FAMILY TREATMENT:
AN ALTERNATIVE APPROACH TO
SPEECH AND LANGUAGE THERAPY

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Before the early 1970's, special education did not recognize the importance of parents in the education of handicapped children. In fact, they were seen more of a hindrance to the educational process rather than of a help. However, since then, this attitude among educators and professionals dealing with handicapped children has changed. With the incentives of a feared shortage of teachers and professionals such as speech pathologists during the 1970's, and the passage of The Education for all Handicapped Children Act, Public Law 94-142 (1975), guaranteeing parents the right to be involved in the education of their handicapped children, programs involving parents have been developed.

At first these programs consisted mainly of counseling parents or giving them instructions on how to help the children (Carpenter and Augustine, 1973 p. 48). Learning packages consisting of materials used by parents to train their children in deficient skills were designed. Evaluation of packages developed by the Special Education Instructional Technology Project at Utah State University showed a certain amount of improvement in the participating children's performance (Hofmeister and Reavis, 1974, p. 56).

An advancement of this concept was the actual training of parents to be tutors of their children by professionals. Many successful tutoring programs have been reported in the literature.
MacDonald, et al. (1974) taught mothers to be language trainers for their language delayed Down's Syndrome children. These mothers were instructed in how to generalize functional language in their children through the use of the Environmental Language Intervention Strategy, a design by MacDonald and Blott (1974) for testing and training the rules underlying children's early sentences. Positive results were obtained with the program. Barnett (1974) discussed the use of evening clinics to train parents in teaching methods for children with learning problems. Although questionnaires filled out by the parents were the only means used to assess the program, parents generally thought that the clinics were beneficial.

Lombardino and Mangan (1983) conducted a parent training program for ten weeks at the University of Florida Speech and Hearing Clinic. These parents of developmentally delayed children were trained to plan and conduct structured language teaching sessions with their children, and were also trained to stimulate language development at home through free play activities with their children. Results of this program indicated that instructing parents could effect change in their communicative behavior which would, in turn, bring positive change to the communicative behavior of their language delayed children.

Barbara Shoenig (1978), a parent of a Down's Syndrome child, described her experience in the P.E.E.R.S. (Parents are Effective Early Education Resources) Program. On Saturday mornings parents involved in the program met with professionals to discuss ways in which to help their children. The parents, then, utilized these techniques at home during the week. A program teacher visited the
homes of each family once a month to teach additional techniques in the home environment. Shoenig reported that being involved in the program showed her how to incorporate teaching techniques into her family's everyday activities which is essential in order for the generalization of new learned behaviors to occur.

Beveridge and Jerrams (1981) discussed the Parental Assistance Plan (PAP). This two-part plan included 1) talking to parents and demonstrating teaching techniques, and 2) practical demonstrations with small groups of children to reinforce these techniques. It was found that those children whose parents participated in the PAP program showed a significantly greater increase in language development than those whose parents did not.

Not all tutoring programs, however, proved to be this successful. Salzberg and Villani (1983) found that parents of Down's Syndrome toddlers were able to acquire language training skills, but did not generalize these behaviors to the home environment. When these parents were taught to generalize their acquired training skills to the home, however, their children's vocal behavior increased.

Another problem with the tutoring approach is that often these programs are taught in the same manner to all parents regardless of each family's unique characteristics. While tutoring guides for parents may be helpful to a certain extent, for example, Spadafore's A Guide for the Parent as Tutor (1979); they simplify the process of teaching skills to handicapped children and do not account for the differences in families' reactions to similar situations.

Carpenter and Augustine (1973) conducted a study in which
four mothers were trained to be "parent clinicians" for their communicative disordered children. Three of the mothers were able to modify their children's communicative behavior, while the fourth mother was not. Her failure was attributed to her personality and tendency to become easily confused.

Cummings and Maddux (1983) identify four types of parents of handicapped children. The Apathetic Parent is the first type described. This parent is too busy or unmotivated to take an active part in his or her child's education. The professional dealing with this family must make sure that this type of parent feels that his or her input and opinions are truly valued.

