of the language barrier because I was not always able to answer parents' questions or reciprocate what was being said to me since I am not a fluent speaker of isiZulu. A breakdown in communication was always a risk. IsiZulu is not even my fifth language so the language barrier posed a very big communication problem there. I think that being able to speak the same language as your client makes communicative interaction a lot easier.

Seth engaged with me during the session and we completed most of our aims. "Use speech-specific reinforcement," this is what was drummed into our heads by our lecturers when we were at varsity. This is what I did and he responded to me.

"Why do you do that Steph?" laughed the ladies at the reception on more than one occasion when they hear my grandiose affirmations of the clients' targets. I tend to be rambunctious and the kids love it.

"You see, children respond well to praise and speech-specific reinforcement. It was encouraged at university," I said.

This simply means that as the SLT, you must include the target sound/word/behaviour in a celebratory praise so as to reinforce or emphasise the target soon after the child's attempt, especially if their production was incorrect.

At university our tutors would observe us in our clinical sessions. They would tell us a little bit about how we did; they tried to give us the positives and negatives of the session and often in that order. These feedback sessions provided me with constructive guidance. It was also more individually specific to our role as clinicians. I often thought that it would be great if the tutors recorded a session of their own so we could see how it's done by an experienced professional. We often went into clinics blind and not knowing what we were really doing.

In the private practice context I have found that my communication is a little more structured and formal when compared to last year which was informal because I worked simply with worked with what I had. In private practice we have standardised tests and designed resources as in assessment tools. This has made it easier to structure and plan a session. These tools have assisted me to communicate with my kiddies. Obviously, you yourself have to have good communication with your client and their parent and also other

people involved, whether it's the OT<sup>15</sup> or their teacher or anyone else that they might be seeing. I know with some of my kiddies, their tutors or au pairs bring them in. So my communication has to be really good, and I have to express myself well in order for them to then relay this information to the parents. Also when talking to the children and doing your therapy, you have to make sure that you tell them what to do and how to do it. You even have to tell them if they are doing something wrong. It all comes back to communication and making sure that you are guiding them properly and expressing yourself well. This was something that I would have to work on for some time to come. Perhaps it is a matter of emotional growth and professional maturity. Perhaps, in time, this will come.

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<sup>15</sup> OT is an occupational therapist who works with a client to help him or her achieve a fulfilled and satisfied state in life through the use of purposeful activity or interventions designed to achieve functional outcomes which promote health, prevent injury or disability and which develop, improve, sustain or restore the highest possible level of independence (American Occupational Therapy Association [AOTA], 2018).

## 4.7 Zandi: Losing hope

“Motivation plays a huge role in terms of clients’ participation levels in therapy.”

Zandi is a novice SLT, and a bilingual isiZulu–English-speaking black African female. She served her community service at a rural public health facility. At the time of this research, she was working in an urban private practice.

I completed my undergraduate studies about three years ago. Since then I have worked in this public hospital, which also used to be my clinical block<sup>16</sup> when I was at university. One would think that I had an advantage of familiarity of my work environment as well as that I am isiZulu-speaking. However, your experiences as a student and then as qualified therapist are completely different. As a student, I had the support and encouragement of my clinical supervisors. I had been on my own since I qualified, which has been a difficult transition.

I worked with a 12-year girl once and I affectionately call her Sma. Sadly, she had a subdural empyema,<sup>17</sup> which left her with hemiparesis,<sup>18</sup> She was typically very quiet; however, in the session she was talking a bit, in IsiZulu. She mostly just smiled in response to me, but I know she had sentences in there. She had functional speech, which helped her communicate her basic needs. I had been working with her on and off for over a year now. She was warming up to me possibly because I see her quite often. I watched the physios<sup>19</sup> work with her the other day. Or should I say, they worked ‘on’ her. They spoke to her in English and she didn’t reply or speak much to them for that matter. She probably did not understand them. I think she did speak a bit of English before the neurological impairment; after all, she was in Grade 6 in an English-medium school. But I think she must have lost some of that language ability after she fell ill. As her speech therapist, I was able to tell if she did not understand me. I would notice the creasing of her forehead or the lack of head nodding. Sometimes she even cried. I watched her facial expressions. I simplified my language. I asked her if she understood. I have learnt how to read my client. They won’t always let you know outright that they don’t understand you. In each of the clinics during my undergraduate training, the tutors would point out to us if our clients were getting distracted and they gave us tips on how to watch if our clients did not understand

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<sup>16</sup> A defined period of students’ exposure to a clinical context or disorder, typically linked to a clinical module (P.S. Flack, personal communication, September 14, 2017).

<sup>17</sup> Subdural empyema is a collection of pus between the dura mater and the underlying arachnoid mater (French, Schaefer, Keijzers, Barison, & Olson, 2014).

<sup>18</sup> Hemiparesis is unilateral paresis, i.e. weakness of the entire left or right side of the body (Allison, Reidy, Boyle, Naber, Carney, & Pidcock, 2017).

<sup>19</sup> ‘Physios’ – colloquial term for physiotherapists as they are referred to in South Africa.

us. This was not directly taught to us, but if and when it occurred in the clinical session and if the tutor were present, they would help us identify and problem solve this. I often find people, even the other healthcare professionals are not able to identify or understand when a client does not understand something. The client cannot respond to their questions because they don't understand the question. However, this is overlooked by them.

I remembered a time when her mother came to visit her. She was in a good mood for the whole day and the day following that, anticipating the next weekend when her mother would visit her again. But, she did not. Over some time she figured out that she has gone away and she was likely not coming back for a while. This was when she went back into her shell. I could notice these subtle features of communication with Sma because I am a speech therapist. I was able to know when she was uncomfortable, in pain or frustrated or if she was happy, and even proud of what she was doing? I have found that motivation plays a huge role in terms of clients' participation levels in therapy. The low levels of motivation make it quite challenging to work with the clients.

As a speech therapist I found that there were many negatives using communication as the treatment method for the impairment of communication. What made it even more challenging is that it feels like it all depended on the client and you feel like you have no control of it. For example, the physio can do passive movements;<sup>20</sup> at least, they've done something to help their client. Sometimes when I went to the wards, the client just stared at me. They were not actively engaging with me or showing me that they understood. Admittedly, this was demotivating. I felt like I am not really doing anything to help the client. I wondered how it looked to other people who are watching me in the ward, like the doctors and nurses. They probably saw me greeting the client and then showing them pictures. It probably looked like nothing was really happening because of non-responses from the client. I just felt demotivated until such point that the client started to respond to me and my therapy. This sometimes happened.

The clients have been away from home for so long that they lose contact with the family. The lack of family presence and support does have an impact on their overall improvement. There were lots of families who did not come to visit the clients and this was heart-breaking. I was not prepared for this because I didn't know that this was part of the job during my undergraduate training. When I used to come to the hospital as a student, it was just once a week. It was a skewed picture to what actually happened every day. When you come to the real world and you realise that people don't care a thing about their children. This made me so sad. I had gotten used to it to some point because I see it every day, but as a person it was destroying me to see a child waiting for a parent who will most likely never visit. I'm not sure if they're not making an effort or maybe it's their circumstances also. Whatever

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<sup>20</sup> Passive movements: a physiotherapist moves the joint through the range of motion with no effort from the patient (Stockley, Hughes, Morrison, & Rooney, 2010).

their reasons were, you had a child and you needed to make the child know that you cared about them and to care about them was to be present.

I have seen mothers who have given birth and the very next day they leave the child in hospital to go home. They say that they have other children to take care of. But then what happens to this child who is a premmie.<sup>21</sup> A premmie baby is delicate and needs to be taken care of, but they go. This was not something that I was prepared for when I was at university.

Some clients had been here for a very long time, years even. Most of the clients were old. The clients' impairments are quite severe and this pertains to their communication impairments as well. When I greeted most of the clients they turned and looked at me, even if they didn't say hello back to me, they showed that they're interested. Some of the clients were not motivated enough. There are adult clients who I noticed would listen to the other health professionals but not to me. Some clients saw the need to exercise their arm shown to them by the physio, but when I showed them exercises for their tongue, they would not be that keen. It seemed that they thought it a bit odd to have exercises for the tongue. They did not see it as a muscle that also needed strengthening. This has been quite demotivating for me. This made me feel that the clients did not see the value in therapy. Surely, if they saw value, then they would have complied. I motivate myself by focussing on anything positive that happened in the session. I sometimes go back the following day and sometimes the client would be doing better because they were less tired or upset. It worried me, their lack of adherence. Why was this not the first thing that came to their mind when they woke up, that they needed to do whatever it is that the speech therapist said? I didn't know, maybe it was also a fault on my side. Maybe I did not emphasise the importance enough. What was the point? I felt like, well nobody ever listens to a speech therapist anyway, so why would the clients listen to me? I tried to emphasise that they needed to try and do it in their spare time. And I do it with them in the ward, and then I say 'if you have time also please do it, at least twice a day'.

I tried to see it from their perspective. They probably thought, "Why should I work so hard to be sent home when these people don't care about me because they don't visit? If they don't care about me, why should I go back to them? I might as well just stay at the hospital. If somebody stays away from you, they probably don't care about you".

My undergraduate education did have a role in preparing them for the working world, especially clinical practice. While at varsity<sup>22</sup> we worked with real clients and were even scored on the communication strategies used with clients. I was motivated to go an extra mile to keep my communication simple with a client who had a communication problem,

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<sup>21</sup> 'Premmie' is colloquial term for premature babies.

<sup>22</sup> 'Varsity' is a colloquial term for university.

because I was going to get marked on that as well. In working with real clients during my undergraduate training it prepared me for what I am dealing with now.

We had the community based rehabilitation clinical module.<sup>23</sup> So we would go out to visit clients' homes. I remember working in groups where I had to deal with other members of the team which helped me learn about how to communicate with them as well, and not just the clients. As a speech therapist I had to be a sort of a role model when it came to communication. The client had to understand you, the others in the team relied on this. I was motivated to use communication strategies that would make me look like a superhero. I knew how simplify my language so that the client understands better. So there I felt like it was motivating us to work in a team. You had to show them what skills you possess.

If I could offer any suggestions to my alma mater, the Discipline of Speech-Language Therapy it would be expose the students to real clients ... the clients that they're going to be seeing in the real world and make explicit to them that you will be marked on your communication with the client so that they feel like they always have to apply communication strategies that could be applicable for each and every client that they see. They need to know that they cannot just use the same communication strategies with every client because they are going to be different.

The training often focusses on separate communication disorders. They are taught in silos, in boxes. They are taught that there is a speech sound disorders client;<sup>24</sup> then there is a separate language disorders client;<sup>25</sup> a different voice disorders client.<sup>26</sup> They are not exposed to training where the client that has speech, language and voice problems at the same time and needs to be treated for all at the same time. So I feel that teaching them like this is not really real-world exposure. The speech therapist is going to see a client with

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<sup>23</sup> The community-based rehabilitation clinical module is a fourth-level clinical module in which students work in disadvantaged communities conducting health promotion workshops and conducting community-based rehabilitation (CBR) for widespread gain in the community. CBR was initiated by the World Health Organization (WHO) following the Declaration of Alma-Ata in 1978 (see Thammaiah, Manchaiah, Easwar, Krishna, & McPherson, 2017). in an effort to enhance the quality of life for people with disabilities and their families, meet their basic needs, and ensure their inclusion and participation in society.

<sup>24</sup> Speech sound disorders client – a client with a disorder in the areas of articulation and the phonological representation of certain sounds in words or in isolation (Bowen, 2009).

<sup>25</sup> Language disorders client – a client with impairment in the areas of comprehension, spoken language, reading and/or writing (Minifie, 1994).

<sup>26</sup> Voice disorders client – a client with a disorder of the voice due to misuse and/or abuse of the voice, e.g. vocal nodules, polyps (Minifie, 1994).



an aphasia,<sup>27</sup> dysarthria<sup>28</sup> and dysphagia<sup>29</sup> ... everything all together. The training should emulate more of what is happening during the electives.<sup>30</sup> At least they are having this exposure during their two-week elective block but maybe it's just not enough. The electives are not evaluated by a tutor from the university where the mark contributes to the students' year marks. From my experience, the permanent therapist at the elective block is just happy to have a helping hand over the university holiday time.

I have since left the hospital and I have set up my private practice. I think that I want to continue practising as a speech therapist but I would just like to control my environment and create a space that would work for me. So far, so good.

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<sup>27</sup> Benson (1979, p. 5, cited in McNeil & Pratt, 2001 p. 905) defined aphasia as "the loss or impairment of language caused by brain damage".

<sup>28</sup> Dysarthria is defined as "difficult, poorly articulated speech resulting from interference in the control and execution over the muscles of speech usually caused by damage to a central or peripheral motor nerve" (Kramer, Schneck, & Biller, 2012, p. 187).

<sup>29</sup> Dysphagia is a disorder of feeding and/or swallowing (Daniels, Schroeder, McClain, & Corey, 2006).

<sup>30</sup> Electives involves clinical exposure at hospitals of students' choices during the vacation periods under the supervision of the resident speech-language therapist (P.S. Flack, personal communication, September 14, 2017).

#### **4.8 Chapter synthesis**

Chapter four presented five narratives, which were set in a particular order of the most newly qualified to the more experienced SLTs in the ways they negotiated their communication in practice. The narratives brought to the fore the most salient issues regarding the phenomenon of communication, used during clinical engagement, that was subjected to more in-depth analysis by doing a cross-case comparison of all narratives as the key themes were identified. The newly qualified SLTs experienced difficulty negotiating their role as qualified professionals. They felt that they were not listened to. However, in Chapter Five, it will be seen that the experienced SLTs had similar concerns even though they had been in practice for a longer period than these newly qualified participants.

## **CHAPTER FIVE: Narrativising experienced professionals**

### **5.1 Introduction**

This chapter presents the second set of the participants' stories. The stories come from participants who were experienced SLTs from the public hospital and special school contexts. This chapter presents the stories of Amelia, Mbali and Halima.

### **5.2 Orientation to the chapter**

Each story reflects a description of the participant's world of work. The stories are written as first-person narratives. The biography of the story-teller is presented at the beginning of the narrative and in the way they explain how they negotiate their communication strategies during clinical engagement in the world of work while reflecting on their initial professional education (undergraduate education at UKZN). All narratives are reproduced verbatim and without editing.

The narratives have been set in a particular order to portray the continuum of experience in negotiating the participants' communication in practice. The narratives begin with Amelia who was an experienced SLT in a public special school at the time of the research, followed by another experienced SLT, Mbali who had been at a public hospital for the past four years. The narratives conclude with Halima who had been in a public special school context for four years at the time of data collection.

### 5.3 Amelia: Brick walls

“The mundane-ness of it all still surprises me.”

Amelia is an experienced SLT, and an English-speaking Indian female. She was working in an urban, previously disadvantaged special school at the time of this research.

When I saw the plain brown-bricked remedial school for the first time seven years ago, I had never imagined that I stayed here as a professional speech therapist for this long. The mundane-ness of it all still surprises me. But I have always enjoyed working with children with learning disabilities ever since my university days. I had looked forward to the change in work environment especially after having spent some time in a public health context. The school housed about 1 000 children who had learning disabilities. It certainly was not like other schools I had ever known. The dreariness gets to me: it’s a dull space with no colourful murals or anything to really stimulate one’s senses. It announces itself as a remedial school: for those in some form of correctional service imprisonment. Brown bricks, brown bricks. This school building had once been a regional clinic. A portion of the clinic had been turned into a school, possibly due the area being under-resourced in terms of such facilities. Increasingly, the area noted many children who were not coping in the mainstream school system. They were diagnosed as having ‘learning disabilities’.

Most of the children were first-language isiZulu speakers. The remedial school was mandated, as per DoE<sup>31</sup> policy, to engage these learners to access the English language. This meant that there had to be a double-learning: learning to learn English, in order to learn in general. It did not seem fair to me because these learners were already at a disadvantage. Besides having to cope with learning to learn because of their own personal learning problems, they were being required to learn in a language other than their own mother tongue. This was however, the policy from [the] DoE.

I had always felt that I needed to work on my use of isiZulu because I am a first-language English speaker. Yes, I knew phrases, instructions and basic vocabulary; however, was that enough? Sometimes I felt that I needed to do more because when the children sometimes replied to me, I was at a loss. I had no idea what they had said. I only knew what I said.

I developed charts of simple greetings and stuck them on the brick walls outside the therapy department to help encourage the learners to use these greetings. I noticed little Zanele looking at them during the lunch breaks. She only knew a little bit of isiZulu when she came to this school because she had a delay in her language development. At home she was only exposed to isiZulu. “Good morning, Miss,” she managed to greet one day.

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<sup>31</sup> DoE is an abbreviation for Department of Education in South Africa.

“Hello Zanele,” I said. I was so thrilled. I encouraged her to communicate in English on a daily basis. I wrote in her reports to her parents that she needed to read more English books to build up on her vocabulary. She was now in Grade 3.

Zanele’s Grade 3 classroom, where I conducted my weekly speech-language therapy interventions, always smelt of wax crayons and old dusty books. Group therapy included going through phonic sounds and then progressed to the identification of graphemes. We worked on identifying the sound, identifying words relating to the sound and building on vocabulary. I simplified my language and I explained further when I saw some blank stares on their faces, fidgety fingers dancing on the desks, glances out of the window ... I know that attention problems are synonymous with learning problems and I was seeing this with the children. I wondered, “Did they take their medication today? Why didn’t they? How was I supposed to work and achieve success with them if they could not attend to what was happening in the session?” I asked them a few questions to determine whether they had learned anything from my intervention. I was not surprised that they could not answer me. I retraced my words to know at which exact point I had lost them. I tried code switching between English and my version of scant isiZulu although I knew that this was not encouraged at the school. I had to be aware of my communication at all times in order to know what worked and what didn’t. A few looked out the window and had difficulty paying attention, while others rocked back and forth on their chairs. I looked at Zanele who somehow seemed more mature than the others and who had been actively following my lesson. She had learned a few more phrases in English and I think she felt quite accomplished, much more accomplished than what I had been feeling. I knew that I had to do more to better myself, or else I would always feel this empty hollow feeling.

I thought that I might need to attend more workshops; however, there was such a scarcity of them. Who would offer them to me? What would they say I should do? I know that these workshops sometimes demand fancy resources and interventions. But here in this school, there are major resource constraints. I cannot really engage in such extended learning. The Department of Education needs to provide more opportunities for us as therapists in schools. There have been many changes in the education system in the country that impacts on us as therapists working in schools. We must become more aware of these. I needed to liaise more with the teachers and find what goes on in their everyday classrooms. I should have gone to the workshops that the teachers attended so that I know what they are aiming to do in class. There should be some carry over between therapists and teachers.

I needed to develop my communicative competence by learning isiZulu and then being able to instruct and understand in that language. I have rewritten instructions looking at the English and the isiZulu words and I tried to build up on my vocabulary. I hoped that that would be enough. I knew that it might not be because my understanding of spoken isiZulu is not as good. The learners’ accents and dialects play a part too. However, one

must not forget that their version of isiZulu is more often than not, quite disordered. There is a small chance that I would ever understand what they are trying to say.

I met the occupational therapist in the staff room. We spoke about the common classes that we have been seeing. "We did a little bit of group therapy at campus," I said, "you know in terms of how to set up a session, how to incorporate each person by giving each one a chance or an equal opportunity and how to acknowledge each learner," I continued.

"Yes, some of the kids do look for that affirmation, don't they? However, there are some kids do not seem to be interested, you would know how to get their attention, won't you Amelia? You know, how do I get them to converse with me?" Shay asked.

"Well, during undergraduate studies they [the lecturers] used to encourage us to look at different avenues in which to communicate. We did not always have to use our words: we could use a picture or gesture. Shay, perhaps your instructions to the kids are too long or the words that you used were difficult for them to understand? Our lecturers used to say that we must monitor our communication if your client is not responding too well".

"I see, yes, that makes sense. Thanks for that!" said Shay.

"Have I told you the way in which they have changed the clinical training now on campus?" I asked. Shay shook her head.

"Well, I am not in agreement with it. Why reinvent the wheel? The way in which we did things when we were on campus was just fine and it gave us ample opportunity to develop ourselves. You see our clinical blocks were year-long which meant that for a single clinical module, we would do it once a week for the whole year. This gave us time to get to know our clients, research their problems and choose appropriate strategies. Now the students do the clinic in just six weeks, three times a week. That is just not enough time. What if your client does not arrive? This is very common. There are far too many instances for missed opportunities for learning and development."

Shay shook her head again.

I said, "I feel that we were a lot more equipped than what has been happening now". Our conversation then turned to possible reasons for this. We were disturbed by the sound of siren signalling the end of our tea break.

When I went to see the Grade 1s, they were lined up in a single file against the brown brick wall outside their classroom waiting for therapy. Many did not know a word of English. I didn't know how many of them would eventually be relocated into the mainstream schools, or how many of them would be found unsuitable for our remedial school. They definitely need more support of other special schools to resolve their learning disabilities. I did know however, that I would still be here working with them helping them grow and develop.

## 5.4 Mbali: Long-term care

“They relied on me to be here for them.”

Mbali is an experienced SLT, and a bilingual isiZulu–English-speaking black African female. She started working in an urban public hospital, which was also a long-term care facility, and was still working there at the time of this research.

Hidden in the leafy suburbs was a long-term public health facility for clients with strokes and head injuries. This is where I work as a Speech-Language Therapist. Many of the clients spend weeks, months and even years in this hospital-type care facility engaged in a form of rehabilitative therapy. The relatives of these clients came from varied linguistic and cultural backgrounds and had entrusted their welfare to the hospital. When I initially came here, I was overwhelmed by the severity of the communication difficulties. Aside from offering speech therapy to the clients, I had also been involved in teaching the nursing staff how to communicate better with the clients.

Most of the clients had very similar communication problems and their progress was slow. Mrs Ngubane just laid there on her bed in the ward. I went to see her for therapy. She had a stroke and subsequently aphasia and dysarthria, which caused problems with her understanding and production of speech and language. I communicated with her using simple words and language structure. Being an isiZulu-speaking, female therapist myself, one would have thought that it would be easier for me to communicate with her. However, I think it goes to show that impairment in communication definitely shows itself up as impairment nonetheless, which makes communication difficult regardless of the language of the conversational partners. I saw one of the nurses on duty. “Unjani sisi!” I greeted. “How is Mrs Ngubane today?” I asked. “Ha, you know how she can be. She doesn’t do anything. She hasn’t said anything today,” said the nurse. I was tempted to offer an explanation to the nurse for Mrs Ngubane’s apparent state. Sadly I know that it would not have helped much. It was painfully clear the levels of frustration that Mrs Ngubane felt. I saw this right at the beginning at the time of her assessment. Oftentimes, Mrs Ngubane was simply frustrated that she cannot express whatever she needed. At other times, she was frustrated because she waited for family who never did visit her. This was perceived as stubbornness and laziness by the nurses and then they in turn become frustrated.

Mrs Ngubane acknowledged my presence by looking at me and even offered a slight smile. I spoke to her using questions, which aimed to elicit one-word responses, most often yes or no responses. Sometimes no matter what I did to modify my communication she would just copy me. This signalled to me that she did not understand me. I considered three points when I communicated with Mrs Ngubane: what was her level of cognitive

functioning, how should I approach her, and I needed to know when and how I needed to change my strategies.

She often relied on my gestures in order to understand me; however, the overuse of gestures was not natural communication and some of my other clients might have considered it is inappropriate because it may come across as I thought that they were stupid or something. I believed that my communication should come across as comfortable, non-patronising and not dehumanising in any way. Therefore there was not a one-size fits all solution for all clients.

My role was to find easier ways of communicating for Mrs Ngubane. That time when I met with her family, I had to be upfront with them about her ability. I could not work miracles. I told them communication has to be worked on constantly, even outside of therapy however Mrs Ngubane hardly has any visitors with whom she can communicate. This is a big challenge to get family support for her. She needed someone from home who knows her and understands her better. However the family have said that there are work commitments and other excuses. As mentioned previously, this is a long-term care facility, so they did come at first and then it slowly stopped. This had been a huge barrier to progress in therapy and generalisation to the outside environment. I also tried speaking to the nursing staff to get them to stimulate Mrs Ngubane and a few of the other clients in the ward however, they were direct in telling that they do not have the time or patience to sit with the client and wait for them while they're going through an alphabet board in order to work out what they are trying to communicate. They said that they found it easier to just guess what the client wanted. I can understand that this can become frustrating for clients like Mrs Ngubane, but more often the client gets demotivated after some time. I worked hard with her in therapy and she left sometimes smiling however when she returned to the ward she was welcomed by overworked nurses are overworked who do not have the time for her and the others. She think that this is how she ended up getting demotivated and thought it was easier to just give up.

Demotivation seemed to run through these corridors. In the next ward lay a client despondent and depressed with a head injury. His name was Mr Xaba. He was quite difficult to assess because of the severity of his impairment and because he refused to cooperate. I needed to speak with his family immediately. After numerous attempts I eventually got hold of his wife. I learned that he was a father to young children. I also found out that his wife refused to come see him because of the altercation that he was in that led to the head injury. She said it was also very difficult for the family to come and see him because of transport problems. She sounded desperate to get me off the phone, like somehow if I stopped speaking to her then she wouldn't have to remember him anymore. I felt so helpless. I was this client's only communicative partner.

I sometimes reminisce about my days at university. It was a time when I think that I had some idea what speech therapy was about. Now, I am not so sure. Not much can prepare



you for when you step into your first day out in the real working world, and it is just you and the client sitting across from you. The theory goes out and your instinct kicks in. You need to communicate with your client and you just make a plan to do it. For me, this was not something that was really touched on at university. It would be so helpful if there were a course on communication. It could include the communication strategies that speech-language therapists need to interact with clients because this is not something that we, in the profession, think about. I have not ever really worried about my communication up until this point. I did not realise how my communication and my therapy offering would have to change now that I was in a long-term care facility. I am the only conversational partner for most of my clients. Mrs Ngubane, Mr Xaba and the many others, they relied on me to be here for them. I was fortunate that my work allowed me to help people to communicate, to achieve and/or regain lost function. With that being said at university you have the support in the form of your tutor or your lecturer there to assist you even if you don't have an idea what's going on. They pushed you toward working out a problem on your own but they were always there and this did not really allow us to fail and sort it out for ourselves. The formal curriculum made me feel secure; however, it did not really build my confidence. The methods for teaching and learning needed to be more flexible. Sometimes the advice was too rigid and structured. In the real world it has never worked like that.

## 5.5 Halima: The long haul

“I have been here for a few years and I do not know whether it is time for a change.”

Halima is an experienced SLT, and an English-speaking Indian female. She started working in an urban special school and was still working there at the time of this research.

I was easily identifiable during home-time duty with my head scarf and garb. As the only speech-language therapist at the school I was quite well known with the small, diligent group of parents who would often follow up on their children’s progress after school. With 12 years of experience behind me, I had still found it a challenge to provide services for the 185 learners at my school. The learners came from different social, racial, economic backgrounds and many of the learners resided in the hostel which made parental involvement scare and as a result a challenge. The disabilities that the learners had ranged from language learning disabilities, language disorders, language delays, speech disorders, and then more severely Down syndrome, cognitive impairment and autism. I was expected to see each and every learner, which I thought was impossible.

I had to routinely consult with the teachers on how the learners were doing. I also consulted with the teachers and assistants on how they could better communicate with the learners. I used these consultations to also find out what themes they worked on in the classroom according to themes in the CAPS curriculum<sup>32</sup> from the Department of Education. My therapy had to be relevant because at the end of the day when the client went back into the classroom, it had to be functional for him or her. Sadly, therapy was still a challenge, because the teachers, parents and I were not on the same page. There was very little carryover taking place from therapy to classroom or to the home. The principal has promised that we will be drawing up individual programmes for each child and the teachers will be monitored on a weekly basis by the principal. Understandably, the teachers had been quite stressed about this.

Vusi was a new client that I saw for therapy. He was on the autism spectrum. I started the assessment with him. Even though this was an English-medium school I found that supplementing English with the isiZulu instruction helps in getting better understanding and compliance from the clients. As an undergraduate student at university, I did a basic isiZulu course which, as the name implied, was very basic. It did help me though with vocabulary and learning about sentence structure. It was only while doing my community service did I really develop more competence in the isiZulu language. The case history

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<sup>32</sup> CAPS which is an acronym for Curriculum Assessment Policy Statement in SA, which represents a policy statement for learning and teaching in SA schools (Department of Education, 2011).

interview with Vusi's parents was done in isiZulu, which I am quite proud of. The code switching between English and isiZulu initially worked for Vusi however while in the therapy room he was very unsettled. I just put this down to him being in a new environment and he was alone with me in a one-on-one session. His deafening screams were enough for me to promptly return him to his classroom. When we got there the radio was blaring in the background. It was not soothing or classical music. It was the news, loud contemporary music, the radio DJ speaking fast and loud ... people on edge. I tried to talk over that to get the teacher's attention that we returned to class. I have asked the teachers to switch the radio off, but they do not listen to me. It was overstimulating for the learners, especially those on the autism spectrum.

When I was at university, we learnt about environmental modifications for clients who were on the autism spectrum. I had not treated very many learners with autism myself as a student because it was basically the luck of the draw in terms of client allocations to students. Had there been more time for practicals, we could have seen more of a variety of clients. Even with my limited exposure to clients on the autism spectrum I could see that this environment was not conducive to good listening and attention. Surely, the teachers could see how distracting this was for the learners? At university, we were also encouraged to consult with the teachers about modifications to the environment as well as setting functional goals which were in common between us for the learners. I have also spoken to the teachers about us needing to consistently use picture symbols for important information for the learners. I saw a few of these pictures up in the class, but I was not sure whether it was being used properly or just for decorative purposes.

On my way back to my office I noticed the toilet picture symbols that I put up some time ago. I felt that it could have been a good toilet training tool if used properly. A few weeks ago I noticed that on the playground a 12-year-old gesturing to his groin area which I assumed meant that he needed the toilet. And he did. This got me thinking that there had to be another, more appropriate or dignified way for this young man to express a basic need like going to the toilet. I have seen many learners 'do accidents' all because they were not understood because there is no consistent way here for the learners to express these basic needs. We knew that this was not working, yet seemed like verbal language is the only accepted medium of communication here for the teachers no matter the number of workshops and courses that they go to. This was something that I needed to address with them again in the staff meeting.

At our previous staff meeting the principal suggested that we do not send home programmes for the learners because of noncompliance from the parents and the cost implications incurred by the school. I had previously sent homework and I did not get it signed or even acknowledge my efforts. The turnout of parents for parents meetings and parent interviews were so disappointing. It has been the same parents who have attended

time and time again. It appeared to me that parents saw the school as a place of safety for their children from 7.30 to 14:00 and were not actually invested in their learning.

Between the teachers and the parents it felt like no one really seemed to care or acknowledge what the speech therapist had to say. I have been here for a few years and I do not know whether it is time for a change. How will I survive with the lack of reciprocity between the teachers and me? Perhaps I needed to go where my voice will be heard because the frustration was mounting and I did not want to just be another PERSAL number.<sup>33</sup> I wanted to make a significant difference.

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<sup>33</sup> PERSAL is an acronym for 'personal salary system'. PERSAL is a unique system which generates an 8-digit number assigned to each employee who is appointed on the PERSAL system in public service in South Africa.

## **5.6 Chapter synthesis**

Chapter Five presented three narratives, which were set in a particular order of experience of the SLTs, and which reflected how they negotiated their communication in practice. The experienced SLTs appeared to speak about their communication strategies more effortlessly. They felt that they were not listened to within their contexts, which were similar to sentiments expressed by the newly qualified SLTs and reflected in Chapter Four. Further to this, the lack of carryover between themselves and teachers or nurses and parents or families was something that they had difficulty negotiating.

## **CHAPTER SIX: Comparing the cases**

### **6.1 Introduction**

The narrative analysis depicted in Chapters Four and Five, brought to the fore the salient features of the participants' individual journeys in their professional development as SLTs in negotiating their communication in the world of work.

As the SLTs recollected encounters of using communication in their interventions involving their clients and their families, their stories were tinged with relived emotions and with reflections on particular events or people. Relating the narratives in the first-person format was a deliberate choice as I wanted to privilege the participant's voice. The issue of first-person narrative (story) was discussed earlier in detail in Chapter Three (see section 3.4.1). I fully acknowledge and declare the interpretation of events were from my researcher stance. The positioning added multiple layers to the narratives as they told of the enacted, espoused and intended interaction between SLTs and their clients. Primarily, it was their communication that was scrutinised, and it was through this lens that their stories were viewed. The data generated was rich and descriptive of the context and situations in which the participants found themselves. The participants were invited to debrief through the narratives and to provide suggestions to reflect their stories better. Although there were unique characteristics to each participant's story where a storyline was developed, similar nuances resonated through and this will be discussed in this chapter as cross-case comparisons will be made toward a better understanding of the phenomenon under study and toward the next level of analysis.

### **6.2 Orientation to the chapter**

The chapter presents the six issues prominent in the data, which were used for greater levels of abstraction in the subsequent chapters. After each subsection, a synthesis was presented in grey shaded paragraph to highlight the significant findings of the analysis.



Figure 6.1

*Factors influencing the negotiation of communication strategies of SLTs during clinical engagement*

Source: Author's compilation.

Figure 6.1 presents the factors that influence the negotiation of communication strategies of SLTs during clinical engagement. Each of these factors will be discussed further.

### **6.3 Systemic and social issues**

Although not all participants mentioned this category overtly, it was inherent in the sentiments expressed. These were extracted, and include the sub-categories of service delivery, language of service provision, and the healthcare system.

#### **6.3.1 Service delivery**

Effective service delivery was the main goal for all participants. It was interesting to pursue what effective service delivery meant for the participants. In Lynn's narrative,

she expressed concern over effective service delivery when providing therapy to clients who speak languages in which she was not proficient:

Most of the interpreters can help with the Zulu–English language barrier. Even then I am not always able to guarantee that I am providing a 100% service delivery. But then what do I do in situations where clients and their families speak Swahili, Amharic, French or Lingala?

(Extract from Lynn’s narrative, section 4.5)

From Lynn’s concerns, it was evident that she saw that her competence in the language of the client was imperative for effective service delivery, and she became doubtful when she encountered clients from varied linguistic backgrounds.

Amelia expressed concerns about effective service delivery because of systemic changes that took place within the Department of Education, which did not always filter through to therapists at the school. These changes impacted on her service delivery to the learners at the school. She felt that a remediation to this would be to speak to the teachers more regularly in order to find out about activities in the classroom:

There have been many changes in the education system in the country that impacts on us as therapists working in schools. We must become more aware of these. I needed to liaise more with the teachers and find what goes on in their everyday classrooms.

(Extract from Amelia’s narrative, section 5.3)

The preoccupation with effective service delivery was clear from the participants’ responses. Systemic changes, a lack of interpreters and the varied linguistic repertoire of clients were factors affecting their services about which SLTs were concerned. Perhaps a more introspective approach needs to be encouraged so that the professionals may look to themselves as an active resource with the capacity to deal with challenges rather than be passive victims of systemic and social change. The ‘professionalisation’ of an individual should imply that this individual has equipped him- or herself with basic competencies to function in the world of work.

### **6.3.2 Language of service provision**

Amelia experienced policy constraints in her school context based on the medium of language instruction at the school and during therapy:



Most of the children were first-language isiZulu speakers. The remedial school was mandated, as per Department of Education policy, to engage these learners to access the English language. This meant that there had to be a double-learning: learning to learn English, in order to learn in general.

(Extract from Amelia's narrative, section 5.3)

Amelia's understanding of the aforementioned policy is at the centre of this discussion. The policy that she was possibly alluding to was the Language of Teaching and Learning Policy, section 29(2) of the Constitution of South Africa (Republic of South Africa, 1996), which states that every learner has the right to receive basic education in the language of his or her choice, where this is reasonably practicable. The latter part of this statement is of concern. Amelia had interpreted this statement to mean that it was not practicable to conduct therapy in the client's language of choice, as she was a monolingual English speaker and it was considered 'practicable' to target English as the language of medium of teaching and learning since the staff themselves were not sufficiently multilingual in African languages. Amelia was cognisant of the fact that the clients had an extra burden of double learning as they had to learn English first in order to access the content taught. There was however, a lack of recognition that she was complicit to this burden on the client because of her misinterpretation of policy.

### **6.3.3 The healthcare and basic education systems**

Sharon related experiencing problems within the referral system in her context. She followed the correct channels of communication in making the referral; however, the client was not helped. This caused much frustration for her:

I referred Mbongeni and his mum to the educational psychologist for school placement and other issues and the psychologist for counselling. Unfortunately, I have not heard back from the psychologists and they have not acknowledged my referral. I just feel this is a system that's failed. While I was a student a qualified therapist told me that working for the government can make a person lazy. You don't need to show progress with your clients and you will still get paid at the end of each month. So why bother? I have a problem with this thinking.

(Extract from Sharon's narrative, section 4.3)

As a novice professional, Sharon would have learnt about the importance of timeous referrals during her undergraduate education. An integrated approach of different therapies are often required for the holistic management of a client. The lack of following up referrals from other professionals was frustrating for Sharon because she was concerned about the rehabilitation process and the well-being of the client. She became despondent when she realised the non-committal behaviour of other professionals in the healthcare system. She justified these behaviours with what she had learnt about working in the government sector. Although she still strongly opposed these behaviours, she understood that this was a systemic issue rather than a personal one.

Similarly, in the basic educator sector, Halima encountered difficulties when working with teachers and parents:

I had to routinely consult with the teachers on how the learners were doing. I also consulted with the teachers and assistants on how they could better communicate with the learners. I used these consultations to also find out what themes they worked on in the classroom according to themes in the CAPS curriculum<sup>34</sup> from the Department of Education. My therapy had to be relevant because at the end of the day when the client went back into the classroom, it had to be functional for him or her. Sadly, therapy was still a challenge, because the teachers, parents and I were not on the same page. There was very little carry-over taking place from therapy to classroom or to the home ... Between the teachers and the parents it felt like no one really seemed to care or acknowledge what the speech therapist had to say. I have been here for a few years and I do not know whether it is time for a change. How will I survive with the lack of reciprocity between the teachers and me? Perhaps I needed to go where my voice will be heard because the frustration was mounting and I did not want to just be another PERSAL number.<sup>35</sup>

(Extract from Halima's narrative, section 5.5).

Halima made a strong point about not wanting to be lost in the system when she said that she did not want to be another PERSAL number. She pointed out that the efforts

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<sup>34</sup> 'CAPS' is an acronym for Curriculum Assessment Policy Statement, which is an SA education policy, i.e. a policy statement for learning and teaching in SA schools (Department of Education, 2011).

<sup>35</sup> PERSAL is a unique system, which generates an 8-digit number assigned to each employee who is appointed on the personal database system in public service in South Africa.

that she has made to communicate with the teachers and parents were not reciprocated, which left her feeling frustrated. She rationalised this as being undervalued as the (sole) SLT in a school context and that her voice was not loud enough to hear.

### ***On systemic and social issues***

The participants often found that systemic and social issues were constraining and affecting their practice, such as updates and changes in policies and guidelines from the Department of Education. However, their line managers did not pass these updates or changes on to them. It appeared that the participants did not see it as their responsibility to enquire about policy changes and guidelines. This has the potential to constrain their ability to serve as professionals. Not knowing about the broader systemic policy regulations affecting the specific work context is problematic. Further, the professionals within this study expected that they would be informed about what these framing regulations enabled or restricted within the work practice context. However, problematically, they did not believe that they were obliged to take responsibility of sourcing information. This could relate to a lack of adequate guidance provision to participants about the system-wide policies that influence varied work contexts during their initial professional education. They also did not seem to understand professionalism as an exercising of active, independent, autonomous agency to interpret and engage with their specific context. It is to be questioned whether their professional education produced 'passive professionals' instead. Such passivity relies merely on outside sources to activate their personal development.

According to the critical outcomes adopted by SAQA (2000), the National Qualifications Framework (NQF) level 8 graduates (as are speech-language therapy graduates) are expected, as a outcome of the declared curriculum design of their formal education, to "collect, analyse, organise and critically evaluate information" (Nkomo, 2000, p. 18). However, the participants appeared to be unable to assess the challenges that they experience adequately. In the process of 'professionalisation' of healthcare professionals, the analytical engagement of policy ought to be an integral part of the undergraduate curriculum. One needs to question why these systemic considerations are not infused into the operational curricula foci of professional education, especially since the varied contextual spaces and their ambient regulatory

policy frames within which the practitioner is likely to practice, are usually well defined by course designers. The participants' main preoccupation was effectively an abstract form of 'service delivery' disconnected from the operational systemic world with both its constraints and enabling lived worlds. The practitioners in this study seemed to negotiate their professional role in order to maintain an apparently neutral form of professional practice sanitised from the 'messiness' of the real contextual spaces. This fostered their own incapacity to interpret what the likely sources for change were. This inhibited their potential deliberative search for solutions that could be activated to realise their deeper professionalism. Instead, the naïve professionals chose to locate the source of the problems primarily within the systemic context and capitulated, arguing that they themselves were unable to effect any meaningful change. Hence, their preoccupation with a 'neutralised effective service delivery' inhibited their critical thinking about the reasons why these challenges exist. They were also unable to seek their own involvement in contributing to the contextual problems. It is no small wonder that they actively chose to seek out spaces where dissonance with their worldviews was less likely.

## **6.4 Professional education and continued learning**

This category comprises the sub-categories of student training and continuing professional development. Here, participants reflected on their experiences of student training, and provided suggestions to consider in the teaching of future students. Participants also discussed their desire for continuing professional development in the area of communication strategies.

### **6.4.1 Student training**

Participants reflected on their undergraduate professional education with mixed feelings and reactions. Their views on their initial professional education were largely positive. I elaborate here on the elements that they considered to be valuable:

Back at university, we had our supervisors there to offer advice or problem solve with and for us.

(Extract from Lynn's narrative, section 4.5)

At university, our tutors would observe us in our clinical sessions. They would tell us a little bit about how we did; they tried to give us the positives and negatives of

the session and often in that order. These feedback sessions provided me with constructive guidance.

(Extract from Stephanie's narrative, section 4.6)

Well, during undergraduate studies, they [the lecturers] used to encourage us to look at different avenues in which to communicate. We did not always have to use our words; we could use a picture or gesture.

(Extract from Amelia's narrative, section 5.3)

The supervisors, tutors and lecturers mentioned above, all form part of the academic and clinical staff in the discipline. Lynn, Stephanie and Amelia valued the advice, guidance and problem-solving abilities of the academics. This made the students feel secure in their decision-making and sometimes certain about their course of therapy for a client.

However, it was this very security and certainty, which they criticised and did not value, as it showed not to benefit them in the long term, as seen in Carl and Mbali's narratives:

I feel that what we got in terms of guidance was very much on a surface level at university. It was not in depth.

(Extract from Carl's narrative, section 4.4)

At university, you have the support in the form of your tutor or your lecturer there to assist you even if you don't have an idea what's going on. They pushed you toward working out a problem on your own but they were always there and this did not really allow us to fail and sort it out for ourselves. It made me feel secure however it did not really build my confidence.

(Extract from Mbali's narrative, section 5.4)

Samuel (2009) criticises the curricula of teacher education. He contests that the aim is to protect the student teachers within a 'safe' Garden of Eden worldview: a worldview of abstract 'competence' untainted by the sin of the real world (Samuel, 2009). I wonder whether the same argument could be transposed onto the professional training of SLTs. There was an acknowledgement by participants that the real world is different from initial professional education and that initial professional education was too secure with the assistance of lecturers. While they enjoyed the instant gratification of problem solving with their tutors or lecturers in knowing what to do in a specific

situation at the time, they did not always generalise this to other instances in the real-world context when they were alone. The participants provided suggestions to their alma mater, the Discipline of Speech-Language Therapy in how to manage student guidance and feedback better:

The methods for teaching and learning needed to be more flexible. Sometimes the advice was too rigid and structured.

(Extract from Mbali's narrative, section 5.4)

Perhaps the decision-making processes used by the academics to come to solutions in clinical situations need to be broken down to the student. The participants seemed to be asking for more consultation rather than a direct solution from their tutor for the situation at hand. It appeared that the participants would have valued a type of scaffolded support from their tutors. In this way, the student still has to make the linkages and the ultimate decisions; however, scaffolding may assist them in becoming more independent and confident in their own abilities. However, as the metaphor of scaffolding suggests, the long-term goal is not to retain the scaffolds. After a while, the constructors of an edifice must remove the scaffolds it was supporting in order for independent, autonomous existence of the structure to be revealed. Initial professional education should therefore not foster dependent relations between the novice professional and HE educators; instead, the process of building the professional ought to be a process of anticipated dismantling of the scaffolds to allow independent action of the novice professional. By further extension, this might suggest that professional education (especially of the initial pre-service type) should prepare novices to realise that the world of academe is unlikely to provide the full menu of certainties for all practical actions for all times and for all issues or contexts. Instead, professional learning, growth and development should be an ongoing, unfolding of responses to multiple challenges, activating certainties and uncertainties simultaneously.

