Speech-Language Pathology Assistants

A Resource Manual

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Contents

Preface

Speech-language pathology assistants (SLPAs) are "support personnel who, following academic and/or on-the-job training, perform tasks prescribed, directed, and supervised by ASHA-certified speech-language pathologists [SLPs]" (American Speech-Language-Hearing Association [ASHA], n.d., para. 2). The use of SLPAs and support personnel is not new. As early as the 1970s, support personnel in the field of speech-language pathology were being used and regulated by different states in the United States (ASHA, n.d.). ASHA has had guidelines for the use of support personnel since 1969. According to ASHA, attention to the use of SLPAs has increased as professionals in the field look for ways to contain costs and expand clinical services (ASHA, n.d.). ASHA maintains and periodically updates formal policy and guidelines on the training, use, and supervision of SLPAs. Recognizing national inconsistency in SLPA use and training, ASHA also created an optional associates program in 2011 (Robinson, 2010). This program extends ASHA affiliation to qualified support personnel who agree to follow all ASHA policies and guidelines pertaining to the use and supervision of support personnel (*McNeilly, 2010*).

CONTENT

This book is written specifically for SLPAs, addressing their unique needs. It is intended to be a practical resource on a wide range of topics that SLPAs may find of value. It does not cover in depth the areas of normal processes of communication or communicative disorders. Rather, it is intended as a "what now" or real-world perspective in offering suggestions in the area of technical and clinical procedures for an SLPA, including professional issues and ethics of an SLPA's duties, and instruction in workplace behaviors of SLPAs, such as implementing treatment and collecting and summarizing data. Specialized topics applicable to SLPAs, such as augmentative and alternative communication, cultural and linguistic diversity, play and literacy in therapy, speech sound remediation, and autism spectrum disorder, are also included and are meant to extend an SLPA's foundational knowledge in these areas to real-world applications. This book is written for individuals with a variety of SLPA experience and training. It is my hope that SLPAs with all levels of experience and background will find tools and resources of value to them in this book. If you are an SLPA who has been in the field for many years, this book may offer you a fresh perspective on your role as an SLPA and ideas in continuing to refine your skills as an SLPA. If you are an SLPA just starting your career, this book will offer you important information to take with you on your journey. If you are an SLPA in training, this book will provide you with information relevant for your training, particularly to your clinical practicum and future employment as an SLPA.

ORGANIZATION

The first six chapters of this book cover broad topics in the area of SLPA practice, including an overview of the roles and responsibilities of SLPAs and their supervisors. The initial chapters of this book also cover topics such as professional conduct, ethics, cultural and linguistic diversity, and topics important to the health and safety of SLPAs and the individuals they serve. Within these sections, ASHA documents are a cornerstone when referencing policies, procedures, rules, and regulations applicable to SLPA practice. At present, there is considerable variability between states in regulations applicable to SLPAs. As such, ASHA as the sole national professional organization in the United States serves as an important and primary resource on the topic. That is not to say that SLPAs should ignore state regulations. Rather, as will be discussed, SLPAs must be cognizant of both ASHA and individual state regulations. As such, references and suggestions for accessing state-specific information are provided. Furthermore, given the dynamic nature of policies and procedures, readers should view the information in this book as an overview of regulations and policies in place at the time of publication. The reader is referred to ASHA's website, at http://www.asha.org, for the most recent information in this area.

The final nine chapters of the book are organized as "skill development" chapters. These chapters cover a specific set of skills needed by SLPAs in working *clinically* with individuals with communication disorders. Throughout each skill development chapter, helpful tips and applicable references and resources are provided, with the major emphasis on providing information that will be of value in actual clinical work as an SLPA. It should be noted that these chapters are meant for a reader who has knowledge about normal process in communication and communication disorders, as would be covered in coursework to become an SLPA.

CD MATERIALS

A CD is provided with this book. This CD contains important forms that readers can use in their clinical work as an SLPA. These forms can be freely modified and copied. Explanations about the content contained on the CD are embedded within the written material. The following symbol denotes where the content of the CD is referenced. 

REFERENCES

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CHAPTER 11

Group Therapy

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Unity is strength . . . when there is teamwork and collaboration, wonderful things can be achieved.

Mattie Stepanek (nationally recognized poet and peace advocate. Mattie died at age 13 of complications related to dysautonomic mitochondrial myopathy, a rare form of muscular dystrophy)

As has been mentioned, you may be asked to provide treatment services under the supervision and guidance of your supervising speech-language pathologist (SLP) (American Speech-Language-Hearing Association [ASHA], 2013). These services may be delivered to a single individual or to a small group of individuals (Cascella, Purdy, & Dempsey, 2007). Provision of treatment services to small groups of individuals is common in a variety of settings, including school settings for children (Mire, 2007) and medical and community settings for adults (Elman, 2007). Chapter 10 shares ideas for implementing treatment services that are applicable

to both individual and group treatment models. The sections that follow focus on the unique aspects of group models of treatment that warrant additional consideration.