The Burned-out Parent has heard so much negative information about his or her child that interest in helping him or her has diminished. These parents may be helped by a professional with a positive attitude who will listen to their suggestions and comments.

Intimitaded Parents are often uneducated, members of a minority group, or do not speak English well. These parents are generally apprehensive about IEP staffings and other such meetings with professionals concerning their handicapped children. Contact with parents before scheduled meetings and parent-education programs can often be of help to these parents.

Resigned Parents do not become involved with their children's programs because they do not consider them to be useful. This type of parent usually cannot be helped because of the continual academic failure experienced by his or her handicapped child. To reduce or prevent this academic failure, parents must be involved as early as possible in the special education of their children.
Dublinski (1974, pp.227-228) identifies persons as being either Solution Persons or Needs Persons. Solution Persons are those who look for others to assume responsibility for their handicapped child and Needs Persons are those who, themselves, look for ways to help their child. Needs Parents would probably be more successful with tutoring programs than would Solution Parents.

Limitations of tutoring programs have required the development of other approaches in involving parents in special education. According to Turnbull and Turnbull (1982, p. 20), different options in programs involving parents must be available to accommodate the unique characteristics of each family. Parents must also be involved in the decision making processes of developing special educational programs for their children (p. 21).

From results of a study by Dembinski and Mauser (1977), Wolf (1982, p. 80) lists recommendations made by parents for professionals involved in special education.

1. Use terminology we can understand
2. Give us material to read
3. Tell us how our child gets along with others in class
4. Show us how to teach our child
5. Tell us what you expect our child to learn

Parent discussion groups as described by Webster and Cole (1979) can increase the effectiveness of parent involvement. These groups can promote discussion among families with similarly handicapped children about problems experienced and solutions reached by the families in dealing with these handicaps.
Wilson (1983, p. 42) states that a handicapped child upsets the whole family and that parents' frustrations may often impede their ability to help their child. In a nonjudgmental way, professionals must help these parents acknowledge and accept these feelings. These parents, then, can be shown ways in which to help their child.

This leads us to a more encompassing approach to parental involvement—family treatment. Seitz and Riedell (1974) reported on an experimental language therapy program where the treatment target was the parent-child interactions between a severely retarded Hindu child and her parents. The eight-week program consisted of one hour per day sessions for three consecutive days per week. The mother attended the sessions regularly, while the father attended whenever his work schedule permitted. The parents watched the therapists interacting with their child in play for six sessions, and then entered the playroom to practice the behaviors which had been modeled for them.

Although results of this study did not show an immediate increase in the child's expressive language, after the program the child was able to separate from her parents and engage in more independent activities. The child was also raised from a severely mentally retarded classification to a trainable classification, and was predicted to eventually attain an educable classification. The conclusion to be drawn from this study is that parent-child interactions can play a role in facilitating change in the verbal behavior of language delayed children.

The parental involvement in this study was carried out for the most part by the mother. In many of these parent-involvement
programs, the mother performed activities with her handicapped child during the day, while the father was at work. In the 1980's, however, the majority of mothers are also working outside the home, and fathers are beginning to become more involved in the everyday activities of their children. These developments have moved parental involvement in special education toward a more family-oriented one which includes siblings and grandparents when appropriate.

Sampson (1972) and Philage, Kuna, and Becerril (1975) developed programs which removed the focus of therapy from the handicapped child and placed it within the context of the family. These programs recognized the fact that the behaviors of the various members of a family affect the behaviors of all other members of a family. This view is based on family systems theory which views all members of a family as being interrelated so that one member cannot be understood apart from the other members; and that change in one member brings about change in all other members (Andrews and Andrews, 1983).