Sharon shared some of her concerns about when she was a student and realised that in the real world of work, new challenges emerged, for which her initial professional education had not provided ready-made solutions:

Communication is my tool. I didn't realise this when I was at university, or at least it was not made explicit to me. This whole idea would have probably been too abstract for us students at that time. Our focus was more on practical side of things: tell me what standardised tests I would need, what stimuli or toys are best,

what was the general set up of the hospital and how far away it was from home. We wanted facts and tangible answers. Then you get here, to the real world, and then you realise that it's not about any of those things at all.

(Extract from Sharon's narrative, section 4.3)

It is conceivable that the persona that you take on as a student may not be compatible to yourself as a professional, and this is what Sharon found as we see in her narrative. Therefore, Sharon showed insight into her development as a professional as she acknowledged that her foci as a student may not have been relevant to real-world practice as a professional. Hence, a student's focus shapes his or her interpretation and his or her valuing of the curriculum and the way that he or she engages with it. Sharon provided an interesting insight into the readiness of students to accept, interpret and engage the curriculum of their initial professional education. Perhaps she was suggesting that, even though the formal initial professional education did offer some inspiration for understanding the complexity of the real world, the students at that stage of their own trajectory of professional development were not ready to receive or process this information. Perhaps the world of academe needs to look at the divergences between what regulatory bodies (such as the HPCSA) and academics regard as valuable content in the curriculum and what students interpret to be valuable. This emphasises that the curriculum needs to be actively mediated through the filter of the students' worldviews or that students need to be guided through the content in order to appreciate the inclusion in the curriculum.

Participants also offered suggestions on the teaching of communication skills as well as their clinical practicum offering. Lynn, Zandi and Mbali said that student training should ideally mimic the real-world context:

I think that I needed to be thrown in the deep end back then. They needed to task me with everything that I would have been expected to do in the world of work.

(Extract from Lynn's narrative, section 4.5)

The training often focusses on separate communication disorders. They are taught in silos, in boxes. They are taught that there is a speech sound disorders client; then there is a separate language disorders client; a different voice disorders client. They are not exposed to training where the client that has speech, language and voice problems at the same time and needs to be treated for all at the same time. So I feel that teaching them like this is not really real-world exposure. The

speech therapist is going to see a client with an aphasia, dysarthria and dysphagia  
... everything all together.

(Extract from Zandi's narrative, section 4.7)

From the excerpts above, it could be argued that the participants saw compatibility between academe and practice in the real world. It is conceivable that the students might have felt that they had invested four years in professional training and that they should consequently feel equipped for the world of work upon graduation. However, they seemed to be suggesting they would have preferred to have been inducted into the holistic rather than atomised conceptions of the multiple presenting 'disorders', which the clients in the real world reflected. This assessment of the world of academe, which presents discreet units of identified 'disorder', is also reiterated by employers of graduates in the workplace. There are expectations from employers that graduates with professional degrees display competencies that match the real world of work. This would warrant that HE curricula aim to cover a full spectrum of all challenges of the world of work. Perhaps this an unrealistic expectation given the scope of operational and clinical practice challenges that are likely to be confronted in the world of everyday practice. Perhaps both the sending and receiving institutions who work with novice professionals ought to share more dialogical collaborations about their expectations, challenges and possible resources to assist development of the growing professional. The blame-game of shifting responsibility to one source is not useful. What can be the compromise? Both the worlds of academe and of work have co-responsibility in activating a continuum from initial professional education to CPD. Rather than this lifelong journey being simply a regulatory professional development requirement (as outlined by the HPCSA as the professional council – see HPCSA, 2011), this shared strategy should underpin the conception of building blocks for deep professional development of practitioners.

#### **6.4.2 Continuing professional development**

Participants expressed that they would be interested to engage in future professional development in the areas of negotiating communication with clients as many of them had not actively thought about this previously.



A concern from Amelia was that there were a scarcity of such professional development events and relevant opportunities. Then there were financial implications for attending and implementing interventions:

I thought that I might need to attend more workshops; however, there was such a scarcity of them. Who would offer them to me? What would they say I should do? I know that these workshops sometimes demand fancy resources and interventions. But here in this school, there are major resource constraints. I cannot really engage in such extended learning. The Department of Education needs to provide more opportunities for us as therapists in schools.

(Extract from Amelia's narrative, section 5.3)

The above excerpt suggests that there are barriers, which Amelia cited that would prevent her from engaging in CPD activities based on availability and cost. As Amelia was employed by the Department of Education at the time, there appeared to be an expectation that the Department of Education should create opportunities for CPD activities for the professionals. This suggestion seemed to exonerate the professional in developing him- or herself further and investing in his or her professional growth. The responsibility of such activities is shifted onto the employer. However, what of one's own professional autonomy?

Mbali reiterated the point that communication as a strategy is not thought about enough by SLTs:

It would be so helpful if there were a course on communication. It could include the communication strategies that speech-language therapists need to interact with clients because this is not something that we, in the profession, think about.

(Extract from Mbali's narrative, section 5.4)

The communication strategies used by SLTs are the methods that they use to adapt, revise, assist, modify and improve the communication of their client. However, Mbali stated that these strategies were not overtly taught in the undergraduate curriculum nor offered as CPD courses or workshops. Where then do SLTs derive the methods (or tools) of their practice? Are there nuances of communication strategies in the teaching and learning of undergraduate education of SLTs? There appeared to be a call for more explicit and concentrated focus on the teaching of communication strategies used by SLTs in the world of work.

Of interest, was the phrasing of Mbali's comment that this issue is not thought about enough by the profession. There appears to be an externalising of the issue to an 'inanimate' profession. The profession cannot effect change by itself if it is not propelled forward by the professionals (SLTs) who belong to it. Instead, Mbali has cast herself (and others) as deficient, looking to CPD activities to provide outside salvation for the gap in their knowledge. What of independent agency, which is a branch of professional development? The outsourcing of knowledge production further serves this salvation thinking. It is my suspicion that this linked to the previous issues discussed under student training (see 6.4.1) where students looked for guidance and problem solving from their lecturers and enjoyed the instant gratification of acquiring the answers. Has this turned into a cyclic process of learned helplessness perpetuated by HE? If this is so, could it be that the teaching and supervision in HE are deprofessionalising a professional degree? These questions seem to suggest that the initial professional education curriculum might paradoxically be generating passive rather than active autonomous professionals. Learner dependency rather than autonomy characterises their view of their practice.

#### ***On student training and continued learning***

At the surface, the participants were mostly celebratory of their student training as they recalled the guidance received from lecturers and tutors as helpful. Upon further reflection on how their undergraduate education prepared them for the world of work, they realised that they had to do more on-the-job learning. There was then criticism that their undergraduate education was too sanitised. They would have preferred for it to mimic the 'messy' world of work closely. They provided suggestions for clinical practicum and pedagogical methods to try and bridge this gap. In a subservient manner, they expressed their desire for opportunities for continued professional learning with regard to the negotiations that go on during clinical engagement. They cast themselves as deficient while looking to CPD activities as the salvation. Financial constraints and a lack of resources were offered as reasons why they were reluctant to engage in CPD activities.

## 6.5 World of work context

The specific contextual features within the world of work constituted a recurring factor of concern for participants when they commented on their communication strategies. They mentioned links between the worlds of academe and work. This category comprised the following sub-categories: *context creates the communication*, *environmental modifications affect communication*, *clinical health risk*, *working with other professionals*, and *stretched view of time*.

### 6.5.1 Context creates communication

The participants' contexts influenced their communication choices. For the purpose of this discussion, 'context' refers to geographical location, type of establishment or institution, and workplace environment. The type of environment and the clients that one would be treating influence your communication choices. Simmons-Mackie and Damico (2010) offer that context exerts a powerful influence in the clinical encounter. Carl and Mbali, both in public healthcare contexts, emphasised these sentiments as Carl, being a novice, male SLT in a rural public hospital, was not readily accepted by his client who perhaps did not see the need for speech-language therapy. The client perceived his own condition as fatal following a stroke. This influenced the communication used during the clinical engagement, as there was a lack of trust and faith established earlier between therapist and client based on the contextual interpretation by the client of his fatalistic condition.

Mr Khumalo, an isiZulu-speaking male client was one of these people. I vividly recall my sessions with him and the sense of discomfort that I felt. Firstly, he did not want to accept that he needed speech therapy. It felt like an emasculating experience for him. Perhaps it was a cultural thing. When I approached his bed in the ward he furiously shook his head. "Angifuni,<sup>36</sup>" he muttered. "Sawubona,<sup>37</sup> Mr Khumalo. I am here to help you with your speaking."

(Extract from Carl's narrative, section 4.4)

Carl worked in a rural hospital which was without speech-language therapy services for seven years prior to him being there. It is possible that the general community does not know what an SLT does or which function they serve in the hospital. There might

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<sup>36</sup> 'Angifuni' is an isiZulu word which translates to I do not want (to) in English.

<sup>37</sup> 'Sawubona' is an isiZulu word which translates to hello in English.

often be a disconnect between therapist and client because of assumptions made about knowledge that each other should have of the other. In Carl's case, it appeared that the client may not have had sufficient knowledge about speech-language therapy nor did Carl have knowledge about the client's background and the community from which he came. Hence, the disconnection between practitioner and client. It would be important to know what the views of the clients or their communities are on stroke and other serious health conditions prior to meeting with the client. One cannot just assume that every client referred for therapy is willing to receive the therapy. Hence, having prior knowledge of the clinical environment helps prepare the therapist for the context. Carl shared this sentiment related to another issue on clinical training when he said:

I remember that when I was in third year, we went to a hospital in preparation for the upcoming clinical block. It was nice to see the space that you would be working in and the clients that you would see. I think that the context creates the communication.

(Extract from Carl's narrative, section 4.4)

This type of reflection would have assisted Carl in his encounter with his elderly male client. However, the mere exposure in a superficial way to potential contextual work space was inadequate for Carl. He was not able to connect deeply with the context when thrust into full-scale practice in that world. It would be important for the SLT to know the worldviews in connection with the cultural spaces and the contextual environments within which therapy is to be conducted. This includes acknowledging the diversity of clients with whom one would be working, such as paediatric or adult groups, in order to prepare one's intervention and communication accordingly. It is also worthwhile to know whether the establishment is an acute care hospital or long-term care facility, as this would also influence the communication used as we saw in Mbali's narrative.

Mbali who worked in a long-term care facility found that her communication with her clients was influenced because of their prolonged incapacitation (sometimes years) in the hospital as the clients' plateaued in their communication rehabilitation and the nature of the interaction subsequently became stimulation of conversation rather than traditional therapy. Mbali mentioned that she would have discharged the clients from therapy if she had the option. Interestingly, Carl and Mbali were on opposite sides of

the experience continuum, with Carl being a novice SLT and Mbali being an experienced therapist. This therefore became a worthwhile category to explore.

Mbali who works in a long-term public healthcare facility often had to provide therapy to the same clients for months or years on end. A long-term facility means that the clients are housed in that facility for a longer period as opposed to acute care hospitals, such as the one where Carl worked. Mbali did not realise the toll that this took on her communication with these clients:

I did not realise how my communication and my therapy offering would have to change now that I was in a long-term care facility.

(Extract from Mbali's narrative, section 5.4)

In Mbali's work environment, therapy would be long-term interventions, such as months, if not years. The clients remained in hospital during this time and were often abandoned there, without contact by their families. Staff at the hospital, and especially the SLT, become their only communication partners. This is different from acute care hospitals in the public sector where clients remain for a short time before they are discharged home or to long-term care facilities.

Samuel (2009) describes teacher education as a safe haven for those who conceive of professional development as uncomplicated by the realities of the real world. Within this ambit, he suggested that many teacher professional development curricula are targeted at providing services for an often unstated middle-class (white) suburbia. All other contexts are seen as aberrations, which stray from the normative expectation of what is considered that schooling should aspire to be. Could the healthcare scenarios discussed in my study also subscribe (unconsciously) to middle-class suburban standards of practice as has been explored in teacher education, especially considering the history of lack of resources and infrastructure that both the education and health sectors suffered in South Africa? It appeared so, as practitioners, both novice and experienced, seemed to suggest that the workplace does not meet with their notions of an 'idealised space'.

My analysis of the narratives of novice and experienced practitioners suggested that SLTs ought to be engaging with the settings and contexts of their own practice space (including geographically, institutionally and culturally diverse environments), which embed unique challenges and resources. It is unrealistic to expect that there is a

universal interpretation of communicative competence, which will apply normatively across different contexts. As Samuel (2009) suggests, the paradise of a 'Garden of Eden' has long been lost. Each context generates distinctive communication challenges and presents the need to search for real-world solutions and strategies that are contextually appropriate. The negotiation of the communication strategies needed for particular contexts would require the SLTs to utilise the propositional knowledge that they acquire during their initial professional education with their craft knowledge that they would have informally acquired through interactions with their contexts and the community within which they work. The dialogue between the ideal and the real world of work contexts constitutes making situated professional judgement, which has the potential to challenge the worldviews of both contexts, their habituated ways of knowing, being and doing.

### **6.5.2 Environmental modification affects communication**

In the school context, the environment within which therapy was conducted affected the clients' communication. Halima noted how ambient or background noises adversely affected her learner with autism spectrum disorder:

In the therapy room he was very unsettled. I just put this down to him being in a new environment and he was alone with me in a one-on-one session. His deafening screams were enough for me to promptly return him to his classroom. When we got there the radio was blaring in the background. It was not soothing or classical music. It was the news, loud contemporary music, the radio DJ speaking fast and loud ... people on edge. I tried to talk over that to get the teacher's attention that we returned to class. I have asked the teachers to switch the radio off but they do not listen to me. It was overstimulating for the learners, especially those on the autism spectrum.

(Extract from Halima's narrative, section 5.5)

Clients with special needs and who have communication problems often present with attention difficulties. An optimal listening environment is important for adequate comprehension on the listener's part as well as for the speaker. The presence of unnecessary ambient noise can be quite distracting for children in a classroom; hence, Halima's suggestion of turning off the radio.

I have extended the notion of context toward the lack of care that the teacher (in her specific client's world) had toward Halima's professional advice. Halima had been working at the school for a few years and was an experienced therapist. Therefore, it was quite surprising that her suggestion of turning down the radio had been dismissed. It could have been the possibility that the teachers conceptualised the SLT as just a passing visitor who did not encounter the everyday experiences in the classroom and for the length of time that the teachers do. Therefore, it could have been with some resentment that they were not following the advice of the SLT. Why was Halima's professional advice ignored? Could it be that the teacher disregarded Halima because of the method of service delivery that Halima provided, such as the pull-out method (taking learners out of the classroom for speech therapy)? Halima felt that she was considered a passing visitor, a transient professional who was not deeply connected with the school's everyday world. Hence, Halima did not know the classroom dynamics, which the teacher had to negotiate before she could make a judgement on what occurs in the classroom. In this way, Halima felt obsolete because her suggestions have not heard by the teachers and their assistants. Hence, the environment was not conducive to effective intervention on the part of the therapist, teacher or client. It could be argued that the presence of the therapist is not directed to resolving the learners' presenting challenges; instead, it is to provide an officialised semblance of professional support without any actually being given.

Amelia took it upon herself to create a more visually stimulating environment in order to promote language development, which she found effective:

I developed charts of simple greetings and stuck them on the brick walls outside the therapy department to help encourage the learners to use these greetings. I noticed little Zanele looking at them during the lunch breaks.

(Extract from Amelia's narrative, section 5.3)

Amelia found that visual stimuli encouraged the development of communication. This was, however, rare in her school context. There were no charts or murals on the school walls, which was unusual for a learning environment that should be promoting literacy. This was a puzzling conundrum as it was difficult to conceive how learners can be expected to be stimulated without stimulation around them. Communication is not just in the words that we hear and speak. It also lies in all that we see, read and process. Perhaps the school community lacked initiative or care, or perhaps a lack of resources

to signalled the financial strain that the public school system endures. More so, it might be that the normative expectations of what schooling environments ought to be, are being drawn from the therapist's own worldviews of the role and responsibilities of what school teachers as professionals ought to be doing to stimulate learning and development. Why teachers do not share this syntax of development is a matter for exploration that the therapist might not have engaged in deeply enough to understand the teachers choices.

According to the therapists' worldview, the environment has to be conducive to progress in order to benefit the client. This could be the reduction of ambient noise, stimulating murals on the walls, effective communication between referring practitioners. Hence, the environment is not only the physical space, but also the operational space of personnel, aesthetics and the medium of instruction (other than the language used). The mismatch between the worldviews of clients (learners), their caregivers (teachers) and the therapists underpins this above discussion.

### **6.5.3 Clinical health risk affects communication**

This category refers to the underlying communication problem or 'disorder' that the client presents. The severity of communication impairment due to clinical health risks is the central feature to the communication strategies that would need to be used during clinical engagement. Across contexts, but more specifically in the public healthcare context, the burden of disease due to neurogenic disorders affect the communication abilities of clients. Hence, the participants recounted the ways in which these impairments affected their communication. Sharon explained that her client's disorder was severe:

He was a little boy who has cerebral palsy (CP). Why was CP so prevalent in this area, I wonder?

A few days later there was a baby with hydrocephalus who came in for therapy. He had feeding difficulties and was at risk of aspiration pneumonia. His mum needed to follow my advice because there was the potential that the baby could die from aspiration.

(Extract from Sharon's narrative, section 4.3)



Mbali explained that even though she and the client both spoke the same language, she still had great difficulty engaging with her because of the severity of her communication problem:

She had a stroke and subsequently aphasia and dysarthria which caused problems with her understanding and production of speech and language. I communicated with her using simple words and language structure. Being a Zulu-speaking, female therapist myself, one would have thought that it would be easier for me to communicate with her. However I think it goes to show that impairment in communication definitely shows itself up as impairment nonetheless which makes communication difficult regardless of the language of the conversational partners.

(Extract from Mbali's narrative, section 5.4)

Here Mbali tells us of her challenge in communicating with a client with severe impairments because of a stroke. Mbali realised that challenges in communication are not just language-related. It could be that, because spoken language is the most common means of communication in speech therapy intervention, emphasis is placed especially on this. In this particular case, the communicative interaction was multi-layered and many variables had to be considered when accommodating the client.

The participants expressed that they felt sufficiently prepared when dealing with cerebral palsy in paediatric groups and strokes in adults from a technical perspective, which resulted in communication impairments for the clients. These communication impairments however had a marked effect on the communication strategies that the SLTs used during clinical engagement. This was due to the clients' level of understanding and their limited ability to communicate verbally.

#### **6.5.4 Working with other professionals**

In the world of work, most of the participants had problematic encounters when working with other professionals. These encounters left participants feeling that SLTs are not listened to or are superseded in the clinical management of clients, especially when considering doctors, nurses, physiotherapists (in the public health context) and teachers (in the education context).

The above situation could be that the other professionals might not fully understand the role of the SLT, as it is a relatively small and new profession in South Africa in

comparison to other healthcare professions. The incongruent conceptions of who an SLT is and how others view the profession affect the practice of the professional. Therefore, these conceptions could result in the professional and the profession being delegitimised. The SLT is left feeling unheard and misunderstood, which could affect the way in which he or she engages with other professionals in future.

In Carl's narrative, he explained how dismissed he felt as being part of the rehabilitation department:

I knew that once the doctor got involved that he took precedence over me. This spoke to how other people think about us, as therapists in the hospital. I felt that they thought I am just part of the rehabilitation department, so I was not that important.

(Extract from Carl's narrative, section 4.4)

For Halima, the lack of reciprocity between the teachers, parents and herself made her feel like she was not acknowledged, which made this interaction difficult:

Between the teachers and the parents it felt like no one really seemed to care or acknowledge what the speech therapist had to say. I have been here for a few years and I do not know whether it is time for a change. How will I survive with the lack of reciprocity between the teachers and me?

(Extract from Halima's narrative, section 5.5)

The participants highlighted problematic encounters with other professionals during clinical practice. The SLTs did not feel that they were listened to and they were superseded in decision-making processes involving clients. This influenced their communication in clinical engagement.

### **6.5.5 Stretched view of time**

Participants in the public health context found that speech-language therapy was a long-term commitment for the practitioner as well as the clients and families, and that this was a factor contributing to lower levels of motivation for the individuals involved:

I have only been here for short while but it feels like a life time. My clients too perhaps, have this stretched view of time: days fade into weeks, and weeks into months, hopefully awaiting some treatment of their condition.

(Extract from Sharon's narrative, section 4.3)

On the other hand, the notion of time in the private practice context was different. Stephanie often felt rushed as she experienced the time pressure of quick fixes and the need for results imposed on her by parents. She also felt pressured and lacked control over this:

I felt that there was a certain amount of pressure with the short amount of time that I had to work with him. Also Mrs Williams kept asking how long would therapy take. I knew that she knew that it was only a half-an-hour session but her tone gave me the impression that she meant the entire duration of therapy. I told her that I don't want to put pressure on Seth in therapy and that we go according to his pace. But maybe in private practice, you need to be rigid and time-bound.

(Extract from Stephanie's narrative, section 4.6)

### **On the world of work context**

*The world of work context was an important feature that influenced how the participants negotiated their communication. The participants realised that they needed to adopt communication strategies to suit their respective contexts and that there was not just one way of negotiating these experiences. Each context calls for different communication accommodations in terms of the nature of the institution (i.e. schools, hospitals and private practice), the disorders prevalent in the community, and the professional team in that context. Each context generated unique clients, families and expectations of the therapy offering.*

## **6.6 Communicating and accommodating families and clients**

This category comprises three sub-categories of practitioner engagement with the family or parents and the client as well as practitioner communication adaptation that takes place during clinical engagement.

### **6.6.1 Practitioner engagement with the family or parents**

The practitioners' involvement and engagement with the family was one of the most prominent forces that resonated in all narratives. The family structures of the paediatric clients ranged from single (often teenage) mothers to families, i.e. both parents as well as siblings. The adult and geriatric clients' family structures often seemed disconnected with a spouse or child who was responsible for care. These family structures were seen to chart the communication environment either in a productive

or destructive way. For example, in Sharon's narrative, we saw that she seemed to connect with a mother of a young child with communication difficulties:

We tried to understand each other. Somewhere between her broken English and my broken isiZulu, we connected. I think it was after a few sessions that the little boy was able to come to me and ask me for a toy. We both, his mum and I enjoyed that excitement. I think that was the first time that I truly believed in speech therapy and I know so did his mum.

(Extract from Sharon's narrative, section 4.3)

For Sharon, this clinical engagement was about connecting with the client and his mother, and about the mother and Sharon working collaboratively to help the child communicate. The connection with the client and his mother was Sharon's goal. We see here that effective communication can be perceived as sharing a common success.

On the other hand, Zandi's narrative revealed a more destructive force because of a mother's irregular engagement with the client. The client's motivation to communicate was negatively affected by the erratic visits by her mother:

I remembered a time when her (the client) mother came to visit her. She was in a good mood for the whole day and the day following that, anticipating the next weekend when her mother would visit her again. But, she did not. Over some time, she figured out that she has gone away and she was likely not coming back for a while. This was when she [client] went back into her shell.

(Extract from Zandi's narrative, section 4.7)

Zandi acknowledged that contact with the client's family had to be regular in order for their presence to assist in the therapy process. We notice that the infrequent visits of the mother created additional anxiety for the client and left her alone and withdrawn. Perhaps the client was searching for certainty of knowing whether her mother was indeed going to visit her. This lack of support from the client's mother transferred back into the therapy space.

In Lynn's encounter with the client's mother, she realised how the negative description of the client by his mother influenced her (Lynn's) initial perceptions of the client, which affected her communication:

When I had met her previously she had quite a negative description of her son. She said that he doesn't listen and is badly behaved. However, my initial observations gave me a sense that he was much better than what his mother made him out to be.

(Extract from Lynn's narrative, section 4.5)

It was only through her engagement with the client that she realised how she needed to negotiate her communication:

I could see that he didn't understand me when I asked him a few questions. He slowly regained his composure. I communicated with him in simple sentences; I had to repeat myself frequently. I contorted and twisted my face to see if he would react. Would a smile work? Something eventually caught his attention. It was one of the toys that I brought along. As the session progressed, I could tell that this little boy wanted to communicate with me. I felt that he appreciated me trying my best to communicate with him at his level. I think he was enjoying the attention that I gave him.

(Extract from Lynn's narrative, section 4.5)

In this case, the mother lacked the coping strategies to understand her child's communication, and this was transferred into the therapy space.

In the private practice context, Stephanie encountered parents who did not comply with or adhere to recommendations to conduct parent-directed speech-language therapy homework as a means of supplementing SLT-directed therapy, even though this was stated in the therapy contract:

There was a therapy contract that Mrs Williams signed that clearly stated that homework is a big part of therapy. I did not understand how she expected to see progress when I see Seth for half-an-hour once a week. Perhaps she had been very busy and could not do the homework. Perhaps she needed more reminders.

(Extract from Stephanie's narrative, section 4.6)

Here we can see that, even though Stephanie was affirming her frustrations, she followed this up with self-doubt about whether she was justified to feel this way. The use of the words 'perhaps' in two consecutive sentences suggests this. Stephanie also mentioned her reluctance to confront the parent about this:

In private practice there has been this real emphasis on making the parents happy. I really could not say anything because I had to keep my client numbers consistent.

(Extract from Stephanie's narrative, section 4.6)

On the other hand, Halima, working in a school context, regularly encountered a small diligent group of parents who enquired about their children's progress and who attend parent meetings once every school term. She has seen positive outcomes of this parental interest in the development of the children's communication skills.

As the only speech-language therapist at the school I was quite well known with the small, diligent group of parents who would often follow up on their children's progress after school.

(Extract from Halima's narrative, section 5.5)

Parental and/or family attitudes toward speech-language therapy showed that families often did not display positive attitudes toward therapy as seen in Zandi and Mbali's narratives within the public healthcare context:

There were lots of families who did not come to visit the clients and this was heart-breaking. I was not prepared for this because I didn't know that this was part of the job during my undergraduate training. When I used to come to the hospital as a student, it was just once a week. It was a skewed picture to what actually happened every day. When you come to the real world and you realise that people don't care a thing about their children. This made me so sad. I had gotten used to it to some point because I see it every day, but as a person it was destroying me to see a child waiting for a parent who will most likely never visit. I'm not sure if they're not making an effort or maybe it's their circumstances also.

(Extract from Zandi's narrative, section 4.7)

Mrs Ngubane hardly has any visitors with whom she can communicate. This is a big challenge to get family support for her. She needed someone from home who knows her and understands her better. However, the family have said that there are work commitments and other excuses. As mentioned previously, this is a long-term care facility, so they did come at first and then it slowly stopped. This had been a huge barrier to progress in therapy and generalisation to the outside environment.

(Extract from Mbali's narrative, section 5.4)

In the private practice context, similar parental attitudes were noticed:

I have felt sometimes in private practice that parents don't appreciate what you say to them because they have often ignored what I have said. The worlds of urban private practice and that of rural community service areas were really different just based on the attitudes of parents and clients toward therapy.

(Extract from Stephanie's narrative, section 4.6)

Stephanie also mentioned in her narrative that the financial implications of therapy within the private practice context affect the communication as parents or family request 'quick fixes':

Also Mrs Williams kept asking how long would therapy take. I knew that she knew that it was only a half-an-hour session but her tone gave me the impression that she meant the entire duration of therapy. I told her that I don't want to put pressure on Seth in therapy and that we go according to his pace.

(Extract from Stephanie's narrative, section 4.6)

Stephanie felt that she had to commit to a time frame on which Mrs Williams was insisting. Stephanie felt that she would be held to this time frame as a mark of her professional aptitude and skill. She was not willing to commit to this possibly due to her inexperience as a novice therapist and because she did not have sufficient experience to draw comparisons. This might not be something that Stephanie would want to admit, as this would betray her own insecurities in her lack of experience. She therefore chose to transfer the uncertainty back onto the client and his ability.

Lynn – within the public healthcare context – highlighted the financial strain on families in order to attend therapy:

I was sure to hear during the course of the day, the clients' and their families' stories of how dependent on public transport they were, and also how many could not afford the rising costs of transport. I was also sure to hear their silent complaints about the systems here at the hospital: they dread the long queues simply to collect the hospital files. I was aware that coming for therapy either for themselves or for their loved ones meant getting time off work or arranging for care for the other children at home, which may have its own financial implications. It seemed like much sacrifice for a forty-five minute session once or twice a month.

(Extract from Lynn's narrative, 4.5)

We see here that Lynn's compassion for her clients and their families extended beyond the therapy room. She was cognisant of their sacrifices to come for therapy and she appeared grateful for their attempts. From the extract it seemed as though Lynn did not think that the trade-off for therapy and what the client and his or her family had to go through seemed fair. This was an interesting conception from a practitioner. The inability to deal with the 'world' of the client is what disillusioned the practitioner since much of its parameters are outside the SLT's control, such as the employment of the client or parent, transport costs and other lifestyle matters.

It appeared that the practitioner viewed the relief or the comfort that the client received from therapy not worth the effort made to one's everyday life to attend therapy. What does this suggest about the practitioner's inherent views of their own profession?

### **6.6.2 Practitioner engagement with the clients**

The practitioner's engagement with clients is influenced by a number of factors, such as the level of comfort felt between the practitioner and the client, the client's behaviour and demeanour, the practitioner's perception of the client's willingness to participate in therapy, and the practitioner's ability to identify and avoid risks of miscommunication.

Clients' willingness to participate in therapy seems to influence communicative exchanges. Carl was not comfortable in his engagement with one of his male clients due to possible different cultural conceptions of therapy as the client's conceptions about old age and impairment differ from the practitioner's worldview of treatment of impairments. The client might have viewed participating in therapy as a sign that he was weak and needed the help of yet another health professional. The client might also have failed to see how treatment could happen with just 'talk therapy' as the SLT did not work with any other tools or paraphernalia:

I vividly recall my sessions with Mr Khumalo and the sense of discomfort that I felt. Firstly, he did not want to accept that he needed speech therapy. It felt like an emasculating experience for him. Perhaps it was a cultural thing. When I approached his bed in the ward he furiously shook his head. "Angifuni," he muttered.

(Extract from Carl's narrative, section 4.4)



Stephanie also had an unwilling client. However, she did not have the option to postpone therapy because of the nature of private practice and the parent's urgency for a 'quick fix' of the speech problem. Her engagement was influenced by business-related factors:

Little Seth was quite cheeky in the session: what we now label as 'strong-willed'. He did not want to listen to me in the previous session and I was still unsure of how to get him to engage in the session without making him upset... I had to keep my client numbers consistent or else the practice manager would have asked me to source more clients in order to keep an adequate caseload.

(Extract from Stephanie's narrative, section 4.6)

Due to the private practice context operating according to a business model, the 'consumer' (in this case the client's parent), could view therapy as a commodity that had been bought; therefore, it must deliver the expected results. The trade-off between paying for therapy and receiving results in therapy consequently became the focus.

Zandi explained that communication as her tool or method for intervention was a negative factor because communication relies on a sender and receiver. When the receiver (in this case the client) is unwilling, it negatively affects the therapy process:

As a speech therapist I found that there were many negatives using communication as the treatment method for the impairment of communication. What made it even more challenging is that it feels like it all depended on the client and you feel like you have no control of it. For example, the physio can do passive movements; at least they've done something to help their client. Sometimes when I went to the wards, the client just stared at me. They were not actively engaging with me or showing me that they understood. Admittedly, this was demotivating. I felt like I am not really doing anything to help the client.

(Extract from Zandi's narrative, section 4.7)

The client did not want to engage in therapy possibly due to her difficulty in coming to terms with her impairments. She could possibly not believe that speech-language therapy could help her because of mistrust in the overall health system that she has encountered.

### 6.6.3 Practitioners' accommodation in terms of communication

This sub-category refers to the accommodation that SLTs make when communicating with clients and/or families in order to facilitate better communication. Sharon used demonstrations to facilitate the mother's understanding of what she would want to be done in the home environment:

His mum needed feedback and guidance on what to do at home. The only way I was going to achieve this was through demonstration with her and with the child while we played.

(Extract from Sharon's narrative, section 4.3)

In this case, there was a language barrier between the therapist and the client's mother. Sharon had to solve the problem using ways in which she would be able to adapt her communication to accommodate this mother who wanted to help her child but could not understand Sharon's English. Hence, she resorted to demonstration to explain to the mother what needed to be done to facilitate therapy.

The participants needed to engage in the process of negotiating their communication with their clients. This was a continuous process. Lynn and Amelia found it useful to adapt their communication by asking questions, repeating instructions, simplifying their language and using facial expressions to facilitate understanding:

I could see that he didn't understand me when I asked him a few questions. He slowly regained his composure. I communicated with him in simple sentences; I had to repeat myself frequently. I contorted and twisted my face to see if he would react. Would a smile work?

(Extract from Lynn's narrative, section 4.5)

I simplified my language and I explained further when I saw some blank stares on their faces, fidgety fingers dancing on the desks, glances out of the window.

(Extract from Amelia's narrative, section 5.3)

Amelia elaborated that she relied on behavioural cues from the client to monitor her understanding.

#### ***On communicating and accommodating families and clients:***

*The negotiation of the multiplicity of roles within the world of work was a key finding as the participants found that engaging with clients could not take place without*

*engaging with parents or families. The challenge came in when there was a lack of support from the parents or families, which implied handing over of responsibility of care to the SLT, which is discussed in the themes that follow. The SLTs found that in some cases, they became the sole communication partner for their clients. This complicated the nature of the responsibility of the SLT as the director of resolutions, rather than a co-constructed responsibility with the client and their families. The SLTs were not always prepared for this responsibility.*

## **6.7 Practitioner's experience of speech-language therapy**

Within their contexts of practice, the participants shared experiences that influenced their practice. Both the newly qualified participants and the experienced participants often compared their practice experience to their training practice as though they used this experience as a compass for direction and guidance. This category comprises the sub-categories of emotive factors, operational factors and the responsibility of care for the clients.

### **6.7.1 Emotive experience of speech-language therapy**

There was a strong emotive element across all participants that resonated in the narratives, which affected their communication with their clients. Both negative and positive emotions were discussed.

Participants mostly discussed the negative emotions, which led to them using descriptors such as 'overwhelmed', 'helpless', 'sad', 'feeling hollow and frustrated'. These negative emotions were seen across all contexts and among both newly qualified and experienced SLTs. Feelings such as these have affected Sharon as follows:

Nothing happens. My head hangs low: I thought I came here to make a difference, but nothing happens. Today I didn't even feel like coming to work.

(Extract from Sharon's narrative, section 4.3)

Sharon revealed her despondency in the slow progress of her intervention. She had aspirations of effecting a difference with clients. Unfortunately, she did not get the outcome that she had expected. This has affected her motivation to practice.

Stephanie in private practice shared similar sentiments:

It seemed counterproductive to me. This was a big frustration of mine.

(Extract from Stephanie's narrative, section 4.6)

Stephanie felt frustrated that her client's mother was prepared to pay for private speech-language therapy but was not compliant in carrying out homework tasks that helped to facilitate the therapy process. The homework tasks worked in conjunction with the weekly therapy session; hence, if one component was not done, it compromised the entire process.

In the public health sector, Zandi felt demotivated by the attitude that some clients had toward speech-language therapy, and felt that this reflected poorly on her ability to help her clients:

Sometimes when I went to the wards, the client just stared at me. They were not actively engaging with me or showing me that they understood. Admittedly, this was demotivating. I felt like I am not really doing anything to help the client.

(Extract from Zandi's narrative, section 4.7)

There were some positive emotions described, especially when the participants spoke about successful encounters with their clients. Sharon spoke about a particular session where she experienced a communication breakthrough with her client:

I felt success there and so did the little boy and his mum. It made me feel good. Not every case or every day is like that but for that moment, it felt good.

(Extract from Sharon's narrative, section 4.3)

Sharon acknowledged that moments like these may not occur daily. Her experience in the world of work might have taught her this. She therefore relished the moments where she felt of help to her clients and where she felt optimistic.

Zandi explained that she tried to focus on any positive aspects of the session in order to keep her motivated so that she could function efficiently for other clients:

I motivate myself by focussing on anything positive that happened in the session. I sometimes go back the following day and sometimes the client would be doing better because they were less tired or upset.

(Extract from Zandi's narrative, section 4.7)

From the excerpts, it was clear that there were daily disappointments and frustrations felt by the participants. The participants however, developed coping mechanisms to keep up levels of optimism where they had to focus on positive aspects during the

session. As a professional, one has to have self-regulatory mechanisms to be able to weigh up the negative experiences with positive ones, as this is part of professional development (Butler, Lauscher, Jarvis-Selinger, & Beckingham, 2004).

### **6.7.2 Operational experiences of speech-language therapy**

Most participants discussed the day-to-day experiences. They mentioned issues relating to making progress with clients, dealing with clients who refused therapy, coping with client frustrations and negotiating propositional knowledge and craft knowledge (Samuel, 2009).

As Sharon said, her client had progressed to verbal language, which excited her:

Somewhere between her broken English and my broken Zulu we connected. I think it was after a few sessions that the little boy was able to come to me and ask me for a toy. We both, his mum and I enjoyed that excitement. I think that was the first time that I truly believed in speech therapy and I know so did his mum. He progressed to learn more words and speak in sentences.

(Extract from Sharon's narrative, section 4.3)

Of interest here, is Sharon's statement that this encounter was the first time that she truly believed in speech therapy. As a novice professional, she may not have had extensive experience in seeing clients make significant progress in therapy. However, if clinical practice begins at the second-year level during initial professional education, why then had Sharon not experienced this level of progress previously? This could be linked to the limited duration of exposure within each clinical block. Sharon could also possibly have felt this way because it would have been the first time that she, without the help of supervisors, would have attained progress with a client. She therefore felt this as a significantly rewarding experience.

Unfortunately, some clients refuse therapy because of their own perceptions of speech-language therapy, as Carl mentioned:

Firstly, he did not want to accept that he needed speech therapy. It felt like an emasculating experience for him.

(Extract from Carl's narrative, section 4.4)

Carl's geriatric male client refused to accept therapy from Carl. It is interesting that Carl, as a male SLT, described this refusal as an emasculating experience for the

client, implying there would be embarrassment felt by the client. Could it be that Carl was projecting his own insecurities about being a male SLT onto the client to justify his refusal of therapy? Speech-language therapy is deeply rooted in altruism, nurturing and care. It is therefore my suspicion that the enactment of the therapy process by a young male therapist on a geriatric male client could have been an emasculating experience for both the therapist and the client.

Lynn made mention of how problem solving and adapting to one's situation is a daily task and a lifelong commitment:

I will probably die never knowing all the strategies of how to communicate with clients. I think at some point I will be equipped with the skills and will communicate successfully at most if not all sessions with my clients and will learn to adapt and problem solve more ... more ... allowing it to flow and be more easily done.

(Extract from Lynn's narrative, section 4.5)

In Mbali's narrative, she explained how she negotiated theory and practice especially on the first day out in the real world:

Not much can prepare you for when you step into your first day out in the real working world and it is just you and the client sitting across from you. The theory goes out and your instinct kicks in. You need to communicate with your client and you just make a plan to do it.

(Extract from Mbali's narrative, section 5.4)

The operational experiences of speech-language therapy include not seeing enough progress being made with clients and ongoing problem solving on a daily basis.

### **6.7.3 Responsibility of care**

A recurring category noted across contexts was the increased responsibility of care of clients, which went beyond just offering speech-language therapy. This extended care – and the responsibility that came with it – was something that the participants had difficulty negotiating. During their undergraduate education, students are encouraged to work together with families and to view clients holistically. However, in clinical practice, participants found it difficult when families excluded themselves from the therapy process and foisted the responsibility of increased communicative engagement with the client onto the SLT. In the private practice context, Stephanie attributed this to a financial reason:

I offered Mrs Williams to sit in the session because I wanted her to see how I work with Seth so that she may have been motivated to do the same with him at home. I think she got a little bit defensive and afforded an excuse. She didn't want to come into the session. She suggested that we wait for a week or two then she will come and watch. She never did come to watch him. I have really battled to understand this. Perhaps she felt that since she is paying for therapy, that it was solely my responsibility to help the little boy.

(Extract from Stephanie's narrative, section 4.6)

In the public healthcare context, Mbali attributed her increased responsibility of care for clients to the lack of visitation and support from the clients' families:

[H]is wife refused to come see him because of the altercation that he was in that led to the head injury. She said it was also very difficult for the family to come and see him because of transport problems. She sounded desperate to get me off the phone, like somehow if I stopped speaking to her then she wouldn't have to remember him anymore. I felt so helpless. I was this client's only communicative partner ... Mrs Ngubane, Mr Xaba and the many others, they relied on me to be here for them.

(Extract from Mbali's narrative, section 5.4)

In the school context, Halima felt that most of the parents were not interested in their children's development and progress and that the parents treated the school as a place of safety:

It appeared to me that parents saw the school as a place of safety for their children from 7.30 to 14:00 and were not actually invested in their learning.

(Extract from Halima's narrative, section 5.5)

The recurring issue present in all three excerpts was that the SLTs felt that there was a lack of care from the clients' families. In Stephanie's narrative, it appeared that the clinical encounter was transactional with communication and care being the 'commodities' traded for the fee for the session. In Mbali's narrative, she expressed that visitation was a means of expressing care, while the families' lack of visitation showed a lack of care. Halima felt that care meant that families should be interested in their children's learning even though progress might be slow because of the children's cognitive impairment. Due to the decreased levels of care on the part of the

families, the SLTs felt that they had to compensate for this by extending their roles from therapists to carers.

### **On practitioners' experiences of speech-language therapy**

*The operational experiences of speech-language therapy included not seeing enough progress being made with clients and ongoing problem solving on a daily basis.*

*The participants had challenges in coping with the emotive experiences of being an SLT across the varied contexts. Besides working through the clients' severity of their communication disorder, participants had to try to convince parents and families to be custodians of care in the rehabilitation process of the clients. Unfortunately, this was not always successful. The SLTs often became the sole communication partners for their clients. This meant that they often had to extend their role as the therapist to interact with little children waiting for their mothers to visit, adult clients pining for their children, and geriatric clients losing hope as their families' last visit became distant memories. The SLTs felt that they had to compensate for this by extending their roles from therapists to carers who were sometimes understood by myself as vulnerable and unable to resolve all the problems of the client. This is then in turn internalised by the practitioners as being ineffectual; thus, they discredit their professional status.*

## **6.8 Cross-linguistic–cross-cultural communication**

The cross-linguistic and cross-cultural influences on the practitioner's communication were common in all narratives whether the participants were competent in the language of the client or not. This category comprised the sub-categories of cross-linguistic communication, working with an interpreter, cultural issues, and the physical appearance of the practitioner.

### **6.8.1 Cross-linguistic communication**

Cross-linguistic communication was certainly an area of difficulty for most participants, especially the monolingual English-speaking participants who seemed to think that being a competent SLT implied that one had to be multilingual because of the linguistic diversity in the country:<sup>38</sup>

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<sup>38</sup> I acknowledge that most countries are indeed multilingual due to factors of migration (forced or voluntary) and globalisation in broadening employment and life prospects and that this is not unique to South Africa.



But to know isiZulu will only help me only some of the time. There are eleven official languages in South Africa and many others too. What kind of multilingual do I need to be to be a competent speech therapist?

(Extract from Sharon's narrative, section 4.3)

Sometimes I think it would be easier if I could speak and understand multiple languages.

(Extract from Lynn's narrative, section 4.5)

The issues cited above could be indicative that the challenges of multilingualism remain unresolved in South Africa. Stephanie's experience was that the communicative interaction between client and therapist would be easier if both spoke the same language. She compared her current practice in a private setting to her previous setting that was a rural hospital to make this deduction.

I think that being able to speak the same language as your client makes communicative interaction a lot easier.

(Extract from Stephanie's narrative, section 4.6)

On the other hand, when changing the work context was not an option, there were instances of positive interactions between the practitioner and his or her clients and/or their families through the brokenness of language and there was a connection:

We tried to understand each other. Somewhere between her broken English and my broken Zulu we connected.

(Extract from Sharon's narrative, section 4.3)

Important in this excerpt is the acknowledgement that both the practitioner and the client's mother were committed to the interaction and tried to understand each other. This was a key ingredient in successful communication even though the communicative engagement was not without its challenges.

### **6.8.2 Working with an interpreter**

Most of the monolingual English-speaking and bilingual English–Afrikaans-speaking participants in the public health system required assistance from an interpreter when engaging with clients who spoke isiZulu. However, there were often human resource constraints in this regard due to the lack of qualified interpreters:

I suppose I could work with an interpreter, but we don't have one at the hospital and the people who are can help you do it voluntarily. I feel terrible to ask them all the time because I don't want to impose on them and they have other jobs. It's usually the security guards and some of the nurses who are willing to help.

(Extract from Sharon's narrative, section 4.3)

Sharon found sourcing people to help her to translate and interpret from English to isiZulu difficult, as she had to ask other employees who were busy with their job roles. If another staff member was willing to assist her, this would imply that such person had to leave his or her duties for the day or he or she would help in his or her spare time. Sharon felt that this was much to ask from someone else without the expectation of returning the favour or remuneration.

Lynn experienced similar difficulties in sourcing interpreters. She felt that the additional support offered by the public relations officer (PRO) was not always helpful. In order to source an interpreter through the PRO would require forward planning in contacting his office. This did not help much because clients would be referred on the day that they require an assessment, which left no time for preparation.