The purpose of group treatment varies (Roth & Worthington, 2001) but can include the following:

1. Teaching participants a new communication skill at an introductory level
2. Providing participants with practice in skills established in an individual session
3. Providing participants with socialization, self-help, and/or counseling

Not all groups are appropriate for a speech-language pathology assistant (SLPA) to lead. For example, groups in which counseling and adjustment is the primarily (or secondary) purpose would not be appropriate for implementation by an SLPA. Group intervention can occur concurrent with individual sessions or as the sole source of intervention (Roth & Worthington, 2001). It may be provided early, late, or throughout the client's course of treatment. In some cases, group sessions will comprise individuals with similar skills, abilities, and intervention goals, whereas in other instances, group members will be individuals with diverse skills, abilities, and intervention goals (Elman, 2007; Luterman, 2008; Moon-Meyer, 2004). Groups can range in size from as small as two individuals to as large as an entire classroom, as may be the case in community-based groups or in the case of a self-contained classroom in a school setting (Cascella et al., 2007; Elman, 2007). A self-contained classroom is common for students with special needs. Self-contained classrooms place a small group of pupils with special needs with generally one instructor (often assisted by paraprofessionals) for most of the day (Mattinson, 2011; Schubert & Baxter, 1982; Walker, 2009).

The role of the clinician during group treatment can be directive or nondirective (Roth & Worthington, 2001), based on the purpose of the group. In the case of a directive model, the clinician "sets the agenda, chooses the materials and activities, provides specific instruction, and gives corrective feedback (Roth & Worthington, 2001, p. 25). In a nondirective role, the group members participate in these activities and the clinician serves as a facilitator in helping group members to accomplish the group's goal(s). An example of a nondirective group model is that of peer-mediated groups. According to Carter and Kennedy (2006), peer-mediated support interventions involve equipping one or more peers, without disabilities, to provide ongoing social and/or academic support to special needs peers of a similar age, under the guidance of educators, paraprofessionals, or other school staff. This intervention is thought to promote independence, due to the students involved becoming more acquainted with working together and leading their own progress. This support arrangement consists of the following: identifying students with a disability and their peers who would benefit from involvement, equipping peers to provide support, arranging opportunities for students to interact and support one another, and monitoring and offering guidance when needed (McCauley & Prelock, 2013).

In any form, clinicians working with groups maintain responsibility for ensuring that group dynamics and communication among group members support a

positive learning and social environment for all members. Similar to individual sessions, group treatment activities should be driven by a specific set of goals, applicable to either individual group members or a collective group goal, shared by all members.

Table 11–1 contains a list of several advantages and disadvantages of group treatment. As with any aspect of treatment, your supervising SLP will weigh the advantages and disadvantages of group treatment in deciding when and if it is applicable to a client's needs (ASHA, 2013). She or he will also be responsible for establishing the size, composition, and purpose of group intervention, as well as recommending group activities to target treatment goals.

Moon-Meyer (2004) coined an important term: "therapy in a group" (p. 262). This warrants additional consideration, in contrast with group therapy. According to Moon-Meyer, therapy in a group is not the same as group therapy. Rather, therapy in a group employs the same tenets of an individual session but with multiple clients present. As an example, consider a small group of third graders in a school setting with the following treatment goals:

- John has a treatment goal targeting /r/ sounds in the final position of words.
- Sue has a treatment goal targeting the reduction of disfluencies in conversational speech.
- Bill has a social interaction and pragmatic treatment goal.

Using a *therapy in a group* model, time is split between each individual in targeting treatment goals. When John is practicing /r/ sounds in words, the clinician

Table 11–1. Advantages and Disadvantages of Group Therapy

Advantages of Group Therapy	Disadvantages of Group Therapy
• Group participants may motivate each other or offer insight and assistance that a clinician cannot readily provide. • More opportunities exist for natural speaking situations, socialization, and peer interactions. This may enhance carryover and generalization of a target behavior. • Participants have an opportunity to observe group members and may recognize that others have problems similar to their own. • Group interactions, especially when the clinician takes a nondirective role, may decrease dependence of the clinician and thereby increase client independence.	• Individual participants may receive less direct attention from the clinician. • Some participants may be reluctant to participate fully in group interactions, particularly those who are shy or self-conscious. • Some participants may monopolize group interactions. • Generally there are fewer opportunities per participant, per increment of time, to engage in a specific behavior (compared with individual sessions). This may mean fewer opportunities to address specific weaknesses and less direct practice of a specific skill. • The pace of the group (or the rate of progress) may not be exactly matched with each participant.