Another interesting example of this type of interaction as related to language-delayed children is seen in a study by Wellen and Broen (1982). Results indicated that twenty percent of questions directed towards children with normal language were answered by their older siblings, while 75 percent of questions directed towards language delayed children were answered by their older siblings. Because the language delayed children were not allowed to talk as much, they were deprived of normal language interaction with others. As a result, these children did not have the opportunity for an adult to modify their language structures which deprived them the opportunity to learn and expand their
structures. This example clearly shows how faulty interaction among family members may cause delays in language development. Without seeing this family interaction, the cause of the delay may not have been discovered and treatment may not have taken place.

This family systems approach has been utilized in the treatment of communicative disorders at Northern Illinois University Speech and Hearing Clinic by Dr. James R. Andrews of the Department of Communicative Disorders, and by Mary A. Andrews of the Division of Child and Family Studies, Department of Home Economics (1983). In their model the whole family is involved in the assessment and treatment of the problem, rather than just the individual with the problem. Additionally, the whole family joins with the clinician in deciding the goals of therapy, and receives from the clinician all information pertaining to the problem before and throughout the treatment period.

The approach used by the Andrews is based on the process model of convening, assessing, treating, and dismissing. Under convening, the Andrews require that all family members be present at the initial meeting. During this first session, the clinician stresses the importance of all members of the family in the remediation of the problem, and makes it clear that the family therapy will only pertain to the speech and language problem. Family members are only counseled in those areas that will affect change in the member with the speech and language problem. This is emphasized by the Andrews calling their approach "family treatment," rather than "family therapy."
In the assessment stage all members are asked to share their views of the problem. During this stage, the clinician provides the family with all available information about the problem.

During the treatment stage, family members are encouraged to provide feedback about any changes in speech and language behavior that are occurring, and are encouraged to contribute ideas for therapy. The clinician rewards the family members for their contributions, for example, "That is a good idea. We could use that here," and also for their work, for example, "Singing with Mary is a good activity for her."

This reinforcement is extremely important. As with rewarding a child during individual therapy, this reinforcement will increase positive behaviors shown by the parents. Although parents are encouraged to suggest treatment procedures, they do not take over the role of the speech pathologist.

Family members can provide information about various environments encountered by the individual with the problem. This allows the speech pathologist to suggest treatment techniques that can take place within the context of these environments. Family members do not just take techniques learned in the session back home to practice, but actually bring situations from home to be utilized in the therapy session.

As an example, one father involved in the Andrews' program brought in a tape recording to the therapy session of his language delayed daughter repeating words and singing a song. This tape was played during the session with the child repeating the words and singing along with the tape. A list of words modeled by an older sister and imitated by the child at home was also
brought in and utilized during the session. As can be seen, the speech pathologist can see what activities are being done at home and incorporate them into the therapy session. The speech pathologist, however, must tactfully inform the parents of activities they are doing that may impede the treatment process. During the therapy sessions, ways of changing any faulty communication patterns of the family can be practiced.

Spradlin and Siegel (1982, p. 4) list three conditions of the home that may impede language development which the speech pathologist can watch for during the therapy session. The first is that very few appropriate models of language occur. Language is often not related to what the child is doing. Secondly, teachers or parents of handicapped children may provide materials for the child before he or she has a chance to verbally request for them. Finally, parents may not respond to the child's vocalizations, and therefore, these vocalizations are replaced by more physical means of communication, for example, pulling on the parent's sleeve.

Spradlin and Siegel (p. 5) also say that many of the reinforcers (tokens and candy) and the amount of reinforcement in a therapy session are not the same as those provided at home. Reinforcers used at home can be incorporated into a family treatment session. Examples of these reinforcers are the child's own toys or a mother or father's praise.

In some cases, individual sessions between the speech pathologist and the person with the problem are desired as well as the family session. Members of the family should be allowed to observe these sessions, and these sessions can then be discussed in the
family session. By observing these individual therapy sessions, parents can often learn how to reinforce their children and how to structure activities for their children.