One of my biggest problems in my workplace is the language barrier between me and my clients and the lack of interpreters. The PRO [public relations officer] at the hospital sometimes assists in sourcing an interpreter from the PRO but this requires forward planning in notifying his office, finding someone who is available and waiting for his reply.

(Extract from Lynn's narrative, section 4.5)

Some participants found colleagues who were willing to help. However, there were other challenges that arose during these interactions:

I wondered whether my urgency was coming across. There is also lots of work that goes into working with an interpreter. I have to think about how you are going to explain it to the interpreter, and then how the interpreter is going to explain it to them. It's easier when somebody explains in your own language, but when it's somebody coming from a different language, you have to think about it. I get worried, there is a risk involved in miscommunication.

(Extract from Sharon's narrative, section 4.3)

The above excerpt highlights the challenge that arises when working with unqualified interpreters. Langdon and Cheng (2002) state that an interpreter does not simply serve to translate word-by-word messages; rather, the interpreter must understand the context of the interaction. This consequently requires the interpreter to have prior knowledge of the therapy session and to understand the roles of the communicative partners. From the excerpts above, this was clearly not the lived reality of the participants.

There were also situations where interpreters were not available or unsuitable because of the diverse language backgrounds of the clients accessing services:

The foreigners with their little ones or the elderly clients posed the greatest challenge because of the lack of interpreters for the languages that they speak. There were lots of foreigners in the area because it was a business hub to find jobs and start shops. These clients were Swahili, Amharic, Shona and Lingala speakers.

(Extract from Lynn's narrative, section 4.5)

There was also a compounded challenge of clients from other African countries whose languages were other than the eleven official languages of South Africa. The SLT then had to solve the problems around this issue by working together with the family to find a suitable way to resolve the communication breakdown. The unfamiliarity with the language(s) spoken and the cultural nuances of another community were factors that the SLT then had to negotiate. Language difference is a global phenomenon due to migratory mobilisation of people across spaces. With eleven official languages in South Africa and countless other ('unofficial') languages used by people, differences in language is not an unusual occurrence. However the concerns of multilingualism link to the participants' discomfort with language difference possibly due to the participants not knowing how to negotiate this difference.

### **6.8.3 Cultural issues**

Cross-cultural issues related to language, gender, racial and social differences were highlighted. Participants appeared to have difficulty negotiating these factors in their engagement with their clients. Sharon explained that she had tried learning more isiZulu but this has helped her minimally in practice because of the disconnect between her race, social status and language:

I have tried learning more isiZulu because I felt that if I spoke isiZulu then maybe the clients will listen to me more and they will see that I am serious about helping them. But sometimes when I speak isiZulu, it just doesn't click with some people and I think that it is because of who I am. I am a white, bilingual Afrikaans–English-speaking female. Maybe it is a cultural issue.

(Extract from Sharon's narrative, section 4.3)

Carl, as an Indian male SLT, found it difficult engaging with a black African male client:

He did not want to accept that he needed speech therapy. It felt like an emasculating experience for him. Perhaps it was a cultural thing ... He looked at me as if to say "I am a man: why are you making me say /ah/? What is wrong with you?"

(Extract from Carl's narrative, section 4.4)

The participants tended to focus on difference in terms of language, age and gender as their meaning of the construct "culture". However, it is recognised that an alternative, wider definition of what constitutes culture, such as ability and disability, gender, sexual orientation, age, tradition and religion could have been activated to establish the wider conception of this term (Santhanam & Parveen, 2018). The analysis stayed within the participants' worldviews, even though such worldviews are restricted. Nevertheless, the synergy between the SLTs' and the clients' "cultural" worldviews were not always automatically beneficial to the communicative engagement. It was noted that while the SLT interlocutor may not belong to a similar linguistic or age group as did their clients, this did not imply that the communicative exchange was necessarily problematic or hindered. Communication was elevated beyond just linguistic compatibility. Communication was being mediated on a shared interpretation of the goals, purposes and functions of both interlocutors in the therapeutic engagement. Perhaps this signals the enduring effect of how historical restricted categorisations of conceptions of "culture" endemically pervade the ways practitioners interpret their contexts and the clients they serve, but that compatibility of interpretation of therapy is a key component activating successful interventions. Successful communication is established when both the therapist and the client share collective understandings of the therapeutic engagement. This discussion will be addressed again in Chapter 7 (section 7.4).

#### **6.8.4 The physical appearance of the practitioner**

The physical appearance of the practitioner seemed to have affected the participants' communication in the work context. This was most notably seen with the newly qualified participants. In Carl's situation, he had difficulty charting his way as an autonomous healthcare practitioner because of the supposed perceptions of his primary discipline. After not receiving adequate referrals, he resorted to changing his physical appearance to attempt to be perceived differently in his context:

I put on my white coat, a paediatric stethoscope around my neck and I walked around with an air of purpose. The white coat, the one that the doctors also used, was my suit of armour as I navigated through wards and the corridors of the hospital.

(Extract from Carl's narrative, section 4.4)

In Stephanie's narrative, we learn that, as a newly qualified practitioner, she encountered some difficulty when engaging with parents:

I had found that some of the parents in private practice see me as a young person, much younger than them. I felt this when they looked at me, "Can this person really be doing therapy with my kid?" I've never heard them articulate this though, so it might be all in my head. However during my community service last year I never really got this feeling.

(Extract from Stephanie's narrative, section 4.6)

Gender profiling appeared to be a prominent issue in Carl's narrative as he explained how he was received in the world of work as a newly qualified SLT:

They quizzically looked at me and pointed in the direction of derelict park homes. Perhaps they thought that because I was an Indian man in a white "doctor's" coat that I didn't fit in the rehab department. I was met with even more surprised faces when I introduced myself as the new speech-language therapist. I received such a hostile welcome. I could feel their prying question: what is this man doing here? A man in health: men were usually doctors, pharmacists or physiotherapists! I know that male speech-language therapists were not common and I felt their dismissal of me as someone who could offer anything worthwhile.

(Extract from Carl's narrative, section 4.4)

### **On cross-linguistic–cross cultural communication**

*This was a key finding that most of the participants had challenges negotiating. The participants often felt lost and off the beaten track when negotiating differences in language and culture between themselves and their clients and families. Even though interpreters were available in some contexts, this was often controlled by systems that did not allow for a quick turnaround of services, especially when clients arrived without scheduled appointments. This again became a concern about effective service delivery. Even though interpreters for isiZulu were available in a particular context, this was not of help as the clients accessing services spoke languages of other African countries as they have settled in South Africa because of business and employment opportunities. The physical appearance of practitioners was also an interesting find as the participants spoke of their reception by others when they did not seem to fit a particular cultural stereotype that was associated with the profession.*

### **6.9 Response to the first critical question**

Thus far, the data analysis, namely the narrative analysis, revealed examination of the key factors emanating from the data, which allowed further abstraction in the subsequent chapter (Chapter Seven). This brings me to the response to the first critical question of the study:

*What is the nature of communicative competence that is taught and learnt during the initial professional education of speech-language therapists (SLTs)? (the world of academe)*

With respect to question one, the study has revealed that there exist many formal and informal communication strategies that are taught and learnt during the initial professional education during theory modules (see section 6.4.1) but more especially during clinical on-site practicum. Although communication strategies are not taught as part of the formal curriculum, we have learnt that learning opportunities are embedded within clinical engagement. The focus of the undergraduate curriculum is mainly disorder-focussed, which means that the adaptation of communication strategies needed is discussed in relation to a specific disorder and as the opportunity presents itself. The unanimous sentiments expressed by participants were that their initial professional education was considered to be a safe space of certainty. They were comforted during their initial professional education as their academic performance

and grades depended on their abilities to perform during clinical sessions. They were comforted that they had their lecturers and clinical supervisors available to seek guidance and answers. For many of the participants, guidance and answers were not available in the world of work as there was often only a single SLT in an institution. There appeared to be a disjuncture between the world of academe and the world of work, where the world of work was seen as *unpredictable*, *uncertain* and *difficult* to negotiate.

Participants expressed, however, that in retrospect, they wished that they were given more autonomy as students to solve problems for themselves and make 'mistakes' knowing that they had the safety net of the clinical supervisors' guidance. However, the assessment criteria cautioned them as they did not want to veer onto new and uncertain terrain out of fear that their grades would be negatively affected. The participants acquired specific types of learning during their initial professional education, such as social and personal communication with their clients (from different cultural, age and linguistic backgrounds), academic communication (in terms of how to translate what was written in the textbooks to communication in everyday clinical engagement), and therapeutic communication (in terms of how to look out for the clinical signs with regard to the clients' level of understanding, pain levels, attention levels and comfort levels).

During the current research, there were calls from participants for CPD initiatives to focus on communication strategies.

## **6.10 Chapter synthesis**

The current chapter outlined the categorisation of the key factors that were identified. Cross-case comparisons was the method used. This method highlighted the range of communication issues and strategies that SLTs have to negotiate in their respective contexts. Initial findings from this level of analysis showed that there seemed to be a disjuncture between the emotive aspect of therapy and the operational and policy-driven aspects. The varied categories, however, cannot be seen in isolation as they were often integrated in the analysis and in the reporting of results. This cross-case analysis was worthwhile in revealing the anticipated multiplicity of researching communication strategies of SLTs. There is wider and better insight into the phenomenon, and in Chapter Seven, these findings are considered in depth.

The participants were able to use their present experiences to discuss their experiences of their undergraduate education and provide their alma mater with operational and pedagogical suggestions for future students. The second section of the current chapter turned to the discussion of the response to critical research question one. In Chapter Seven, I move to further levels of abstraction in the discussion of the main themes of the study and respond to the second critical question.



## CHAPTER SEVEN: Recurring themes and outliers

### 7.1 Introduction

This chapter presents the thematic analysis of the narrative data, which builds on from the cross-case comparisons that were discussed in Chapter Six. The themes were derived through a process of identifying, analysing and reporting patterns within the narrative data (Thomas & Harden, 2008). This level of data analysis followed on from the cross-case comparisons of the data sets. I used an inductive approach as I did not focus on the a priori categories from the literature review. The themes were based on my interpretation of the data as I initially produced the transcripts that were sent for member checking. I then transcribed the narratives and invited the participants to conduct a (factual) member check of them. I coded the narratives and extracted factors that influenced the negotiation of communication strategies of SLTs during clinical engagement. Further abstraction of the data allowed me to identify the themes. As a layer of the validation process, I presented the findings to my peers in the Higher Education PhD cohort programme at UKZN and invited their comments. There were concerns around how the narratives linked back to the raw data. Verbatim quotes from the participants as well as a process of member checking were used to facilitate this. A search for the 'atypical' cases (outliers) in this study involved searching for and discussing elements of the data that did not support or appeared to contradict the patterns or explanations that emerged from the data analysis to establish further credibility of the analysis. The narratives of Zandi and Mbali were identified as the atypical cases and were used to cross-check and validate the data analysis process (Miles & Huberman, 1994). Later in the chapter (see 7.4), I will explain why these narratives were considered the atypical cases.

### 7.2 Orientation to chapter

Chapter Six served as the introduction to this chapter, which now attempts to achieve greater levels of abstraction as I report on the analysis and abstract interpretations of the data. This chapter is presented in two sections. In the first section, I unveil the dominant themes that were theorised. The dominant themes identified were as follows:

- *Productive remembering of educational experiences*
- *Problematizing clinical engagement*
- *Undervaluing of speech-language therapy*

- *Searching for certainty*
- *Moving to comfort*

Each of the themes is discussed while referring to important instances in the narratives to augment my discussion. Figure 7.1 below presents the themes in relation to the phenomenon of the study.

The second section presents the atypical cases underlined by the stories told by Zandi and Mbali. Their stories highlight that one cannot categorically typify an SLT's practice no matter how similar individuals or contexts may be. Zandi (novice) and Mbali (experienced) were female, black African, bilingual isiZulu–English speakers. It is conceivable that their linguistic and cultural capabilities being similar to those of the clients they serve would have solved the problems that the profession is facing in terms of linguistic and cultural dissonance between the SLT and the client. Practitioners in the profession tend to use 'culture' to refer to 'linguistic', 'racial', and 'ethnic' factors. However, after the re-reading the analysis, I agree with Pillay (2003b) that we have come to acknowledge and accept an alternative, wider definition of what constitutes culture, such as ability and disability, gender, sexual orientation, age, tradition and religion. While someone may belong to a similar linguistic or racial group as oneself, it does not imply that the communicative exchange will be free of challenges and breakdown. Hence, ethnicity markers, such as race and language, are insufficient ways to predict the ways in which individuals might interpret their work place contexts and the clients they serve. This is because individuals have unique features that are dominant beyond the apartheid markers of ethnicity, to which the SA society have subscribed.

The chapter concludes with a synthesis of the key discussions, and critical question two is answered.

### 7.3 Section One: Thematic analysis

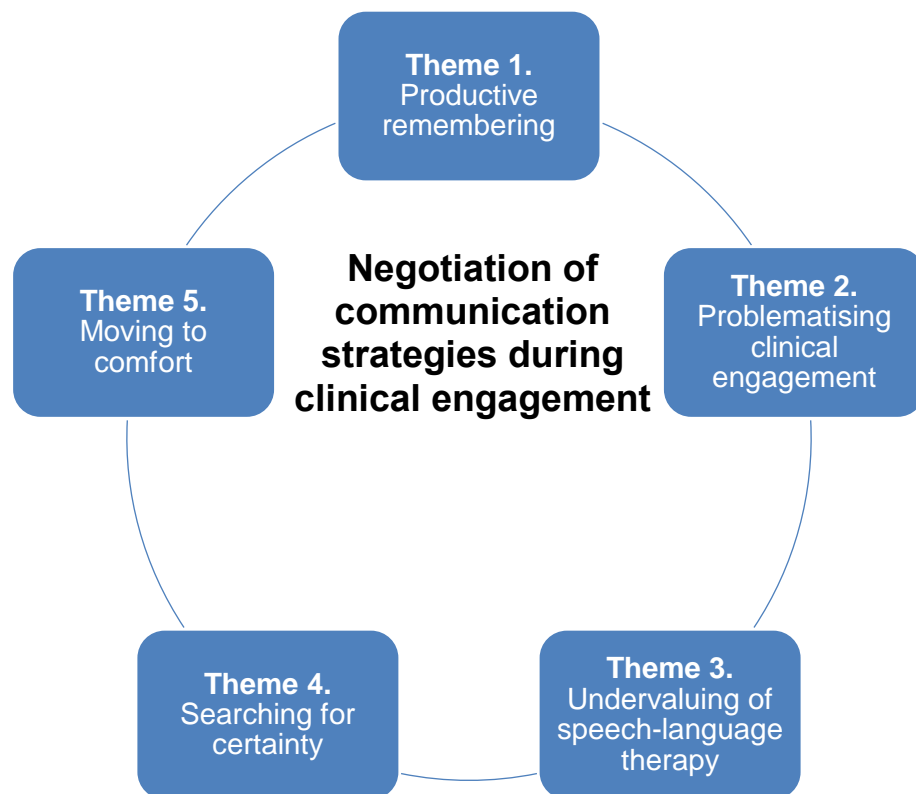


Figure 7.1

*Themes emerging from the narrative data on how SLTs negotiate their communication during clinical engagement*

Source: Author's compilation.

#### 7.3.1 Theme 1: Productive remembering of educational experience

The concept 'productive remembering' is drawn from Samuel's (2015) article "Remembering and re-directing the self: An educational journey" after the introduction of the concept by Huyssen (2003). The concept foregrounds how working with our memories assists in the construction, interpretation and understanding of present and future trajectories. During the interviews, the participants reflected on their personal educational philosophy, values and principles and discussed how their past memories have been infused to influence present and future practice (Samuel, 2015).

The participants' recall of educational experiences was used as compass to navigate the path of clinical decision-making where possible. These educational experiences affected their practices with their clients in some way or another. This relates to the concept of reflective practice (Wilson, 2008), which refers to reflecting on behaviour or

practice in order to improve current or future practice. This is done to potentially encourage professional growth and development. The data analysis in Chapter Six revealed that participants perceived that there was compatibility between academe and the world of work. Participants acknowledged that the real working world is different.

Lynn pointed out that the undergraduate clinical practicum should draw more parallels to the real working world. Students should be granted some self-sufficiency to develop the competencies required in the real working world. Sharon and Stephanie both spoke on the issue of guidance from clinical supervisors when they were students, which sometimes was unhelpful and at other times, constructive. It nevertheless formed the building blocks on which students could build and develop further. As novice SLTs, there might have been the expectation that there needed to be more alignment between initial professional education and the world of work. As mentioned in Chapter Six (see 6.4.1), it is conceivable that the students may feel this way as they had invested four years in professional training and had expected to feel equipped for the world of work upon graduation. There are expectations from employers of graduates with professional degrees to display competencies required in the world of work. Initial professional education cannot provide all answers to every scenario in the world of work. Novice therapists, nevertheless, enter the world of work expecting unrealistically that their professional discipline (to which they had been orientated in their initial university education) has all the tools to address every contextual and practical challenge. Kamhi (2011) provides an interesting argument regarding this phenomenon of balancing certainty and uncertainty in clinical practice when he says that it is not possible to interpret information without being influenced by prior beliefs, assumptions and personal feelings (Kamhi, 2011). There are limits to every professional discipline and the lack of certainty engenders anxieties in terms of being an ineffective practitioner. Paradoxically, the lack of certainty does infuse the search for more pragmatism into practice. It appears that the participants were commenting that the initial professional educational space (the lecture room and clinical practice) activated only selected and restrictive forms of reflective inquiry for them, which minimally enabled them to see the connection between the world of academe and the world of work. This exposure was inadequate because it did not address the wider

scale of diversities of contexts and potential clients and prospective experiential encounters.

Students and novice therapists need to be made aware that when becoming a professional, one cannot expect a recipe approach to education. There should be allowance for the uncertainty of individual experiences in order to realise their own professional development. Therefore, uncertainty, in this context is seen as favourably as it allows the novice therapist to craft his or her own niche approach to practice intervention.

Perhaps what Spivak (2017) argues could assist to understand the linkages and breakages between academe and the workplace context for future professional practice. Spivak comments that society (the university lecture room and clinics) is stratified to accommodate prefigured conceptions of seminal spaces, which jettison other worldviews and conceptions along a hierarchy of importance or degrees of relevance. Her statement relates to the nature of the HE curriculum, which paradoxically could be seen to enslave rather than to liberate potential for novice professionals. The question is then whose interests are indeed being served by the nature of the curriculum being designed in initial professional education. Spivak (2017) suggests that it is ultimately the academics and regulatory bodies who decide on the curriculum in the interests of often undeclared favoured constituencies. Curriculum development is supposed to uphold the interests of students in preparation of mediating a range of competing interests:

- the profession (including the professional councils);
- the professional academic world;
- the presenting members of the communities of clients or patients; and
- the communities of practitioners, none of which are neutral in their agenda, purposes, preferences and perspectives.

Initial professional education should be seen as learning to negotiate (interpret and challenge, adapt and extend) these multiple spaces.

Although lecture rooms and clinics are filled with students with a diversity of demographic and cultural worldviews, such as age, racial profile, orientation, gender, social background, and not all of these are given equitable prominence as areas of focus of the curriculum. This wide range of diversities, however, is active in the spaces

of the everyday world from which clients and professional clinical and practitioners operate. The multiple diversities affect the individual (novice) professional and his or her functioning in this system. The world of academe should consider the method of teaching and the curriculum in order to reach our diverse and multiple spaces with more attentive detail, starting perhaps with embracing the diversity of worldviews and cultural variants of the student body itself. Students should be encouraged to embrace this diversity and individuality instead of succumbing to a process of a 'sausage-making factory' capitulating to the hegemony of 'traditional' ways of operating in a 'medical' space. What if the world of academe encouraged students to be their own brand of therapist? What if the world of academe encouraged them to bring in their cultural capital in creating their uniqueness and contribution to the profession in South Africa while maintaining professional ethics and morality and values of the profession? Celebrating differences could, perhaps, take the pressure off students to conform to the preconceived ideas of whom an SLT ought to be. This could possibly alleviate an 'impostor syndrome' that budding professionals sometimes feel as they are being acculturated into their prospective professions.

Where then does on-the-job learning or learning how to adapt to a particular context feature? This could also alleviate the students' expectations and overdependence on university education to provide them with all the answers and a blueprint for professional expertise. Is it realistic to expect one's initial professional education to provide you with all the answers for future-dated practice? The data seems to suggest that students sanitise out their own university professional education, and adopt an inherited worldview of the hegemonic world that it celebrates. This can be found in the reluctance to engage with a client who speaks a different language than that of the SLT, or a reluctance to engage in activities, which they perceive could affect their marks negatively. There is a paradox here, 'As a student, I want to create a space of certainty for the four years of initial professional education, while as a practitioner I enter a space of uncertainty for life-long practice.' When reflecting on their undergraduate experience, now that they are in the world of work, Sharon and Lynn reflected that the uncertainties should be embraced in initial professional education when one has the support of your peers, clinical tutors and lecturers.

The length of clinical practicum exposure was another issue about which participants expressed strong views. They argued repeatedly for the need for prolonged

engagement in a particular context and with clients. It was discussed that clinical practica should not be offered in a tick-box manner where limited exposure to a client is considered sufficient.

With the development of the CanMEDS competency framework and other graduate attributes or competency lists from research reports, competency-based education can often be seen as aiming to fulfil an agenda of multiple exit level outcomes being addressed. This could foster an atomisation of the competences, which are reduced to lengthy lists to be engaged during clinical practice. The academic curriculum could become characterised as simply a space to demonstrate compliance with 'engaging' targeted competencies in rather superficial levels. Students consequently falsely believe that they have indeed acquired the 'requisite competence' sufficient for professional complex practice.

Moreover, the clinical setting was interpreted by novice 'apprentice' professional as imbued with co-optive forces of adhering to the experienced master professionals. In developing competencies, following a master–apprenticeship model has its merits of observing the practice of an experienced therapist, which should serve as a good example to emulate practice (Gravett, 2012) but there are significant limitations. Where is the 'human' element involved here rather than the robotised modelling of another? The human element of being personalised, individualistic and creative in clinical engagement with clients is very important in forming one's own professional identity or philosophy. While the master apprenticeship model may be more sanitised and easier for the student to just imitate another in clinical engagement, in my opinion, this model serves to augment the process of professional development.

Samuel's (2015) professional self-development strategy encouraging professionals to embrace their own pasts, present and futures suggests that professional growth is a deeply complex iterative process. It challenges the over-emphasis on initial professional certification and qualification of a university-based professional development model and suggests that learning continues through a dialogical relationship between the academic world and the work context. Lynn, Amelia and Mbali all expressed the need and desire to continue learning so that they would grow more comfortable with their evolving roles as SLTs.

The purpose of initial professional education is an enculturation into the profession and professional discourse. Initial professional education should have an appreciation of the personal biographical and contextual experiences in reflecting who novice practitioners are and where they want to be in the future. Productive remembering and redirecting ought to be valued as a legitimate way of reflective practice (Samuel, 2015). It sets the platform for lifelong professional learning, a forever growing of professional competence. Reflective practice should therefore be engrained through every level of initial professional education.

### **7.3.2 Theme 2: Problematising clinical engagement**

I reflected on the purposive sample criteria that I chose for the study and the problematic encounters within each of these criteria, i.e. experience (novice or experienced), language, race and gender. I begin my discussion around the concept of ageism as proxy for the level of experience of the participants (novice/experienced) and how this relates to problematics in clinical engagement.

#### **7.3.2.1 Ageism**

Ageism is a type of prejudice against people because of their age (Cherry, Allen, Jackson, Hawley, & Brigman, 2010). Among the novice SLTs, it was seen that they experienced a form of prejudiced ageism from their clients and families.

Carl and Stephanie's clinical encounters with their clients left them feeling disconnected from them and they attributed this to their young age, as they were novice SLTs. In Carl's narrative, he encountered an aging black African male who had had a stroke. The client seemed confused at Carl's presence and disregarded his attempts to initiate therapy. The client could have behaved in this way because of Carl's youth.

In Stephanie's narrative, we saw that the client's mother was less than cooperative and adherent to the suggestions and homework offered by Stephanie in a private practice setting. As one possibility, Stephanie attributed to this to her youthfulness and her inexperience in managing children (as perceived by the client's mother), despite her professional education. The parent was indirectly questioning whether a youthful graduate has the capacity to advise an older parent about how to stimulate his or her own child. The parent might have felt that the youthful inexperience of the SLT did not present the necessary gravitas to offer solutions to a mother with years of experience



of being a mother. This is a discounting of professional knowledge in preference to lived experiential knowledge of motherhood. The issues here do not only pertain to age, but also experience and the types of knowledges that are considered to be important (in this case, the knowledge of dealing with children). The parent believes her own length of experience as a practising mother overrides the professional knowledge that a novice professional could offer. Motherhood experience trumps professional knowledge. This possibly aligns to the old adage “mother knows best”. Everyday knowledge contested professional knowledge. The perception of the SLT was that she was discounted and disregarded. This could lead to breakdown in communication during clinical interaction. One of the pillars of effective communication is connecting with one’s conversational partner (Minifie, 1994), which was not achieved here.

The above examples link to the CAT, according to which conversational partners adapt and modify their communication to facilitate the communication process (Giles & Ogay, 2007). When there is a breakdown in this process, misunderstandings and problematics in communication could come about. Time constraints during the therapy could cause such problematics. The SLT is under pressure to help the client and family progress in the therapy journey in the minimum amount of time as this defines success of therapy. While doing conducting therapy the SLT has to ensure that he or she is understood by the client, family or others as appropriate human communication requires one to have the need to leave a conversation with clarity of thought and feeling understood. This relates to CAT (see section 2.4.1) and PIT (see section 2.4.2) on either side of the binaries (i.e. certainty and uncertainty). Communication accommodation is activated in a conversation to rectify the communicative breakdown. This is when the therapist paraphrases what he or she had said, provides examples to facilitate understanding, or uses gestures to augment what he or she is saying. On the other hand, problematic integration in a conversation is activated to acknowledge that one cannot fully explain all conceptions to the client, and that an air of uncertainty can prevail to facilitate more questions from the client, which may allow for more clarity.

The sub-theme of ageism has provided an insight into how novice therapists feel slighted during clinical engagement with clients possibly due to their own insecurities about their levels of experience. Adapting and modifying communication while helping the client achieve success in the minimum amount of time might be overwhelming for

the novice therapist and they may be sensitised to comments regarding age and level of experience.

### **7.3.2.2 Sexism**

Speech--language therapy is largely a female-dominated profession. Research conducted by Frederick Schneider (1997, as cited in Maier, 2013) highlighted three reasons that may account for this. It was reported that speech-language therapy was not an attractive enough career choice for males because it did not offer an adequate income or career advancement and had limited opportunities for professional development to higher-ranking positions (Maier, 2013). Maier (2013) reports that male therapists are unfairly regarded as less nurturing than their female colleagues. It is this unfair perception that left Carl, the only male participant in this study, feeling uncomfortable when he first announced himself as the SLT at the hospital. He felt that his co-workers thought of him as being unable to secure a more masculine, prestigious occupation. He thus interpreted this as being devalued as a professional. He quickly adorned himself with the trappings of the medical hegemony of the white coat and stethoscope around his neck as the outward parading of the powerful professional in order to elevate his reputational status.

The white coat reminds physicians of their professional duties, as prescribed by Hippocrates, to lead their lives and practice their art in uprightness and honor. The white coat is a symbol of our profession (Karnath, 2011, p. 673).

In Carl's narrative, we see how uncomfortable he was when he received the quizzical looks when he first arrived at the hospital. He possibly felt that he had no other option but to subscribe to what he saw around him to feel more comfortable. Because he was a male in a white coat, he inherited a symbol of power (Karnath, 2011). He made himself more visible around the hospital by doing ward rounds and putting up posters which promoted his services. He embraced the discomfort by promoting himself as a professional in the only manner that he knew how.

### **7.3.2.3 Language difference**

When two communicators from different linguistic or cultural backgrounds with a lack of proficiency in each other's language engage, it would be likely for communicative breakdown to ensue, especially if the medium of communication is verbal and/or

written. Communication breakdown should not occur during clinical engagement as this may affect the course of therapy.

Sharon and Lynn were among those who encountered these difficulties often in their contexts where they felt a dissonance between themselves and their clients. They both chose to resolve their clinical problems by enlisting the assistance of family and/or caregivers and colleagues who may have been able to interpret across the divergent languages of client and therapist. This often created more difficulties because families were not always available and colleagues in the hospital had to fulfil the primary roles of their own jobs. This resolution was not a definite arrangement and this often left the SLTs despondent because their options in helping the client were limited. Both Sharon and Lynn would attempt to speak in the language of the client themselves. This brought upon the therapists concern about the effectiveness of their service delivery in providing therapy in a language in which they were not proficient. The aim of the SLTs is to provide effective service delivery within the minimum time for their clients. Initially, it may be the SLTs who are concerned about their service delivery; however; this could transfer to their line managers who are monitoring their caseloads and to their clients who are the recipients of this service. This brought me to question this notion of effective service delivery when looking at language difference. It appears that for the SLTs, linguistic competence was of more importance than matters of attempting to develop efficient or expedient modes of communication. This means that there appeared to be a preoccupation with the linguistic dissonance between the therapist and the client. Perhaps this assertion of a new hegemony lies in the attempt for equity of language usage to redress the history or previously marginalised languages.

There was an appearance of engaging in the act of consultation, which was seen as more important than what the consultation or engagement actually aimed to achieve, i.e. an outcome of successful communication. The question is whether these attempts at a language in which one is not proficient are just to act out therapy in order to respond to a referral, to appear to be doing therapy or to ease one's conscience. It seems that this is a contrived engagement in a set of actions. These issues may appear to be harsh or a judgement, but that is not my intention. I think these issues need to be addressed to challenge our thinking about the problematics that we face in clinical engagement. It will be worthwhile to consider what the clients expect this clinical engagement to offer and whether they believe that the clinical engagement

could have any consequences. This brings me to the next sub-theme on the cultural conceptions of therapy on the part of the clients and practitioners.

#### **7.3.2.4 Cultural conceptions of therapy**

As an Indian male, Carl was concerned that he was an agent of the imposition of Eurocentric ideas on his black African female paediatric client. Colours, numbers and the English alphabet comprise the usual repertoire for the stimulation and acculturation of the paediatric population in the English-speaking world. Carl, however, questioned whether this was appropriate for children from other linguistic and cultural groups. Are there universal guidelines for paediatric language stimulation? Concerns such as these form the cornerstone of contestation as a simple act such as the stimulation of colours, numbers and the English alphabet could be reinforcing Western conceptions of literacy and imposition of a medical hegemony within the profession without bringing in the biography of the client. In an instant, speech-language therapy diverted from being altruistic to being culturally imperialist. Brewer and Andrews (2016) stated that it is often difficult to see ethnicity-based discrimination as part of cultural imperialism in one's own practice, even when one is aware of this discrimination in general.

Related to Carl's engagement with his black African elderly male client, we see there were mixed conceptions of speech-language therapy on the part of Carl and his client. This client had had a stroke and was referred to Carl for speech-language therapy by the doctor. The client was despondent and refused therapy. He could have also responded in this way because of his level of understanding that a stroke is perhaps the natural process of aging, in a fatalistic sense. The client was perhaps interpreting the interventions offered by Carl as inappropriate to circumvent the inevitable fatalistic end point of life: death. He had possibly abandoned hope as can be read from his reaction. It is important to note that this explanation is for the purpose of theorisation and conception of this argument pertinent to clinical engagement and is not true for all aged or senior members of society. Carl could have understood the benefit of therapy and his role with this client differently from the client. Carl could have interpreted this encounter as palliative care where an SLT has a significant role to play in the management of communication and swallowing impairments and disability in people (O'Reilly & Walshe, 2015). Roe and Leslie (2010) state that the aim of the SLT in palliative care is to affirm life and minimise the complications of life-limiting disease. The concern is that the role of the SLT has been perceived as frequently

misunderstood or unrecognised among SLTs themselves internationally; hence, there is considerable uncertainty and absence of clarity regarding what is appropriate and ethical speech-language therapy involvement in this client group (O'Reilly & Walshe, 2015). If the role of the SLT is so uncertain among SLTs themselves, then it is no wonder that clients may be resistant to this idea as well. As can be seen in this case, the mixed understandings and conceptions of therapy have consequences beyond the clinical engagement. This interaction left Carl questioning his role as an SLT, the value of speech-language therapy, and his positionality as a novice male SLT. Notions of the overlap of speech-language therapy with palliative care (unfortunately) did not feature in his worldview.

Lynn's clients travelled distances to attend therapy and had to incur substantial financial costs for transport and subsistence to access therapy. As revealed in the narrative, often the clients' journeys to the hospital, the long queues to collect hospital files, the financial burden, and the logistical arrangements could be understood as all too much for the client and the family. Therefore, by the time they entered the SLT's room, they might consider their commitment to the therapy process fulfilled. The SLT, though, expects the client and the family to be integral to the therapy process even during and after the clinical practice session. The mismatch of conceptions of commitment and continued expected engagement (from both the clients and the therapists) is what could bring about problematics about the purposes and outcome of the clinical engagement.

Similarly, in the private practice context, the mother of Stephanie's client appeared to expect more of a return on payment for speech-language therapy. The nature of the therapy sessions was seen as a contractual financial arrangement between the practitioner and the client and/or family. The parent is paying for certainty that she assumes that the SLT should provide as though therapy is a transactional process. There is no recognition for the added factor of the complex communicative engagement between therapist and client. The mother's actions indicated that she did not consider herself to be part of the therapy process other than providing payment for services rendered.

In a long-term rehabilitation public healthcare facility, Mbali experienced a lack of interest and co-operation from the clients' families. Many clients in this setting were left in the care of the state, i.e. in the custody of the hospital or in the care of the

healthcare professionals because their families had abandoned them. Some of these clients have plateaued in terms of their performance in therapy yet due to their 'hospitalisation' they were receiving and continued to receive services. What then are their conceptions and expectations of therapy? What should the SLT do with these clients from an ethical and moral perspective? Is speech-language therapy (from the perspective of both the client and the therapist) merely a ritualistic practice not really intended to achieve any outcome? Is too little and/or too much expected of the professional and the client? When Mbali contacted the client's wife to discuss his condition and therapy with her, the wife was not interested and rushed Mbali off the phone. We see that Mbali attempted to make contact and involve the family in the way she knew how but this interest was not reciprocated. This highlights some of the problematics faced in the clinical context and reflected on in the narratives.

The cases above suggest that the novice SLT tended to circumscribe the scope and intersected-ness with the worldviews of the clients in a deep sense. The prime adherence seems to be guided by the participants' conception of upholding a 'normative' (hegemonic) notion of idealised practice.

### **7.3.3 Theme 3: Undervaluing of speech-language therapy**

This theme takes us back to Chapter Two of the thesis, which dealt with the history of speech-language therapy as a professional discipline. The roots of the profession are in linguistics, special education, psychology and medicine, among others. From traditional linguistics, the profession adopted a descriptive, ahistorical and rule-driven approach to the problems of human communication, which aimed to be based on objective methods and rational experience (Beecham, 2002). Special education and psychology offered scientific thinking and the ideology of pathology. Within this worldview, the SLT was expected to remediate the pathological deficits discovered during criterion-based, standardised testing. But it was through the medical roots that the profession adopted the bio-medical model, which was seen as a legitimate way of expressing care while maintaining professional boundaries between the knowing expert or professional and the unknowing and pathologised patient (Beecham, 2002). SLTs operating within this worldview are regarded as autonomous health professionals. There is a social understanding that society grants autonomy to health professionals to determine the presence of pathology and the subsequent remediation thereof, which is covertly operating in a sphere of certainty. Over decades, it has been

this autonomy that SLTs have come to enjoy as Pillay (2003b, p. 175) refers to SLTs in his study as the “powerful expert”.

However, what happens when SLTs who are supposed to offer ‘truths and certainties’ are unable to provide ‘answers’? The narratives of Sharon, Stephanie, Zandi and Mbali offer some insight into how they feel being a disempowered practitioner. The findings reveal that the profession is being destabilised and its legitimacy questioned by clients too because of its inability to offer immediate remedy and cure as seen in Stephanie’s narrative. Clients expect immediate solutions, an expectation that possibly derived from advances in clinical diagnostic analyses or other such diagnostic forms akin to the medical profession. However, ‘knowledgeable’ or professional therapists are often seen as not able to deliver such. This undermines the authoritativeness of the professional in not being able to offer solutions, or being the saviour who resolves clients’ problems.

The undervaluing of a professional health profession is not an uncommon occurrence. We live in a time when diagnostic rates for disorders are at an all-time high, possibly due to more sophisticated and sensitive diagnostic measures or advances in Western medicine, which assists in prolonging clients’ lives but not necessarily their quality of life. Communication is a basic human right and the ability to communicate effectively improves a person’s quality of life. Herein lies the role of the SLT who is involved in enhancing and improving the clients’ communication abilities. However the role of the SLT in palliative care is the uncertain and undeveloped in the area of palliative care. There are potential challenges to SLTs working with clients who require palliative care, such as the influence of working with people who are dying, limited professional preparation, ongoing educational constraints, and legal and ethical considerations (Weaver et al., 2016). Clients have come to expect professional health practitioners, like their counterparts in the medical fields, to be able to offer a diagnostic assessment and an intervention programme that resolves the pathology. However, the SLT is caught in a binary reality with the certain and uncertain realities that the SLTs’ engagements may not always result in improving the quality of clients’ communicative or swallowing status. Other medical practitioners are developing marketable practices, which offer increased diagnoses in pathologies, including (unfortunately) saleable ‘cures’ and ‘quick fixes’ to attend to their ‘diagnoses’.

The SLT does not seem to be able to offer this degree of certainty in trading problems for remedies. In the course of therapy, the optimism, hope and patience once felt by clients at the onset of therapy often run out. The client becomes disillusioned by the promises from a 'quick-fix' world of healthcare and has come to realise this disillusionment. Following on from this, the defaming of the professional and the profession becomes the focus, and there could be feelings of disregard and scepticism of the profession. This could result in a lack of adherence on the side of the client and his or family. The non-adherence and the broken trust in the professional could lead to no progress made by the client and this could further discredit the profession(al) as being ineffective to instigate progress for the client. The SLT in turn could have feelings of despondency, despair and burnout. These feelings will typically have a negative effect on the SLT and his or her professional practice, and in turn, question the efficacy and effectiveness of their practice, which could result in SLTs undervaluing themselves as professionals as well as their profession. The undervaluing of the profession on the part of the client and the professional has dire consequences for the overall perception of the profession.

#### **7.3.4 Theme 4: Searching for certainty**

The concept of certainty in the medical profession has been a contentious topic documented in medical literature (Gillett, 2004; Ginzburg, 1979; Hodgkin, 1996; Kay, 2017; Lantos et al., 1989; Risse, 1971; Siegler, 1981). It can be argued that blood test results, scans and conducting a physical medical examination could be considered legitimate ways of determining the presence or absence of disease and being able to offer tangible feedback to patients or clients. The medical profession has prided itself on objectivity, a positivist 'truth-seeking' mission that creates the perception of receiving answers for the patient. Together with this conception go the dynamics of power that this professional holds in society. The results comprise the breeding ground of obedience of the patient to the powerful expert where patients still appear to perceive the medical sciences with hope and faith and as the bringer of solutions.

Spivak (2017) offers a different insight into this phenomenon although addressed to teachers and supervisors:

I want you to know that I am your enemy because history is larger than personal goodwill and I want you to be able to work without me (Spivak, 2017, p. 137).



Spivak (2017) explains that her role is merely to be resourceful in order to help the intended beneficiary. She says that one needs to take ownership and agency of one's own life but if one transfers that agency to the 'expert' you are creating the expert as the source of the problem. In this context, Spivak refers to how developing agencies relate to servicing the needs of marginalised or under-resourced communities. My suggestion is that this argument can be extended to include the relationships between 'powerful therapists' and compliant clients. The client often enters into a salvation mentality where the 'expert' is considered to be the bringer of solutions.

This supports distancing of the therapist from the contextualised client's situation, and therefore the client comes to be constructed as 'the problem' by the therapist. Why would this occur? Perhaps the practitioners would want to stay true to what they know and to continue in a manner of habit and ritual within a safe space of formulaic operations of everyday practice.

The SLT should promote the view that the client (or the adult custodian) must also own his or her responsibility in the therapeutic process so that the client and/or family work with the SLT to find solutions to the clients' own therapy.

### **7.3.5 Theme 5: Moving to comfort**

After the completion of their community service, the novice SLT has to register with the HPCSA for independent practice. The registrar may register a person as a speech therapist, speech therapist and audiologist, an audiologist or hearing aid acousticians in the category independent practice if such person –

- holds an appropriate qualification from an accredited university training site;
- has complied with the requirements of community service in terms of section 24A of the Health Professions Act 56 of 1974; and
- has paid the applicable registration fee (HPCSA, 2011).

Once a fully independent practicing SLT, the practitioner has more choice in the context where he or she works. Three of the five novice SLTs changed their contexts in the hope of finding a better fit for themselves. Sharon moved from a small community health clinic (CHC) to a larger healthcare facility. Carl moved from a rural public hospital to an urban private hospital. Stephanie was previously in a rural public hospital but also moved to an urban private practice. As Stephanie mentioned in her narrative, private practice is seen as a career aspiration for most SLTs. Perhaps in

private practice, there is unofficial control of one's caseload, which perhaps offers the SLT more comfort.

What is 'comfort' in this context? Why do the novice therapists not feel comfortable in the contexts of their community service placement settings? I think that it is more than just the physical attributes and aesthetics of the work space that influence this. Their feelings of discomfort could be related to reasons to which they alluded in their narratives, i.e. financial, social or emotional reasons. I will theorise each of these conceptions.

Surprisingly, financial reasons were not a strong motivator to change work context as it was only alluded to by Stephanie who merely mentioned that being in a private practising SLT was considered a career promotion aspiration (presumably because of an increased salary) by many. To this end, colleagues, clients and the general society could see the SLT in private practice to hold a more favourable position due to the perceived prominence and recognition that practitioners in private healthcare in South Africa enjoy.

Related to this point, is Sharon who moved from a small CHC to a larger public healthcare facility possibly due to having more outreach to a larger community. This could result in her growing in experience as she was desperately looking for that to achieve job satisfaction.

Carl also moved to find comfort in a private urban hospital (or a 'better fit' as he phrased it in his narrative). It could be speculated that male therapists are more easily accepted in urban areas due to the influence of patriarchy in healthcare. He was therefore content with his move to an urban work context.

There was also an emotional motivator when Sharon mentioned that she was excited to change context so that she would have access to peer support from a more experienced SLT at the hospital. Medical literature has been sporadic on reports about the emotional influence of adverse events on healthcare professionals (Van Pelt, 2008). Peer support is seen as a vital service for healthcare professionals (Van Pelt, 2008). However, due to financial constraints in public healthcare in South Africa, there is a lack of available posts for non-critical healthcare professionals, which include SLTs; therefore, the peer support idea may not always be possible.

The themes brought forward through the data analysis revealed that when negotiating their communication during clinical engagement, the SLT has to engage a number of factors from his or her previous educational experience through to his or her future career plans. Ultimately, the SLTs are in search for certainty and they look to move to comfort, in whichever form they consider this to be. Section Two below will serve as a verification process of these themes as the data from the two outliers (defined in section 7.4) is explored as ‘the outliers’ negotiate their communication during clinical engagement.

#### **7.4 Section Two: Considering the ‘outliers’**

The term ‘outlier’ referred to data, which, while telling us something about a central theme, deviated from the rest of the data because of inherent contradictions to the rest of the data set (Phoenix & Orr, 2017). Often referred to as ‘negative cases’, the outlier data is often considered a valuable strategy for assessing the credibility or validity of qualitative research claims (Denzin & Lincoln, 2011). The term ‘outliers’ has traditionally been associated with the positivist orientation, however I wish to reappropriate the term in this qualitative study to consider the negative or deviant cases in my research.

So far, Chapter Seven has presented the dominant traditions within the profession of speech-language therapy as revealed by the data of this study. The profession has historically been represented by white female therapists with language proficiencies mainly in English and/or Afrikaans. Although the demography has changed in recent years with a bigger intake of black African students, differences in linguistic and cultural aspects between therapists and clients are still prevalent today.

I present an argument for the choice of Zandi and Mbali as the atypical cases or as the ‘outliers’ when exploring the phenomenon of communication during clinical engagement. I then proceed to illustrate how their cases can deepen our understanding of the communication strategies that SLTs negotiate during clinical engagement.

Zandi and Mbali were black African SLTs proficient in speaking isiZulu and English. Approximately 15 years ago Pillay (2003a) stated that the profession continued to be fixated on the issues of ethnicity and language and this still holds true today, as shown by the data. My exploratory analysis was therefore directed consciously towards

understanding ‘beyond the fixations of race, language and ethnicity’ to expand which other factors may be at play during the negotiation of communication during clinical engagement.

Zandi, as a novice SLT who has only worked in a single hospital, and Mbali, an experienced SLT who has had a variety of work experiences in different settings, were used to drive this argumentation of the atypical cases. Their ‘atypicality’ derives from the recognition that black African speech therapists constitute a minority in the profession in South Africa to date. At the time of data collection (i.e. January 2016) both these participants worked in long-term healthcare facilities. However, Zandi worked mostly with children and a few adult clients, whereas Mbali worked only with geriatric clients.