Source: Roth & Worthington, 2007, p. 26.

interacts with him, providing feedback and correction to shape accurate production of target words. While this occurs, Sue and Bill wait for their turn. Next, Sue receives the clinician's attention, practicing fluent speech in short narratives. Again, the clinician focuses her attention on Sue, while John and Bill now wait. Finally, it is Bill's turn, and the clinician turns her efforts to discussing sample scenarios of appropriate and inappropriate personal space diagrams, while group members John and Sue now wait. As you can see from this interaction, there is very little interaction *between* the group members themselves, as well as a reduction in the total amount of interaction each group member has with the clinician. This is problematic, particularly when you consider the amount of treatment received per the amount of participation. If this were, for example, a 30-minute session, each participant would have received roughly 10 minutes of *treatment* and 20 minutes of *waiting*. This is not group therapy. None of the advantages of group therapy (described above) could be realized with this model (e.g., group participants motivated by each other, group participants engaging in natural speaking situations), but all of the disadvantages are magnified (e.g., less direct attention from the clinician, fewer opportunities to practice). In this instance, a group member's time is better spent engaging in other activities and attending only an individual session with the clinician for 10 minutes.

As this example shows, the main distinguishing feature of group therapy and that of therapy in a group is interaction, both between the clients and with the clinician. In terms of client interactions, Moon-Meyer (2004) outlines two types of interaction that should be considered: non-goal-related interaction and goal-related interaction. With non-goal-related interaction, as the name suggests, the interaction between clients does not target the treatment goal, as in the case of waiting their turn or performing tasks not related to their treatment goal. In contrast, goal-directed interactions target each of the client's treatment goals. Maximizing the amount of goal-directed interaction should always be your primary goal during group sessions. This, of course, is easiest when individuals share a similar goal, but with careful planning, group therapy and maximum goal-directed interaction can also be achieved when individuals do not share similar goals.

CHARACTERISTICS OF EFFECTIVE GROUP DYNAMICS

The term *effectiveness* refers to "the extent to which a specific intervention, regimen, or service, when deployed in routine practice, does what it is intended to do" (Baum, 1998, p. 237, cited in Last, 1983). Travis (1957) outlined five characteristics that aid in effective group dynamics, including creating a positive atmosphere, facilitating observation, making tools available, providing opportunities for repeated experiences, and helping to reduce barriers. Each is a factor to consider in designing and/or modifying the dynamics of a group treatment session.

In *creating a positive atmosphere*, as an SLPA, you must demonstrate acceptance, respect, and belonging for each individual. This process may be implemented through your behaviors of speech, facial expressions, postures, and so forth, which should all communicate a positive and

welcoming attitude toward group members. This will set the foundation for group interaction. In addition, you must be conscious of the fact that the world is viewed differently by others. Therefore, not projecting your own attitudes on the group will benefit the group atmosphere. Furthermore, allowing group members to participate in selecting and planning activities will influence this as well and create a sense of belonging within that group.

By exhibiting these behaviors and attitudes, you also promote the next characteristic of an effective group dynamic: *facilitating observation*. This means that you assume that group members will be influenced by the behavior(s) they observe, both your behavior and those of the other group members. One issue in this area is placing undue pressure on a group member to respond. You can be mindful of how you introduce group activities and what will be required of group members. You want to ensure the group dynamic is such that group members can participate with ease and pleasure. In addition, as much as possible, use naturally occurring, intrinsic rewards over artificial rewards (such as tokens or "good work"). In educational settings, it is common for students to become influenced by their group members, especially if those members seem to be doing better than them (Travis, 1957). For example, when a student struggles to produce a target utterance, this may create anxiety within the student, especially when she observes overt and artificial praise given to other students. This may decrease future participation in group activities.

The third characteristic of effective group therapy dynamics is *making tools available*. Use of the proper tools to complement the group and individual goal(s) is critical. You can plan in advance of group sessions by listing the materials needed to implement group treatment. This information can be listed on the lesson plan for that session (see Chapter 7). You should make sure all materials are modified to meet each group member's abilities and that there are ample materials, accessible to all members. You will want to ensure, however, that emphasis is on the interactions of group members and the goals of the group session. Chapter 10 discusses the concept of the "game mirage" (Moon-Meyer, 2004). This applies to groups as well. You can avoid the game mirage and reinforce goals of group treatment by providing an introduction to the session, stating the goals to be targeted, elaborating on them during the session, and then concluding with a summary of the group session (Vinson, 2009, p. 310).

Opportunities for repeated experience is also a characteristic of effective group dynamics. This does not mean learning will take place solely through repetition of an activity, as discussed in Chapter 10 relative to clinician-directed treatment that employs drill activities. It does mean, though, that group dynamics and learning are enhanced through opportunities to practice skills with diverse peers who may differ in gender, age, and status (e.g., authority figure vs. peer).

Reducing barriers is the final factor to consider in ensuring a positive group dynamic. This can vary greatly but would include the group leader analyzing factors that impeded the effectiveness of the group, the group dynamics, or group learning. In the field of augmentative and alternative communication (AAC), researchers describe barriers that may impede the use of AAC. These principles