Reinforcement is perhaps one of the most important ways in which a parent can effect change in a child's behavior. Correct reinforcement of a desired behavior is a topic that is often addressed in family treatment. The Andrews have found that parents learn to accurately reinforce their children quite easily. They have also found that one parent will often be better at reinforcing than the other, and often these roles will change during the course of treatment. As one parent becomes more proficient at rewarding, the other parent may drop back. The speech pathologist must be aware that this could occur, and continue to reinforce each parent for his or her work with the child.

Many parents will be anxious to show improvement, however slight, in their child to the speech pathologist. The speech pathologist must be sensitive to this need and respond appropriately even if improvement was not that significant. The speech pathologist must always reinforce the efforts of the parents, be a concerned listener, and seriously consider the parents' suggestions.

The Andrews believe that certain disorders can be treated especially well with the family approach. These include language disorders, stuttering, hearing impairment, and aphasia. Because these types of disorders have a perhaps more marked effect on other members of the family, treatment will be more effective with a family approach.

As can be seen, one of the main advantages to the family treatment approach is that the individual characteristics of a
family can be taken into account and utilized during the treatment process.

Another benefit of the family treatment approach to communicative disorders is that it can help bridge the gap between the family, the school, the speech pathologist, and other professionals who work with the child. Many parents are often intimidated by the IEP staffings that are required by P.L. 94-142. In many IEP staffings the parents are told what the goals for their child will be during the school year. They are not asked if they have any suggestions for goals or even if their child has already mastered some of the proposed goals at home. In addition, these goals are often presented in jargon that they do not understand.

A speech pathologist involved in family treatment can provide parents with much needed support at an IEP staffing. They may attend a staffing with the parents and interpret anything not understood, and can also provide the school officials with information about activities that are being done in the therapy sessions and about behaviors exhibited by the child in question. The speech pathologist also becomes aware of the school's goals for the child in speech and language as well as other areas. Some of the school's goals may then be dealt with in the family treatment session. In this way, family treatment can help coordinate all of the services that the child is receiving, providing the child and his family with cohesive strategies for dealing with or remediating his or her problem.

Because it will be more difficult to remediate a problem within a dysfunctional family system, the speech pathologist must have some knowledge of the workings of this system in order
to maximize the family treatment session. Longo and Bond (1984, p.62) reported on studies which indicated that two coping strategies may be predictors of successful adaptation in families with handicapped members. These are 1) "effectively sharing the burden of the child's illness among family members, and 2) the family's ability to make philosophical sense of what happened to them." If a family appears to be dysfunctioning as a result of the child's handicap, the speech pathologist can present these two strategies to all the members so that adaptation will be more likely to occur.

Longo and Bond (p. 63) also state that parents who know in advance about critical periods or issues related to their child's handicap are better able to deal with any difficulties that may arise as a result of the handicap. This relates back to the Andrew's model of giving the family all information concerning the problem throughout the treatment period.

Girdner and Eheart (1984, p. 90) list crisis periods for families with handicapped children which are useful for a speech pathologist to know so that he or she can provide emotional support to families he or she works with if needed. These include the time of diagnosis, when the child reaches the age that walking normally begins (twelve to fifteen months), when the child reaches the age that talking usually begins (24 to 30 months), when the child reaches the age at which most children begin school, when the child reaches puberty, when the child reaches the age of legal majority, and when a younger sibling surpasses the handicapped child in terms of abilities. Also when there are considerations about placing the child outside the home, when serious of life-
threatening health and behavior problems occur, and when decisions are made regarding care of the child in the event of the parent's death.

Schilling, Gilchrist, and Schinke (1984, p. 49) state that families with handicapped members functioned better if they had shared their burdens with others along with using personal coping strategies. They also state that while families may be in contact with social support systems, such as self-help groups, they must more importantly be able to skillfully interact with others in order for these groups to become effective coping mechanisms. In order to become an effective social support, the speech pathologist conducting a family treatment session must know how to promote effective interaction among family members and him or herself.

The speech pathologist must realize that he or she becomes part of the family's system, and, as a result, has a direct influence on that system. The mere presence of the clinician effects change within the system, and he or she must know how to use this presence to direct the change in the desired direction.