The disquiets that these SLTs faced in the clinical engagement with their clients reflected the frustration levels and demotivation of clients, and the lack of family involvement and support in the therapy process, which perhaps, stretched beyond matters of race, linguistics and ethnicity.

I discuss how these two therapists – one a novice and the other, an experienced SLT – experienced their practice contexts. After reviewing the participants’ narratives, several issues were revealed as those that affected the clinical engagement. These experiences are presented as two individual cases below.

#### **7.4.1 Zandi: The novice SLT**

Zandi surprised me with her critical reflection on practice and her sound understanding of her context. She discussed how she was able to ‘read’ her clients in terms of their willingness to engage in therapy. She was open about how some clients refused speech-language therapy, and how they possibly did not see the value in the profession. Zandi admitted feeling as if she had no control during clinical engagement and that she became despondent and demotivated unless her patient responded to her. Noteworthy was how she over-extended herself in terms of her paediatric clients for whom her heart bled as they waited for their mothers to visit – which rarely happened. She said that this emotive component was not something for which her undergraduate education prepared her, and she found it to be a significant challenge.

### 7.4.2 Mbali: The experienced SLT

Mbali's comments about her work context were that client progress was slow and therapy was repetitive. Due to the long-term incapacitation of clients in the relevant hospital, Mbali found herself seeing the same clients for years on end. Chronically and sometimes terminally ill, these clients present with their own frustrations of having impaired communication and of being held incapacitated with little to no family contact. Mbali saw and heard their frustrations; after all she was often the sole conversational partner for these clients. She had to remind herself and others (the clients' families) that she cannot work miracles in helping the clients. Immediate and long-lasting solutions were not guaranteed, something the clients and their families did not want to hear.

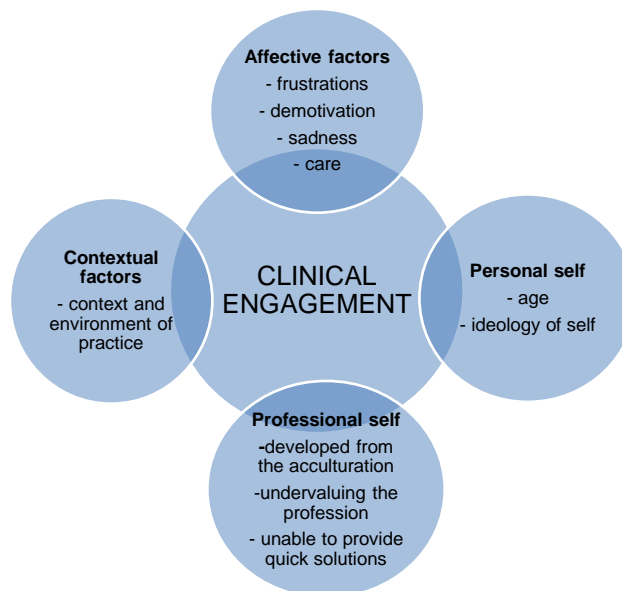


Figure 7.2

*The inter-relatedness of factors negotiated during clinical engagement for the outlier cases*

Source: Author's compilation.

### 7.4.3 Thematic analysis of the outlier cases

In Figure 7.2, we see that the clinical engagement is influenced negotiation of the issues above by the SLT and his or her clients. However, for the scope of this study,

the focus was on the SLT, as the phenomenon under study was the communication of SLTs in the world of work.

The affective factors were found to be a driving force in the communication strategies that the SLTs used. Feelings of sadness, hopelessness and despondency were noted. Of importance is that one's emotional state significantly influences the communication used such as your choice of words, tone of voice, body posture, projection of voice, and inflection in speech. These all can reveal one's emotional state. Their emotional states were affected by the clients with whom they worked and the backgrounds of these. The participants mostly discussed negative emotions, which led to them use descriptors such as 'overwhelmed', 'helpless', 'sad', 'feeling hollow', 'frustrated'.

The personal self was another construct that influenced the clinical engagement. The personal self was drawn from the participants' biographies and their personal experiences. It is necessary for SLTs to understand their personal self through reflection as this underlies their practice. The process of reflection can be expected from the student entering the profession, for this is when they have an understanding of the desire to pursue a profession in healthcare. This reflection should continue throughout the course of study to ensure that there is alignment between the personal and professional selves. Kamhi (2011) points out that clinical practices can often be traced to the personal and professional history of practitioners, such as where they went to school, who their mentors were, where they have worked and so forth. I wish to extend this notion that it is not just the clinical practices that are affected but also the communication that is used as the subject, method and object of the clinical engagement that is at the crux of the matter.

The professional philosophy is related to the acculturation process that SLTs underwent during initial professional education. It is the professional ethos and hegemony of the profession that makes one feel like a professional and part of a community of practitioners. It was found that the participants often reflected on their initial professional education to navigate through clinical engagement in the world of work.

Context of practice influenced the clinical engagement because the data showed that long-term care facilities required different communication strategies to an acute care setting. Each context generated unique clients, families and expectations of the

therapy offering. This influenced the relationship developed between the SLTs and clients and the levels of care shown in these contexts.

The study of the atypical participants served a twofold purpose. The first was a validity check of the emerging thesis argument. Hence, this served as a negative case analysis. I needed to see beyond the obvious problematics of clinical engagement in speech-language therapy. Our profession is often so fixated with the helpless mentality of language and racial differences (most of the time referred to as 'cultural differences') that we neglect to see the other dynamics at play during problematic clinical encounters. The analysis of these cases brought forward the point that the negotiation of communication strategies at the heart of clinical engagement was laced with complexities. The complexities go beyond language. Fundamentally, the clinical engagement is influenced by more than just the obvious differences in language, race and culture. It was revealed that when there is incongruence between one's personal and professional selves as well as between context and affective factors, this then set up a process of difficulties negotiating communication in the clinical engagement.

### **7.5 Section Three: Response to the second critical question**

*How do speech-language therapists (SLTs) negotiate communication strategies during clinical engagement within workplace contexts? (the world of work)*

The communication strategies provided by participants included those learnt at university during their undergraduate training either directly (intended as part of the curriculum) or indirectly (based on observation or informal conversations with lecturers or tutors) as well as those strategies that they have improvised on and picked up through experience and on-the-job training.

The narrative data clearly showed that there are many elements within clinical engagement that an SLT has to negotiate when planning his or her communication. For instance, when engaging with the family, one has to establish the role that the family plays in speech-language therapy in terms of contact with the patient or client and stimulation of communication for therapy outcomes. Some family members play a more or less dominant role in the rehabilitation of the patient's or client's communicative function. This also lends to the argument on the environment or context within which the clinical engagement occurs.

The SLT has to explore the influence that a particular context or environment has on an SLT's communication with his or her patient or client, for example, the differences or similarities between public healthcare and private healthcare, or hospital contexts versus school contexts, and the influence of context and environment on the negotiation of communication in the world of work.

The language of instruction used in the relevant contexts influence the negotiation of these communication and language choices. In the school context, for example, English was mostly used as the language medium of communication because this was what the participants believed to be the 'school language policy', which in reality is far more complex than simply a view that 'English is the language of instruction'. However, this reasoning was used as a justification for the use of English as the medium of instruction in the clinical engagement. I will explore this further in Chapter Eight. In the public healthcare contexts, attempts were made to access interpreters. However, this was often difficult due to financial, human and linguistic constraints. In the private practice context, the participants hardly ever encountered language differences between their clients and themselves.

Often, levels of motivation were low from the perspectives of the participants (SLTs) and this affected how they perceived their clients' level of motivation (or that of the client's family), which affected their communication. Reasons for low motivation could be related to the clients' ill health and their concern and uncertainty about the future.

The methods of communication used to facilitate and negotiate the SLTs' communication in the therapy sessions with their clients included verbal and nonverbal communication. The attitudinal behaviours of clients and/or their parents toward speech-language therapy were found to be mostly negative. This was a puzzling finding as it was difficult to rationalise why the clients then continued to attend therapy. The SLTs were left to engage with these attitudes and behaviours in therapy, which they felt were challenging. The SLTs perceived this to be an undervaluing of the profession.

The sociological and cultural issues that affected the interaction between the SLTs and the mothers of the children were factors such as teenage pregnancy in lower socio-economic communities and the high incidence of babies born with congenital impairments. Society is negatively affected, as socio-economic factors, such as



poverty, unemployment and poor literacy are interrelated with adolescent pregnancies (Van Rensburg, 2004). Given that teenagers have less prenatal knowledge, their general health behaviour and prenatal health practices (such as substance abuse) may affect pregnancy outcomes (Reddy, Sewpaul, & Jonas, 2016) as substance abuse is strongly associated with health complications for the mother and the baby (Bhutta, Darmstadt, Hasan, & Haws, 2005). Lower socio-economic living conditions exacerbate the problems of teenage pregnancy and birth anomalies.

Gender identity issues in professional roles, dissonance between the economic backgrounds of the participants and those of their clients and a lack of resources were all factors that had to be negotiated when communicating with the clients. The way the participants used their communication to negotiate these issues was the focus here.

The participants reflected on their context-specific work issues encountered on a daily basis. These included their frustrations, anxieties, insecurities, challenges, strengths, successes, preparedness and comparisons to the world of academe. Newly qualified therapists and experienced therapists shared commonalities. There were however, unique differences also noted between the two groups across contexts. A myriad of feelings and emotions experienced by the SLTs in the world of work as well as when reflecting on their undergraduate education were noted.

There was also an overwhelming sense of belonging to an undervalued profession. This undervaluing was evident by the way in which clients, families or caregivers of clients and other healthcare professionals interacted with the SLTs. In turn, it was found that the SLTs started undervaluing themselves because they strongly felt that the inability to offer an immediate remedy and cure or answers of certainty gave the impression of the lack of value within the profession. These findings contradict previous studies (e.g. Pillay, 2003b), which argued that the profession previously occupied an elevated status. The participants felt that their clients were in the search of certainty, immediate cures and remedies, which the participants were not comfortable committing to, because they suspected that they might not achieve such results. The participants themselves were in search for certainty, which resulted in three of the five novice therapists moving to what they considered to be 'more suitable contexts'.

Changes in the physical work space were common amongst the novice SLTs as the therapists often changed work contexts after the mandatory year of community service. It was thought that the therapists moved to 'comfort'. Comfort was deemed to be found in the financial, social and emotional situations in the new work environment. I will explain each of these constructs further.

Three of the novice SLTs moved from a public hospital setting to private practice after their community service. This was motivated not only by the lack of available posts in the public healthcare sector but also by private practice tending to appear a more 'controllable' context as the therapist has more autonomy over the private caseload with which he or she works. Financially, private practice is often considered to be a financially more lucrative option than other contexts of employment. The physical space in which SLTs operate plays a significant role in the negotiation of their communication strategies. The participants in community service placement sites were often unhappy with their physical work space because these were small, under-resourced spaces, often shared with other health professionals. In two contexts, the SLTs had to move their work space around the schedules of the other healthcare professionals. This brought up feelings of marginalisation and alienation of the professional as a less-than-important member of the healthcare team; hence, yet another tenet in the undervaluing of the profession.

## **7.6 Synthesis of the chapter**

This chapter presented the thematic analysis of the narratives, and the atypical cases were discussed to present an alternative perspective to the phenomenon. I chose to highlight the embedded complexities of negotiating communication in the clinical engagement, which influences the choices and strategies used with communication. The atypical cases were selected as Zandi and Mbali were black African SLTs proficient in speaking isiZulu and English. Therefore I wanted to remove the one variable (language) in exploring the negotiation of communication during clinical engagement, in order to explore the other communication factors participating SLTs had to negotiate during clinical engagement. Taylor (1973, cited in Peters-Johnson & Taylor, 1986) writes that it is not enough to know the sociolinguistic behaviours of adults in order to conduct speech and language therapy that is culturally appropriate. In the cases of Zandi and Mbali, they had sufficient background to their clients' sociolinguistic behaviours. However there were other factors influencing the clinical

engagement. The affective issues, professional and personal selves and contextual issues were shown to influence communication during clinical engagement even without the influence of cross-linguistic–cross-cultural communication.

The response to the second critical question of the study was also presented. SLTs had to negotiate how they could utilise families in the therapy process. They also had to explore the influence that the context and environment had on the clinical engagement. Linguistic challenges had to be negotiated as English was often used as the medium of instruction and interpreters were accessed to bridge the language differences between therapist and client. Low levels of motivation and emotion affected SLTs' approaches to their clinical engagement with clients as well as differences in sociology and culture. The main consideration in Chapter Eight will be to theorise critical question three, which will delve into what explains the SLTs' choices of communication strategies during clinical engagement.

### **PART THREE: MOVING FROM THE FIELD TO THEORY BUILDING**

Part Two of the thesis comprises those chapters relevant to working in the field of data analysis. Part Three of the thesis will report on an abstraction of the phenomenon of the study in relation to new ideas and thinking emanating from the data analysis.

Chapter Eight brings forward a discussion around the three theoretical constructs that were engaged for the initial theoretical framing of the study. The discussion around the world of academe refers to the process of the development of competence while the student SLT is engaged in the curriculum through the formal HE programmes. The problematic integration theory was used to elucidate the discussion on the clinical engagement between the client and the SLT. The discussion on policy and guidelines that underpin SLTs' practice, which includes the CanMEDS framework is then presented. Thereafter critical question three will be theorised.

Chapter Nine will present the thesis framework as well as discuss the ways in which my study has extended methodological, contextual and theoretical boundaries. A critical appraisal of the study and implications for clinical practice, the undergraduate training programme and future research conclude the thesis.

## CHAPTER EIGHT: Prospecting the data with existing literature

### 8.1 Introduction

As indicated in Chapter Two, the literature reviewed for the study referred to a multitude of layers, as understanding communicative competence within clinical engagement is a complex process. However, the two communication theories, i.e. CAT (the world of certainty) and the PIT (the world of uncertainty) and the CanMEDS competency framework has limited application to the notion of communicative competence as part of graduate competence and in the field of speech-language therapy. In this current section, I challenge the linear set up of the initial theoretical framing presented in Chapter Two (see section 2.3.6). I discuss the confirmations, rejections and elaborations of each of these constructs in relation to the initial professional education of SLTs and the world of speech-language therapy practice.

Chapter Eight provides an answer the third critical research question –

What explains the choices of communication strategies speech-language therapists (SLTs) use during the clinical engagement within workplace contexts?  
(the world of data, literature, practical, theoretical and philosophical explanations)?

This chapter takes us back to Chapter Two of the study where I presented the literature review and theoretical framework, which guided me during data production. Although the data underwent a grounded analysis where the findings were extracted without the imposition of *a priori* concepts, I could not ignore the influence that the initial theoretical framework (i.e. the CAT, the PIT and CanMEDS competency framework) had on the data findings.

When engaging in data analysis and when writing this chapter, I realised that the temporary theoretical lens presented in Chapter Two (see section 2.4) was found to be inadequate when further elaborations and abstractions of the data were conducted. The analysis showed that the complexities and contestations of negotiated praxis during clinical engagement in the world of work were not overtly dealt with which sustained the normative hegemonic practices of what is it considered to be a professional. For the purpose of this study, 'praxis' referred to knowledge on a theoretical basis and the enactment of skills. Praxis had a significant effect on the participants in the following ways:

- their interpretation policies and guidelines reflected in Section Three, namely the government, regulatory bodies and professional associations;
- the way in which the participants negotiated their professional training into practice; and
- the way in which the participants enacted their knowledge and skills in practice.

## 8.2 Orientation to the chapter

In this chapter, the key selected themes are organised as main elements of the negotiation of communication in the world of work. The purpose of this chapter is to highlight the key elements of the negotiation of communication strategies within the world of work through cross-case analysis of the participants of the study and it is an extension of the themes that were presented in Chapter Seven. In this chapter, the world of work will be talking back to the world of academe.

Figure 8.1 presents a refinement from the models presented in Chapter Two (i.e. Figure 2.1 and Figure 2.4) to present an intersected layout of the negotiations between the worlds of academe and clinical practice.

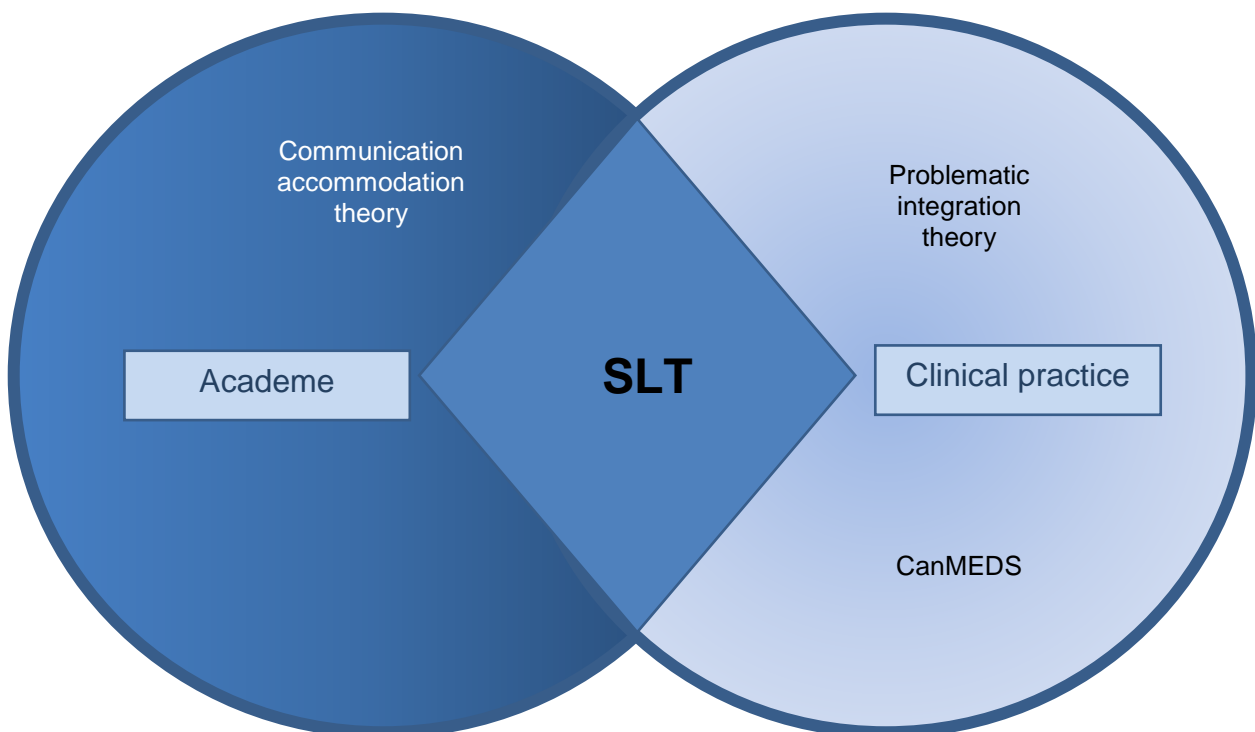


Figure 8.1  
*Negotiation between the worlds of academe and work and of the theoretical constructs influencing the clinical practice*

Source: Author's compilation.

In Figure 8.1, the speech-language therapist is positioned at the centre of the diagram, negotiating between the worlds of academe and clinical practice, with the theoretical framings of communication accommodation theory dominating the world of academe, whereas problematic integration theory and CanMEDS present in the world of work which serve to present as potential disruptors to destabilise the hegemony. The professional who has tended to operate within a space of certainty to reaffirm the hegemonic norm of 'professionalism' is destabilised when presented with problematics during the clinical engagement. Problematic integration theory and CanMEDS appear not to have been adequately incorporated into the curriculum to assist the practitioner with the tools to negotiate the dynamics during clinical engagement. When the problematics during the clinical engagement have not been negotiated, the speech-language therapist experience challenges in sustaining their sense of professionalism and tend to move to contexts that reinforce the hegemonic status and where patterns of power are less dominant.

Section One of this chapter presents a discussion on the world of academe in terms of the development of 'competences' through the application of the communication accommodation principles of pedagogy and practice, intended to be developed through the undergraduate curriculum. Section Two presents a discussion on the problematic integration during clinical practice with specific focus on the contexts of practice of SLTs. Section Three presents a discussion of the CanMEDS framework, policies and guidelines that underpin clinical practice and provide the foundation on which the curriculum can be developed and shaped. Finally, Section Four presents a response to the third and final critical question of the study –

What explains the choices of communication strategies speech-language therapists (SLTs) use during the clinical engagement within workplace contexts? (the world of data, literature, practical, theoretical and philosophical explanations)

### **8.3 Section One: The world of academe**

This section will present a discussion around the development of competence in the curriculum. For the purpose of this discussion about the curriculum, I choose to use Eraut's (1994) depiction of competences referring to knowledge, skills and attitudes in its varied manifestations.

### **8.3.1 Knowledge valued**

Eraut (2012) suggests that there are different forms of knowledge that are valued in the academic space and in the workplace space. In the professional, applied fields such as speech-language therapy, there is a significant gap between the theories of practice taught by academics, based on how they would have liked to have practised, and the activities performed by current practitioners (Eraut, 2012). The participants spoke of elements in the curriculum that they valued, which were more aligned to practice rather than the other 'irrelevant' knowledge offered to them during their initial professional education.

According to Eraut (2012), codified academic knowledge plays a dominant role in academic settings. This is the overt and tangible knowledge found in texts that have been peer-reviewed. Similarly, codified knowledge is important in the workplace contexts as the practitioner has to draw on the knowledge acquired during initial professional training and further episodes of formal learning, or in the workplace itself, such as job-specific technical knowledge.

The relevance of the theory that one needs in any particular situation and which is mainly learned through participation in practice and by getting feedback on performance was evidenced in the data. Most components of a practitioner's theoretical repertoire remain dormant until triggered by a very specific aspect of the situation (Eraut, 2012). This is related to why the participants were so praiseworthy of clinical practice when explicit linkages were made between the theory and what they saw in clinical practice. Hence, one does not see the value of something taught until it becomes relevant and utilised in practice. This speaks to the theory-to-practice approach or the applied science model which promotes that theoretical modules precede clinical practice modules and the theory modules supply the content for students to apply to clinical practice (Gravett, 2012). I argue however, that this lends to an assumption that all experiences in clinical practice can be pre-empted in theory which is simply not feasible. The application of personal, private knowledges (also referred to as craft knowledge) to clinical practice are important skills to accommodate unexpected occurrences. Samuel (2009) explained that both propositional and craft knowledge need to be engaged in order to affect professional growth. As Kamhi (2011) points out, clinical expertise requires years of experience integrating different types of knowledge with the procedural and problem-solving skills involved in assessment,



diagnosis and treatment, and this of course requires adaptability and reflective and reflexive thinking on the part of the practitioner.

Which knowledges are privileged in higher education? The participants offered insight into the types of knowledge that they valued, namely –

- practical knowledge and skills (knowledge and skills learnt through clinical tutorials, practicals and real-life examples);
- methodological knowledge (how to manage information collected); and
- generic skills (the ‘side-effect’ of academic work acquired through initial professional education).

It is worthwhile here, to consider a practical example of a child who is a bilingual isiZulu-English speaker with a speech and language disorder. The practical knowledge and skills that the student will need to tap into would be the signs and symptoms of a speech and language disorder, the anatomical structures of oral musculature, what classifies the ‘problem’ as a ‘disorder’ and the ages and stages of child speech and language development coming from Eurocentric or western ideologies. The methodological knowledge would be how to collect a speech and language sample from the child, to engage the child’s interests in order to collect a sample that is representative of the child’s speech and language abilities. The generic skills that would be developed would be the interactional skills in working with the bilingual child and his/her parent or other involved persons. I argue however that there are other layers to the knowledges that are needed for clinical engagement. This would include critical knowledges of the cultural value system of the family and community and how the said community created or valued the pathology and how the community will respond to the child with the speech-language disorder. It is this uncertainty of not knowing the multiplicity of critical knowledges and the SLTs’ discomfort with difference that leaves the SLTs destabilised.

### **8.3.2 Acquiring professional skill through the curriculum**

The CHE (2013, p. 5) refers to the HE curriculum as the ‘formal curriculum’ which includes all the planned learning experiences that students are exposed to with the view of achieving the desired outcomes in terms of knowledge, competencies and attributes. It is my argument that the curriculum is more than just a planned educational approach, and learning goes beyond a cognitive process in graduates just needing to

obtain knowledge and skills in order to be an SLT. In the everyday world of work, uncertainty and complexities operate; hence, curriculum developers need to be cognisant of the critical knowledges needed by students to engage complexities and uncertainties of practice embedding the reality of context into the curriculum. The critical knowledges go beyond the creation of opportunities for exposure to contexts; rather this involves the deep introspection of the personal, professional, contextual and sociological knowledges that are required during such opportunities. If curriculum designers of professional education in the HE system fail to do this, they risk an opportunity to use the curriculum to make a political statement about the positionality of the profession with regard to the transformation agenda and its social responsiveness to the challenges experienced in healthcare.

One of the generic skills claimed to be acquired through initial professional education, is interpersonal communication (Eraut, 2012). The SLT's communication skills in terms of understanding and expression are great importance because client desires need to be understood, common ground with the client and families about priority issues need to be reached, and shared decision-making about best courses of action need to occur (King, Servais, Bolack, Shephard, & Willoughby, 2012). The participants however have expressed that while they understand the implications of their communicative competence, they lacked certainty and confidence in their abilities due to the problematics encountered in clinical engagement.

### **8.3.3 Developing a professional attitude and the curriculum**

The political past of apartheid in South Africa is still prevalent in our discourses and our narratives, even within our profession of speech-language therapy, which has been accused of being structurally engineered in South Africa to serve the white, middle-class population (Pillay, 2003b). It is worth looking at the speech-language therapy curriculum (within higher education) from this perspective. The curriculum should include the history of South Africa in a naturalised manner and not in a problematised way (Pinar, 2017). The various diaspora who have settled in South Africa over the centuries and the history of the earliest inhabitants of the land should be celebrated as this speaks to the diversity of the country. Unfortunately, the disparities of resources between the privileged and the disadvantaged communities during the apartheid era are still prevalent today, and evident in the health and education sectors. Therefore, if the curriculum perpetuates this line of thinking as a

problematic past, it does not leave much room to steer into the future. The tendency that the SLTs had toward conducting the clinical sessions in English is an example to these statements. Even though they were aware that they had to prioritise the primary language of the bilingual client, they reverted to the argumentation that English is the language medium of a child's school, for example. Hence, the participants have been instrumental in promoting English through a colonised framework and they have not challenged their identity as English promoters. Instead, the participants have tended to operate within these 'safe spaces' as mono/bi/multilingual English speakers themselves while perpetuating the privilege that the English language has enjoyed in this profession over the years. It is such attitudes that need to be guided during initial professional education in order to prevent this hegemony from perpetuating itself. Of course, this does not mean that the HE curriculum alone will be required to challenge the hegemony of English. The curriculum in HE is only one contributor to helping shape reflection on the power of hegemony and the selections being made which favour some and marginalise others.

#### **8.4 Section Two: Problematic integration in clinical practice**

This section presents a discussion of the problematics encountered during clinical practice and the negotiations that SLTs make, which ultimately and intimately have an effect on the individual within his or her contexts.

##### **8.4.1 Bringer of solutions**

The data showed concern and frustration felt by the SLTs that clients and their families look for quick (and easy) answers to the problems with which they present on admission. The SLTs felt that they were not able to offer an immediate remedy or a cure to their clients. This started the process of undervaluing of the SLT and the profession on both the part of the SLT and the client and/or family.

There are certain presumptions and expectations set up by clients on what a clinical engagement ought to offer presumably from their former engagements with other healthcare professionals (Simmons-Mackie & Damico, 2010). In some instances, this could be the search for answers to their communication problems. In order to appear relevant, the SLT acts in accordance with these presumptions and with an air of certainty. As a mark of professionalism in front of the client or colleagues or to validate

their years of training, overt public manifestations of certainty are paraded. This lends an air of professionalism that suggests the worth of the professional health practitioner. The biomedical model is still being used to acculturate students in healthcare into the respective professions whereby the expectation is set up that they need to be the 'bringers of solutions'. The biomedical model focuses on objective findings that emphasises the cause of a disease or disorder that needs to be eliminated by medical interventions to cure the client (Lundström, 2008). Hence, the biomedical model of medicine tends to limit the interpretation of a disease or disorder to mere physical signs and symptoms (Chin, 2001). The healthcare–practitioner relationship has long been assumed to be a straightforward association and encounter between an expert in healthcare and a person in need of healthcare (Chin, 2001; Pillay 2003b). However clinical engagement is a co-constructed event (Simmons-Mackie & Damico, 2010) hence this engagement will define how the participants function in therapy. If there is an expectation for the SLT to effect a solution, then the client might become a passive communicator and not realise their own power and responsibility or they might lose their other competencies as communicators (Simmons-Mackie & Damico, 2010). The biopsychosocial model is a scientific model, which was developed to address the missing dimensions of the biomedical model (Engel, 1980), namely client-focussed intervention and it motivates the healthcare practitioner to become more informed and skilful in the psychosocial areas of practice. Therefore the salvation mentality by clients looking for 'cures' from the healthcare practitioner does not align to the shared decision-making prerogative that the co-construction of therapy and the biopsychosocial model aim to provide.

#### **8.4.2 Conception of care**

In the conception of care and being an emotional caregiver, the SLT has to draw from his or her previous experiences and on role models from their communities, and negotiate between their personal and professional roles to assist the client.

Foucault (1973) makes the distinction between 'assistance' and 'care', where 'assistance' refers to the observing, clinical gaze of the health professional that is focussed upon *assisting* the alleviation of symptomatology; while 'care' is a deeper construct in which the symptoms of the disease are perceived and treated as part of an integrated and compassionate whole.

An unexpected experience and role that the SLTs had to negotiate was that of being an emotional caregiver to clients and their families. As seen in the stories by Lynn, Zandi and Mbali, this was not something that the SLTs expected in practice and it was not something for which they were prepared during their undergraduate education.

During their undergraduate education, speech-language therapy students are not taught how to 'care' for their clients, but they are taught the professional ethical codes of practice and they are told to practice within these guidelines in 'assisting' the client. The student has to negotiate his or her own understanding of care and his or her role as an SLT within the boundaries of the ethical codes of practice. Students in healthcare education are taught about boundaries of professional behaviour such as to be empathetic and not sympathetic with their clients. It is considered to be 'professional' to maintain emotional distance and affect has been constructed in this way.

What then happens when the client's family abandons the client as related in the narratives in Chapters Four and Five? A client's caregiver 'takes responsibility' of the client's well-being. This is a show of the primary expression of a caring communicative relationship. The data suggests that the family who should offer 'care' to the client abandons this role and foist this responsibility onto the SLT. The SLTs acknowledged this engagement that they needed to activate assistance and care toward the client however; it appeared that they were not able to embrace this 'foisted care'. The SLTs could have seen that the foisted care was an over-extension of their professional roles. Perhaps they were not entirely prepared for the emotional investment that they would have to make beyond the scope of therapy with their clients. This draws us to acknowledge the significant irony of how the training programme aimed at educating professional communicators and providing 'helping' educational training has actually de-legitimised 'taking responsibility' and 'care'.

Why is this so? Many therapeutic approaches in speech-language therapy advocate and encourage family and parent involvement in speech-language therapy. Such programmes include the Palin Parent-Child Therapy programme (Michael Palin Centre for Stammering Children, 2008, cited in Guitar, 2014) and Parents and Children together in Therapy (Bowen, 2009) in order to achieve progress and success with the client. Family-centred intervention is seen as more beneficial and favourable to achieve therapy outcomes as opposed to traditional one-to-one speech-language

therapy. Therefore, dissonance could be created between what the SLTs were taught during initial professional education and what they experience in clinical practice.

It might be conceived that SLTs have challenges negotiating their communication and therapeutic interventions in cases where parental or family involvement is lacking or when greater levels of [foisted] care are expected of the practitioners. This could possibly highlight a gap in the undergraduate curriculum as students might be exposed to these realities of practice where families are absent, mothers abandon their premature babies and clients are left unstimulated in isolation however the students do not know how to negotiate these realities as professionals. Perhaps the aim of clinical teaching is to construct 'ideal' teaching and learning experiences that allow students to develop expertise in assessing and treating particular pathologies, which will enable the SLT to understand 'assistance' as the primary goal of the therapeutic encounter as opposed to 'care' (Beecham, 2002). Therefore, when SLTs are expected to display deeper levels of 'assistance' in other words 'care', they appear to have difficulty in negotiating this role in real-life practice. Perhaps the HE curriculum also tends to emphasise the "unit of one": where the graduating professional's competence is interpreted to reside only within the one individual, rather than in relational connectivities. The HE curriculum promotes individualism, whilst professional practice warrants shared collaborative effort between ranges of partners.

#### **8.4.3 Cross-cultural–cross-linguistic communication**

Cross-cultural–cross-linguistic communication is perceived as a significant dilemma in the provision of effective services in South Africa even though multilingualism and cultural diversity is a global phenomenon. It is the SLT's responsibility to be knowledgeable about and to provide culturally and linguistically appropriate services. There is a lack of interpreters due to human resources challenges in the public healthcare context, hence this was problematic for the practitioners. Even if interpreters were available at the hospital, the interpreters often could not help because they themselves did not speak the languages of the clients who were from other African countries.

Sharon, a bilingual speaker, desperately asks in her story in Chapter Four, "What kind of multilingual [speech-language therapist] do I need to be to be a competent speech therapist?"

Further layered on this argument of language issues is that the school context has additional complexities where language is the medium of instruction for teaching and learning in the classroom. Hence, collaboration between the SLT and teachers becomes very important, as SLTs are well equipped to support teachers with in-service programmes in facilitating language for literacy (Wium & Louw, 2013) in ways to facilitate the learners' access to the concepts being taught. However, as evidenced in the data, this collaboration is lacking between these two professionals in the school context where the SLT has an important role. Hence, this requires attention at an undergraduate level in how the SLTs can negotiate their communication to promote and advocate for their skills in the school setting. The SLT might know the role that they could play however; they do not seem know how to bring this across to colleagues.

Besides not being able to speak the languages of the clients, the participants had difficulty negotiating the clinical engagement when there were cultural differences between the therapists and clients. These cultural differences could present as the SLT not knowing how to respond to the resistances offered by the client or his/her family. In Carl's narrative, there is cultural dissonance between himself and the client in terms of differences in age and cultural conceptions of therapy. Carl might be able negotiate the engagement in terms of knowledge of the communication disorder as well as the need to know about Zulu linguistics, however what Carl is uncertain of is how the client has configured pathology and disorder, hence the client's overt resistance to therapy.

This section highlighted the professional and personal conflict felt by the SLTs. They are perceived to be the bringer of (communication and social) solutions for their clients, carers which they consider and over-extension of professional role, while negotiating differences in language and culture between themselves and their clients and families. Hence, the clinical engagement goes beyond the propositional knowledge and taps into the craft knowledge of the practitioner on a professional and personal level. It is such problematics that leave the practitioner with unresolved issues in clinical engagement which only perpetuate from one client to the next. The lack of resolution leaves the practitioner destabilised.

## **8.5 Section Three: Policy and guidelines influencing communication strategies**

This section presents a discussion about policy and guidelines influencing communication strategies in the different work contexts, viz. the public hospital context, the public (special needs) school context and the private practice context.

### **8.5.1 The public hospital context**

Policy is a set of interrelated decisions (Pillay et al., 1997). The power of policies should never be underestimated (Jansen, 1995). Similarly, they who generate policy must consider the pragmatic enactment of policy (Pillay et al., 1997). Policymakers should consider the stakeholders when policies are developed. For example, the DoH offers free healthcare to children from zero to six years of age (Leatt, Shung-King, & Monson, 2006). School-aged learners are not given priority for speech-language therapy services by the DoH if they do not have an accompanying medical condition, which leaves a major gap for support of learners who require speech-language therapy in the education sector. The challenge of the provision of speech-language therapy in the education context arises because the Department of Education does not have sufficient staff or finances to service the need for intervention of children in mainstream schools requiring specialist services (Kathard et al., 2011). This is so, even though the Inclusive Education White Paper 6 policy (see Department of Education, 2001) theoretically appears to make a progressive and politically correct statement. The White Paper states that there is a commitment by government to provide access to education to all learners who have a disability and those who experience barriers to learning whether these be economic, social, language, class, behaviour or other barriers (Department of Education, 2001). However, the enactment of the policy has failed to materialise. Therefore, this still leaves thousands of children requiring special services, such as speech-language therapy, without intervention. The SLT participants who worked in public hospitals reported that their clients who were older than six years were lost in the system because they were unable to access speech-language therapy in the private sector due to financial reasons. This meant that those children who were older than six years were often not treated for their speech-language disorders in their mainstream public schools. SLTs employed by the DoH continued to provide speech-language therapy (without this being allowed or seen as a priority) to children older than six years for their various speech and language disorders. Access issues pertaining to the discrimination of a client's age is of the focus here. The participants



have challenged the current service delivery model where the DoH can provide services for children who are only six years old and under. However, the lack of speech-language therapy posts in the Department of Health and Department of Education alike leave children in communities who have been identified as having communication pathologies but who are unable to access services because of bureaucracy. This highlights the way in which the participants have configured the ideology of 'health' for a child in that there is a dialogic relationship between the health status of a child and their educational level. For a child to be considered 'healthy' the child needs to be physically, developmentally and intellectually stimulated through their environments, i.e. family, schools, community.

### **8.5.2 The public school context**

South Africa has exemplary and progressive language policies (such as the Language in Education Policy [Department of Education, 1997] and the Inclusive Education White Paper 6 policy [Department of Education, 2001]), which were developed to protect the linguistic diversity and promote language equity of the 11 official languages in the country. The aim of these policies is to promote multilingualism (Kathard et al., 2011). However, there is overwhelming agreement that the policies have not been implemented in the public nor education domains (Kathard et al., 2011). Beukes (2009) cites three reasons for the incongruence between policy and practice:

- the hegemonic position of English;
- government's lack of political will; and
- public's negative attitudes toward the African languages.

The CanMEDS framework has the potential to address the above concerns regarding communicative competence, among other competences that the framework asserts. However, the framework has not yet been translated overtly into the curriculum specificities within the higher education system. It remains for now, a targeted symbolic redirection. This is surprising given the concern of promoting social justice and transformation especially within a post-apartheid South African context. It is possible that the profession may infuse these political and ideological foci into the generic orientation and ethos within the curriculum practices which could become manifest in how matters of equity, justice and hierarchies are discussed or enacted. Alternatively, this lack of overt featuring in the official curriculum might signal the

resistance of the profession to embrace an explicit conscious political agenda; the effect would be to (un)consciously uphold normative hegemonic forces which appear neutral, but that perpetuate the conservative manner of practice.

As evidenced from the data collected for this study, the incongruence between policy and practice is that the participants displayed problematic interpretations of policies, which affected their practice. The provision on the right to education (section 29(2) of the SA Constitution of 1996) proved contentious at the time of deliberations on the policy with regard to the issue of language in education and single medium institutions (Henrard, 2001). The previous ruling party, then called the National Party (prior to 1994) insisted on a right to single medium institutions in the public education sector which was considered a strategy to maintain apartheid racial and linguistic separatist affirmations. Furthermore Afrikaans, the language of the ruling party was imposed as a compulsory language within schooling irrespective of whether the language was spoken within the respective communities; this was considered as a means of propagating the spread of the language of Afrikaans through schooling (*ibid.*). However, the African National Congress (ANC), which is the current ruling political party, opposed this right to prevent the return to apartheid practices. Eventually an agreed to but considerably diluted version of the original proposal in the provision of the medium of language instruction stated that every learner has the right to receive a basic education in the language of his or her choice, where this is reasonably practicable (Henrard, 2001). Nevertheless, the phrase 'reasonably practicable' can be considered to be an escape clause, open to the interpretation of the people implementing the policy to suit their abilities and comfort levels and at the risk of them reverting to the normative hegemonic forces with perpetuate colonialisation and the maintenance of English and Afrikaans mediums of instruction in the profession. This arises because the historical remnants of apartheid school geographies and distributions of resources, even more than twenty years after the birth of the new democracy, are still noted in present day schooling. Inequities of human, physical and financial resources still prevail in many schooling systems despite attempts at shifting state investment of resources. Such resourcing includes linguistic resourcing in situations where the language profiles of current staff at schools are skewed in preference to sustain apartheid educational policies. Not all schools can therefore practically enact the ideals of the new South African constitution. This argument does

not undervalue the possible conservatism that prevails in some contexts that practically hold onto their past comfort zones, ideologies and beliefs making new national language policy implementation un-enactable in practice.

In Grades 1 to 3, the majority of learners are schooled in their home languages. However, the majority of learners do not learn in their first language from Grade 4 onwards and there is a major transition to English as the medium of instruction as a consequence of the Language in Education Policy (LiEP) (Department of Education, 1997). The participants were of the understanding that the language of learning and teaching (LoLT) in the school context is English. The sentences, “[t]his is an English-medium school” or “the client goes to an English-medium school” was often used during the interviews. As mentioned in section 8.4.3 the participants have been instrumental in promoting English through a colonised framework and they have not challenged their identity as English promoters.

When an SLT is employed within a school context, it is conceivable to think that he or she would be aware of the policies that operate in this context. Hence, the policies around the language of teaching and learning should be operational within the school and to be followed by all staff in the school community, including the SLT. Also, for the senior staff or school management committee, school level should ensure that the staff at the school are aware of and practising the rules, guidelines and policies that govern the school and the education rights of the learners. However, it appears that this is not being done.

During the data collection, it was reported that a second-language English-speaking learner is referred for speech-language therapy by his or her class teacher presumably because the learner speaks a first language other than English. The learners’ inability to transition into the targeted language that is not always the learners’ home language, at the appropriate pace within the classroom setting, predisposes the teacher to interpret the children as having a linguistic deficiency. This may have more to do with the teachers’ own lack of expertise or willingness to deal with multilingual teaching and learning, rather than an inherent language pathology. The pathology perhaps lies within the systemic educational teacher/teaching expertise rather than within the individual learners themselves. The second-language English-speaking client will be assessed in English (language of lower proficiency) and will be (incorrectly) diagnosed as having a pathology. There is a (incorrect) pathologising of

the client by a pathologised system. In one of the school contexts used as a data collection site, only black African learners accessed services at the school, possibly because of the geographic location of the school being near a community that was historically reserved for black African residents under the Group Areas Act in South Africa. However, there are currently (in the year 2018) mainly monolingual English-speaking SLTs based at the school. This affected the practice of the SLTs, as they had to prepare in advance for the learners in the form of code switching between different languages in a multilingual context, which left them unsure of how to respond to the client. Aside from these potential challenges in the breakdown of communication, the double-learning phenomenon is something on which I want to elaborate. For the purpose of this discussion, 'double learning' means that a second-language English learner will need to learn English first in order to learn the content of the session or lesson. The learner in this context (in a special needs school) is already linguistically compromised as he or she has a language learning disability.

The data revealed that there was a lack of enacting policy in practice on the part of SLTs. This could be due to the participants' lack of knowledge of official policies governing the language used at schools. It could further point back to the curriculum that the participants received as students. This shows that the speech-language therapy curriculum does not deal in any (successful) depth with matters of how language policy functions within school contexts. It further shows that the speech-language therapy student might merely see the 'placement' sites as 'places', rather than as 'sites for partnerships about service'. There is, at provincial and national level, a relationship of collaboration and sharing between the Departments of Health and Education and the university (V.Z. Peter, personal communication, August 15, 2018). This permits students in the Discipline of Speech-Language Therapy at UKZN to conduct their clinical practice at DoE sites.

The role of the SLT in the education sector is still developing, which could account for the uncertainty around implementation of speech-language therapy and policy in the mainstream school contexts. There still needs to be a bilateral quality check by the DoE and the university sending students that such students at the school are aware of and practising the rules, guidelines and policies that govern the school and the education rights of the learners. I believe that this ethical and moral issue requires

attention. I will now discuss the private practice context in relation to policy and guidelines influencing clinical engagement.

### **8.5.3 Private practice context**

In terms of the private practice context, practitioners need to abide by the ethical rules for conduct for practitioners registered under the Health Professions Act 56 of 1974 (HPCSA, 2006), which outlines rules for practice around issues such as advertising a private practice, naming of a practice, and fees for the healthcare service. More specifically directed at the profession, Annexure 11 of the Health Professions Act 56 of 1974 provides rules of conduct to which the SLT should abide. At professional association level, the South African Speech Language and Hearing Association (SASLHA) also provides guidelines for SLTs to adhere to when in private practice. However, practitioners sometimes have to develop their own policies and guidelines in order for their practices to run effectively.

In Stephanie's case, she encountered situations whereby she felt that her therapy offering and herself as an SLT were being undervalued by clients. The non-adherence to prescribed interventions in the home context and the lack of follow-through with homework tasks left her feeling that she needed to create contracts between herself and her clients to help forge clearer conditions of service and boundaries. In this instance, the purpose of developing a policy was therefore to assist the practitioner in asserting her professional boundaries where she felt that it might have been lacking in order to regain control of the situation that left her feeling vulnerable. However, this participant might need to acknowledge the vulnerability that she faces might not be entirely due to the mother's non-commitment to therapy but that she too is accountable in terms of interpretations of her irrelevance as a healthcare practitioner. The SLT seems to be absolving herself as part of the problem. Client compliance and adherence to therapy is a critical mediator of therapy outcomes (Behrman, Rutledge, Hembree, & Sheridan, 2008). There appears to be a moral-ethical dilemma whereby Stephanie is uncertain on whether to engage the parent on their non-compliance at the risk of offending the parent and the client. As the nature of private practice involves remuneration based on client attendance and participation a disgruntled or unhappy client could perhaps choose not to return to therapy, which would have a negative impact on Stephanie's caseload. Stephanie appeared to tolerate this non-compliance so as not to overtly offend the client's mother. The issue highlighted here is that the

context exerted a powerful influence on this clinical engagement (Simmons-Mackie & Damico, 2010). The private practice context is very different from the public hospital and public school context because there is direct remuneration for speech-language therapy services to the practitioner. This could have set up an expectation by the client's parent that the SLT should be solely responsible for the outcomes in therapy, while the parent becomes a passive participant (Simmons-Mackie & Damico, 2010). Due to remuneration and issues related to client case-load in the private practice context influenced the participant's communication as she was unsure in how to engage the client's mother. The discussion of unpleasant aspects of the clinical engagement appear to be difficult and challenging to engage verbally with the client's parent. Perhaps these difficult aspects of practice can be addressed through a memorandum of understanding between the practitioner and the client (or parents) to stipulate the nature of clinical engagement and prescribed interventions in the home context. The idea of being 'professional' in private practice has been constructed in a particular way, so as to perform the acts of therapy in an individualistic and non-collaborative manner, while ensuring that one is not assertive toward the client at the risk of offending the client (or the parent) and losing their business. The negotiation of these variables in the clinical engagement places much demand on the practitioner. I will now move on to crafting a response to the third critical question of the study.

#### **8.6 Section Four: Response to the third critical question**

The third and final critical question of the study was:

*What explains the choices of communication strategies speech-language therapists (SLTs) use during the clinical engagement within workplace contexts? (the world of data, literature, practical, theoretical and philosophical explanations)*

The epistemological-ontological nuances around communication during clinical engagement will start this discussion. I am mindful that a simple answer does not exist to this critical question. I would rather theorise the discussion.

I suggest that the dominant view of 'knowing' is to equate, in the present worldview of Speech-Language Therapy, with an absolute certainty. This is aligned to the paradigmatic worldview that expects profession(al)s to provide solutions to presenting problems since the elements of traditional speech-language therapy draw parallels to other familiar healthcare contexts, e.g. visiting a doctor (Simmons-Mackie & Damico, 2010). Speech-Language Therapists would have acquired knowledge through formal

and informal training and education and then would have to engage with the world of clients with communication pathologies as the knowers and the bringers of solutions.

But what if Speech-Language Therapists did not actually know what they need to know for clinical engagement? What if 'not knowing' was their certainty? And what if speech-language therapy educators also 'did not know', how then can the educators teach? As Pillay (2003b) said, that would leave the profession with a practical and methodological dilemma. This is the reality of practice that requires educators and practitioners have to function. There are multiple knowledges that are privileged in initial professional education, with propositional knowledge given the most importance. It is my argument that craft or personal knowledge, especially in a healthcare profession is of importance too. There has to be an appreciation of the sociological aspects of the co-construction of the clinical engagement as both the therapists and the clients bring unique social and cultural experiences (Simmons-Mackie & Damico, 2010).

Speech-language therapy, like other healthcare professions, cannot hide behind being called 'scientific', which rests on positivism. This way of thinking may be perceived as a convenient escapism from dealing with the humanising elements of clinical engagement. Being 'scientific' is inclined to the biomedical model of practice, which lends itself to positivism. Positivism is favoured by many other health science disciplines, which implies there is a single truth and the practitioner is often the truth-bearer. This is possibly due to the powerful stance that the healthcare practitioner possesses when one ascribes to this paradigm as the knower of truth which results in power asymmetries during the engagement. However, in speech-language therapy, there are multiple ways of understanding a clinical encounter and co-constructing clinical interactions to create authentic engagement between the therapist and the client (Simmons-Mackie & Damico, 2010). Philosophy confirms this. As the philosopher Heraclitus (c. 540–480 BC, cited in Gaarder, 2007) said that everything flows; nothing is abiding. His famous words resonate that one 'cannot step into the same river twice'. Client A is not the same as Client B no matter the similarities in age, background, and pathology; hence, intervention has to be tailored-made for individual clients and there is not a one-size-fit-all solution.

During clinical engagement, the SLT has to negotiate many factors, which privileges one's professional self without acknowledging the effect that one's personal self has

on the engagement. For example, the SLT may have an antagonistic view to a mother who does not want to do the speech therapy 'homework'. The SLT's personal self could strongly feel that this is the duty of the mother. This 'judgement' could be relayed in the clinical engagement possibly causing further dissonance between the therapist and the parent. This dissonance between personal and professional selves could prepare the soil for the growing myriad of emotions that the therapists feel thereafter. A therapist's professional philosophy could be influenced by and developed from his or her initial professional education.

In the data we saw how the participants attempted to accommodate their clients in terms of choice of language, words, nonverbal cues (to touch or not to touch), continued persistence or eventually ceasing to assist. Knowing how to negotiate these situations could have come from the formal education and/or social capital of the individual. In the data, the participants also offered that this problem solving of accommodating one's conversational partner in terms of nonverbal cues and persistence or cessation of assistance was not part of the formal curriculum. Disciplines within the professional realm, such as speech-language therapy, have often been criticised of having an obsession with the overt codified knowledge of the field of study, such as a curriculum that is designed and geared toward the development of a knower. Propositional knowledge ('book knowledge') is often the focus in professional development activities (Samuel, 2009). However, what I contend is that evident from the data, the problematics that occurred in the clinical engagement did not necessarily arise from a lack of propositional knowledge. It was, however, the difficulty in negotiating the craft or personal knowledge. I suggest that the negotiation of craft knowledge as a body of study is relatively underdeveloped. Both of these knowledges, propositional knowledge and craft knowledge, are needed to effect any substantial professional growth as depicted in the iceberg model of knowledges (see Chapter Two).

## **8.7 Synthesis of the chapter**

This chapter presented an argument of a way of thinking in which SLTs negotiate communication during clinical engagement. A discussion around the world of academe and curriculum in relation to the engagement between higher education and the world of work, the problematics encountered in clinical practice and the policy and guidelines that influence speech-language therapy practice were presented in accordance to the



initial theoretical framing. I discussed the confirmations and elaborations of each of these constructs in relation to the initial professional education of SLTs and the world of speech-language therapy practice. The analysis brought forward the discussion that perhaps the HE curriculum tends to promote individualism, whilst professional practice warrants shared collaborative effort between ranges of partners. The chapter concluded with a response to the third critical question of the study. Speech-language therapy comes from a tradition of positivism, as do other healthcare professions. However, I argue that this can be perceived as a convenient escapism from dealing with the humanising elements of clinical engagement. Practitioners have been found to favour the power asymmetries during the engagement where the healthcare practitioner ascribes to the knower of truth. During clinical engagement, the SLT has to negotiate many factors, which privileges one's professional self without acknowledging the effect that one's personal self has on the engagement. This dissonance between personal and professional selves is an issue that I will explore further as this chapter sets the scene for the elaborations of my thesis, which will be presented in the next chapter. I also propose to discuss the ways in which my study has extended methodological, contextual and theoretical boundaries. I will also present a critical appraisal of the study.

## **CHAPTER NINE: Mining the diamond framework: Towards a curriculum of resilience**

### **9.1 Introduction**

We have come to the culmination of the study. The aim of the study was to explore how SLTs negotiate their communication during clinical engagement.

This chapter presents and elaborates on the new insights that emerged on rethinking the phenomenon examined in this study, namely communication used during clinical engagement. The thesis framework was revealed and discussed in accordance to the main constructs that elucidated the framework.

### **9.2 Orientation**

This chapter comprises four sections. Section One will present the process of building the thesis framework. Section Two presents the thesis framework: The diamond framework: Towards a curriculum of resilience. Section Three will present a discussion of the ways in which the study has pushed methodological, contextual and theoretical boundaries. Section Four will present the critical appraisal of the study, which will include the strengths and limitations as well as the implications for future research. The chapter concludes with closing remarks on the thesis.

### **9.3 Section One: Building the framework**

When I reviewed the literature and relevant theories in preparation for data collection and rationalising the need for the study, I found that the selected literature provided a range of perspectives. However, after analysis of the data, I found that the initial lens was too restricted as each of those theories reviewed were idealistic and not entirely relevant to the current research context. While the CAT was applicable to the study, I considered that a limitation of the theory was that it did not focus on the problematics around communication that are so commonly found in clinical interactions between practitioners and clients. The theory focussed on the role of conversation during social interaction (Giles & Ogay, 2007). The theory is about resolution of communication breakdown and conflict and about accommodating one's conversational partner. However, conversation is more complex than to be reduced to immediate linear interactive resolution. Hence, the CAT was found to be lacking for the exploration of clinical interactions, which are often complex in nature due to the coexistence of

multiple factors being negotiated simultaneously, sometimes coherent and at other times, contradictory and paradoxical. Multiple influences compete for dominance both in the world of work context and within the internal worldview of the practitioners themselves, influencing them to doubt their own professionalism and even their own professional education itself. Their workplace contexts become infused by larger degrees of uncertainty rather than imbued with stability and coherence. Seeking spaces to support comfortable resonance with their internal and external environment become the patterns of maintaining semblances of professionalism.

The PIT was also limited in handling the incongruence that the participants experienced between their personal and professional selves which resulted in coincidental affective factors. The participants revealed that their desire was not to be shown the ideal clinical engagement throughout their initial professional education; rather, they wanted to be shown the complexities of real-world practice, no matter how difficult it may be to accept at the time of being students.

It is my criticism that the CanMEDS competency framework was found to be too idealistic and unrealistic to cope with the complexities of real practice. The CanMEDS competency framework focusses on performance outcomes in a rudimentary manner. However, we have come to learn that competency development goes beyond a linear, tick-box approach, as it is about the negotiation of the professional and personal selves.

The 'prospecting' [examining] of the appropriate literature to contextualise the need for the study can be likened to the prospecting of a diamond mine. The data collection was the mining process and the analysis revealed the jewel embedded in this research. The study therefore proposes a synthetic metaphorical representation, which could serve as a model to understanding the complexities of SLTs negotiating communication strategies during clinical engagement. I have chosen to name this metaphor 'The diamond framework: Towards a curriculum of resilience'. Four recurring constructs have emerged as influential in shaping the communicative strategies of SLTs: personal philosophy, professional philosophy, context and affective factors. These factors are akin to the key factors when establishing the hallmarks of a diamond in a retail setting such that each stone is classified according to its unique cut, clarity, colour and carat – a 4 Cs universalist system (see Bruton, 1978). These hallmarks offer currency, worth and value to the diamond. Gemologists have developed methods

of grading and certifying diamonds. The hallmark grading of a diamond helped me make sense of the data to depict the four facets of the clinical engagement and communicative strategies of SLT, namely, the intersecting worlds of ‘certainty’, ‘uncertainty’, ‘academe and ‘work’, which graduates negotiate and navigate. Figure 9.1 presents the diamond grading chart from the Gemological Institute of America illustrating the 4 Cs under discussion.



Figure 9.1

*Diamond grading chart illustrating the 4 Cs of diamonds – cut, clarity, colour and carat*

Source: Visual source: <http://4cs.gia.edu/en-us/blog/gia-diamond-grading-scales/>

The mining sector in South Africa is one of the major driving forces behind the historical unfolding of the country's economy (Bruton, 1978). Today, diamonds from South Africa feature across global markets, including the famous Cullinan I, or the Star of Africa diamond (at 530.20 carats), which to date is the largest cut diamond in the world. It is pear-shaped, with 74 facets (Bruton, 1978). As part of the history of the British Empire, the famous diamond was presented to the colonial authorities and was then set into the British Royal sceptre and is housed in the Tower of London, owned by Queen Elizabeth II. The diamond industry is controversial in itself as the issue of conflict diamonds or 'blood diamonds' as they are commonly known must be mentioned. The United Nations has defined conflict diamonds or 'blood diamonds' as "diamonds that originate from areas controlled by forces or factions opposed to legitimate and internationally recognized governments, and are used to fund military action in opposition to those governments, or in contravention of the decisions of the Security Council" (United Nations, N.d., cited in Armstrong, 2011). I have chosen to use the physical characteristics of the diamond in my metaphor: The diamond framework: Towards a curriculum of resilience, and have therefore not discussed with great detail the underlying principles of the supply and demand of the trade in diamonds and the controversies surrounding it.

Perhaps education, and more specifically higher education, like a unique diamond entity, is a rare and beautiful commodity that has much potential value to offer. Similarly, our graduates entering the world of work have unique characteristics, each with unique inner value, not yet unleashed until it is shaped under the influence of the work of the skilled diamond cutter.

Before a diamond is cut, its carat value is not known. Equally so, when a student sits in the lecture room or in a clinical session, his or her potential value is not entirely known. It is only when the diamond is put under pressure and is trimmed and polished that the true value is revealed. There is much uncertainty that lies in the early stages of academe (the diamond cutting phases) and that the student has to go through the social and emotional transitioning in the higher education space (Mudhovozi, 2012) (the polishing) and the disciplinary process of their profession to reveal their value (the shaping and nurturing of the facets to establish the clarity and colour of the diamond). Just like a diamond, the graduate needs his or her certification and registration with the relevant council in order to hold true value (its carat value). The diamond is the

hardest natural substance, and it is regarded as the world's most precious stone. The Moh's scale ranks minerals by how hard they are from 1 to 10, with 10 being the hardest (Wilks & Wilks, 1979). The diamond ranks 10 on the Moh's scale as it is formed from pure carbon, being placed under high pressure and high temperatures in the earth's crust (Wilks & Wilks, 1979). Due to the attributes cited above of the diamond's hardness and the ability to withstand pressure, that a diamond can be referred to as 'resilient'. It is my contribution and contention that this metaphor be applied to the development of the graduate with competences as a professional with resilience who is able to embrace adversity but remains strong and robust and is able to use their communication to negotiate these challenges in the world of work. Hence, the current thesis has been analogously named The diamond framework: Towards a curriculum of resilience.

#### **9.4 Section Two: The diamond framework: Towards a curriculum of resilience**

In the process of professional development and the development of competences, the novice SLT has to be acculturated into his or her field of study through the influences of propositional and codified knowledge. This has been well documented in the literature (see Morrow, 2007; Samuel, 2009). The novice therapist still has tenets of his or her personal philosophy idling within him or her as he or she acculturates, learns and abides by the professional hegemony. This hegemony has been crafted over decades, and has been informed by policy and practice, such as the Patient's Rights Charter (see HPCSA, 2008b), the SA Constitution (Republic of South Africa, 1996), the Batho Pele Principles (see Republic of South Africa, 1997), and the Inclusive Education Policy: White Paper 6 of South Africa (see Department of Education, 2001). These are forward-thinking and progressive policies, which we, as healthcare professionals, have to honour and abide by, as well as analyse and deliberate. Then there are other conventions of ethical practice that are to be followed strictly, such as to refrain from judgement of the client and not to impose personal views onto the client. It is through the negotiation of these processes that the professionalisation occurs.



Figure 9.3

*The diamond framework: Toward a curriculum of resilience*

Source: Visual source: <https://encrypted-tbn0.gstatic.com/images?q=tbn:ANd9GcRqaZm7ET1WYnsC0rEPwS4Q2MOW650XID-WVPGAigJan4OH9aYH>

When evaluating a diamond that has been crafted into a jewellery setting, two main characteristics are used to describe its features: that part which is visible above the surface of the metal (the crown), and that which is characteristically hidden from view (the pavilion) (Matlins, 2011). Whilst the former is regarded as the part most noticed by viewers, it is the latter part, which provides the structuring, locatedness and brilliance of the diamond by the way in which it refracts light into and out of the stone. The supporting metal framework holds the stone in place. Therefore, the ‘crown’ is the ostensible elevated form, which is measured in terms of its height above the surface of the metal frame. Evaluators describe the outward shape of the visible crown to classify the type of ‘cut’ of the diamond (Matlins, 2011).

Conventionally, diamonds are cut into classified shapes, such as round, brilliant, princess, square, oval, marquise and emerald – each depicting different ways of translating the raw stone into a refracting source of light. The cut selected is directly related to the presenting form of the raw elements of the unprocessed rock ore. Skilled

diamond cutters spend many hours of contemplation and examination of the raw stone before a final cut is chosen to best reveal the stone's potential (Bruton, 1978).

To relate the metaphor to the study, the diamond is likened to the curriculum as the shapes or cuts of the diamond could refer to the curriculum of formal professional higher education. This professional education is crafted in relation to the specifics of the students who could be considered the raw material or ore. The choice of the appropriate (initial professional education) curriculum ought to be in relation to the unique characteristics of the students, not simply a choice foisted upon the raw ore.

The choice of a wrong cut could, in practice, completely destroy the quality of the diamond, and the cutter (curriculum maker) could destroy the potential for emergence of the brilliance of the stone.

"We are in a curriculum craze in South Africa" (Ramrathan, 2010, p. 107), where every sector is looking to education intervention due to the implementation of new policies and changes to the (higher) education system, which has resulted in a major influence on teaching contexts (Ramrathan, 2010). Pinar (2017) reminds us that curriculum development (and revision) is a creative and intellectual undertaking and should be an ongoing process informed by expertise and consultation. Ramrathan (2010) elucidates two constructs that are followed when conceptualising curriculum intellectualisation. The first is the response to demands and drivers, which influence the curriculum to prompt reconceptualisation and innovation to ultimately uphold the objectives of the Constitution, such as drivers like the HPCSA, SAQA and the CHE (Council on Higher Education). The other construct is serendipity, which refers to the opportunity as it presents itself in opportune moments in our history and redirects the focus on the curriculum and intellectualisation. I want to elaborate on the latter construct. Calls from the world of work, the Lancet commission (Frenk et al., 2010) and the development of frameworks such as the CanMEDS competency framework, which are steadily gaining momentum, all allude to the focus on the process of the initial professional education of graduates in the development of competencies required for professional practice.

The metaphor of the diamond can also be used to relate to the constructs of the framework, i.e. the professional self, context of practice, affective factors and the personal self.



The cut of the diamond is representative of the **professional self**. The professional self is the outward portrayal and usually the first aspect noticeable to others. It is also usually noticeable as the size of the diamond: one of the elements used to determine the carat of the stone (Matlins, 2011). However, the carat is not simply a visual matter; it also encapsulates the weight of the stone. Moreover, a trained eye looking at the table size of the diamond, i.e. how the diamond presents itself to the naked eye in its unique setting, usually ascertains the carat. Simultaneously the size, weight and presenting show of the diamond is referred to as the stone's carat (Matlins, 2011). To relate to the metaphor, the carat could refer to the 'context of practice', the pragmatic space within which the practitioner operates in a social setting. The colour of the diamond is usually a feature of the specific rock stone characteristics, but its full manifestation is truly established when it is polished. To link to the metaphor, the colour could refer to the 'affective factors' of the professional self, which draw unique characteristics of the individual into his or her personal practice.

The bottom part of the diamond, called the 'pavilion', (Matlins, 2011) is usually not noticeable by just looking at it because this is the part that is usually set in the metal framework. This pavilion is measured in terms of its depth below the surface of the metal frame. The pavilion depth, even though unseen, is an important part of the diamond as the kind of arrangements of the 'below the surface characteristics' allows light and refraction to pass through the diamond, which gives the stone its brilliance. The ability of the light to pass through the diamond is referred to as its clarity (Bruton, 1978). Clarity is often a less noticeable feature of a diamond and is classified according to a grading chart, which measures the stone's transparency, opaqueness and refractability (Bruton, 1978). The clarity of a diamond is often graded using a diamond loupe, which is a magnifying lens to inspect diamonds (Matlins, 2011). Without this further inspection using a loupe, much uncertainty lies in the grading of the diamond. To link to the metaphor, the clarity could refer to the elements of the personal self, which draw from inner qualities, such as the ability to refract and displace light and engage agentic resources to shine.

I will discuss each of the components of cut, colour, carat and clarity in more detail:

#### **9.4.1 Cut: The visible professional self**

The 'professional self' is developed through an acculturation process into the profession and is usually the most noticeable outward feature of the practising professional. This occurs over the four years of the initial professional education through engaging with academics, literature and policy, and fieldwork or clinical experiences. Experiences gained as students in both formal and informal contexts provide the fertile ground in which competence begins to blossom, and so does their professional development. It is this acculturation that brings about a heightened awareness of what it means to be a professional and how to conduct intervention, such as how to negotiate communication during clinical engagement. The student picks up on the discourses used in the profession and enacts these ideals and discourses as he or she starts to attempt to belong to a community of professionals.

This professional self is the subject of overt formal curriculum agendas, and is usually the preoccupation of many designers of the professional education of prospective professionals. The professional self draws on the propositional knowledge of the profession. This embeds elements, which aim to draw out the raw potential of the individuals and to present their evolving working development in contextual spaces against the backdrop of the conventions that are specified in the specific (national) broad overarching professional bodies or acculturating agents. It should draw on inherent, embedded qualities of the individual novice professionals, but is usually primarily focussed on the outward forms (shapes) of professional practice. Acculturation is usually established in terms of standardised conventional cuts, which are the established traditions of the profession.

#### **9.4.2 Carat: Contextual factors**

The context of practice was key in negotiating communication during clinical engagement. The data of this study showed that long-term care facilities required the SLTs to select different communication strategies to an acute care setting compared to a school setting. A paraphrase of one participant's narration is that "context creates the communication choices that practitioners make". These selections are not restricted to the operational spaces of work settings only. It also refers to a broader reality of practice in a context like South Africa where multilingualism, multiculturalism, service provision to marginalised communities, a lack of resources, a lack of

knowledge and of awareness of the profession, and communication disorders are prevalent.

A dominant feature of this linking to context reveals that the participants repeated characterisation of the world of practice as engendering discomfort and uncertainty. Rather than the practice of work generating feelings of being able to contribute to professional service, the participants reported dominantly their recurring emotional disconnectivity from their practice, and their feelings of being rendered vulnerable and/or obsolete. Sometimes this uncertainty produced views of either the irrelevance or the worthwhileness of the profession itself. Babrow (1992) proposes that this kind of 'uncertainty' can be a positive experience when communicating with clients. Not knowing completing and certainly, could offer hope to search for alternatives, and opens up possibilities with the eventual realisation of ability or professional self-worth. It has the potential to tackle the conceptions of power, which are embedded in professional–client relationships.

Uncertainty also provides a vantage to evaluate the choices of current policies and their relevance to the systemic challenges, such as under-resourced facilities that many SLTs experience, especially in needy contexts. However, like facilitative anxiety<sup>39</sup>, uncertainty has particular thresholds, which could incapacitate the novice practitioner to capitulate and resort to more comfortable spaces where more certainty prevails.

What then are the practical and operational implications for everyday practice as novice professional in an era of uncertainty?

One needs to change the way one thinks about uncertainty. One needs to embrace uncertainty instead of shying away from it. Stable certainty is likely to be a (distant) historic conception, especially for those who resist a conservative fundamentalist perspective. Uncertainty is likely to be the new norm as new contextual spaces are forged through migratory mobilisation in the exchange of worldviews, cultures, and communication strategies. Truly, one needs to practice within a problematic integration approach to embrace transformation and diversity. This needs to start at the level of

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<sup>39</sup> Facilitative anxiety is the positive interpretation of anxiety, usually reflecting a degree of readiness necessary for success (Eys, Hardy, Carron, & Beauchamp, 2003). Facilitative anxiety is considered to be the opposite of debilitating anxiety.

academe, its selections of curricula and normative acculturation tendencies to allow for a dynamic transference into the world of uncertainty of professional work.

#### **9.4.3 Colour: Affective factors**

The data of this study showed that affective factors influenced the communication strategies used during clinical engagement, because as Kamhi (2011) reminds us, we are influenced by our feelings, emotions, desires, goals and self-interests. The participants described feelings of being hopeful and optimistic when working with their clients and families; however, at the other end of the spectrum, they also described hopelessness, depression, despondency and feelings of giving up. This affected the motivation of both novice and experienced SLTs and left them at risk of burnout. The SLTs were not comfortable with the responsibility of being the sole communication partner and emotional caregiver for their long-term care clients. In another scenario, there were clients who were adamant that they did not want to receive speech-language therapy. SLTs are advised to respect the autonomy of the client, especially if the client has appropriate decision-making abilities (Brookshire, 2003). This could signal that this is a form of undervaluing therapy, a recurrent theme in the data set. While the SLT is encouraged to respect the client's decision to refuse therapy, one has to consider the emotional effect that this has on the SLT.

The individual practitioner has to negotiate elements of the professional self and conceptions of their personal self, which are influenced strongly by the ambient micro- and macro-conditions, which activate positive and/or negative responses from practitioners. The professional curriculum of academe ought to embrace the responsibility to ensure that novice professionals are able to negotiate the world of practice and to expect that their experiences will characteristically involve both negative and positive emotions. Such emotional resilience is often neglected in the journey of professional curricula.

#### **9.4.4 Clarity: The personal self**

The personal self was drawn from practising professionals' biographies and their personal experiences of negotiating the world of everyday practice. Characteristically, this biographical heritage is often sanitised, suppressed or hidden from view during the stages of early professional development. Many professionals are preoccupied

with demonstrating their overt compliance with their 'professional selves' (discussed above) since this earns them official status of being called 'a (certified) professional'. It is necessary to understand one's personal self and the philosophies that underlie one's deeper commitments and choices in one's lives. It is usually when one makes sense of what one has experienced that deeper reflective notions of self can be activated. The personal self draws on craft knowledge, such as through experiences in one's life. Like the diamond, the clarity of an individual stone (the personal self) is best revealed when it allows light to refract through its depth, and emerge as brilliance above the surface. Both the professional self and personal self work in unison to create the sparkle of professionalism and the choice of appropriate communicative selections.

If one were to navigate towards a 'curriculum of resilience', these multiple refractions of outer and embedded notions of the formal curriculum and professional development (the professional and personal selves in dialogue with each other), could become an agenda that could be drawn from to inform emerging pedagogies for the initial and continuing professional growth of SLTs. Such a curriculum will recognise the need for competing complementarities among the competences being developed and nurtured, the responsiveness of emergent practitioners to their specific contexts of practice, their turbulent emotive embattlements, as well as their recognition of their deeper embedded values and philosophies.

A pragmatic consideration is where novice practitioners are placed during the clinical practicum, how they are monitored and evaluated, and how they reflect on these placements. Further to the actual physical context, the clinical supervision offering also 'creates that context'. University training and its formal curriculum have tended to perpetuate a world of certainty, the presentation of a world of practice that is considered a safe and sanitised space as mentioned by the participants. The dilemma arises when clinicians face the 'uncomfortable' uncertainty of everyday practice, when they encounter professional practice on their own without the safety net of the official normativising monitoring and evaluating strategies of the university. I propose that the levels of normativising support offered to the student should taper off within a clinical block and across the curriculum in order to generate more dialogue between the students' professional and personal selves. This is to facilitate more professional and personal growth and autonomy.

It is my suggestion that, when there is congruence between the professional and personal self within specific contexts, that this set up a chain of emotions that positively influence the communication used during clinical engagement and the practitioner operates within a space of certainty (Figure 9.3). The affective factors include optimism and hope. However, when there is incongruence between the professional and personal self, this negatively influences the clinical engagement and the communication strategies, and the practitioner tends to operate in a space of discomfort and uncertainty. These situations could come about when the practitioner's personal identity does not agree with what the professional identity expects of him or her. In cases where mothers abandon their babies, mothers are uninvolved in the therapy process or teenage mothers have babies out of wedlock – these are all sociological issues. The therapist may not be comfortable working with these cases because of their personal value system related to who mothers ought to be and the role of the mother in a child's life. Both therapists and clients bring unique sociological and cultural experiences to the clinical engagement, as clinical engagement is a co-constructed event (Simmons-Mackie & Damico, 2010). Hence, when there is dissonance between the therapists and clients and their families in the clinical engagement problematics arise. How does a professional rise above this to resolve the dissonance between his or her personal and professional self? This is where aiding the professional in a curriculum of resilience finds its place.

When forming a professional identity, one cannot be devoid of the personal background. One should further be cognisant that the role that one's personal feelings have in the development of one's professional identity, as this influences the communication that a professional uses during clinical engagement.

One such example is the obvious levels of discomfort that practitioners feel in not being able to provide immediate solutions to their clients' communication problems. In current times, communication has changed rapidly. With the advances in electronic communication, humans are more 'connected' and 'engaged' than ever before. Answers to our questions can be found with the click of a mouse or with a single emoticon. We have the technology to know when messages are delivered and read. As human beings, we live in a time of instant communication. What happens when this communication is disrupted through impairment, disorder or disease? It appears that clients and their families also expect instant communication solutions. SLTs must

therefore learn how to deal with rapidly changing and unstable ways of knowing, being and becoming.

From the narratives that were presented in Chapters Four and Five and the subsequent analyses in Chapters Six, Seven and Eight, we see that SLTs have to negotiate many competing and contradictory factors in the clinical engagement with a client. The high degree of discomfort these practitioners reflect in their narratives suggest that they tend to expect quick, easy and reliable solutions to their clients' communication impairments. This set up a series of events that led the participating SLTs feeling that their profession was being undervalued by their clients. In turn, the SLTs started undervaluing their profession themselves. It could be argued that the formal officialised curriculum of initial professional education at university led them to consider communication to be instant and easily accessible. However, within their professional practice, the remediation of a communication pathology is long drawn and uncertain. The incongruence between these two worldviews of the presenting professional self (an acculturated 'certain' self) and the personal self (in the embedded 'uncertainty' of practice) could be where the festering of undervaluing the profession happens. A dialogical relationship between the professional and personal selves could foster a renewed commitment to resolve emergent challenges of the worldviews and practices of certainty and uncertainty.

I propose that more effort be put into understanding the student's personal self so that there could be better linking to his or her professional self in charting his or her career trajectory. If, during the intervention with clients, the professional has moved toward a biopsychosocial model of acknowledging the client as a person first rather than the pathology with which he or she presents, then I think it is worth acknowledging that in initial professional education, the same approach is adopted whereby the student is seen as a person first. More attention should be given to mediating one's personal and professional selves so that the transition toward becoming a professional may be more fluid and coherent.

### **9.5 Section Three: Methodological, contextual and theoretical interests**

This section will elaborate on the new understandings and directions that my study brought about. The emergent constructs are discussed in relation to the

methodological, contextual and theoretical contribution of the study to the existing literature.

### **9.5.1 Methodological interests**

Traditionally, speech-language therapy has tended to emulate core concepts or paradigms, which inform the 'hard' sciences, and this is reflected in the choices of the dominance of the experimental research approaches adopted by the profession. By contrast, qualitative approaches to research allow for a more flexible and comprehensive method of exploration into the complex clinical or research work. Many disciplines, recognising their social and humanities connectivity and the role of the researcher in making sense of a complex, dynamic social setting, have chosen to include other ways of researching their phenomena and practices (Eastwood, 1988).

Narrative analysis is a relatively under-used method of analysis in the field of speech-language therapy. Drawing on the traditions of those who have explored such alternative strategies of researching in the health sciences (Beecham, 2002; Kathard, 2003), my own study undertook to engage in constructing stories of the participants' experiences as they entered the world of work and reflected on their communication strategies adopted. This was an exciting venture for the participants and me. When involved in the member checking exercise, participants commented that they realised for the first time how their stories of practice may appear to others when retold. This gave the participants an opportunity to be the outsiders looking into their stories. This was even more effective because the stories were written in first-person narrative. The use of video-stimulated recall (Fox-Turnbull, 2009) was novel in that there is a lack of research studies that have captured qualified SLTs during clinical engagement and then asked the participants to be reflective on their practice. The participants were in agreement of this method of data collection because of the established relationship between the researcher and the participants. This method was highly effective in getting participants to be reflective of practice, which optimised the data obtained in the post-observation interviews. Such an approach to data production allowed me, as the researcher, to probe not just the lives of practitioners as is characteristic of other life history research approaches using narrative inquiry (Dhunpath & Samuel, 2009), but also to hone in on one specific dimension of their clinical practice. This was the negotiation and choices of communicative strategies when working with diverse clients in diverse settings. It was revealed that it was not just the selections of communicative



strategies that they made, but how these selections came to define their understanding of themselves, the profession and their professional education.

### **9.5.2 Contextual interests**

To the researcher's knowledge, a study of this nature has not been explored in the field of speech-language therapy, especially in South Africa previously. There have been studies conducted on doctor–patient relationships and the communication used during these interactions. Previous studies in the SA context have foregrounded communication as a competence (Beecham, 2002; Kathard, 2003; Pillay, 2003b). Contextually within the field, the current study was novel. Previously, much research focus has been on the influence on service delivery in healthcare when there is a mismatch in language and culture between the practitioner and the client in post-apartheid and post-colonial South Africa largely due to the rich linguistic and cultural diversity of the country (Mophosho, 2016; Penn et al., 2009). However, the current research found that when the linguistic and cultural differences are removed from the clinical engagement, other problematics arise, such as dissonance between personal and professional selves, contextual issues and affective factors.

### **9.5.3 Theoretical interests**

The term 'clinical engagement' has been defined for the purpose of this study (see section 2.3.2) and has been used to frame the interaction between the practitioner and the client. This interaction presents with the common challenges of incongruence between the therapist and the clients in terms of language, race and culture. This raises the issue of whether the initial professional education has provided adequate resources and ways of thinking for dealing with inter-cultural collaboration. The presence of people of different racial and cultural groups in single institutions does not necessarily mean that the space is activating 'inter-cultural collaboration'. Inter-cultural collaboration could be sensitising the people to the nuances of interacting with diversity; however, in a professional sense, interaction and collaboration take on different meanings, with collaboration being a deeper conception than interaction. In clinical engagement, collaboration is necessary for successful outcomes for the client and the practitioner. It would be interesting to explore the multicultural spaces in HEIs that foster inter-cultural collaboration. Further, the data has elucidated the point that the negotiation of communication strategies at the heart of clinical engagement is

laced with complexities that go beyond language, race and culture. It has been revealed that when there is incongruence between one's personal and professional selves as well as between context and affective factors, this sets up a process of difficulties negotiating communication in the clinical engagement.

The thesis framework, 'toward a curriculum of resilience', is an extension of the diamond metaphor used to illuminate the discussion of the framework. Resilience is a construct that acknowledges challenges and real-life happenings; yet, there is still progressive movement in being resilient (Martínez-Martí, & Ruch, 2017). Resilience, in this context, also speaks to being adaptable and accommodating in one's context, which extends the discussion of the CAT, presented earlier (see section 2.4.1). In becoming resilient, the student should be encouraged to embrace the diversity of his or her personal self that he or she brings to the professional space instead of feeding into a process of a 'sausage-making factory' striving for hegemonic capitulation to serving the interests of a restricted set of discursive space. This will facilitate the appreciation of a person's cultural capital in creating his or her uniqueness and contribution to the profession in South Africa. Celebrating personal differences could encourage intercultural collaboration, and this could possibly alleviate an impostor syndrome that budding professionals sometimes feel when they are being acculturated into their prospective professions. The impostor syndrome is found where one does not truly believe that newcomers belong in a space that they have chosen. This notion of the impostor syndrome could have had the participants retreating to more 'certain' spaces of practice where they were promoted to independent practice after doing their community service. The comfort zone to which they retreat is one which allows them to offer a service resonant with their own personal imbibed worldviews of what constitutes certain practices, since this afforded them legitimacy as a professional. This legitimacy spans age, gender, language groups and experiences and might be a consequence of the reduced ability of the initial professional education enabling them to deal with uncertain or non-idealised contexts. This does not imply that initial professional education did not provide opportunity for the students; rather, the tools to manage and negotiate the contexts have not been activated. This highlights the difference between interaction (exposure) and collaboration (tools for negotiation).

## **9.6 Section Four: Critical appraisal of the study and implications for clinical practice, the undergraduate training programme and future research**

This section presents the critical appraisal of the study, implications for clinical practice, including the undergraduate training programme in the Discipline of Speech-Language Therapy at UKZN, and future directions for research.

### **9.6.1 Critical appraisal of the study**

This study was the culmination of years of learning about the field of education, specifically higher education and learning about speech-language therapy, and myself as a (qualitative) researcher and academic. I ventured into something new when I embarked on this study; yet, there was something familiar about it as I progressed through the data production and the analysis because some of the data findings were common to what I had experienced as therapist and to what I now see in my lecture room or clinics. Therefore, at the outset, I declare that the findings of this study are based on my own interpretation of the data from my ontological and epistemological view, and could be interpreted differently by another researcher. With that being said, there are other merits. The stories presented journeys, which provided an inner world, which challenges the degrees of confidence that many curriculum designers tend to conceptualise as existing in the profession and in the world of professional education. This study also allowed an insight into the aggregation towards middle-class private practice amongst many of graduating professionals, despite the attempts to offer an alternative exposure to the complex worlds of working class, rural and under-served clinical settings.

The study also reflected that the SLTs in these under-served settings are sometimes understood as not able to intervene appropriately. However, the undervaluing of the profession is perhaps a disconcerting finding, which spans not only the under-served, but also affluent settings, which suggest the profession's inability to offer 'curative solutions'. This serves to undermine its very rationale. But, I have argued that the response is not to give up hope, to capitulate to offerings of semblances of certainty. Instead, I suggest an opening up of more critical discursive dialogues between certainty and uncertainty of clinical practice and of higher education in general. This could help challenge institutions to consolidate pathology rather than attempt to

resolve it as this resolution still works within a curative framing. This study has highlighted the embrace of uncertainty in order to realise resilience.

## **9.6.2 Implications for clinical practice, the undergraduate training programme and future research**

The implications related to clinical practice, undergraduate training and future research are elaborated.

### ***9.6.2.1 Implications for clinical practice***

It is hoped that the positive experiences and challenges that SLTs in the field encounter will help practitioners to reflect critically on their practice and encourage dialogue amongst practitioners formally and informally in spaces such as Department of Health and Department of Education forum meetings and the national congress held annually by SASLHA.

There is a need for policy guiding the interaction between teachers and SLTs in the Department of Education context to ensure effective service delivery to learners. This could also become a formal feature of the SLT pre-service agenda.

There is a need to equip novice SLTs with the skills and resources to function as autonomous professionals upon graduation. Structured support from mentors in the field who are more experienced, professional clubs and frequent meetings to be held to help novice therapists through practice dilemmas are encouraged. In this way, we could create a community of care among our professionals to elevate levels of morale and collegiality.

### ***9.6.2.2 Implications for the undergraduate training programme***

At an undergraduate training level, the curriculum content and focus should be reconsidered in order to prepare SLTs better to cope with complexities and uncertainties during clinical engagement. The participants offered insight into the types of knowledge that they valued, namely practical knowledge and skills (knowledge and skills learnt through clinical tutorials, practicals and real-life examples); methodological knowledge (how to manage information collected); and generic skills (the 'side-effect' of academic work acquired through initial professional education).

The concept of 'professional development' tends to suggest 'certainty' to reaffirm the hegemonic norm of 'professionalism' however this is destabilised when presented with

problematics during the clinical engagement. Problematic integration theory and CanMEDS appear not to have been adequately incorporated into the curriculum to assist the practitioner with the tools to negotiate the complexities, contestations and dynamics during clinical engagement. Thus, the speech-language therapist experience challenges in sustaining their sense of professionalism and hegemonic status. Academics and developers of the curriculum should be cognisant of the feedback from the world of work in the development of graduates in reconceptualising elements of the curriculum. The narratives developed during data production could be used as teaching tools to encourage students to engage critically with the stories in order to explore the negotiation of communication during clinical engagement prior to clinical practice as well as during clinical practice modules. This can be done in peer support groups, which could facilitate problem solving, working in a team and peer learning. The understanding and negotiation of the personal and professional selves could start in this forum to be developed further during clinical practice. The narratives could also be used to conduct CPD workshops with practitioners in the field where practice-related communication strategies can be discussed in a formal and supportive forum with other professionals, thus facilitating peer learning as well. It has been found that there is a need for education and research to support service development and understanding of the role of SLT in palliative care populations (O'Reilly & Walshe, 2015).

### ***9.6.2.3 Implications for future research***

As this was a case study of UKZN (a historically black university, formerly the University of Durban-Westville) graduates, it will be worthwhile to explore whether similar concerns and experiences resonate with graduates from other universities in South Africa, specifically other historically disadvantaged university but also historically privileged universities.

It may also be worthwhile to explore the negotiation of clinical engagement used with other healthcare professionals such as medicine, nursing and rehabilitation professionals and the strategies that are used to resolve matters to realise professional resilience.

The life histories of students entering higher education using the framework of the curriculum of resilience could be gathered, whereby the negotiation between their personal and professional selves could also be explored.

The use of narrative research as an alternative modality of documenting and expressing participants' perspectives in the field of higher education needs further exploration. Narrative development is considered an alternative form of expression from the conventional forms of data representation, such as interview transcripts or focus group discussions.

### **9.7 Limitations of this study**

While this study has generated insight into the strategies that participating SLTs had to negotiate in clinical engagement, the study is not without its shortcomings. I acknowledge that, although certain methodological decisions were taken with substantiation, these did constrain the study in some ways. The choice of videoing the observations of the participants and their clients was intended to facilitate the stimulated recall interviews. The presence of the camera however impeded the interaction of the participant and the client in certain instances where some of the interaction appeared to be contrived. The follow-up (stimulated recall) post-observation interviews provided an opportunity to address these instances, as the participants were encouraged to provide examples of interaction to elucidate their points.

The video recording of the clinical engagement only captured the clinical engagement that occurred in the therapy room or SLT's office and not the other milieus in which they work, as it was not logistically possible to transport the video equipment around. I however did explore the work environment of the participants and made notes in my research journal.

The study did not explore whether the participants' communication strategies led to improved communication outcomes for their clients, but instead explored how the participants negotiated their communication in practice, while reflecting on their initial professional education.

Like my participants, I too traversed between my personal and professional self; hence, my analysis of the data and my interpretation of it are based on my world views and my paradigmatic orientation. It is understandable that if the data were presented

to someone from a different background, the interpretation might have been quite different.

## **9.8 Concluding thoughts**

This study has sought to theorise the communication strategies that SLTs negotiated during clinical engagement and has argued that the focus should be on acknowledging the interaction of the personal and professional selves when negotiating communication. Whilst recognising the interconnectedness of policy frameworks, competency development in the curriculum and practice realities in the clinical context, this study argued for initial professional education to be informed by a sound valuing of the personal self that students bring with them into the profession. The curriculum needs to include activities that activate the deep understanding of the students' personal self in order to realise their professional identity, thereby addressing the incongruent affective factors that are realised when there is dissonance between their professional and personal selves. Professional development must incorporate the holistic understanding of the SLT as the whole person who is the provider of the intervention. Hence, the personal self is not devoid of the process. Speech-language therapy is about providing comprehensive care to populations requiring intervention to improve their overall quality of life so that they can communicate their wants and needs and engage with people in their environment. Communication is, after all, a basic human right and SLTs have an important role in caring and assisting clients realise their communicative potential. The case study of the Discipline of Speech-Language Therapy at UKZN showed that graduates had strengths and challenges in activating strategies when it came to communication in the clinical engagement. When there is congruence between the professional and personal self, the practitioner tends to operate in a space of certainty. However, when there is incongruence between the professional and personal selves, then practitioners tend to operate in a space of uncertainty. These conceptions were evident in the participants' ability to show care and competence. The study presented a view that there are potentially many aspects of clinical intervention that are destabilising for SLTs because of the uncertainty in providing definite cures and answers to clients and to bring solutions to their communication impairments. This was more strongly noticed with the novice practitioners who had not yet gravitated toward places and contexts of comfort as they were still in their community service placement. This signalled that the participating

SLTs were possibly working within a biomedical model, which has its roots in positivism implying that there is a single truth to an answer. When the SLT is unable to bring this truth to the client, he or she is interpreted by the clients as delegitimising the profession by not being able to be effective in helping them. A process of deprofessionalising could ensue as therapists are interpreted as not being able to offer immediate answers and cures. Dominant curricula need to be reconceptualised with being comfortable with uncertainty in a society looking for quick and easy solutions to communication impairments.

I realise that, while my study has brought about a better understanding of the communication strategies that SLTs negotiate in clinical engagement, it has given rise to new issues as well. Historically, problematics during clinical engagement referred to the linguistic and cultural differences between the practitioner and the client. However, this study has revealed that other affective, personal and professional selves and contextual factors also influence the negotiation of communication strategies. While looking to the reconceptualisation of the curriculum to inculcate the personal selves of future students in the professional education, there has to be cognisance of the strong hegemonic forces of the profession that are still dominant. Therefore, the ethos of the professional training needs to revisit these ideals. Engaging deeply with their personal selves by acknowledging the cultural, social, political and contextual influences in their development of person, while developing their professional selves is a skill that may need to be guided and encouraged in HE spaces. This is especially important in the professional fields of healthcare, whereby the student is assuming a new and often unfamiliar persona of being a professional person and where his or her use of communication demonstrates this development as it is the most outward portrayal of competence. In the negotiation between one's personal and professional self, one may realise the resilience that lies within oneself to achieve one's professional status. It is through one's own communication that competence and professionalism are echoed.