It is often assumed that families with handicapped children are dysfunctional. Longo and Bond (1984, p. 63) report that this may not be the case in many families with handicapped members. Speech pathologists who think of such a family as dysfunctional may set inappropriate goals for the family which will not aid in the remediation of the actual problem. A speech pathologist working in family treatment should, therefore, be thoroughly knowledgeable about what constitutes functional and dysfunctional families in order to set appropriate goals for the family. This implies that university curriculums used in the training of
speech pathologists must include courses in family systems and counseling.

Dismissal, the last component of the Andrews' process model, is the least developed. This stage depends a great deal on the particular family involved. If the problem is more functional, for example articulation, and the goals of therapy are met, dismissal is more clear cut. In many of the Andrews' cases, treatment was terminated after therapy goals were reached. This often occurred and the child was picked up by the school speech pathologist at the beginning of the school term.

With organic disorders, such as mental retardation, dismissal is not as clear cut. Termination with these families more or less evolves out of the therapy sessions. During therapy, parents become more aware of the development of their children and more knowledgable about their limitations. With this increase in knowledge, parents are often able to take techniques learned in the therapy session back home after therapy will no longer bring about change in behavior. At this point, parent's continued work at home with their children will probably be enough to maintain the level of behavior that their children have achieved. It is also to be stressed that the decision for dismissal must be a mutual decision between the speech pathologist and the family.

The Andrews suggest following up on a dismissed case in about a year to make sure that the goals of therapy have been maintained. At this time, if appropriate, additional interventions can be made. If the family has not maintained behavior, they may attend a few additional sessions to get back to their desired level of functioning.
One of the main advantages of family treatment is that speech and language remediation does not take as long as it would with only individual therapy. This hypothesis has not been tested experimentally, but has been supported by clinical observations by the Andrews. They report that their most rapid treatment occurred in fifteen sessions over five months. Their longest treatment to date continued for eighteen months. One of their present cases, a language disorder attributed to mental retardation, may surpass eighteen months of treatment. This, as discussed before, is an example of an organic problem that may take longer to reach a point of dismissal. More research and experience with these types of cases will be needed before definite conclusions can be made.

Problems with this method of treatment have also been encountered. As mentioned before, speech pathologists have not and are still not being trained in family systems theory. Because of this, most speech pathologists are not qualified and, perhaps more importantly, are not comfortable with the family treatment approach. This problem can easily be corrected by providing more training courses and more practical experience in family systems and family treatment.

Another related problem concerns the clinics, themselves. Most clinics are set up for individual sessions. Larger therapy and observation rooms must be constructed in order to accommodate all the members of a family and the speech pathologist. The Northern Illinois University Speech and Hearing Clinic has set up a large room capable of comfortably seating members of a family for the purpose of their family treatment sessions. This room
also contains a wall-size, one-way mirror allowing the treatment sessions to be observed by students. This room provides a comfortable setting for the family, while also providing the students with a means of first-hand observation of the family treatment process.

Perhaps the most prevalent problem associated with the family treatment method is the scheduling of sessions. Because most parents work, and often at different times, it is difficult to schedule sessions so that all members may attend. Usually sessions will have to be scheduled at night after regular clinic hours. Parents, speech pathologists, and children alike are often more tired at this time of the day than they would be at other hours.

All efforts should be made to come up with the most convenient meeting time for members involved. The speech pathologist must try hard to convince a reluctant parent that the advantages of a family treatment program will outweigh the disadvantages of scheduling problems. The speech pathologist must convince these parents that treatment will be more rapid and that improvement obtained will be more lasting with a family approach.

We have come a long way in treating communicative disorders and other handicaps since the early 1970's. No more are parents thought of as being in the way of the effective treatment of communication problems. With the incorporation of family systems theory into speech therapy, family members are now considered essential in treating communicative disorders. The task now is to inform all speech pathologists of this approach, so that they may incorporate it into their own therapy sessions for the greater benefit of their clients.
REFERENCES