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# Zertifikat Certificat Certificado Certificate

Promouvoir les plus hauts standards éthiques dans la protection des participants à la recherche biomédicale  
Promoting the highest ethical standards in the protection of biomedical research participants



## Certificat de formation - Training Certificate

Ce document atteste que - this document certifies that

### Urisha Naidoo

a complété avec succès - has successfully completed

### Introduction to Research Ethics

du programme de formation TRREE en évaluation éthique de la recherche  
of the TRREE training programme in research ethics evaluation

May 24, 2018  
CID: MjA5IzA5

Professeur Dominique Sprumont  
Coordinateur TRREE Coordinator



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30 September 2015

Ms Urisha Naidoo 200304137  
School of Health Sciences  
Westville Campus

Dear Ms Naidoo

Protocol reference number: HSS/0447/015D

Project title: Communication strategies of Speech-Language Therapist during clinical engagement; A case study of UKZN graduates

**Full Approval – Expedited Application**

In response to your application received on 30 April 2015, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol have been granted **FULL APPROVAL**.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number.

**PLEASE NOTE:** Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

.....  
Dr Shenuka Singh (Chair)  
Humanities & Social Sciences Research Ethics Committee

/pm

Cc Supervisor: Prof MA Samuels & Prof M Pillay  
Cc Academic Leader Research: Professor P Morojele  
Cc School Administrator: Ms T Khumalo

Humanities & Social Sciences Research Ethics Committee

Dr Shenuka Singh (Chair)

Westville Campus, Govan Mbeki Building

Postal Address: Private Bag X54001, Durban 4000

Telephone: +27 (0) 31 260 3587/8350/4567 Facsimile: +27 (0) 31 260 4609 Email: [simbao@ukzn.ac.za](mailto:simbao@ukzn.ac.za) / [stymann@ukzn.ac.za](mailto:stymann@ukzn.ac.za) / [mohunp@ukzn.ac.za](mailto:mohunp@ukzn.ac.za)

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## Request for gatekeeper permission from Department of Health

Date: \_\_\_\_\_

To Department of Health – Head Office Research section

As a PhD student in the School of Education at the University of KwaZulu-Natal, I am conducting a research study titled: Speech-language therapists' negotiation of communication during clinical engagement.

Speech–Language Therapists globally share similar practice issues with other health care professionals with regard to responding to the changing health care landscape and the changing nature of practice as well as seeking to enhance communication in the delivery of care. Communicative competence is regarded as a generic skill for all health practitioners, however as speech-language therapists, communication is more than just a generic soft skill, it is the core skill that is central to a speech-language therapists' work. Therefore, the **purpose of the study** is to determine how speech-language therapists use communication strategies within the workplace during clinical engagement. It is requested that the Department of Health provide gatekeeper permission for the study to be conducted at public hospital sites using Speech-Language Therapists as participants in the study.

### How will the data be collected from the participants?

An interview will be conducted with the Speech-Language Therapists and this will be approximately 1-2 hours in duration. Thereafter the Speech-Language Therapist will be observed during clinical practice with a client of their choosing for approximately 45 minutes. The clinical session will be video recorded to facilitate a stimulated recall interview with the Speech-Language Therapist thereafter. This follow-up (post-observation interview) may be conducted on the same day as the observation or on another day, depending on the Speech-Language Therapist's availability.

### What are the benefits of the study?

The results from the study have the potential to allow us to better understand communication as a graduate competency in the profession of Speech-Language Therapy. This may inadvertently feedback to undergraduate training and teaching. There are no risks to the participants or the hospital concerned.

### Who will receive the results of the study?

The results of the study will be presented in the form of a thesis. All identifiable information from the participants will be kept strictly confidential. The data will be presented in an anonymised manner. A summary of result findings will be forwarded to you upon request.

### Can I withdraw access to my institution?

You may withdraw access at any stage of the research process without any liability or consequence.

***Your signature indicates that you have read the above information, that you have no queries regarding the study and that you consent to the Department of Health facilities being accessed as a data collection site in this study. Kindly return the signed version of this document to [naidoou@ukzn.ac.za](mailto:naidoou@ukzn.ac.za). Should you have any queries, please feel free to email me or contact me on 031 260 7140.*** Further clarification can be obtained from my supervisors, Professor Michael Samuel (Tel) 031 2601859 (Email) [samuelm@ukzn.ac.za](mailto:samuelm@ukzn.ac.za) and Professor Mershen Pillay (Tel) 031 260 8109 (Email) [pillaym1@ukzn.ac.za](mailto:pillaym1@ukzn.ac.za). Should you have

any questions about your participation and your rights in the study you may contact Ms Phume Ximba of UKZN Humanities and Social Sciences Research Ethics Committee at [ximbap@ukzn.ac.za](mailto:ximbap@ukzn.ac.za) or call her at 031 2603587.

Gatekeeper's signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Request for gatekeeper permission from the School Principal

Date: \_\_\_\_\_

To The School Principal

As a PhD student in the School of Education at the University of KwaZulu-Natal, I am conducting a research study titled: Speech-language therapists' negotiation of communication during clinical engagement.

Speech–Language Therapists globally share similar practice issues with other health care professionals with regard to responding to the changing health care landscape and the changing nature of practice as well as seeking to enhance communication in the delivery of care. Communicative competence is regarded as a generic skill for all health practitioners, however as Speech-Language Therapists, communication is more than just a generic soft skill, it is the core skill that is central to a Speech-Language Therapists' work. Therefore, the **purpose of the study** is to determine how Speech-Language Therapists use communication strategies within the workplace during clinical engagement. It is requested that as the school principal, you provide gatekeeper permission for the study to be conducted at the school using the Speech-Language Therapist as a participant in the study.

### **How will the data be collected from the participants?**

An interview will be conducted with the Speech-Language Therapists and this will be approximately 1-2 hours in duration. Thereafter the Speech-Language Therapist will be observed during clinical practice with a client of their choosing for approximately 45 minutes. The clinical session will be video recorded to facilitate a stimulated recall interview with the Speech-Language Therapist thereafter. This follow-up (post-observation interview) may be conducted on the same day as the observation or on another day, depending on the Speech-Language Therapist's availability.

### **What are the benefits of the study?**

The results from the study have the potential to allow us to better understand communication as a graduate competency in the profession of Speech-Language Therapy. This may inadvertently feedback to undergraduate training and teaching. There are no risks to the participant or the school concerned.

### **Who will receive the results of the study?**

The results of the study will be presented in the form of a thesis. All identifiable information from the participants will be kept strictly confidential. The data will be presented in an anonymised manner. A summary of result findings will be forwarded to you upon request.

### **Can I withdraw access to my institution?**

You may withdraw access at any stage of the research process without any liability or consequence.

***Your signature indicates that you have read the above information, that you have no queries regarding the study and that you consent to the school being accessed as a data collection site in this study. Kindly return the signed version of this document to [naidoou@ukzn.ac.za](mailto:naidoou@ukzn.ac.za). Should you have any queries, please feel free to email me or contact me on 031 260 7140. Further clarification can be obtained from my supervisors, Professor Michael Samuel (Tel) 031 2601859 (Email) [samuelm@ukzn.ac.za](mailto:samuelm@ukzn.ac.za) and Professor Mershen Pillay (Tel) 031 260 8109 (Email) [pillaym1@ukzn.ac.za](mailto:pillaym1@ukzn.ac.za). Should you have any questions about your participation and your rights in the study you may contact Ms Phume Ximba of UKZN Humanities and Social Sciences Research Ethics Committee at [ximbap@ukzn.ac.za](mailto:ximbap@ukzn.ac.za) or call her at 031 2603587.***

Gatekeeper's signature: \_\_\_\_\_

Date: \_\_\_\_\_



## Request for gatekeeper permission from the Private Practice Manager

Date: \_\_\_\_\_

To The Practice Manager

As a PhD student in the School of Education at the University of KwaZulu-Natal, I am conducting a research study titled: Speech-language therapists' negotiation of communication during clinical engagement.

Speech–Language Therapists globally share similar practice issues with other health care professionals with regard to responding to the changing health care landscape and the changing nature of practice as well as seeking to enhance communication in the delivery of care. Communicative competence is regarded as a generic skill for all health practitioners, however as speech-language therapists, communication is more than just a generic soft skill, it is the core skill that is central to a speech-language therapists' work. Therefore, the **purpose of the study** is to determine how speech-language therapists use communication strategies within the workplace during clinical engagement. It is requested that you, as the practice manager provide gatekeeper permission for the study to be conducted at the private practice sites using the Speech-Language Therapist as a participant in the study.

### **How will the data be collected from the participants?**

An interview will be conducted with the Speech-Language Therapists and this will be approximately 1-2 hours in duration. Thereafter the Speech-Language Therapist will be observed during clinical practice with a client of their choosing for approximately 45 minutes. The clinical session will be video recorded to facilitate a stimulated recall interview with the Speech-Language Therapist thereafter. This follow-up (post-observation interview) may be conducted on the same day as the observation or on another day, depending on the Speech-Language Therapist's availability.

### **What are the benefits of the study?**

The results from the study have the potential to allow us to better understand communication as a graduate competency in the profession of Speech-Language Therapy. This may inadvertently feedback to undergraduate training and teaching. There are no risks to the participants or the private practice concerned.

### **Who will receive the results of the study?**

The results of the study will be presented in the form of a thesis. All identifiable information from the participants will be kept strictly confidential. The data will be presented in an anonymised manner. A summary of result findings will be forwarded to you upon request.

### **Can I withdraw access to my institution?**

You may withdraw access at any stage of the research process without any liability or consequence.

***Your signature indicates that you have read the above information, that you have no queries regarding the study and that you consent to the practice being accessed as a data collection site in this study. Kindly return the signed version of this document to [naidoou@ukzn.ac.za](mailto:naidoou@ukzn.ac.za). Should you have any queries, please feel free to email me or contact me on 031 260 7140. Further clarification can be obtained from my supervisors, Professor Michael Samuel (Tel) 031 2601859 (Email) [samuelm@ukzn.ac.za](mailto:samuelm@ukzn.ac.za) and Professor Mershen Pillay (Tel) 031 260 8109 (Email) [pillaym1@ukzn.ac.za](mailto:pillaym1@ukzn.ac.za). Should you have any questions about your participation and your rights in the study you may contact Ms Phume Ximba of UKZN Humanities and Social Sciences Research Ethics Committee at [ximbap@ukzn.ac.za](mailto:ximbap@ukzn.ac.za) or call her at 031 2603587.***

Gatekeeper's signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Request for gatekeeper permission from the CEO of hospitals in the Department of Health

Date: \_\_\_\_\_

To the CEO of \_\_\_\_\_ Hospital (Department of Health)

As a PhD student in the School of Education at the University of KwaZulu-Natal, I am conducting a research study titled: Speech-language therapists' negotiation of communication during clinical engagement.

Speech–Language Therapists globally share similar practice issues with other health care professionals with regard to responding to the changing health care landscape and the changing nature of practice as well as seeking to enhance communication in the delivery of care. Communicative competence is regarded as a generic skill for all health practitioners, however as speech-language therapists, communication is more than just a generic soft skill, it is the core skill that is central to a speech-language therapists' work. Therefore, the **purpose of the study** is to determine how speech-language therapists use communication strategies within the workplace during clinical engagement. It is requested that the CEO of the hospital provide gatekeeper permission for the study to be conducted at the hospital site using Speech-Language Therapists as participants in the study.

### **How will the data be collected from the participants?**

An interview will be conducted with the Speech-Language Therapists and this will be approximately 1-2 hours in duration. Thereafter the Speech-Language Therapist will be observed during clinical practice with a client of their choosing for approximately 45 minutes. The clinical session will be video recorded to facilitate a stimulated recall interview with the Speech-Language Therapist thereafter. This follow-up (post-observation interview) may be conducted on the same day as the observation or on another day, depending on the Speech-Language Therapist's availability.

### **What are the benefits of the study?**

The results from the study have the potential to allow us to better understand communication as a graduate competency in the profession of Speech-Language Therapy. This may inadvertently feedback to undergraduate training and teaching. There are no risks to the participants or the hospital concerned.

### **Who will receive the results of the study?**

The results of the study will be presented in the form of a thesis. All identifiable information from the participants will be kept strictly confidential. The data will be presented in an anonymised manner. A summary of result findings will be forwarded to you upon request.

### **Can I withdraw access to my institution?**

You may withdraw access at any stage of the research process without any liability or consequence.

***Your signature indicates that you have read the above information, that you have no queries regarding the study and that you consent to the Department of Health facilities being accessed as a data collection site in this study. Kindly return the signed version of this document to [naidoou@ukzn.ac.za](mailto:naidoou@ukzn.ac.za). Should you have any queries, please feel free to email me or contact me on 031 260 7140.*** Further clarification can be obtained from my supervisors, Professor Michael Samuel (Tel) 031 2601859 (Email) [samuelm@ukzn.ac.za](mailto:samuelm@ukzn.ac.za) and Professor Mershen Pillay (Tel) 031 260 8109 (Email) [pillaym1@ukzn.ac.za](mailto:pillaym1@ukzn.ac.za). Should you have any questions about your participation and your rights in the study you may contact Ms Phume Ximba of UKZN Humanities and Social Sciences Research Ethics Committee at [ximbap@ukzn.ac.za](mailto:ximbap@ukzn.ac.za) or call her at 031 2603587.

Gatekeeper's signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Information document to Speech-Language Therapists

Date: \_\_\_\_\_

Dear Speech-Language Therapist

As a PhD student in the School of Education at the University of KwaZulu-Natal, I am conducting a research study titled: Speech-language therapists' negotiation of communication during clinical engagement.

Speech–Language Therapists globally share similar practice issues with other health care professionals with regard to responding to the changing health care landscape and the changing nature of practice as well as seeking to enhance communication in the delivery of care. Communicative competence is regarded as a generic skill for all health practitioners, however as speech-language therapists, communication is more than just a generic soft skill, it is the core skill that is central to a Speech-Language Therapists' work. Therefore, the **purpose of the study** is to determine how Speech-Language Therapists use communication strategies within the workplace during clinical engagement.

You are being kindly asked for your permission and informed consent to take part in this study.

### How will the data be collected from the participants?

An interview will be conducted with you and this will be approximately 1-2 hours in duration. Thereafter you will be observed during clinical practice with a client of your choosing for approximately 45 minutes. The clinical session will be video recorded to facilitate a stimulated recall interview between you and myself thereafter. This follow-up (post-observation interview) may be conducted on the same day as the observation or on another day, depending on your availability.

### What are the benefits of the study?

The results from the study have the potential to allow us to better understand communication as a graduate competency in the profession of Speech-Language Therapy. This may inadvertently feedback to undergraduate training and teaching. There are no risks to you or your institution concerned.

### Who will receive the results of the study?

The results of the study will be presented in the form of a thesis. All identifiable information from the participants will be kept strictly confidential. The data will be presented in an anonymised manner. A summary of result findings will be forwarded to you upon request.

### Can I withdraw from the study?

You may withdraw access at any stage of the research process without any liability or consequence.

**Please complete the section that follows to either consent or not to participate in this study by ticking the relevant boxes to the corresponding statements:**

- I understand that I can withdraw my consent in this study.

- I voluntarily consent to the researcher observing the clinical session.
- I understand what this study is about and why it is being done.
- I consent to the sessions being audio recorded.
- I consent to the sessions being video recorded.

***Your signature indicates that you have read the above information, that you have no queries regarding the study and that you consent to the Department of Health facilities being accessed as a data collection site in this study. Kindly return the signed version of this document to [naidoou@ukzn.ac.za](mailto:naidoou@ukzn.ac.za). Should you have any queries, please feel free to email me or contact me on 031 260 7140.*** Further clarification can be obtained from my supervisors, Professor Michael Samuel (Tel) 031 2601859 (Email) [samuelm@ukzn.ac.za](mailto:samuelm@ukzn.ac.za) and Professor Mershen Pillay (Tel) 031 260 8109 (Email) [pillaym1@ukzn.ac.za](mailto:pillaym1@ukzn.ac.za). Should you have any questions about your participation and your rights in the study you may contact Ms Phume Ximba of UKZN Humanities and Social Sciences Research Ethics Committee at [ximbap@ukzn.ac.za](mailto:ximbap@ukzn.ac.za) or call her at 031 2603587.

Speech-Language Therapist's signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Informed consent form for adult clients

Dear Client

I am Urisha Naidoo, a PhD student from the School of Education at the University of KwaZulu-Natal. The **purpose of the study** is to explore how Speech-Language Therapists use communication strategies within the workplace during clinical engagement with their clients.

### **How will the data be collected from the participants?**

I am interested in undertaking observations of the clinical engagement between the speech-language therapist and you, the client. The clinical sessions will be video and audio recorded. The observation will take place in the usual institution that you attend. Gatekeeper's permission has been sought from the Department of Health and the hospital manager.

You are being kindly asked for your permission for information to be collected during the speech-language therapy session where you are the client. With both you and the speech-language therapist's permission, I will install a video camera to capture the session. The session will also be audio recorded.

### **Who will receive the results of the study?**

The results of the study will be presented in the form of a thesis. All identifiable information will be kept strictly confidential. The data will be presented in an anonymised manner. Your name will be replaced with a number and it will not be possible for you to be identified at any stage of reporting the data gathered. At the end of this study, a summary of key results will be given to you, if requested.

I am interested in undertaking observations of the clinical engagement between the speech-language therapist and the client. The clinical sessions will be video recorded. The observation will take place in the usual institution that you attend. Gatekeeper's permission has been sought from the Department of Health/the hospital/practice manager.

I will explain what I will be doing in the session and will answer any questions that you may have.

### **What are the benefits of the study?**

The results from the study have the potential to allow us in Higher Education as well as in the profession of Speech-Language Pathology to better understand communication as a graduate competence in Speech-Language Therapy. This may inadvertently feedback to undergraduate training and teaching. There are no risks to you.

### **Can I withdraw from the study?**

Taking part in this study is completely your choice. You may withdraw at any time without any consequence. You can stop the recording at any time once it is started without any effect on your care.

**Please complete the section that follows to either consent or not to participate in this study by ticking the relevant boxes to the corresponding statements:**

- I understand that I can withdraw my consent in this study.
- I understand what this study is about and why it is being done.
- I consent to the sessions being audio recorded.
- I consent to the sessions being video recorded.

Client's signature: \_\_\_\_\_ Date: \_\_\_\_\_

***Your signature indicates that you have read the above information, that you have no queries regarding the study and that you consent to the Department of Health facilities being accessed as a data collection site in this study. Kindly return the signed version of this document to [naidoou@ukzn.ac.za](mailto:naidoou@ukzn.ac.za). Should you have any queries, please feel free to email me or contact me on 031 260 7140.*** Further clarification can be obtained from my supervisors, Professor Michael Samuel (Tel) 031 2601859 (Email) [samuelm@ukzn.ac.za](mailto:samuelm@ukzn.ac.za) and Professor Mershen Pillay (Tel) 031 260 8109 (Email) [pillaym1@ukzn.ac.za](mailto:pillaym1@ukzn.ac.za). Should you have any questions about your participation and your rights in the study you may contact Ms Phumelele Ximba of UKZN Humanities and Social Sciences Research Ethics Committee at [ximbap@ukzn.ac.za](mailto:ximbap@ukzn.ac.za) or call her at 031 2603587.

**In anticipation, thank you very much for your help.**



## Declaration of consent from the caregiver or parent form

Dear Parent/Caregiver/Guardian

I am Urisha Naidoo, a PhD student from the School of Education at the University of KwaZulu-Natal. The **purpose of the study** is to explore how Speech-Language Therapists use communication strategies within the workplace during clinical engagement with their clients.

**The purpose of the study** will therefore to contribute to development of communicative competences of graduates as this is the nature of a Speech-Language Therapist's work and feedback to undergraduate curriculum in Speech-Language Pathology.

### How will the data be collected from the participants?

I am interested in undertaking observations of the clinical engagement between the speech-language therapist and the client. The clinical sessions will be video and audio recorded. The observation will take place in the usual institution that you attend. Gatekeeper's permission has been sought from the Department of Health/Education and the hospital/practice manager/school principal.

You are being kindly asked for your permission for information to be collected during the speech-language therapy session where your child/your relative/ward is the client. With both you and your speech-language therapist's permission, I will video and audio record the session.

### Who will receive the results of the study?

The results of the study will be presented in the form of a thesis. All identifiable information will be kept strictly confidential. The data will be presented in an anonymised manner. Your child's/relative's name will be replaced with a number and it will not be possible for it to be identified at any stage of reporting the data gathered. At the end of this study, a summary of key results will be given to you, if requested.

### What are the benefits of the study?

The results from the study have the potential to allow us in Higher Education as well as in the profession of Speech-Language Pathology to better understand communication as a graduate competence in Speech-Language Therapy. This may inadvertently feedback to undergraduate training and teaching. There are no risks to the client involved.

### Can I withdraw from the study?

Taking part in this study is completely your choice. You may withdraw at any time without any consequence. You can stop the recording at any time once it is started without any effect on your care.

(Please turn to page 2)

**Please complete the section that follows to either consent or not to participate in this study by ticking the relevant boxes to the corresponding statements:**

- I understand that I can withdraw my consent in this study.
- I understand what this study is about and why it is being done.
- I consent to the sessions being audio recorded.
- I consent to the sessions being video recorded.

Parent's/relative's signature: \_\_\_\_\_ Date: \_\_\_\_\_

***Your signature indicates that you have read the above information, that you have no queries regarding the study and that you consent to the Department of Health facilities being accessed as a data collection site in this study. Kindly return the signed version of this document to [naidoou@ukzn.ac.za](mailto:naidoou@ukzn.ac.za). Should you have any queries, please feel free to email me or contact me on 031 260 7140.*** Further clarification can be obtained from my supervisors, Professor Michael Samuel (Tel) 031 2601859 (Email) [samuelm@ukzn.ac.za](mailto:samuelm@ukzn.ac.za) and Professor Mershen Pillay (Tel) 031 260 8109 (Email) [pillaym1@ukzn.ac.za](mailto:pillaym1@ukzn.ac.za). Should you have any questions about your participation and your rights in the study you may contact Ms Phumelele Ximba of UKZN Humanities and Social Sciences Research Ethics Committee at [ximbap@ukzn.ac.za](mailto:ximbap@ukzn.ac.za) or call her at 031 2603587.

***Kindly return the signed version of this document to [naidoou@ukzn.ac.za](mailto:naidoou@ukzn.ac.za).  
Alternatively you may hand this document over to me, in person.***

**In anticipation, thank you very much for your help.**

## VERBAL ASSENT SCRIPT FOR THE PAEDIATRIC PATIENT

Hi. My name is Urisha Naidoo and I am a student at the University of KwaZulu-Natal. Right now, I'm trying to learn about how Speech-Language Therapists (SLTs) communicate/talk with/to the children that they work with. I would like to ask you to help me by allowing me to watch your session but first I want to explain what will happen if you decide to help me.

You and the Speech-Language Therapist (insert name for familiarity) will play games during therapy and I will sit in this corner and watch what is happening. Please remember that I am not watching you, I am only watching (insert the SLT's name). There will be a video camera and this is just to help me remember all that has happened.

When I talk to other people about my study, I will not use your name, and no one will be able to know who I'm talking about.

Your (mum/dad/grandmother) said that it is okay for me to watch your therapy session with (insert SLT's name). But if you don't want me to be here, I can leave. I won't be upset, and no one else will be upset with you if you don't want me to be in your therapy session. If you want to be in the session now but you change your mind later, that's also okay. You can stop me at any time and let me know. If there is anything you don't understand you, should tell me so I can explain it to you.

Do you have any questions for me now?

Is it okay for me to watch your therapy session?

Is it okay for me to audio record your therapy session

Is it okay for me to video record your therapy session?

**NOTE:** The patient child should answer with a definite "Yes" or "No." If a definite "Yes" is obtained then this will be taken as assent to participate.

**Name of Child:** \_\_\_\_\_

**Parental Permission obtained:** Yes No

*(If "No," do not proceed with assent or research procedures.)*

**Child's Voluntary Response to Participation:** Yes No

Signature of Researcher: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_\_

(Optional) Signature of Child: \_\_\_\_\_

**PRE-OBSERVATION INTERVIEW SCHEDULE:  
Speech-language therapists' negotiation of communication during clinical  
engagement**

**Opening and establish rapport:** (Greeting) (participant's name). My name is Urisha Naidoo and I am a PhD student in the School of Education at UKZN. I am conducting a research study on speech-language therapists' negotiation of communication during clinical engagement.

As a/an newly qualified/experienced Speech-Language Therapist, you may be able to best provide insight to this issue.

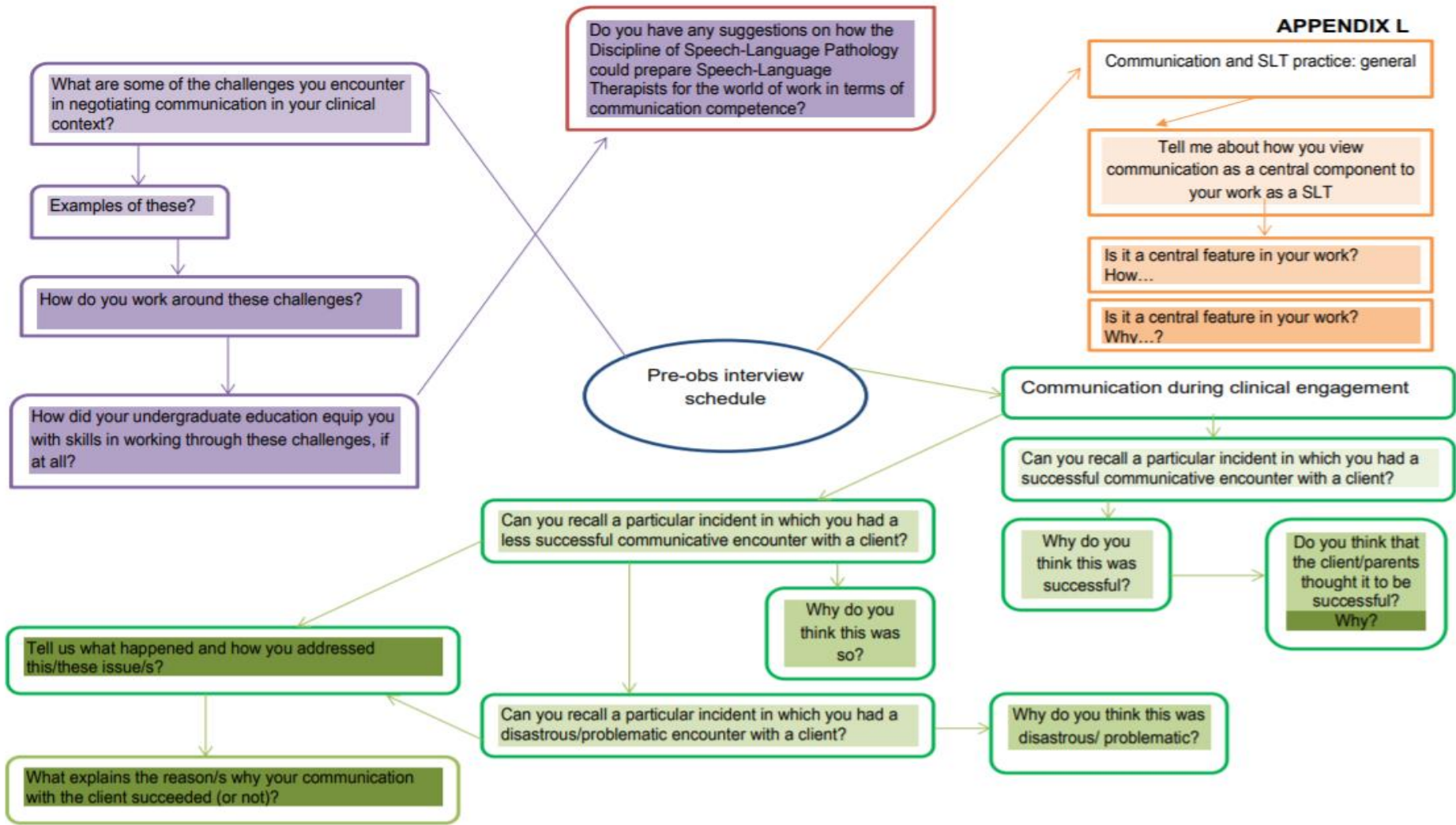
**Purpose:**

The purpose of this interview is to explore with you what you consider to be the challenges/opportunities facing you as a newly qualified SLT especially when it comes to issues of communication.

**Time line:** The interview will take approximately one hour.

1. Provide examples where there may be situations of communication differences between you and your clients?
  - 1.1 If so, describe how do you work around these?
2. Tell me about how you view communication as a central component to your work as a Speech-Language Therapist.
  - 2.1 Is it a central feature in your work?
  - 2.2 How... ?
  - 2.3 Why... ?
3. Can you recall a particular incident in which you had a successful communicative encounter with a client?
4. Can you recall a particular incident in which you had a less successful encounter with a client?
5. Can you recall a particular incident in which you had a disastrous encounter with a client?
6. Can you recall a particular incident in which you had a problematic encounter with a client?
7. Tell us what happened and how you addressed this/these issue/s?
8. What explains the reason/s why your communication with the client succeeded (or not)?
9. What are some of the challenges you encounter in negotiating communication in your clinical context?
10. Do you have any suggestions on how the Discipline of Speech-Language Therapy can prepare Speech-Language Therapists for the world of work in terms of communication competence?

**APPENDIX L**



## ZANDI PRE OBS INTERVIEW TRANSCRIPT

- I: OK, WE'RE GOING TO START THE INTERVIEW. SO ZA (SAID FULL NAME IN THE INTERVIEW) MY RESEARCH IS ON THE COMMUNICATION STRATEGIES THAT SPEECH LANGUAGE THERAPISTS USE IN THEIR WORLD OF WORK, SO WHEN THEY'RE WORKING WITH PATIENTS. SO I JUST WANT TO GET IS YOUR PERSPECTIVE ON HOW THIS HAPPENS FOR YOU AS A SPEECH THERAPIST WORKING IN A PUBLIC HOSPITAL. YOUR HOSPITAL IS QUITE DIFFERENT FROM OTHER HOSPITALS BECAUSE IT'S A LONG TERM CARE FACILITY AS WELL. SO HOW DO YOU THINK COMMUNICATION PLAYS A ROLE IN A SPEECH LANGUAGE THERAPIST'S WORK?... HOW IMPORTANT DO YOU THINK COMMUNICATION IS, LIKE YOUR COMMUNICATION WITH THE PATIENT?
- P: I think as a speech therapist, communication is the centre of whatever it is you do with the patient (hand gestures - illustrators). So it's very, very important for you to have communication strategies that are (umm) I would say suitable for your patient at that time where... and the environment that you work in, so I'd say communication is very important on speech therapy job... part of your job as a speech therapist.
- I: CAN YOU TELL ME MORE ON HOW YOU USE COMMUNICATION IN YOUR WORK? (background noise) SO JUST TO REPEAT, CAN YOU TELL ME HOW YOU USE COMMUNICATION IN YOUR WORK?
- P: Ok, so if you, if you say how I use communication like can you explain?
- I: WHAT ARE THE TYPES OF COMMUNICATION STRATEGIES THAT YOU USE? HOW DO YOU KNOW WHAT TYPE OF COMMUNICATION STRATEGY YOU NEED TO USE FOR THE PARTICULAR CLIENT? THINGS LIKE THAT, LIKE WHAT'S YOUR TOOLS ALMOST THAT YOU USE WITH YOUR PATIENTS?
- P: Ok so ok, let's say it depends on the type of patient that I'm seeing at that time. Let's say if it's a paediatric patient it's going to be different from an adult patient. Because maybe with an adult patient you... based on your assessment you'll see whether the patient will understand more of spoken language or if you have to supplement it by writing stuff for the patient or even using gestures for the patient. I'm not too sure if that's what you were...
- I: YES.
- P: Yes, ok. So maybe for paediatric patients<sup>40</sup> you'd find that you'd have to use a lot of visuals<sup>41</sup> for the patients instead of verbal communication or written communication. So most of my patients are that I see... most of my adult patients you find that most of them won't understand, like if you speak to them like how I'm speaking to you now, because of different disorders; aphasia<sup>42</sup>, or whatever. You find that for some of them you have to like... we even have a deaf patient in the ward now, so we have to use a lot of writing and a lot of signing<sup>43</sup> with the patient.
- I: AND IF THEY HAVE A PROBLEM WITH UNDERSTANDING, HOW DO YOU WORK WITH OR AROUND THAT?

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<sup>40</sup> Paediatric patients – patients under the age of 14 years old.

<sup>41</sup> Visuals refer to stimuli used in a session such as pictures and other visual cues (e.g. gestures)

<sup>42</sup> Benson (1979, p. 5) defined aphasia as “. . . the loss or impairment of language caused by brain damage’ (cited in McNeil & Pratt, 2001).

<sup>43</sup> Signing – refers to the use sign language.

P: Ok so it would have a lot to do with your simplifying of your own language. Maybe instead of using sentences you can use single words, and supplement it with cues and gestures for your patient, it could make it easier for that patient to understand.

I: YOU WORK IN A REHAB TEAM AND BEING A SPEECH THERAPIST YOU DON'T HAVE MACHINES AND EXERCISES LIKE THE PHYSICAL EXERCISES LIKE THE OTs<sup>44</sup> USE AND THE AND THE PHYSIOS<sup>45</sup> DO. EVEN FOR THE DOCTORS THEMSELVES, YOU KNOW, THEY EXAMINE THE PATIENT AND THEN THEY GIVE THEM THE MEDICATION. NOW A SPEECH THERAPIST'S THERAPY INVOLVES TALKING...

P: Yes.

I: CAN YOU TELL ME HOW YOU FEEL ABOUT THAT AS A SPEECH THERAPIST? ARE THERE GOOD POINTS ABOUT THAT, AND THEN ARE THERE CHALLENGES AROUND THIS FOR YOU?

P: I feel that it has a lot of negatives.

I: YES?

P: (Short laughter). Because it's almost like it's expected of you to make a difference in this patient's life or in their communication. And it feels like it all depends on the patient. You feel like you have no control of it. Because if the physio can do passive movements<sup>46</sup>, at least they've done something to help their patient. If you get there and you greet the patient and the patient is just staring at you know, they are not showing any kind indication that they understand anything that you're saying. You feel like... you're demotivated as well... So you feel like you're not really doing anything to help the patient. But you know you're doing something but you feel like other people are looking at you and they just see you there... Trying to greet the patient and showing the patient pictures or trying to get the patient to follow some instruction, but then it's not really happening. Yes. On the positives... (long pause) well really I don't see any positives.... I feel like it just demotivates you, the fact that you... mostly I feel like I can't do anything about this patient. Until you can see that the patient is responding to whatever you are trying to do.

I: HOW WOULD THE PATIENT TYPICALLY RESPOND?

P: Even if it's like... if you're greeting the patient they turn and look at you, even if they don't say hello back or anything, they show that they're interested in whatever you're doing but it's just that they can't do anything; they can't respond. Even if it's just you asking them a yes/no question and they say yes for everything and you know that they're saying that because they don't understand and not because they're not interested.

I: YOU MENTIONED THAT YOU GET DEMOTIVATED, HOW DO YOU COPE WITH THAT DEMOTIVATION? WHAT DO YOU DO TO KEEP MOTIVATED?

P: Well you can motivate yourself by telling yourself that it's your job, it has to be done. So you have to go back and see that patient maybe the following day it would be better. Maybe that patient is just tired, because they'd just had their physio session<sup>47</sup>. So maybe tomorrow it's going to be better, so... And most of the times it does get better. When you go back the next time you find maybe the patient was upset because the doctor was not saying anything about discharging them. So that's why they were upset, but the following day it's getting better and they're responding or they are looking at you at least.

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<sup>44</sup> OTs – occupational therapists

<sup>45</sup> Physios - physiotherapists

<sup>46</sup> Passive movements: a physiotherapist moves the joint through the range of motion with no effort from the patient.

<sup>47</sup> Physio session – physiotherapy session

- I: WITH MOST OF THE PATIENTS THAT YOU SEE HERE.. DO YOU SEE THEM HAVING MORE COMMUNICATION DIFFICULTIES THAN THEY DO PHYSICAL DIFFICULTIES?
- P: Yes, a lot, a lot. In the medical wards I'd say, because we have surgical wards and then more in the physical ward that have communication problems, but then in the medical wards where you'd find a lot of the CVA<sup>48</sup> patients. So most of them... like more than 50% of them will have communication difficulties and they'd be referred to a speech therapist. So it's... I see more communication difficulties than... sometimes it's both. Its physical and communication but they find that the communication is more impaired than the physical.
- I: SO WE SPOKE ABOUT THE STRATEGIES THAT YOU USE AND HOW YOU WOULD KNOW IF YOUR PATIENT IS ENGAGING WITH YOU. SO ON THAT NOTE CAN YOU THINK OF A SUCCESSFUL COMMUNICATIVE ENCOUNTER THAT YOU'VE HAD WITH A PATIENT, WHERE YOU FELT THIS IS WHY I'M A SPEECH THERAPIST AND I USE COMMUNICATION TO MAKE COMMUNICATION BETTER FOR THIS PATIENT. CAN YOU THINK BACK TO SOMETHING?
- P: I had a patient that... this is the patient that I was actually planning to bring but he got discharged. This patient was a highly demotivated patient. This patient was just not talking to anyone in the ward you know. And then when we got here I explained to the patient that this is what I do. I'm a speech therapist, I help people communicate. I explained my role and then I explained to the patient... because I was seeing that this patient was limiting himself. He had a lot more potential and he was not doing anything. And then I explained to the patient how important it is for people... for other people to know that you can communicate with other people. To know that if we discharge you home, you'll be able to communicate your needs with other people. So I sat the patient down and I explained to him that he needed to do more than he was doing. And then I took out all my pictures and then we started trying... I gave him single words<sup>49</sup> and we... he started... I was seeing the patient was getting motivated a bit. He could see that he could do things, I think he also didn't think that he could do it. Yes so...
- I: SO YOU THINK HE NEEDED COUNSELLING?
- P: He needed more, yes he needed more counselling than anything else. So we were trying. The bedside screener<sup>50</sup> that we were doing, he actually passed the screener. The patient passed the screener and no one knew that he was even talking. The patient would just keep quiet and would not say anything.
- I: WAS HE POSSIBLY DEPRESSED BY WHAT HAPPENED?
- P: He was, because he then... when we were finished with the single words and we moved on to sentences and stuff, and he was doing them, started crying. Yes so it was a really good experience for me, yes. So when we went to the ward, I said to him that he needed to communicate with the other patients, to communicate with the nurses so they know that he can do it. Because the doctor was just waiting for him to be able to do something, say something, at least so that she can discharge him home. Yes and then he started talking in the ward. Whenever I came to the ward he'd wave at me, and call me... it was such a nice experience.
- I: THAT IS NICE. DID THIS PARTICULAR PATIENT HAVE FAMILY THAT WOULD COME AND VISIT HIM?
- P: Yes he had. But he had a girlfriend and a child. I don't think they, that part of his family was coming, but his mother and his sisters and everything were coming to visit him.

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<sup>48</sup> CVA – cerebral vascular accident, i.e. stroke

<sup>49</sup> Single words – speech therapy targets where single word productions are expected from the patient.

<sup>50</sup> Bedside screener – a screening assessment done at the patient's bedside to determine whether the patient presents with communication and/or swallowing problems. Based on a pass or fail criteria.



- I: OK AND DO YOU KNOW IF HE WOULD COMMUNICATE WITH THEM?
- P: No, he wouldn't. The family was also so worried about him because he was just so not motivated about everything.
- I: AND SO, YOU KNOW, I JUST WANT TO EXPLORE THIS A LITTLE BIT MORE BECAUSE ALL IT TOOK WAS YOU IDENTIFYING THAT THIS CLIENT NEEDED A LITTLE BIT MORE MOTIVATION. HE NEEDED TO HEAR FROM SOMEONE THAT HE CAN DO IT. DO YOU THINK THAT SPEECH THERAPISTS HAVE MORE OF A ROLE IN COUNSELLING, IN USING THE COMMUNICATION TO COUNSEL PATIENTS, SO THAT THEY FEEL MORE MOTIVATED?
- P: Yes I think we do. I think we have that role... a lot to do with counselling and... especially for patients with communication impairments, because we know how to simplify our language so that the patient understands it. Because you can go on and on counselling and the patient don't understand you, it's almost pointless. So even using pictures or things like that to just motivate the patient and see if they understand. Because most of them will start talking and then you can see that they understand what you're saying, trying to motivate them, and they just break down and they start crying. You can see that they've been bottling this up and they just don't know what to do. So I feel like as speech therapists we have a lot of... we have a role to play in counselling.
- I: YOU KNOW YOU MENTIONED SOME OF THE STRATEGIES THAT YOU USE IN YOUR COUNSELLING, LIKE SIMPLIFYING YOUR LANGUAGE, USING PICTURES... DO YOU FIND THAT YOUR PATIENTS RESPOND WELL TO THAT?
- P: Yes I do think ... especially simplifying... you'd say something first like how I'm talking to you right now, when you see that they're lost, and then you start maybe saying it in single words or phrases and then you start seeing that ok they're starting to follow. And then as soon as they start following you know now this is the level that they... this is the level of language that I should be using with the patient. And then if you'd find that your conversation, as much as it's like simplified with words and phrases, but you're getting each other, you understand each other.
- I: AND THAT'S VERY EMPOWERING FOR YOU AND FOR THE PATIENT BECAUSE YOU'RE CONNECTING...
- P: Yes
- I: AT THAT LEVEL?
- P: Yes
- I: SO PERHAPS THAT COULD ALSO BE SOMETHING THAT'S KEEPING YOU MOTIVATED, YOU KNOW TO MAKE A DIFFERENCE.
- P: Make a difference, yes.
- I: SO ZA TELL ME WHERE DID YOU LEARN HOW TO SIMPLIFY YOUR LANGUAGE TO THE LEVEL OF THE PATIENTS? IS IT SOMETHING THAT WAS TAUGHT TO YOU?
- P: No. I think it's just a skill that you pick up along the way. You feel that there is a need for you.
- I: WHERE DID YOU LEARN HOW TO COUNSEL PATIENTS?
- P: In as much as you know that it's a role of a counselling psychologist or a social worker, but I feel like every member of the team, be it a doctor or whoever, the medical team, we should all have a skill, even if it's a basic skill in counselling. Because if your patient is breaking down now, what are you going to do? You're not going to write a referral, 'go to the psychologist'.

- I: YES
- P: You have to say something to motivate the patient. So I feel like it's a skill that you pick up along the way. Most of us it's not taught at varsity or anything, so you learn and do just as you go.
- I: SO YOU'RE NOT TAUGHT COMMUNICATION FOR COUNSELLING OR COMMUNICATION FOR MOTIVATING PATIENTS?
- P: Yes. You are taught this is how you conduct therapy 1, 2 and 3. You're not taught if the patient starts crying then what do you do. You can't just go on like 'we need to finish these aims or activities<sup>51</sup> now' you know.
- I: YES, BECAUSE THAT WOULD SEEM LIKE YOU'RE COLD AND DISCONNECTED?
- P: Yes. You have to move away from your therapy and then get into whatever is bothering the patient and get back to whatever you were doing.
- I: YOU RAISED A VERY GOOD POINT THERE BECAUSE IF YOU DON'T GET TO THAT ISSUE THEN IT DOESN'T MATTER WHAT THERAPY TECHNIQUES YOU'RE USING.
- P: Yes, your session, it's not going to happen.
- I: YES
- P: Yes, it's like when they're trying to tell you something. You can see they're trying to tell you something until you find what it is that they're trying to tell you, your session is not going to go forward. You have to find whatever it is they're trying to tell you.
- I: AND IT'S LIKE THIS BUY-IN TO THERAPY. SO YOU KNOW THE PATIENT HAS THIS IMPORTANT SOMETHING TO TELL YOU, AND YOU'VE GOT TO LISTEN AND UNDERSTAND IT.
- P: Yes, then they will be more willing to say more to you, yes. Yes, because these other people don't understand, maybe try, they try to say to the nurse and the nurse just disregarded them and then when you come, and they see that you understand 'oh this person understands or I can say more to this person. I can respond to this person's questions because they understand me.
- I: I AGREE WITH YOU THAT LISTENING AND COUNSELLING ARE VERY VALUABLE THERAPY TOOLS, BECAUSE IT'S STILL COMMUNICATION TO HELP THE PATIENT'S OVERALL COMMUNICATION AND YOU KNOW IT SHOULD GO HAND-IN-HAND WITH THE OTHER THERAPY THAT IS PLANNED. LET US FLIP IT, RIGHT. SO THAT WAS A SUCCESSFUL ENCOUNTER THAT YOU'VE HAD. CAN YOU THINK OF A SITUATION WHERE YOU HAD A PROBLEMATIC OR A CHALLENGING ENCOUNTER? WHERE YOU FOUND USING YOUR COMMUNICATION WAS DIFFICULT?
- P: Well I can think back. We went to an old age home and I had a patient that was just out there... Globally aphasic<sup>52</sup>... and I had to get all of these things out of the patient for my assessments. And I felt like whatever it is that I did, the patient was either not understanding me or the patient just didn't want to do what I would ask. I would try to get the patient to do the OPE<sup>53</sup>. I tried for the patient to copy me, showed the patient to 'do this, do that'. Showed the patient you know the very basic things. And I was doing it at the simplest level, showing the patient this is what... I even called one of my colleagues to come and help me. I would show... I would demonstrate for the patient what it is that I was expecting them to do but the patient did not do, 'cause I remember crying after my session. I was like 'maybe this patient hates me' because... but then when I spoke to the nurses they said, you know, she just

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<sup>51</sup> Aims and activities – specific speech therapy aims and activities that have been planned for the session.

<sup>52</sup> Globally aphasic – type of aphasia that a patient may present with. If a patient is globally aphasic this means that all areas of language functioning are impaired, i.e. comprehension, spoken language, reading and writing.

<sup>53</sup> OPE – oral peripheral examination – a speech therapy assessment procedure conducted to examine the structure and functioning of the oral mechanism.

doesn't do anything. But then back then I didn't understand. I expected that when you get to someone you will greet them then, even if they can't say hello, but they would nod their head or something. But this patient was just not doing anything. Even those nurses, even her relatives would say the same thing, she's not responsive and there was nothing they could do. And the patient later on passed on.

I: YES SO EVEN COUNSELLING IN THAT CASE WOULDN'T HAVE WORKED?

P: No, it didn't work. I even tried to find out from the family the things that interested the patient. Her child spoke about TV programmes that she said she used like, but she was just wasn't responding.

I: SO THAT PATIENT COULD HAVE BEEN A CHALLENGING PATIENT FOR YOU?

P: Yes, yes, especially at that time.

I: YES. SO AND THEN DID YOU FEEL A LITTLE BIT DEMOTIVATED?

P: Demotivated, because that was the patient I couldn't even get past OPE. So everything else afterwards started...

I: SO DID YOU HAVE TO GIVE FEEDBACK TO THE FAMILY?

P: Yes but it was a long term patient facility so then we didn't get to speak to the family immediately. We were lucky that we got there once when the family was there, so we spoke to them about that... the communication impairment.

I: FOR YOUR JOB HERE AT THE HOSPITAL ARE THERE ANY OTHER CHALLENGES THAT YOU EXPERIENCE ON A DAY TO DAY BASIS WITH PATIENTS AND USING COMMUNICATION? WHAT ARE THE CHALLENGES THAT YOU HAVE BEING A SPEECH THERAPIST IN A LONG-TERM CARE FACILITY?

P: It is challenging. You find that most of the patients are old, because they come from other hospitals so they come in here for... they say they come in here for rehab. So it's like this patient has been sitting with a CVA for a year and they've never been rehabilitated. So the progress is slow. So you find that (clears throat) they... you feel like sometimes they're not even candidates for rehab anymore, but you still have to do something because you're expected to do something. So you'll find that even they are not motivated enough like that part, the motivation, it also plays a huge role in terms of patients being motivated to do whatever it is that you ask them to do. Some patients will see a need to exercise their arm, but if you come and show them whatever it is that they have to do with their tongue, they'd be like they're like 'why do I need to do that?' you know, and they don't. They won't do it, so we put like, I used to do this ward exercise programme and gave it to them. For patients that could understand like those who had a dysarthria<sup>54</sup> could do their exercise... I do their exercises with them. And when I would come back and I asked them 'did you do the exercise on your own?' and they'd say 'please show me how to do it', and we'll start doing it. I'm like 'I'm not the physio'. I came and I gave them the oral motor exercises<sup>55</sup>... and I would show them. Then they'd say 'oh, I forgot'.

I: HOW DOES THAT MAKE YOU FEEL?

P: Gosh! Even if it does make me feel like 'ok so it's not important.' It's not the first thing that comes to their mind when they wake up, that they need to do whatever it is that the speech therapist said. But they feel like they have to do their exercises for their arms. They don't even get that part. So like it's just like 'ok maybe yes, speech therapy...' maybe our hospital can do without speech therapy. What's the point?

I: WHY DO YOU THINK THEY WOULD NOT REGARD THAT AS IMPORTANT?

P: I don't know, maybe it's also a fault on my side. Maybe I don't emphasise the importance in life.

I: DO YOU THINK THE PHYSIOS ARE EMPHASISING THE IMPORTANCE OF THEIR ARM AND OTHER EXERCISES?

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<sup>54</sup> Dysarthria is defined as "difficult, poorly articulated speech resulting from interference in the control and execution over the muscles of speech usually caused by damage to a central or peripheral motor nerve." (Kramer, Schneck & Biller, 2012, p. 187).

<sup>55</sup> Oral motor exercises – exercises and physical manipulation of oral structures conducted to strengthen muscle tone of the affected areas.

- P: Because maybe the patient feels like they need to start walking or they need to start doing things for themselves, then they'd feel like they have to exercise their arms, they have to exercise their legs. But because I am talking it's just that my speech is slow, so what? I can still talk, they can still understand.
- I: I SEE.
- P: Yes. 'It will get better. I don't need to do this exercise or whatever'
- I: WHAT'S THE FEELINGS THAT GO THROUGH YOUR MIND AT THIS TIME?
- P: In my mind at that time? I just feel like well nobody ever listens to a speech therapist anyways so why would this patient listen to me? Yes, and I try. I don't show them that I'm demotivated by whatever it is that they do. I try to emphasise that they need to try and do it in their spare time. And I do it with them in the ward, and then I say 'if you have time also please do it, at least twice a day', but then its depending on the type and the severity of their problem.
- I: SO THESE ARE PATIENTS IN THE WARD?
- P: In the ward
- I: THAT CAN DO THE EXERCISES BY THEMSELVES AND...
- P: By themselves, yes
- I: OK, WHAT ABOUT THOSE PATIENTS WHO ARE IN NEED OF ASSISTANCE, WHO HELPS THEM WITH, YOU KNOW, THE EXERCISES THAT YOU GIVE THEM?
- P: It's normally the nursing staff, so the nursing assistants and all that. So if you leave the instruction... I have seen that if you... it's different from adult patients and paediatric patients. In the adult ward, if you leave an instruction 'do not to feed this patient' because you haven't finished your swallow assessments<sup>56</sup> or you feel like there's a risk of aspiration or whatever, the next morning you will get there and the patient is being fed and you find out that the patient maybe has an NG<sup>57</sup> and they are feeding. And when you say no oral sips<sup>58</sup>, no nothing orally, and then you get there and they say 'oh but then we gave her water, she was fine'. This happens after I just left an instruction to say please don't.
- I: HOW DOES THAT COMPROMISE YOUR ASSESSMENT IF THEY HAVE TO FEED THEM?
- P: You'd find that the patient has already aspirated<sup>59</sup> or whatever. One patient actually died in the ward of chronic aspiration<sup>60</sup>. The patient was being fed. The patient was coughing until he was pink in the face. Coughing and coughing and coughing, tears running down his cheeks, and as no one was looking at the patient. They'll keep giving... they give porridge with his cup, the sippy cup. And then you get there, you're like 'please stop. Can you not see? Can you not see?' They never inserted an NG for that patient. Countless recommendations from me and the dietitian, 'please put an NG for this patient. Stop oral feeding the patient. Patient has a very increasing aspiration'. Kept feeding the patient. I don't know if they wanted to kill the patient, but the patient later on died of aspiration. So it's those kinds of things that make you feel like they just don't listen to anything that you're saying. Maybe we're not that important. It demotivates you. I keep saying I'm demotivated but it does demotivate you to see that whatever it is, whatever recommendation you put down, no one will listen. No one regards it. But like I said that it's different for adults and paediatrics. You find that when you get to paed and you leave an instruction there, it will get done the way that you recommended it. So I feel like maybe also the, you know how they treat paed like carefully. So they feel like if anything go wrong and they find that the speech therapist had recommended this and it was not done, something happens, they would be in trouble. But then no one really investigates what happened if something happens to someone, so I feel like if they... there is that difference between paediatric patients and adult patients. Because even the mothers, they're motivated to do things because they want their child to get better

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<sup>56</sup> Swallow assessments – assessments conducted by a speech-language therapist of the swallow and feeding systems.

<sup>57</sup> NG (tube) – nasogastric tube feeding are recommended when patients cannot feed orally. They are usually inserted for short periods of time, up to 6 weeks until an alternative feeding solution can be determined.

<sup>58</sup> Oral sips – sips of liquid (usually water) taken orally.

<sup>59</sup> Aspiration pneumonia is a term that refers to pulmonary abnormalities following abnormal entry of endogenous or exogenous substances in the lower airways (Ferri, 2014).

<sup>60</sup> Chronic aspiration – a chronic condition of the above disorder which can be fatal.

and go home. There, no one is, the family is not there. So it's up to the patient. The patient can't do it for themselves, so it's up to the nurses.

I: YES. OH OK, SO EVEN COMMUNICATION WITH THE NURSING STAFF?...

P: Yes, it's a challenge. Yes.

I: I WANT TO ASK YOU NOW ABOUT YOU KNOW WE'VE SPOKEN ABOUT ALL YOUR EXPERIENCES WHILE WORKING. AND I WANT TO NOW GO BACK TO YOUR UNDERGRADUATE TRAINING. IN WHAT WAY DID THAT HELP YOU, IF AT ALL, IN DEVELOPING YOUR COMMUNICATION SKILLS IN DEVELOPING COMMUNICATION STRATEGIES, AND IN DEVELOPING COMMUNICATIVE COMPETENCE TO WORK WITH PATIENTS WITH COMMUNICATION DISORDERS?

P: I feel like it did have a lot in preparing me for the working world or the hospital setting. Because we... especially the clinical practice the part we had to visit clinics. We had encountered real patients, so we were even scored on our communication strategies that we used with the patient. So we were motivated to go an extra mile to keep your communication simple with a patient with a communication problem, because you were going to get marked on that as well. So I feel like having encounter with the real patients in, during our undergraduate training, it had a lot to do with preparing us for what we're dealing with now.

I: YES. WERE THERE ANY PARTICULAR EXPERIENCES IN YOUR UNDERGRADUATE TRAINING WHERE YOU REALISED THIS IS GOING TO HELP ME; THIS IS SOMETHING THAT'S GOING TO HELP ME BE A BETTER COMMUNICATOR WITH MY PATIENTS IN THE FUTURE?

P: (LONG PAUSE) What I think?...

I: IT DOESN'T HAVE TO BE ONE INCIDENCE, IT COULD BE LIKE A FEW, IT COULD BE A MODULE, IT COULD BE EXPERIENCES

P: Ok I think so, because in undergraduate we had community based rehabilitation<sup>61</sup>. So we would go out to go visit patients' homes. We worked a lot in groups and stuff. So you'd have to deal with other members of the team. So you had... in as much as you had to deal with the patient, you had to deal with them as well. So you had to learn how to communicate with them as well, and not just the patients. And you would observe how the OT's doing it. We'd watch how the physio is doing it and as a speech therapist you had to be the sort of a role model when it comes to communication. The patient had to understand you, if you go there. When the speech therapist gets there the patient must understand, so you were motivated to use communication strategies that would make you seem like you're the superhero. When you get there, the patient starts understanding. And it's not because you're speaking in another language or anything, but it's because you know how to simplify the language so that the patient understands better than they did the OT, or the... better than they understood the physio. So there I felt like it was motivating us to work in a team. You had to show them what skills you possess.

I: YES, OK

P: So I felt like that clinic was enough. It had enough to prepare for them that worked

I: YES. DO YOU HAVE ANY SUGGESTIONS FOR THE TRAINING OF SPEECH LANGUAGE THERAPISTS? SO DO YOU HAVE ANY SUGGESTIONS TO THE DISCIPLINE OF SPEECH LANGUAGE PATHOLOGY; HOW THEY CAN BETTER EQUIP THEIR STUDENTS FOR COMMUNICATION IN THE WORLD OF WORK?

P: Yes, maybe just to... it's not much of what they're not doing already, it's just that maybe to expose them more to real patients. The patients that they're going to be seeing in the real world, and then maybe they should then... when they get marked, there should always be a section where they're marked on your communication strategies so that you feel like you always have to apply communication strategies that could be applicable for each and every

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<sup>61</sup> Community-based rehabilitation clinical module a fourth level clinical module in which students work in disadvantaged communities in conducting health promotion workshops and conducting community based rehabilitation for widespread gain in the community. Community-based rehabilitation (CBR) was initiated by WHO following the Declaration of Alma-Ata in 1978 in an effort to enhance the quality of life for people with disabilities and their families; meet their basic needs; and ensure their inclusion and participation.

- patient that you see. You can't just... it's not a standard for... you can't just use the same communication strategies with every patients. Every patient is going to be different. So if they introduce a system with the students getting marked on their communication strategies.
- I: YOU RAISED A VERY IMPORTANT ISSUE THERE THAT I JUST WANT TO ELABORATE ON. YOU SAID THEY SHOULD EXPOSE STUDENTS MORE TO REAL PATIENTS THAT YOU WOULD SEE IN THE REAL WORKING WORLD. WHAT DO YOU MEAN BY THAT?
- P: The way the training is being done... I don't know how it can be changed but I feel like the patient is ... the students are being exposed to this patient. This patient is a SSSD<sup>62</sup> patient; then this patient is a language patient<sup>63</sup>; this patient is a voice patient<sup>64</sup>. They are not exposed to training where the patient that has speech, language and voice problems at the same time and needs to be treated for all at the same time. So I feel like the speech patient, the language patient and the voice patient are not really real patients that the speech therapist is going to see in the real world. The speech therapist is going to see a patient with an aphasia, dysarthria and dysphagia<sup>65</sup>... everything all together. So I feel like those boxes are not real patients. So I feel like maybe bring students to a hospital setting. I know they're doing it already with electives<sup>66</sup>, but maybe it's just not enough, because we see patients in our clinics for clefts<sup>67</sup>, for voice, or whatever. And the electives are not evaluated where the mark contributes to the students' year marks. The permanent therapist is just happy to have a helping hand over the university holiday time... so they don't get evaluated clearly.
- I: YES. SO IF THEY AREN'T ABLE TO INTEGRATE THEIR KNOWLEDGE, FOR THIS PATIENT WITH MULTIPLE PROBLEMS, THEY DON'T REALLY KNOW WHAT MARK THEY WOULD'VE GOTTEN OR THE FEEDBACK THEY WOULD HAVE GOTTEN BECAUSE IT'S NOT BEING EVALUATED?
- P: Yes.
- I: YES THAT'S AN IMPORTANT POINT. SO IN THE REAL WORLD YOU'RE SAYING THAT THE PATIENT VERY RARELY HAS A SINGLE PROBLEM?
- P: Yes.
- I: IS IT OFTEN MULTIPLE PROBLEMS?
- P: Yes, because you would know how to communicate with a patient who has a voice problem. But this patient now has a voice problem and aphasia, so what you going to do then? Because they're not going to understand you.
- I: THAT'S A VERY IMPORTANT POINT WHICH YOU BROUGHT UP.
- P: So I feel like they need real patients.
- I: THANK YOU FOR THAT. THAT WAS A VERY IMPORTANT POINT THAT YOU BROUGHT UP. OK SO I'M GOING TO LEAVE IT THERE AND YOU'RE GOING TO NOW GO ON TO THE SESSION.

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<sup>62</sup> Speech sound disorders client – a client with a disorder in the areas of articulation and the phonological representation of certain sounds in words or in isolation.

<sup>63</sup> Language disorders client - a client with impairment in the areas of comprehension, spoken language, reading and/or writing.

<sup>64</sup> Voice disorders client – a client with a disorder of the voice due to misuse and/or abuse of the voice, e.g. vocal nodules, polyps, laryngectomy.

<sup>65</sup> Dysphagia is a disorder of feeding and/or swallowing (Daniels, Schroeder, McClain & Corey, 2006).

<sup>66</sup> Electives involves clinical exposure at hospitals of students' choices during the vacation periods under the supervision of the resident speech language therapist.

<sup>67</sup> Clefts – refers to cleft lip and palate.



## OBSERVATION SCHEDULE

### 1. Observer information

Observer name:	
Date and time of the observation:	
Purpose of session:	
Venue:	

### 2. Participant characteristics

Name:	
Gender:	
Number of years in practice:	
Race:	
Language(s) spoken:	

### 3. Client's characteristics

Client's age:	
Client's gender:	
Client's race:	
Client's language(s) spoken:	

4. Who is in the session – who is taking part?
5. Is this the first session with the client or not?
6. How many people are present, what are their identities and their characteristics?

## OBSERVATION CODE BANK

The codes presented below represent a wide variety of possible variables during clinical engagement in the profession of speech-language therapy. The researcher will select the codes as they are observed during the clinical session.

The observation schedule has been stratified according to 5 minute intervals and codes are presented in these intervals.

The code will be marked with a (\*) for every time the variable is observed per 5 minute interval.

### 7. Verbal clinician-client interaction

**Type of instructional method** (of the SLT to the client) in terms of orientation to the session, aim(s), activities to be carried out.

- DIS Discussion
- VS Visual schedule
- DEM Demonstration
- INS Instructions

**Types of elicitation methods** (used by the SLT with the client) when eliciting communication targets.

- MOD Modelling
- IMI Imitation
- DIM Delayed imitation
- REC Recasting
- FAL Forced alternatives
- ABS Absurdities
- DQU Direct questioning
- SP Spontaneous production



<u>DW</u>	Drill work
<u>EXP</u>	Expansions of targets
<u>CUE</u>	Cues/cueing

#### **Illocutionary acts**

GRT	Greeting
REQ	Request
COM	Compliant
INV	Invitation
REF	Refusal
REI	Reinforcement/compliant

#### **Locutionary acts**

ASK	Asking a question
ANS	Answering a question
INF	Give some information/assurance/warning
INT	Announcing an intention
APP	Making an appeal
DES	Giving a description
STA	Statement

#### **Perlocutionary acts**

PER	Persuading
CON	Convincing
GET	Getting the client to do something

#### **Vocalics (Aspects of voice)**

LOU	Loudness of voice	Does the intensity or loudness of the clinician's voice increase and decrease through the conversation? <i>Increased loudness LOU(+)</i> and <i>decreased loudness LOU (-)</i>
PIT	Pitch	Does the pitch of the clinician's voice increase and decrease through the conversation? <i>Increased pitch PIT(+)</i> and <i>decreased pitch PIT(-)</i>
ACC	Accent	Does the clinician modify his/her accent to accommodate the listener?
TON	Tone	Does the clinician's tone alter during speech to facilitate understanding? E.g. <i>increased tone TON(+)</i> , <i>decreased tone TON(-)</i>

### **8. Clinician-client interaction (non-verbal/paralinguistic features)**

#### **Kinesics (Body movements)**

<u>EMB</u>	Emblems	Body movements that carry meaning in and of themselves, e.g. thumbs up.
<u>ILL</u>	Illustrators	Body movements which need verbal accompaniments so to understand the message better, e.g. hand gestures that usually accompanies a person's speech.
<u>REG</u>	Regulators	Body movements to help guide conversation, e.g. head nod, eye contact to signal that you are actively listening to the speaker, smile, raised finger to caution patient to be more attentive.
<u>ADP</u>	Adaptors	Body movements that signal or satisfy physical or psychological state/needs, e.g. repeatedly tapping foot to signal anxiety, touching conversational partner's hand to signal empathy.
<u>AFF</u>	Affect	Body movements that express emotion <i>without</i> the use of touch or verbal accompaniment for understanding, e.g. manipulating facial features of the eyes and forehead to signal sadness or raised eyebrows and creased forehead to signal uncertainty or the need to raise questions, smile to show emotion.

#### **Haptics (Touch)**

<u>PROF-T</u>	functional/professional touch	Specific task-related purpose to carry out a procedure, e.g. manipulating the ear to conduct an otoscopic examination.
<u>POL-T</u>	Social/polite touch	Relatively formal touches that accompany greetings, e.g. a handshake or hug. The use of this is largely dependent on cultural factors.
<u>FRI-T</u>	Friendship/warmth touch	Qualities of touch that increase bondedness, e.g. partial embraces, full embraces, pat on the back.

*Proxemics*

SPA	Spatial needs	What is the distance between the conversational partners where both seem comfortable in their <i>territories</i> .
BOU	Personal space/boundaries	Signals for the need of personal space, e.g. stepping back from a person after the person has moved closer into the personal space.

**9. Instructional artefacts/stimuli used**

CRF	Craft activities
BKS	Books
TAB	Tablet
PIC	Picture stimuli
OBJ	Objects
BG	Board games
DRA	Drawings
SOF	Software game
AAC	Augmentative/alternative communication devices
PHO	Photographs
VID	Videos



NON-VERBAL CLINICIAN-CLIENT INTERACTION																		
Minutes	0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44	
Kinesics (Body movements)	EMB ILL REG	ADP AFF	EMB ILL REG	ADP AFF	EMB ILL REG	ADP AFF	EMB ILL REG	ADP AFF	EMB ILL REG	ADP AFF	EMB ILL REG	ADP AFF	EMB ILL REG	ADP AFF	EMB ILL REG	ADP AFF	EMB ILL REG	ADP AFF
Haptics (Touch)	PRO	POL	PRO	POL	PRO	POL	PRO	POL	PRO	POL	PRO FRI-T	POL	PRO	POL	PRO	POL	PRO	POL
Proxemics	SPA	BOU	SPA	BOU	SPA	BOU	SPA	BOU	SPA	BOU	SPA	BOU	SPA	BOU	SPA	BOU	SPA	BOU
NOTES:																		

INSTRUCTIONAL ARTEFACTS/STIMULI																		
Minutes	0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44	
Instructional artefacts/ stimuli used	CRF BKS TAB PIC OBJ BG	DRA SOF AAC PHO VID	CRF BKS TAB PIC OBJ BG	DRA SOF AAC PHO VID	CRF BKS TAB PIC OBJ BG	DRA SOF AAC PHO VID	CRF BKS TAB PIC OBJ BG	DRA SOF AAC PHO VID	CRF BKS TAB PIC OBJ BG	DRA SOF AAC PHO VID	CRF BKS TAB PIC OBJ BG	DRA SOF AAC PHO VID	CRF BKS TAB PIC OBJ BG	DRA SOF AAC PHO VID	CRF BKS TAB PIC OBJ BG	DRA SOF AAC PHO VID	CRF BKS TAB PIC OBJ BG	DRA SOF AAC PHO VID
NOTES:																		

## COMPLETED OBSERVATION SCHEDULE

## 1. Observer information

Observer name:	Urisha
Date and time of the observation:	25 January 2016; 10:00am
Purpose of session:	Speech Therapy session – observation for PhD data collection
Venue:	KZN Public Hospital – long-term care facility

## 2. Participant characteristics

Name:	ZANDI
Gender:	Female
Number of years in practice:	3
Race:	African
Language(s) spoken:	Zulu, English

## 3. Client's characteristics

Client's age:	12
Client's gender:	Female
Client's race:	African
Client's language(s) spoken:	Zulu

## 4. Who is in the session – who is taking part?

Speech-Language Therapist (Zandi) and the client (Sma)

## 5. Is this the first session with the client or not?

Not the first session.

## 6. How many people are present, what are their identities and their characteristics?

Speech-Language Therapist and patient – as described above.

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<u>DW</u>	Drill work
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## APPENDIX O

and creased forehead to signal uncertainty or the need to raise questions, smile to show emotion.

### *Haptics (Touch)*

<u>PROF-T</u>	functional/professional touch	Specific task-related purpose to carry out a procedure, e.g. manipulating the ear to conduct an otoscopic examination.
<u>POL-T</u>	Social/polite touch	Relatively formal touches that accompany greetings, e.g. a handshake or hug. The use of this is largely dependent on cultural factors.
<u>FRI-T</u>	Friendship/warmth touch	Qualities of touch that increase bondedness, e.g. partial embraces, full embraces, pat on the back.

### *Proxemics*

SPA	Spatial needs	What is the distance between the conversational partners where both seem comfortable in their <i>territories</i> .
BOU	Personal space/boundaries	Signals for the need of personal space, e.g. stepping back from a person after the person has moved closer into the personal space.

### **9. Instructional artefacts/stimuli used**

CRF	Craft activities
BKS	Books
TAB	Tablet
PIC	Picture stimuli
OBJ	Objects
BG	Board games
DRA	Drawings
SOF	Software game
AAC	Augmentative/alternative communication devices
PHO	Photographs
VID	Videos

\*\*\*See previous pages for code keys and instructions\*\*\*

VERBAL CLINICIAN-CLIENT INTERACTION																		
Minutes	0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44	
<b>Types of instructional method</b>	DIS***** ** VS	DEM** ***** * INS*** ***	DIS***** ***** VS	DEM* INS*** **	DIS VS	DEM INS	DIS VS	DEM INS	DIS VS	DEM INS***** *****	DIS VS	DEM INS	DIS VS	DEM INS	DIS VS	DEM INS	DIS VS	DEM INS
<b>Notes:</b>																		
<b>Types of elicitation methods</b>	MOD IMI DIM REC FAL CUE	ABS DQU** *** SP DW EXP	MOD IMI DIM REC FAL CUE	ABS DQU** ** SP DW EXP	MOD IMI DIM REC FAL CUE*** **	ABS DQU* SP DW EXP	MOD IMI DIM REC FAL CUE	ABS DQU ***** SP DW EXP	MOD IMI DIM REC FAL CUE** **	ABS DQU** ***** SP DW EXP	MOD IMI DIM REC FAL CUE**	ABS DQU** ** SP DW EXP	MOD IMI DIM REC FAL CUE	ABS DQU SP DW EXP	MOD IMI DIM REC FAL CUE	ABS DQU SP DW EXP	MOD IMI DIM REC FAL CUE	ABS DQU SP DW EXP
<b>Notes:</b>					Phonetic cues used				Semantic and phonetic cues used		Semantic and phonetic cues used							
<b>Illocutionary acts</b>	GRT REQ COM	INV REF REI	GRT REQ COM	INV REF REI	GRT REQ COM	INV REF REI	GRT REQ COM	INV REF REI***	GRT REQ COM	INV REF REI	GRT REQ COM*	INV REF REI*	GRT REQ COM	INV REF REI	GRT REQ COM	INV REF REI	GRT REQ COM	INV REF REI
<b>Notes:</b>																		
Minutes	0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44	
<b>Locutionary acts</b>	ASK***** ***** ANS INF*****	INT APP DES* STA** *****	ASK*** ***** *** ANS INF*	INT APP DES** STA	ASK*** ***** ANS INF*	INT APP DES* STA*** *****	ASK*** ***** *** ANS INF***	INT* APP* DES STA*** *****	ASK*** ***** ANS INF***	INT** APP DES*** * STA*	ASK*** ***** ***** ***** ANS INF	INT**** **** APP*** DES** **** STA*** ***** ***	ASK ANS INF	INT APP DES STA	ASK ANS INF	INT APP DES STA	ASK ANS INF	INT APP DES STA
<b>NOTES:</b>																		
<b>Perlocutionary acts</b>	PER CON	GET** *****	PER CON	GET**	PER CON	GET	PER CON	GET	PER CON	GET	PER CON	GET** ***** *****	PER CON	GET	PER CON	GET	PER CON	GET



NOTES:																		
Vocalics	LOU (+) PIT (+)	ACC TON	LOU PIT	ACC TON	LOU(-) PIT (-)	ACC TON(-)	LOU PIT	ACC TON(-)	LOU(+) PIT (+)	ACC TON	LOU PIT	ACC TON	LOU PIT	ACC TON	LOU PIT	ACC TON	LOU PIT	ACC TON
NOTES:	Increased loudness and pitch to emphasise correct response from patient.				Lowered loudness, pitch and tone to caution and prompt patient. Deeper voice used.		Reduced tone to caution patient.		Emphasis placed.									

### NON-VERBAL CLINICIAN-CLIENT INTERACTION

Minutes	0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44	
Kinesics (Body movements)	EMB* ** ILL*** * REG*	ADP AFF*	EMB **** ILL** ***** * REG ***	ADP* AFF*	EMB*** * ILL***** *** REG***	ADP AFF**	EMB*** ILL*** REG*	ADP AFF*	EMB** ** ILL**** ***** REG** *	ADP AFF***	EMB* ILL**** **** REG	ADP AFF*	EMB ILL REG	ADP AFF	EMB ILL REG	ADP AFF	EMB ILL REG	ADP AFF
Haptics (Touch)	PRO	POL	PRO	POL	PRO	POL	PRO	POL	PRO	POL	PRO FRI-T*	POL	PRO	POL	PRO	POL	PRO	POL
Proxemics	SPA	BOU	SPA	BOU	SPA	BOU	SPA (-)	BOU	SPA	BOU	SPA	BOU	SPA	BOU	SPA	BOU	SPA	BOU
NOTES:			REG – smiled at patient to prompt for more responses.				SPA (-) clinician sat away from patient.				FRI-T - high five to signal correct response.							

### INSTRUCTIONAL ARTEFACTS/STIMULI

Minutes	0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44	
Instructional artefacts/ stimuli used	CRF BKS TAB PIC* OBJ BG	DRA SOF AAC PHO VID	CRF BKS TAB PIC* OBJ BG	DRA SOF AAC PHO VID	CRF BKS TAB PIC* OBJ BG	DRA SOF AAC PHO VID	CRF BKS TAB PIC* OBJ BG	DRA SOF AAC PHO VID	CRF BKS TAB PIC* OBJ BG	DRA SOF AAC PHO VID	CRF BKS TAB PIC* OBJ BG	DRA SOF AAC PHO VID	CRF BKS TAB PIC OBJ BG	DRA SOF AAC PHO VID	CRF BKS TAB PIC OBJ BG	DRA SOF AAC PHO VID	CRF BKS TAB PIC OBJ BG	DRA SOF AAC PHO VID

## ZANDI OBSERVATION TRANSCRIPT AND CODING

## KEY:

RED = Type of instructional method  
 BLUE = Types of elicitation methods  
 GREEN = Illocutionary acts  
 YELLOW = Locutionary acts  
 PINK = Perlocutionary acts

Line	T/P	TRANSCRIPT
	T	OK, THERE'S 1, 2, 3, 4. WHAT DID WE SAY YOU'RE GONNA DO? S'MA? DON'T LOOK AT HER, LOOK AT ME. LOOK, I SAID YOU WILL PICK UP ONE LIKE THIS, OKAY? AND THEN YOU PICK ANOTHER ONE, WHICH EVER ONE YOU LIKE. ARE THESE TWO THE SAME? IF THEY'RE NOT, YOU PUT THEM BACK, YOU SEE? AND YOU PICK UP ANOTHER 1, 2. OH! DO THESE LOOK THE SAME?
	P	No.
	T	IF THEY'RE NOT THE SAME YOU PUT THEM BACK. YES, AND PICK UP 1, 2. ARE THEY THE SAME? IF THEY ARE, YOU TAKE THEM, THEY'RE BOTH YOURS, OK? AND GO AGAIN. 1, 2. ARE THEY THE SAME?
	P	Yes.
	T	SEE, I'M GOING TO TAKE THESE, I'M KEEPING THEM. OK, LET'S TAKE ANOTHER ONE. LET'S USE OTHER PICTURES NOW. OK, YOU MUST REMEMBER WHERE YOU HAD SEEN ANOTHER ONE. REMEMBER, IF YOU PICK UP 1, 2, AND THEY'RE NOT THE SAME, GO AHEAD, PICK UP ANOTHER ONE, AND PUT IT DOWN. 1, 2.
	P	Yes.
	T	ARE THEY THE SAME (SHORT LAUGH)? TAKE THEM, THEY'RE YOURS, THEY'RE SMA'S NOW, PUT THEM THERE. OK, GO AGAIN. 1, 2. THOSE ARE SMA'S SINCE THEY'RE THE SAME. OK, I'M NOW GONNA MAKE IT 1, 2, 3, 4, 5, 6. OK? OK. 1, 2, 3, 4, 5, 6. SEE? THERE'S 6 NOW, YOU CAN PICK UP ANYONE YOU LIKE. 1, 2. IF THEY'RE THE SAME THEY'RE YOURS, IF NOT, YOU PUT THEM BACK, ANYONE. 1, 2. (LAUGHTER) ARE THEY THE SAME? OK THEY'RE YOURS THEN, GO AHEAD AND PICK ANOTHER ONE. THEY'RE NOT THE SAME, PUT THEM BACK.
	P	Mhm (nodding head)
	T	THIS IS HOW YOU SHOULD DO IT, PICK ONE AND ANOTHER ONE, IF THEY'RE NOT THE SAME YOU PUT THEM BACK. SO THEN YOU... YOU PUT IT BACK WHERE YOU PICKED IT UP. SEE? LIKE THIS (ILLUSTRATING) MHM.
	P	Mhm (nodding head). Uh.
	T	(LAUGHS) YOU'VE ALREADY PICKED IT UP, YOU'RE CHEATING. LET'S MIX THEM. YOU HAVE TO REMEMBER WHERE YOU'VE SEEN A SAME ONE, YOU HAVE TO REMEMBER WHERE IT IS. IF I PICK UP 1, 2 AND THEY'RE NOT SIMILAR, I PUT THEM BACK. THEN I GO 1, AND THEN I REMEMBER WHERE I HAD SEEN ONE SAME TO THIS ONE. WHERE IS THE ONE SAME TO THIS ONE?
	P	It...
	T	I'VE PICKED IT UP BEFORE, BUT WHERE? SEE. 1, 2. I PUT THEM BACK. GO AGAIN. 1, 2. OH, LOOK. WHERE'S THE ONE SAME TO THIS ONE?
	P	Mh? Green
	T	NO, ONE SIMILAR TO THIS ONE. LOOK
	P	Aaahhhh!

APPENDIX P

T	(LAUGHS) SEE? HERE IT IS. LET ME SHOW YOU. PUT THOSE BACK. SEE, WHERE IS IT? WE PICKED UP HERE AND HERE. SEE? THEY'RE NOT THE SAME. NOW WATCH WHEN I PICK UP ONE HERE. OH, WHERE'S ONE SIMILAR TO THIS ONE?
P	This one
T	YES, SIMILAR TO THIS ONE? YOU ARE GUESSING. YOU'RE SUPPOSE TO BE REMEMBERING. YOU NEED TO REMEMBER WHERE IT IS, OK S'MA? YOU HAVE TO REMEMBER WHERE IT WAS, THEN YOU PICK UP THIS ONE, AND THAT ONE. SEE? PICK UP ONE AND PUT IT BACK HERE. ANOTHER ONE. HERE, ARE THEY THE SAME? NO THEY'RE NOT. SO THAT MEANS YOU PUT THEM BACK AGAIN. LOOK, I AM PICKING ONE UP. ARE THEY SIMILAR AS YOURS (LAUGHS)? THEY'RE MINE BECAUSE THEY'RE THE SAME. OK. LETS GO FOR THE LAST TIME. OK? 1, 2, 3, 4. YOU WILL PICK ONE UP AND REMEMBER WHERE YOU'VE SEEN ONE SIMILAR TO IT. GO AHEAD THEN, AND PUT IT HERE. MHM. (LAUGHS) NO, YOU NEED TO REMEMBER. DON'T PUT IT TOO FAR SO THAT YOU CAN REMEMBER WHERE IT IS. DO YOU STILL REMEMBER WHAT WAS HERE?
P	Mhm
T	PICK ONE UP. WHERE IS ONE SIMILAR TO THAT?
P	This one?
T	WHERE WAS ONE SIMILAR TO THIS ONE? HERE
P	Mhhh
T	SEE? (LAUGHS) WHY ARE YOU THROWING IT AWAY NOW? ALRIGHT (CLEARS THROAT) LETS DO THIS. I'M GONNA PUT PICTURES FOR YOU, OK? YOU WILL HAVE TO REMEMBER WHAT IT WAS THAT I SHOWED YOU, ALRIGHT? OK, TAKE THESE ONES
P	Mhm
T	PUT THEM HERE (CLEARS THROAT) PUT 1, 2. 1, 2. WHAT'S THIS CALLED?
P	It... eh...
T	A HOUSE
P	House
T	YES, AND WHAT ELSE? WHAT IS THIS?
P	A pen
T	A PEN. OH OK. A HOUSE, A PEN. NOW I'M PUTTING THEM AWAY. YOU HAVE TO REMEMBER WHAT IT WAS. WHAT WAS IT?
P	House
T	WHAT ELSE?
P	A pen
T	A PEN. GOOD GIRL S'MA. OK, LET ME PUT IT HERE. ANOTHER ONE. (SOMEONE GREET)S MHHH, HERE'S TWO. WHAT ARE THESE?
P	A spoon
T	A SPOON. MH (LAUGHS). OK I'M LISTENING. IT'S A SPOON?
P	A snake
T	A SNAKE. AND WHAT ELSE?
P	A spoon and a snake.
T	OK, NOW I'M PUTTING THEM AWAY. WHAT WERE THEY?
P	A spoon... n...
T	YOU'VE FORGOTTEN
P	(Laughs)
T	IT'S SOMETHING SCARY. SOMETHING YOU WERE SCARED OF
P	What?

APPENDIX P

T	SOMETHING YOU WERE SCARED OF. YOU SAID YOU WERE SCARED TO EVEN LOOK AT IT. IT...? MH (LAUGHS) YOU DON'T REMEMBER? YOU DON'T REMEMBER BOTH OF THEM S'MA? MH, LETS START HERE. THIS ONE?
P	Chic... uh
T	(LAUGHS) CHICKEN
P	(Deep sigh)
T	A FROG
P	Frog
T	I AM PUTTING THEM AWAY NOW. WHAT WERE THEY?
P	It...
T	WHAT WAS IT?
P	What?
T	WHAT WAS HERE? MH S'MA? WHAT WAS IT?
P	A frog
T	YES
P	Mhhhh, uhmmmm
T	A CHIC-?
P	Chicken
T	HAHHHH! YES. [THI (MAKING CHICKEN SOUND).
P	Yes
T	EH?
P	Chicken
T	A CHICKEN (LAUGHS). A FROG. THE CHICKEN IS SUPPOSE TO COME FIRST BEFORE THE FROG.
P	A chicken
T	YES, HOW DID YOU FORGET IT? OK THESE ONES I'M GONNA PUT AWAY... WHATS THAT? OK. ITS EASY, VERY EASY. I SAID THIS ONE IS VERY EASY. THIS ONE?
P	A star
T	THE SUN
P	The sun
T	WHAT ELSE?
P	Boy
T	NO, THE ONE THAT GOES (MAKING CAR NOISE)
P	It...
T	IT'S BEING DRIVEN. YOU PUT IN THE KEYS AND IT GOES (MAKING MOTOR VEHICLE SOUNDS) WHAT IS IT?
P	Chicken
T	THE ONE THAT GOES (MAKING MOTOR VEHICLE SOUNDS)? BEING DRIVEN
P	A car
T	YES, YOU DRIVE A CAR. AND THEN IT'S THE SUN...
P	Chicken (laughs)
T	THE SUN...?
P	Car
T	A CAR, THE SUN... WHAT ELSE?
P	Bread (laughs)
T	I'M NOT PLAYING. I'M NOT PLAYING S'MA, OK? I'M NOT PLAYING (LAUGHS)
P	What?



APPENDIX P

T	MH?
P	S'mana
T	(LAUGHS)
P	And the chicken
T	WHAT WAS IT S'MA?
P	Chicken
T	NO, THERE WAS NO LONGER CHICKEN HERE, WHAT WAS IT?
P	Qhu...
T	MH? IT WAS THE SUN...
P	The sun, a car
T	A CAR. THE SUN, A CAR. BUT YOU'VE FORGOTTEN, RIGHT S'MA? THIS ONE? WHAT IS THIS?
P	Hot
T	IT'S A STAR, THIS IS NOT THE SUN. IT'S A STAR...? A STAR AND WHAT ELSE?
P	A car
T	A STAR, A CAR. OK NOW I'M GONNA PUT THEM AWAY.
P	It's a star and a car
T	NOW THAT YOU'RE NO LONGER SEEING THEM, DO YOU STILL REMEMBER WHAT IT WAS?
P	Pen
T	OK I'M GONNA PUT THE ONE'S YOU'VE ALREADY SEEN, THE ONES YOU ALREADY KNOW. YEAH, MHM
P	A pen, a car, a... a bug
T	MH? A PEN, CAR AND CHICKEN
P	Chicken
T	A PEN...?
P	A car, a chicken
T	A CHICKEN. I'M HIDING IT NOW, WHAT WAS IT?
P	A pen, a car...
T	A PEN...?
P	(Takes a deep breathe)
T	REMEMBER, REMEMBER, REMEMBER, DO YOU REMEMBER? MH? DO YOU RECALL?
P	A bug
T	OK, WHAT WAS IT?
P	A car... (Laughs)
T	IT WAS THERE, BUT IN THE MIDDLE. WHAT WAS AT THE BEGINNING?
P	A pen, uhhh
T	MHM, MHM
P	A pen, a car, a chicken
T	THERE YOU GO S'MA! HIGH FIVE, HIGH FIVE, HIGH FIVE! (LAUGHTER) WELL DONE. THIS IS HOW I LIKE IT. OK. THIS ONE 1, 2, 3. MEMORISE THEM. MEMORISE THEM PROPERLY SO YOU CAN REMEMBER THEM
P	A pen and... a spoon
T	A HOUSE...?
P	Oh! A house, a spoon...
T	MHM. WHAT ELSE?

APPENDIX P

P	And... a pen
T	I'M PUTTING IT AWAY NOW. GO THROUGH IT AGAIN
P	A pen
T	NO, LOOK AT THE PICTURE PROPERLY. WHAT IS THIS?
P	A pen
T	AND WHAT ABOUT THIS ONE?
P	What?
T	WHAT'S THIS THEN?
P	A pen
T	AND THIS ONE?
P	A house
T	MHM
P	A spoon
T	MHM, NOW I'M PUTTING THEM AWAY. WHAT WAS IT?
P	Uh.....
T	WEEH (inaudible)
P	A... a pen
T	NO, HERE, HERE, HERE
P	What?
T	START HERE. DO YOU REMEMBER THAT THING BUILT BY BLOCKS? THE ONE YOU LIVE IN...
P	Blocks
T	YOU LIVE IN IT
P	(Laughs)
T	THEY SAY WE'RE BUILDING A...?
P	House
T	YES. WHAT IS IT?
P	A house
T	AND WHAT ELSE?
P	A, a pen. Oh!
T	THE ONE YOU USE TO EAT
P	Ohh! A spoon, a pen
T	YOU SHOULD REMEMBER THIS. PUT HERE AND REMEMBER THIS. LIKE YOU'RE TAKING PHOTOS WITH YOUR EYES. OK? REMEMBER EXACTLY WHAT IT WAS. I'M GONNA PUT ANOTHER 3, OK. WHAT WAS IT?
P	A car, a pen...
T	YOU'VE FORGOTTEN?
P	Mhm
T	REALLY S'MA! A CAR, A PEN, AND...?
P	A pig
T	A FRO-?
P	Frog
T	I HAD TO REMIND YOU THAT MUCH? A CAR, A PEN AND...?
P	A pig
T	IS IT A PIG NOW?

APPENDIX P

P	What?
T	WE WERE SAYING IT NOW NOW. WHAT DID WE SAY IT WAS? FRO-?
P	Frog
T	NOW REMEMBER. WHAT WAS IT?
P	A...
T	YOU'VE FORGOTTEN THIS ONE AS WELL?
P	A car, a pen, and a pig
T	A CAR, A PEN AND A FROG
P	A frog
T	OK NOW I'M PUTTING THEM AWAY AND WANT TO SEE IF YOU WILL REMEMBER THEM?
P	A pen
T	WHERE WAS THE PEN, AT THE BEGINNING?
P	What?
T	WAS IT AT THE BEGINNING? WAS IT NUMBER 1? WAS IT HERE?
P	A car
T	HERE? LET ME SEE. MH OK, THE CAR? AND WHATS HERE?
P	A pen
T	A PEN, WHATS HERE?
P	A frog
T	THERE YOU GO S'MA, OK? (LAUGHS) OK. LET'S DO THIS. LET'S DO SHAPES NOW, OK. WE WILL DO THIS SOME OTHER TIME. PUT THE BOOK DOWN. PUT IT THERE. FAR AWAY. WE'RE DOING SHAPES NOW. LOOK HERE. DO YOU SEE THIS SHAPE? FROM THESE SHAPES YOU WILL PICK ONE THAT LOOKS LIKE YOURS. GOT IT? LOOK HERE. WHAT'S THIS ONE CALLED?
P	Mhh shapes
T	WHAT'S THIS SHAPE CALLED? IT'S ROUND. WHAT IS IT CALLED? IT'S CALLED A CIR-...? IT'S... A CIRCLE. WHAT COLOUR IS THIS CIRCLE?
P	I... I don't know.
T	IT'S BLACK. AND WHICH ONE DO YOU THINK LOOKS LIKE IT? LOOK FOR ONE THAT LOOKS EXACTLY LIKE IT. LOOK AT THEM ALL. LOOK EVERYWHERE. LOOK FOR ONE THAT LOOKS EXACTLY LIKE IT, ROUND AND BLACK. LOOK HERE S'MA. CAN YOU FIND ONE THAT LOOKS LIKE IT? SEE THIS ONE LOOKS EXACTLY LIKE IT? NOW YOU CHOOSE YOURS ANYONE YOU LIKE HERE. CHOOSE 1. CHOOSE 1. CHOOSE ANYONE S'MA. CHOOSE ANYONE THERE. I CHOOSE THIS ONE. WHICH ONE DO YOU CHOOSE?
P	This one
T	OK, YOU CHOOSE THIS ONE. MINE IS A BLUE CIRCLE. IT LOOKS LIKE THIS ONE (POINTING AT IT). THIS ONE IS ALSO A CIRCLE, THEY'RE BOTH BLUE? WHERE IS YOURS? DESCRIBE IT
P	What?
T	DESCRIBE YOURS. IS IT RED. IS IT A CIRCLE? WHICH ONE DOES IT LOOK LIKE?
P	This one
T	HERE ON THIS PAGE? WHICH ONE LOOKS EXACTLY LIKE IT? LOOK AT THIS ONE. DO YOU SEE IT? WHICH ONE DOES IT LOOK LIKE? HERE IN THESE ONES. IT'S BETWEEN THESE ONES. DO YOU SEE WHERE I'M POINTING?
P	Uh
T	WHICH ONE DOES THIS CIRCLE LOOK LIKE? A GREEN CIRCLE. WHICH ONE DOES IT LOOK LIKE? OK, ANOTHER ONE. CHOOSE ANOTHER GREEN ONE. GOOD. WHICH ONE

APPENDIX P

		DOES IT LOOK LIKE WITH THIS SHAPE? A TRIANGLE, WHICH ONE DOES IT LOOK LIKE? GOOD. CHOOSE ANOTHER ONE.
	P	Here
	T	DO YOU LIKE THE BLACK ONE? WHICH ONE LOOKS LIKE IT? THAT ONE? GOOD (LAUGHS). OK, WE'RE DONE WITH SHAPES FOR NOW, WE'LL DO THEM SOME OTHER TIME. LET'S DO ONE LAST ONE, WHICH ONE DO YOU WANT?
	P	This one
	T	THE ONE WHERE YOU CAN WRITE YOUR NAME ON, THIS ONE OR THAT ONE? LET'S DO THIS ONE. (EXCUSE ME) LET'S DO THIS ONE TODAY, OR THIS ONE, OR THAT ONE, WHICH ONE DO YOU WANT? WHICH EVER ONE YOU LIKE, YOU WANT THIS ONE? I'M ALSO GONNA CHOOSE MY OWN, OK.
	P	A pen
	T	OK LET ME CHECK IF IT'S WRITING BEFORE I GIVE IT TO YOU. YEAH. THIS ONE? OK, MH. WHAT DOES IT SAY?
	P	(laughs)
	T	OH, MH! TRY AGAIN S'MA. LET ME WRITE MY NAME AS WELL. YOU'VE WRITTEN TWO, I'VE ALSO WRITTEN TWO. WRITE A THIRD ONE. I'M ALSO GONNA WRITE THREE. WRITE WRITE WRITE WRITE. YOU SHOULD ALSO DO THIS. ARE YOU TIRED ALREADY? (LAUGHTER) OK, YOU WANTED TO WRITE S'MA. OK, LET ME WRITE MY NAME, 'K.... MHM, YOU...
	P	Za
	T	YES, BUT YOU SHOULD SAY AUNT. SMA, SMA. WHO'S GONNA COUNT? THERE'S NO ONE. DO YOU WANT TO USE CRAYONS? WHAT COLOURS DO YOU WANT? CHOOSE WHAT COLOUR YOU WANT. TIME IS TICKING. DO YOU WANT RED? WHICH COLOUR DO YOU WANT? (LAUGHS). HERE IS A RED CRAYON, I'M COMING BACK, OK? I'LL BE BACK. YOU WRITE HERE AND I WILL WRITE HERE.
	P	(laughs)



**Speech-language therapists' negotiation of communication during clinical engagement**

**Post-observation interview schedule**

Thank you for allowing me to observe your clinical session. As you know the session as video recorded. Both you and I are going to watch parts of the videoed session together. You will have a remote control and you can use this to stop at any part in the session where you think you are experiencing any successes, challenges or difficulties. We will then discuss these. I too will forward the video to parts of the session that I would want to explore further with you. I will also ask you a few questions about the session. Is this alright?

1. How do you think the clinical session went? **(General impression/reflection and Communication accommodation)**
2. I saw that you use ... [hand-over-hand facilitation, modelling and recasting, positive reinforcement] ... Tell me more about what it is like to use that with this client. **(Communication accommodation)**

Probes: how often do you use this? Does the client typically respond in this way? What do you like about using this method? Are there any challenges that you face in using this method? What are these challenges? **(Uncertainty)**

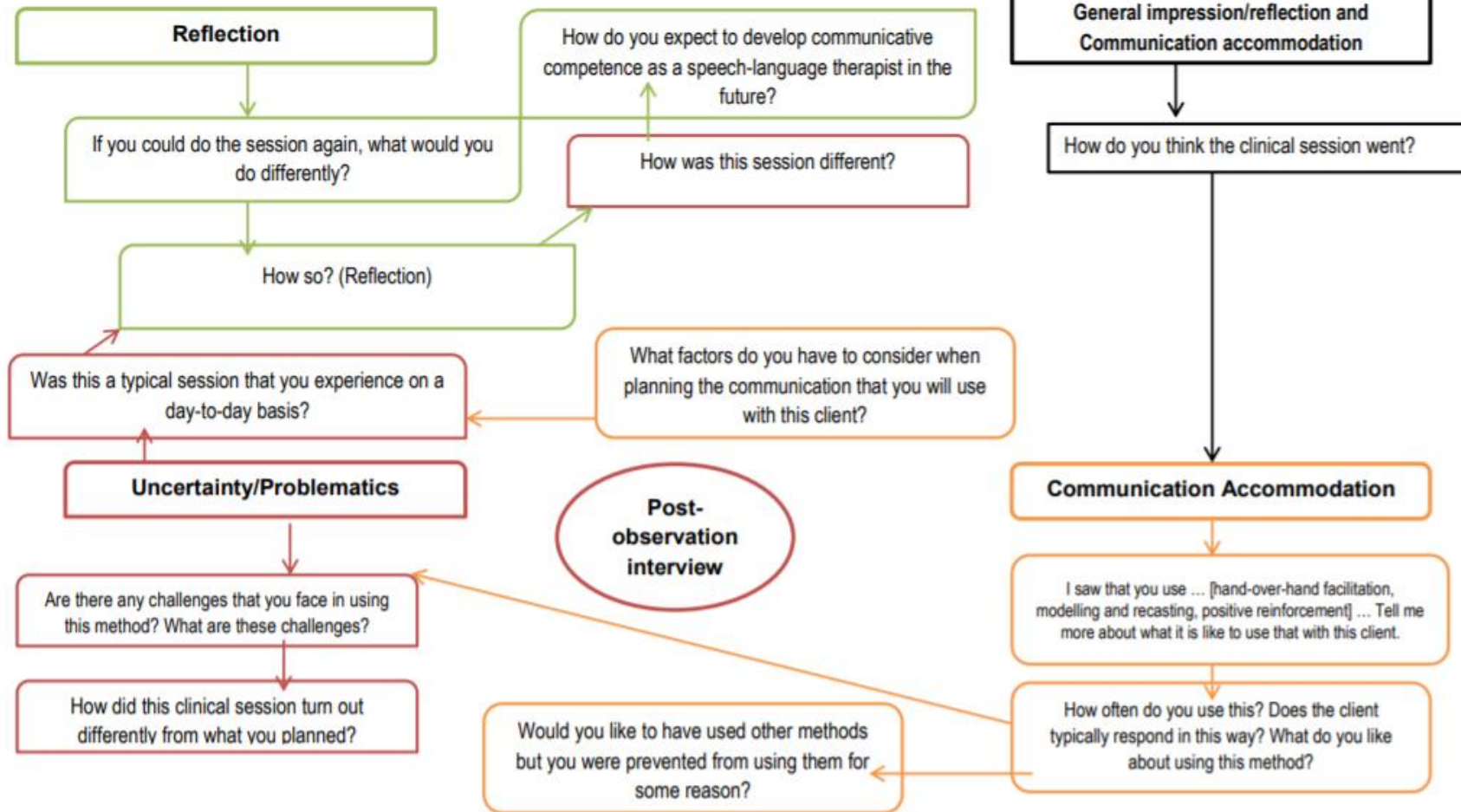
3. How did this clinical session turn out differently from what you planned? **(Uncertainty)**

Probe: Would you like to have used other methods but you were prevented from using them for some reason?

4. If you could do the session again, what would you do differently? **(Reflection)**
5. What factors do you have to consider when planning the communication that you will use with this client? **(Communication accommodation)**
6. Was this a typical session that you experience on a day-to-day basis? How so? **(Reflection)** [How was this session different?] **(Uncertainty)**
7. How do you expect to develop communicative competence as a speech-language therapist in the future? **(Reflection)**

***Thank you very much for talking with me and letting me see your class. I hope that you had as positive an experience as I did.***

**APPENDIX R**



**ZANDI (STIMULATED RECALL) POST OBSERVATION INTERVIEW TRANSCRIPT**

I = INTERVIEWER

P = PARTICIPANT

I: OK SO I'M GOING TO HAVE THE VIDEO HERE FOR YOU. SO LET'S JUST GO THROUGH IT. IT'S THIS ONE. (PLAYS VIDEO) OK WHAT WE'RE GOING TO DO NOW IS TALK ABOUT THE COMMUNICATION STRATEGIES THAT YOU ACTUALLY USE IN A SESSION AND IN THIS PARTICULAR SESSION WITH UMM THIS CLIENT, AND THEN IF THERE'S ANY POINT IN THE SESSION THAT YOU WANTED TO ELABORATE ON, YOU WANT TO JUST SHOW ME AND YOU KNOW USED THAT AS AN EXAMPLE TO DEMONSTRATE WHAT YOU SAID, THEN WE CAN PLAY THE VIDEO FORWARD TO THAT POINT.

P: Ok.

I: OK SO CAN YOU TELL ME A LITTLE BIT ABOUT THE PATIENT THAT YOU SAW?

P: Oh, her name is Sma. She's a 12 year old who had last year... we started last year. She had a, what you call, a Subdural Empyema and then she had to be drained out whatever, so it left her with hemi . You can see that here. (pointing to the screen) And then her speech was also affected. Not too much her speech , but more of her language and her cognition.

I: I SEE. OH SHAME.

P: So most of what I was doing with her is like memory stuff<sup>1</sup>, building vocabulary and basic concepts.

I: OK. AND HOW DO YOU THINK THE CLINICAL SESSION WENT? WHAT WAS YOUR OVERALL IMPRESSION OF IT?

P: (laugh) I think it went very well because normally this child is the quiet one. She doesn't want to talk. She would use head nods and smile but she won't verbalise. But at least today she was talking a bit.

I: YEAH. HOW DO YOU COMMUNICATE WITH HER? HOW DO YOU KNOW WHAT SHE WANTS, WHAT SHE NEEDS (DOOR SLAMS) SORRY. HOW DO YOU KNOW HOW TO COMMUNICATE WITH HER IN TERMS OF WHAT SHE WANTS AND HER REQUESTS?

P: Ok she has functional speech<sup>2</sup>.

I: DOES SHE?

P: She has functional speech, yes; she has sentences in there. Yes she said she doesn't like to talk, so prefers to smile especially if she doesn't know the person. She'll just smile and nod and whatever, just to get through the conversation or whatever but if you like make her talk, if you like encourage her to talk, she'll talk.

I: IS IT ALSO BASED ON A TRUSTING RELATIONSHIP?

P: It could be. It could be, because even with me as well, when she, when, when I had started seeing her, I saw her like on and off last year because she'd be out and admitted again... she'll come back then she go again. But it used to be like that. I haven't seen her in weeks or like... yes and then when we start doing sessions like daily or every two days the, she'd start warming up to me and talking again. But normally the physios, because you know they stick to an English so

<sup>1</sup> Memory stuff – strategies and techniques to enhance memory.

<sup>2</sup> Functional speech – sufficient vocabulary and language ability to make basic needs known.



maybe she doesn't understand some of the times so and then she'll just smile, she'll nod, but she'll talk to the nurses if they speak to her in Zulu and yeah she talks to me as well.

I: SHE SPEAKS TO YOU IN ZULU THEN?

P: In Zulu, yes.

I: AND WAS SHE BILINGUAL BEFORE HER ILLNESS?

P: She should've been, because she was in grade 6; and which I'm thinking that the school should be teaching her English as a language of learning, but I don't think she was fluent in speaking in English. But I'm sure she has a few words because if you ask her sometimes like the colour, say it in English.. she would say it.

I: I DID NOTICE WHEN I WAS DOING THE VERBAL ASSENT AS CONSENT WITH HER AND BEFORE YOU TRANSLATED, THERE WERE CERTAIN THINGS I WAS SAYING AND SHE NODDED. SO I COULD SEE THAT.

P: She has some understanding, yes.

I: YES. OK, YES SO HOW DID YOU THINK THE SESSION WENT? WAS IT...

P: I think it went very well.

I: YES, AND SHE WAS COMMUNICATING AS YOU EXPECTED?

P: She was communicating, yes. Not.. I don't think to her full, full capacity, but she was communicating. I'm not too sure if it's because she knew that she was being taped or whatever, but she seemed to be.. she was fine, yes.

I: SO I DID NOTICE THAT YOU HAD QUITE A RELAXED INTERACTION WITH THE CLIENT. SHE SEEMS QUITE COMFORTABLE WITH YOU AND YOU KNOW EVEN WITH USING HAND OVER HAND FACILITATION, SHE WAS COMFORTABLE WITH THAT. DO YOU HAVE OTHER STRATEGIES, LIKE THAT, THAT GETS HER TO ENGAGE WITH YOU IN A SESSION?

P: Like the hand over hand facilitation?

I: YES. POINTING, ANY OTHER NONVERBAL STRATEGIES?

P: Yes, like basic gestures, like if I want her to think about something, I'd show her. It's basically just gestures that I use that are nonverbal or if we're using pictures as well

I: AND SHE RESPONDS WELL TO THAT?

P: Yes, she responds. She responds very well to that (nodding head).

I: OK SO WITH HER DO YOU FIND THAT YOU HAVE TO USE MULTIPLE MODES OF COMMUNICATION.

P: Yes. I do. I do 'cause.. Sometimes you see in her face that if you're just going on and on, you'll see that she is lost now. She will just show you with her facial expression that I'm lost. And then once you start explaining to her word for word what you mean, and then she.. you'll see that she understands. She'll nod. She'll show that she's following whatever you're saying. Yes.

I: THAT'S AN IMPORTANT POINT THAT YOU MENTIONED AND I WANT TO JUST PICK UP ON THAT, KNOWING WHETHER YOUR PATIENT IS WITH YOU STILL IN A SESSION IS

IMPORTANT FOR A THERAPIST TO KNOW. AND SO YOU SAY THAT YOU PICK UP ON THEIR FACIAL EXPRESSIONS. WHAT ARE THOSE FACIAL EXPRESSIONS AND WHAT ARE THE CUES THAT YOUR CLIENTS GIVE YOU OR DO YOU LOOK TO SEE IF THEY ARE UNDERSTANDING YOU... YOU KNOW 'OK, YOU ARE UNDERSTANDING OR I DON'T THINK YOU'RE UNDERSTANDING, I'M GOING TO HAVE TO WORK AROUND THIS'?

- P: Ok. With this particular patient, I'm so used to her now that I know that I have to look for the expressions that show that 'ok now I don't understand' because she will look at you like 'ok', and then if you start explaining to her in the way that she understands then she'll smile or nod or sometimes verbalise and say, if you ask her 'do you understand?' she'd say 'yeah' or nod. She prefers the nodding and shaking her head when she's saying no. So with the other patients as well I had to look for cues that will show me whether the patient understands. Some of my patients will just get distracted if they don't understand me, and they'll start looking on the side or whatever, so I have to make sure 'please look at me'. 'Do you still understand what I'm saying?' And then if they can, if they're capable of saying yes or no... (hand gestures - illustrators) if I can see that they're not saying yes or not saying no, but I can still see that they're still lost in their face and they're like... they're just blank, then I'll try and explain it like simplify my language in a way that I think they should understand now. And then sometimes you'll see that no, they'll start showing that they're following me.
- I: HOW DID YOU LEARN THAT SKILL?
- P: Well it's also one of the things that I had picked up along the way... Like to be able to read your patient. Yes because it's not all the time that they'll tell you that they don't understand (hand gestures - illustrators). So you have to find things that for every patient that you see, especially young... I'm lucky enough to work in a hospital where I work with patients for a long time. Long enough that I can learn to understand and I know each and every one of my patients. That's why if they don't understand they just turn their backs on me; if they don't understand they'll start crying, or if they don't understand they'll show me like Sma, they'll show me with their facial expressions That they're lost. So it's something that I picked up along the way.
- I: IS THERE ANYWHERE IN YOUR UNDERGRADUATE TRAINING WHERE YOU WERE TAUGHT TO LOOK FOR THE PATIENTS NONVERBAL EXPRESSIONS OR LOOK FOR CUES YOU KNOW WHERE... WERE YOU TAUGHT THAT?
- P: Yes I think in each and every clinic they tried to include it in a way for us to be able to pick up if the client was not understanding us, especially in the adults' clinics like NACD<sup>3</sup>, where we were taught to, not really like was... it wasn't like a part of a module, but like whenever you were in a clinical session a tutor would tell you that 'do you see that the patient is, is getting distracted? Do you think she's not understanding you? You must be able to read those cues'.
- I: OR IF THE PATIENT IS NOT COMFORTABLE (cross talk)
- P: If the patient is not comfortable whatever, but you must find out what it is that they're trying to tell you, if they're giving you that facial expression or they're getting distracted or they start crying or whatever.
- I: IF YOU WEREN'T A SPEECH THERAPIST DO YOU THINK YOU WOULD'VE BEEN AS AWARE OF THIS? OR DO YOU THINK IT IS BECAUSE YOU'RE A SPEECH THERAPIST THAT YOU FEEL YOU HAVE TO KNOW THIS?
- P: I think it is because I'm a speech therapist, because I have seen people how they interact like... lay people, how they interact with patients. They expect them to know all these things. How can

<sup>3</sup> NACD – Neurologically acquired communication disorders – a clinical module offered at UKZN at fourth year level



you not know your name? Like how can you not understand if I'm asking you yes or no? Yes so like, how can you just start crying when I'm asking something so simple? Yes so, like even other professionals as well. You know, Doctors, like 'ok, I think she understands. No she understands. Her understanding is intact', but you'll find that the patient is not understanding anything. But they'd keep saying expressive aphasia<sup>4</sup> (short sharp laugh). Yes so I think it is because I'm a speech therapist that I am able to pick up things, like subtle things like that (hand gestures - illustrators).

- I: AND YOU KNOW AS A SPEECH THERAPIST NOW WHO UNDERSTANDS THOSE NONVERBAL COMMUNICATION OR THESE CUES THAT'S COMING THROUGH FROM YOUR CLIENT, HOW IMPORTANT DO YOU THINK THIS IS FOR A HEALTH CARE PRACTITIONER TO PICK UP ON? AND DO YOU THINK IT'S AN IMPORTANT ASPECT OF COMMUNICATION?
- P: To be able to pick up all those cues I think it's important for every health care professional. If you have direct interaction with a patient, it's very important because how are you going to know that they're not comfortable with whatever you are doing. You should be able to... if you're a physio doing exercise with a patient and the patient showed whatever facial expression or they're showing that they're not comfortable to a certain level, you should be able to read the patient. If you're saying something and the patient starts crying, you should be able to read the patient to know this patient is not comfortable with this topic or something, and try to find out what it is that the patient is not comfortable with. It's not only us that deal with things like where the patient has to interact with you and, and answer you or whatever.
- I: YES...
- P: The OTs doing the cognitive assessment, they should be able to understand if a patient is not understanding a question. It's not because maybe they don't know the answer or whatever. Maybe they don't understand the way they're phrasing the question, they should be able to you know... maybe the patient is going say 'ok let me simplify my language.' And I do think that it's a very important aspect of communication.
- I: SO WHAT MAKES YOU AS A SPEECH LANGUAGE THERAPIST THEN SO AWARE OF THIS?... YOU KNOW BECAUSE YOU'RE SAYING THAT YOU SEE OTHER PROFESSIONALS INTERACTING WITH THE PATIENTS AND THEY SEEM TO JUST CARRY ON. AS A SPEECH LANGUAGE THERAPIST WHAT MAKES YOU REALLY FOCUS ON THAT AND PAY ATTENTION TO THAT, AS OPPOSED TO SOMEONE ELSE?
- P: Well I think it's because it's your job. It's your job as a speech therapist to... assess and know these things, as opposed to maybe a physio...
- I: THESE THINGS BEING?
- P: Well in this session I was just doing like pictures, trying to get her to remember. Maybe I'd put like 2 pictures at a time, then turn it down. Turn it face down and then I'll ask her... maybe I'll like put like a 5 second delay or 10 seconds then I'd ask her like in order... or she must tell me what she saw; what it was that she saw. And then I... increase it. I'll maybe put 3 pictures at a time, and then so that she can only cope with up to 3, remembering like 3 items at a time. And then I also have like matching pictures. I'd put like 4 at a time. And then she'd have to know that... she'll turn and if it's not the same, she'll put it back facedown and then she'll have to remember... she tells the other peer she has to remember when she saw the picture that was the same as the other

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<sup>4</sup> Expressive aphasia – type of aphasia that affects language expressive, i.e. spoken language and writing.

- one. So it was basically using her visual memory, yes. So I was doing a lot of that. I had planned to do some stuff for auditory memory<sup>5</sup> as well but I didn't get to that one.
- I: DOES SHE REMEMBER WHAT HAPPENED IN THE PREVIOUS SESSION? DOES SHE CARRY FORWARD KNOWLEDGE FROM THE PREVIOUS SESSION TO THIS SESSION?
- P: She does because you know when we've done an activity before she would, she'd know how to do it, so I can see that she's remembering some things from the previous session, but it won't be everything that she remembers. Like the things that she... like if we do something in the previous session and by the end of the session she had mastered it, she knows it. Then come the next session she would have forgotten, so...
- I: SO WHAT DO YOU DO IN THAT CASE?
- P: Well you try and review what we had done in the previous session first and like recap, umm and then like she remembers, and then we move on to something else. But we have basically been doing the same thing.
- I: AND HAVE YOU COME TO EXPECT THIS NOW THAT SHE WILL FORGET?
- P: She will forget, yes. Because the doctor even said she has actually booked her with a psychologist. Yes for them to see her as well because she's also worried about her memory, because it also affects her, not just the short-term memory, and the long term memory as well. Sometimes she'll remember which school she went to, but sometimes she'd say 'no, I can't remember'. But sometimes I think that as much as there is a memory problem, it is her as well not wanting to talk to people. Because she'd just say... if you ask her 'do you remember the name of your school?' she'd just say 'no'. But sometimes if you ask her, like if you find her in a good mood, you'll ask her 'so what's the name of your school?' and she'd tell you 'Spingo Primary'<sup>6</sup> or whatever.
- I: SO BESIDES YOU, WHO ELSE IS WORKING WITH HER? DOES SHE HAVE FAMILY THAT COME AND HELP HER WITH HER THERAPY TARGETS OR...
- P: No they don't come and help her with any kinds of stuff like that. They come maybe once a week or so, just to see her during visiting hours and then they'll go. If you're lucky enough that you're in the ward during that time you will see them and you'll get to chat to them. They don't really help with anything, so it's more like an 'us' therapy staff that are involved.
- I: AND SO, YOU KNOW, CAN YOU TALK ABOUT HOW THAT'S POSSIBLY IMPACTING ON HER PROGRESS, ON HER ABILITY TO REMEMBER, ON HER OVERALL PERFORMANCE?
- P: Well in terms of her being able to remember things, I think it is affecting her because she is not seeing the people that she used to be with during that time you know... If you see the familiar faces it helps maybe, could help trigger some something, help her with the memory. Also her overall improvement, I think her motivation levels are just so down. She sees that, ok they only come once a week, maybe they don't care about me so what's the point? Why should I work hard so that I get out of here, because these people don't care about me? Maybe these people don't care about me so why should I go back to them? Might as well just stay here.' And she's a bright child. She knows all of these things, that if somebody stays away from you, they probably don't care about you. So I think it does have an impact on her overall improvement as well.
- I: IT'S DIFFERENT FROM ANOTHER HOSPITAL SETTING WHERE THE OUTPATIENT COMES AND YOU WORK WITH THE FAMILY...

<sup>5</sup> Auditory memory – refers to stimuli transferred through the auditory medium to be held in memory.

<sup>6</sup> Spingo Primary – Islington Primary School



- P: Yes, very different.
- I: AND THEN YOU CAN GIVE THEM A HOME PROGRAMME<sup>7</sup>
- P: Home programme, yes. Here it's just you, and you know that if you leave the ward programme no one's going to do it, so the nurses are always busy running around doing that, doing that. So if you need something done with that patient you're going to have to do it yourself basically. Well upon discharge, maybe you can like do a home programme, which is most likely won't even be, get done but you will have to do it anyways
- I: FROM YOUR PREVIOUS CONTEXT WHERE YOU WORKED, COMING HERE, DID YOU KNOW THIS WAS HOW THE SITUATION WAS HERE?
- P: I had an idea that it was a bit... they told me it was a long-term care hospital so I expected that people would stay longer, but like I didn't know how long.
- I: DID YOU KNOW THAT YOU KNOW THE HOME PROGRAMMES DON'T GET DONE, AND LIKE DID YOU KNOW ALL OF THAT?
- P: No, that part, no. I knew about the ward programmes because, it was also happening at the previous hospital that I was at. All the nurses won't carry out, but the home programmes... we would always give the programmes and you would see by the next session that they had done it, you know. Because.. maybe I don't know, there is that thing of just giving up here. Like patients just give up as if someone said 'just give up'. Yes, because you'd find that this patient has been admitted at King Edward for a month before that, before they came here. So this month here is already 2 months. They've been away from home for 2 months, you'll find that the family doesn't come and visit anymore. They've run out of funds to come every 2 days or every 3 days to the hospital. So that you'll find that everything that has to be done has to be done by someone who's in the hospital, you can't rely on the family to do anything, except upon discharge where you can transfer everything to them. So it's very different from an acute care facility, it's very different.
- I: SO WAS THE SESSION THAT YOU HAD WITH SMA A TYPICAL SESSION THAT YOU'D SEE ON A DAY TO DAY BASIS HERE AT THE HOSPITAL?
- P: With my paediatric patients I would say yes. Not really with my adult patients.
- I: HOW IS IT DIFFERENT?
- P: Normally my adult patients are not very interested in doing anything. Yeah you know most of them, like I've said, they've given up on life basically, so like what's the point
- I: YOU DID MENTION IN THE PREVIOUS INTERVIEW THAT WITH THE PAEDIATRIC PATIENTS THE NURSES TEND TO GIVE A LITTLE BIT MORE CARE, BUT IN SMA'S CASE DO YOU THINK THAT THAT'S SO?
- P: No I don't think so in her case. They seem to focus more on the baby babies, than the other ones. They attend to them, but you know it, it's different from the babies, the small babies. Especially if they have their parents here, you'll find that the nurses attend to them more because probably they want to impress the parents. But like with these ones they know that they... for they have to care for them. I think there's about 4 of them in the ward, all Sma's age, all no parents. So you know, it's there. They make sure that they have to take care of them, yeah. So you find them, if they have to do things like additional things, like therapy for them, you know, it's not even an option
- I: AND YOU DID MENTION THAT YOU HAVE TO SEE SMA AND YOU HAVE TO DO THE THERAPY. YOU'RE GIVING HER INPUT AND STIMULATING HER. WITH SMA'S CASE THEN

<sup>7</sup> Home programme – refers to therapy targets that are compiled by the speech therapist for the patient to practise when not in therapy, i.e. at home or in the ward.



YOU MENTIONED THAT SHE SEEMS DEMOTIVATED AND SHE SEEMS LIKE SHE'S LOSING HOPE. IT'S NOT SOMETHING THAT SHE HAS SPOKEN ABOUT WITH YOU BUT YOU'VE PICKED IT UP IN HER BEHAVIOUR?

P: Yes.

I: YEAH, SO WHAT WAS THAT BEHAVIOUR THAT SHE SHOWED THAT MADE YOU REALISE THAT THIS IS THE PROBLEM?

P: It's like that thing of, of... not wanting to respond to people verbally when she can. Like yes, no, yes, no'. Like it's like she wants people to just, just get it over with this conversation I'm not interested.' Yes. It's only when she's like happy or whatever, especially when her parents... when her mother comes. On the day that her mother comes, she'd be in a good mood or maybe the following day as well. So you pick up that it has a lot to do with the background and what the child is... if they have the family support, then they respond better. So I've picked it up that when her mother comes to visit, after the visiting hour she's like over the moon. The following day, she'd be over the moon. Then when she starts seeing that they've gone away and they're not coming back then she goes back into her shell.

I: AS A THERAPIST, SEEING THAT, WHAT DOES IT DO TO YOU; HOW DOES IT MAKE YOU FEEL?

P: Oh! I mean we try to get used to it every day, but as a person it makes you feel very sad and its heart breaking to see a child like that. Because you can see that they're happy around these people, but these people are not... I'm not sure if they're not making an effort or maybe it's their circumstances also, but if you feel... if you see that they're not giving enough effort to show this child that 'I'll always be around; I care about you; I'm here every 2 days, every 3 days.' If they're here once a week, who sees their child once a week when they're from KwaMashu? Really I don't know but... I don't know about their circumstances. It is very heart-breaking.

I: WAS IT SOMETHING THAT YOU WERE PREPARED FOR TO SEE WHEN YOU WERE TRAINING TO BE A SPEECH THERAPIST? DID YOU KNOW THAT THIS WOULD BE AN EVERYDAY THING THAT I'M GOING TO SEE IN MY JOB?

P: No, I actually didn't. I didn't think about this, because you know when you're doing clinics at varsity you see all these parents; they care about their children; they come with them every Tuesday to the DLD clinic and they're happy to see this home programme. So you think it's like that everywhere, and then when you come to the real world and you realise that people don't care a thing about their children. They give birth, the next day they want to leave the child in hospital and go home. And they'd say 'I have other children and I have to take care of them'. But what about this child? It's a prem. This child needs to be taken care of like delicately, but they'd leave. They go. So it's not something that you get prepared for when you, when you're training. It's only something that you see when you actually come here to work.

I: IS THERE ANYTHING ELSE THAT YOU WOULD LIKE TO ADD TO WHAT HAS BEEN DISCUSSED?

P: No, I don't think so.

I: OK, THANK YOU Zandi. WE'RE GOING TO STOP THE INTERVIEW THERE.

APPENDIX T

LEVEL 2 DATA ANALYSIS GRID

A Other studies In the extant literature review (LR) and theoretical frameworks (TF) Original lens at start of study	B The extant knowledge KEY theorists/Studies	C KEY THEMES/FINDINGS PROPOSITIONS	D My study POST DATA ANALYSIS	E Confirmed Reject and why	F Surprising Something that the research did not expect to find	G New lens at the end of study Different/extended from A and B The thesis contribution About the PHENOMENON of the study
1. Understanding competences	<p><b>Eraut (1994)</b></p> <p><b>Chomsky (1965)</b></p> <p><b>Hymes (1972)</b></p>	<p>Professional competence – attributes such as knowledge, skills and attitudes.</p> <p>Competence vs performance</p> <p>Communicative competence – inherent grammatical competence and the ability to use grammatical competence in a variety of communicative interactions.</p>	<p>Mixed feelings regarding IPE.</p> <p>The real world is different from initial professional education and that initial professional education was too secure with the assistance of lecturers.</p> <p>The participants confirmed that they do not know all that they need to know to be a competent SLT – therefore this confirms this statement.</p> <p>Novice therapists suggested the observation of good practising practitioners to serve as good examples to emulate.</p>		<p>The participants offered insight into the types of knowledge that they valued, namely –</p> <p>practical knowledge and skills (knowledge and skills learnt through clinical tutorials, practicals and real-life examples);</p> <p>methodological knowledge (how to manage information collected); and</p> <p>generic skills (the 'side-effect' of academic work acquired through initial professional education).</p>	<p>Professional knowledges and personal knowledges.</p> <p>Critical knowledges of the cultural value system</p> <p>It is this uncertainty of not knowing the critical knowledges and the SLTs' discomfort with difference that leaves the SLTs destabilised.</p>
2. Communication as a core and soft skill in speech-language pathology	<p>Ferguson &amp; Armstrong (2004)</p> <p>Pillay (2003)</p> <p>Bill of Rights</p>	<p>Clinical discussion forum in the <i>Journal of Language and Communication Disorders</i> when they introduced the term "speech-language therapists' talk" (SLT talk)</p>	<p>The need to evaluate critically the processes and nature of acculturation that occurs during the first stages of professional development as a student speech-language therapist through to the ongoing development of</p>	<p>Challenges negotiating differences in language and culture.</p> <p>Interpreters were available but did not allow for a quick turnaround of services especially when clients arrived without scheduled</p>		<p>Personal and professional factors.</p> <p>Contextual factors:</p> <p>When there is incongruence between the professional and personal self, this negatively influences the clinical engagement and the communication strategies,</p>



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			professional practice in terms of communicative competence.		appointments. Interpreters available for isiZulu but clients spoke languages of other African countries – migratory mobilisation.  Physical appearance of practitioners – resistance from client when they did not seem to fit a particular cultural stereotype that is associated with the profession.		and the practitioner tends to operate in a space of discomfort and uncertainty. These situations could come about when the practitioner's personal identity does not agree with what the professional identity expects of him or her.  The high degree of discomfort these practitioners reflect in their narratives suggest that they tend to expect quick, easy and reliable solutions to their clients' communication impairments.
3. Bringing higher education (HE) in South Africa into focus	Morrow (2007)	Epistemological access Agency of the learner	Productive remembering of educational experience  The recall of past educational experiences were used as compasses to navigate the path of clinical decision-making by participants. These experiences have impacted their practices with their clients in some way or the other.				The negotiation of propositional and craft knowledge as a body of study is relatively underdeveloped in initial professional education. Both of these knowledges, propositional knowledge and craft knowledge, are needed to effect any substantial professional growth.

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4. 'Communicating' between the worlds of academia and work	Griesel & Parker (2009)	The articulation (communication) between higher education and employment in the workplace has been the focus of government initiatives for many years	We should look to the method of teaching and curriculum in order to reach our diversified students and thereby the diversified discursive space (existing and prospective) within which they operate.				Personal factors and professional factors:  The negotiation of propositional and craft knowledge as a body of study is relatively underdeveloped in initial professional education. Both of these knowledges, propositional knowledge and craft knowledge, are needed to effect any substantial professional growth.
5. Academic and communicative competence	Gravett (2012)  Gravett, Petersen and Petker (2014)  Hammemes, Darling-Hammond, and	Theory-practice divide:  Epistemological chasm between the two – do the theory first and then the clinic.  Differentiation of knowledge <i>for</i> practice and knowledge <i>of</i> practice.  Need to link abstract theory with pragmatic practice.  Knowledge, skills and attitudes (competence) for optimal practice is not fully developed in initial professional education. This is where the role of continuous professional	On student training and continued learning  Most of the participants recounted that their student training was helpful at the time but once in the world of work they had to do more on-the-job learning. They felt that their undergraduate education was too sanitised and would have preferred for it to closely mimic the messy world of work. They provided suggestions for clinical practicum and pedagogical methods to try and bridge this gap as well as to watch experienced				Personal factors and professional factors:  Knowledges which are privileged in higher education namely – <ul style="list-style-type: none"> <li>• practical knowledge and skills (knowledge and skills learnt through clinical tutorials, practicals and real-life examples);</li> <li>• methodological knowledge (how to manage information collected); and</li> <li>• generic skills (the 'side-effect' of academic work acquired through</li> </ul>



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	Bransford (2005)  Dreyfus Model cited in Eraut (2009)	development facilitates the lifelong learning.  Model of progression of professional development	SLTs to serve as good examples to emulate. They expressed their desire for opportunities for continued professional learning with regard to the negotiations that go on during clinical engagement.			initial professional education).
<b>6. The world of work and communicative competence</b>	Frankel (2001) McNeillis (2001)  King, Servais, Bolack, Shephard & Willoughby (2012)  Candlin (2000)  Sarangi & Roberts (1999)  Frenk et al. (2010)	Poor communication can result in lack of patient compliance and misunderstandings resulting in readmissions.  Without effective communication skills on the part of the SLT, client situations will not be appreciated, client desires will not be understood, common ground with the client and families about priority issues will not be reached, and shared decision-making about best courses of action will not occur.  SLTs globally share similar practice issues with other healthcare professionals seeking to	Practitioner’s emotive experience of SLT,  On policy:  The participants often found that policy was constraining their practice. There were systemic changes that impacted their practice however they were not always made aware of these overtly.  On cultural and power matters related to communication between the SLT and families and the client.	Participants mostly discussed the negative emotions which led to them using descriptors such as overwhelmed, helpless, sad, feeling hollow, frustrated. These negative emotions were seen across all contexts and with both newly-qualified and experienced speech-language therapists had challenges with the interpretation of policy.  Responsibility of care: Handing over of the responsibility of care of clients was something that the participants had difficulty negotiating. During their undergraduate	The medium of language for service provision in the education context led to concerns about the double learning that second language English learners will have to go through. This double learning refers to the learning of English in order to learn content. Their main concern was effective service delivery and negotiated their professional role in order to maintain this.	Affective factors: Affective factors influenced the communication strategies used during clinical engagement, because as Kamhi (2011) reminds us, we are influenced by our feelings, emotions, desires, goals and self-interests. The participants described feelings of being hopeful and optimistic when working with their clients and families; however, at the other end of the spectrum, they also described hopelessness, depression, despondency and feelings of giving up. This affected the motivation of both novice and experienced SLTs and left them at risk of burnout. The SLTs were not comfortable with the responsibility of being the sole communication partner and

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		enhance communication in the delivery of care.			education students were encouraged to work together with families. Participants then found it difficult when families handed over this responsibility to the speech-language therapist.		emotional caregiver for their long-term care clients.
7. Communication accommodation theory	Giles and Ogay (2007)	<p>This framework is aimed at predicting and explaining many of the adjustments individuals create, maintain or decrease during interaction with communication partners, i.e. convergence and divergence.</p> <p>Convergence – adaptation of <i>linguistic features</i> (rate of speech, accent), <i>paralinguistic features</i> (pauses, length of utterances) and <i>nonverbal features</i> (smiling, eye contact, gazing).</p> <p>Divergence - emphasises the difference in communication styles between the conversational partners.</p>	<p>Moving to comfort – where communication with the conversational partner (client) can be more easily accommodated than in the previous work setting.</p> <p>While doing conducting therapy the SLT has to ensure that he or she is understood by the client, family or others as appropriate human communication requires one to have the need to leave a conversation with clarity of thought and feeling understood.</p>		Physically moving employment to settings that may be seen as more suitable/manageable in terms of communication.		A limitation of the theory was that it did not focus on the problematics around communication that are so commonly found in clinical interactions between practitioners and clients. The theory focussed on the role of conversation during social interaction (Giles & Ogay, 2007). The theory is about resolution of communication breakdown and conflict and about accommodating one's conversational partner. However, conversation is more complex than to be reduced to immediate linear interactive resolution. Hence, the CAT was found to be lacking for the exploration of clinical interactions, which are often complex in nature due to the coexistence of multiple factors being negotiated simultaneously, sometimes coherent and at



**APPENDIX T**

A	B		C	D	E	F	G
<b>Other studies</b> In the extant literature review (LR) and theoretical frameworks (TF) <i>Original lens at start of study</i>	<b>The extant knowledge KEY theorists/ Studies</b>	<b>KEY THEMES/ FINDINGS PROPOSITIONS</b>	<b>My study POST DATA ANALYSIS</b>	<b>Confirmed</b>	<b>Reject and why</b>	<b>Surprising</b> Something that the research did not expect to find	<b>New lens at the end of study</b> Different/extended from A and B The thesis contribution About the PHENOMENON of the study
							other times, contradictory and paradoxical.
8. Problematic integration theory (PIT)	Babrow (2007) Brashers (2007) Sampaio (2014)	A sociological theory of uncertainty and communication that examines how we make meaning of information and experiences and how we deal with uncertainty through communication.	On practitioners' experiences of speech language therapy: - Operational experiences > Families not wanting to be part of therapy > Client's refusal of therapy > SLT as sole communication partner for client Problematising clinical engagement: Ageism Sexism Language difference Cultural conceptions of therapy Undervaluing of speech language therapy		Many of the participants had challenges in coping with the emotive experiences of being a speech-language therapist in the varied contexts. Besides working through the clients' severity of their communication disorder, participants had to try to convince parents and families to be custodians of care in the rehabilitation process of the clients. Unfortunately this was not always successful and so the speech-language therapist often became to the sole communication partner for their clients. This meant that they often interacted with little children waiting for their mothers to visit, fathers who were clients pining for their children and geriatric clients losing hope as their families' last visit became distant memories.	Emotive factors	Affective factor Personal factors Professional factors The PIT was limited in handling the incongruence that the participants experienced between their personal and professional selves which resulted in coincidental affective factors. The participants revealed that their desire was not to be shown the ideal clinical engagement throughout their initial professional education; rather, they wanted to be shown the complexities of real-world practice, no matter how difficult it may be to accept at the time of being students.

**APPENDIX T**

A	B		C	D	E	F	G
<b>Other studies</b> In the extant literature review (LR) and theoretical frameworks (TF)/ <i>Original lens at start of study</i>	<b>The extant knowledge</b> <b>KEY theorists/ Studies</b>	<b>KEY THEMES/ FINDINGS PROPOSITIONS</b>	<b>My study</b> POST DATA ANALYSIS	<b>Confirmed</b>	<b>Reject and why</b>	<b>Surprising</b> Something that the research did not expect to find	<b>New lens at the end of study</b> Different/extended from A and B The thesis contribution About the PHENOMENON of the study
					The negotiation of the multiplicity of roles within the world of work was a key finding as the participants found the experiences of engaging with clients cannot be done in isolation to engaging with parents or families. The challenge came in when there was the lack of support from the parents or families which implied the handing over of responsibility of care to the SLT. The speech-language therapist found that in some cases they became the sole communication partner for their clients, this complexified the nature of the responsibility of the therapist as the director of resolutions, rather than a co-constructed responsibility, something that they were not always prepared for.  Among the novice speech-language therapists it was seen that they experienced a form of prejudiced		



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					ageism from their clients and families.		
9. The Canadian Medical Education Directions for Specialists (CanMEDS) competency framework: Graduate competence/attributes	Frank (2005)	<p>The Canadian Medical Education Directions for Specialists (CanMEDS) is an initiative to improve patient care by health professionals in the world of work. Its focus is on articulating a comprehensive definition of the competencies needed for medical education and practice.</p> <p>According to the CanMEDS Competency Framework, communicators are healthcare practitioners who effectively facilitate carer-patient relationships and the dynamic exchanges that occur before, during and after intervention</p>			With the development of the CanMEDS competency framework and other graduate attributes or competency lists from research reports, competency-based education can often be seen as aiming to fulfil an agenda of multiple exit level outcomes being addressed. This could foster an atomisation of the competences, which are reduced to lengthy lists to be engaged during clinical practice. The academic curriculum could become characterised as simply a space to demonstrate compliance with 'engaging' targeted competencies in rather superficial levels.		It is my criticism that the CanMEDS competency framework was found to be too idealistic and unrealistic to cope with the complexities of real practice. The CanMEDS competency framework focusses on performance outcomes in a rudimentary manner. However, we have come to learn that competency development goes beyond a linear, tick-box approach, as it is about the negotiation of the professional and personal selves.

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Jackie Viljoen  
Language Editor and Translator  
16 Bergzicht Gardens  
Fijnbos Close  
STRAND 7140

Accredited member of the South African Translators' Institute  
No APSTrans No. 1000017  
Member of the Professional Editors' Group (PEG) No. VIL003  
Member of Safrea No. SAF03316

☎ +27+21-854 5095    ☎ 082 783 0263    ☎ 086 585 3740  
Postal address: 16 Bergzicht Gardens, Fijnbos Close, STRAND 7140 South Africa

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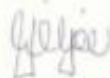
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JACKIE VILJOEN  
Strand  
South Africa  
13 December 2018

Jackie Viljoen  
Language Editor and Translator  
16 Bergzicht Gardens  
Fijnbos Close  
STRAND 7140

Accredited member of the South African Translators' Institute  
No APSTrans No. 1000017  
Member of the Professional Editors' Group (PEG) No. VIL003  
Member of Safrea No. SAF03316

☎ +27+21-854 5095    📠 082 783 0263    📠 086 585 3740

Postal address: 16 Bergzicht Gardens, Fijnbos Close, STRAND 7140 South Africa

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JACKIE VILJOEN  
Strand  
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