Book Review / Évaluation de ressource écrit

Phonological awareness: From research to practice
Gail T. Gillon (2004)

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This book was written for professionals and students who are responsible for helping children who are at-risk or experiencing difficulties with the acquisition of reading and spelling skills. It is intended to help the reader understand phonological awareness and its role in the development of reading and spelling. Furthermore, it is intended to make explicit the path from research to practice by providing a framework for the accurate identification and successful resolution of phonological awareness deficits.

The book is comprised of ten chapters. The first defines the construct of phonological awareness and describes the tasks that are used to measure it at the syllable, onset-rime, and phoneme levels. The next three chapters are focused on reading and spelling development, with the second reviewing models of literacy acquisition, the third discussing the role of phonological awareness in reading development, and the fourth describing the phonological awareness skills of children with dyslexia. The fifth chapter discusses the phonological awareness skills of children with specific language impairment, articulation disorders, phonological delay of unknown origin and dyspraxia of speech. Chapters six through nine are focused on clinical practice, describing assessment tools, instructional frameworks, and some of the activities that can be used to remediate deficits in phonological awareness for children of different ages. The final chapter, with sections written by Sally Clendon, Linda Cupples, Mark Flynn, Teresa Iacono, Traci Schmidtkie, David Yoder, and Audrey Young, briefly reviews the literature relating to the phonological awareness skills of children with physical, sensory, or intellectual impairments.

This book is a very good resource for any professional who is working with children who are at risk for phonological awareness deficits. The review of the research evidence is comprehensive but readable. The right balance between breadth and depth of coverage is maintained throughout the book. Individual studies are described with just enough detail to allow the reader to fully understand the findings and conclusions (although the author's evaluation of the quality of the studies is somewhat shallow as described below). The implications of the research literature for clinical and educational practice are made explicit at the end of each chapter. Informative case examples appear throughout the book. The two chapters on intervention do not provide a step-by-step 'how-to' guide to the remediation of phonological awareness deficits. Rather, these chapters emphasise guiding principles that should underlay the development of a comprehensive intervention program that is customized to meet the needs and interests of each individual client. Some specific intervention activities are described but the clinician is advised to continually monitor the client's progress and adapt the activities accordingly.

This book would also be appropriate as a text book for a senior undergraduate or graduate level course on phonological awareness. As with any text book, however, the instructor would need to be thoroughly familiar with the background literature in order to compensate for some of the weaknesses of the literature review. The primary weakness of the book is that the links drawn between research and practice are more intuitive than systematic. The author fails to explicitly apply the principles of evidence-based practice when helping the reader use the research evidence to guide clinical practice. (More information about the process of evidence-based clinical decision making can be found on the ASHA website[1]). A particularly important aspect of evidence-based decision making is the necessity of evaluating rather than simply summarizing the available research. This failure to evaluate the research evidence is apparent in some of the unresolved issues that reoccur throughout the book. For example, the literature relating to the relationship between rime awareness and reading acquisition is, on the surface, highly confusing, leaving the clinician uncertain about whether to teach rime awareness to a child with delayed phonological awareness skills. In order to make sense of the conflicting conclusions of researchers who have investigated this relationship, it is necessary to consider the psychometric properties of the tests used and the quality of the research designs employed. For example, correlational studies in which an unreliable measure of rime awareness yields a restricted range of test outcomes by the participants should be discounted. Unfortunately, this level of analysis is curiously lacking in much of the book and some studies with glaring weaknesses are cited repeatedly (the final chapter is an exception as it contains some nice examples of appropriate evaluation of the quality of evidence). Another unresolved issue concerns the number of different skills that should be taught within the context of a phonological awareness intervention. Some programs recommend a dizzying array of target skills while others focus on one or two core skills, such as segmenting words into phonemes. Specific guidelines for evaluating the quality of evidence have been proposed

and could have been applied in an effort both to model this decision-making process and to answer the question about the optimum number of target skills. Unfortunately the author appears to credit her own study (in which a non-experimental, self-selected control group was employed) more highly than the meta-analyses that have examined the efficacy of phonological awareness interventions. Non-experimental studies can make very valuable contributions, especially when establishing the feasibility of a treatment approach early in the history of a research program. However, randomised control trials and meta-analyses constitute the strongest evidence that can be brought to bear on questions of relative efficacy of competing treatment practices. This criticism notwithstanding, the book is still valuable as a textbook and would provide an opportunity for the instructor to demonstrate the use of evidence-based decision making to resolve some of the conflicting findings that emerge from the literature that is summarized by Gillon.

In summary this book would be a valuable resource for practicing clinicians and educators as well as a useful textbook for students who expect to help children who may have difficulties with phonological awareness. It provides a valuable introduction for readers who are new to this topic as well as a useful quick reference for those who are more familiar with this large literature.

[1]ASHA members can access the Technical Report entitled 'Evidence-Based Practice in Communication Disorders: An Introduction' at www.asha.org.

Materials Reviews / Évaluation des ressources

Inpatient Functional Communication Interview

Robyn O'Halloran, Linda Worrall, Deborah Toffolo, Chris Code and Louise Hickson

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The Inpatient Functional Communication Interview (IFCI) was developed by the authors to "provide speech & language therapists working in the acute hospital setting with a measure to identify how well hospital inpatients can communicate in everyday hospital situations." It also allows the clinician administering the tool to investigate any techniques that facilitate the patient's ability to communicate. Those techniques found to be successful can then be shared with hospital staff to promote more effective communication in hospital situations. The book is well organized, containing chapters that provide an overview of the IFCI, its development, administration guidelines, scoring guidelines and case studies. Three appendices provide reproducible copies of the Staff Questionnaire, IFCI Interview Form and a sample Interview Script.

The IFCI is an easy and quick read, which is always helpful for clinicians with busy inpatient caseloads. It is designed to be used by speech-language pathologists in acute hospital settings for patients who are likely to have a communication impairment because of visual or hearing impairments, pre-existing cognitive or communication impairments or medical illness commonly associated with communication deficits (e.g. Parkinson's disease, stroke, etc.). It is designed to be used at the bedside during the therapist's first visit with the patient. As a result, the clinician is able to determine facilitative techniques and/or environmental changes that can make communication between the patient and staff more effective early on. It also provides a forum for establishing rapport between the clinician and patient. Finally, it allows the clinician an opportunity to determine if the patient requires further speech and language assessment.

The authors undertook considerable research when selecting the communication situations to be included in the IFCI. They interviewed hospital staff and inpatients to determine what communication situations were important (Toffolo, 1998). As well, communication

situations were identified by direct observation (McCooey, 2002). These two sources were combined to form a list of 31 hospital communication situations. The list was then shortened to 15 situations using the criteria that the final measure: a) was valid; b) was reliable; c) reflected typical hospital situations; d) included situations important in providing health care; e) included situations that were important to patients and f) could be administered within 30-45 minutes. Examples of the 15 situations include: attending to the clinician, describing what led to the hospital admission, following instructions, expressing feelings, asking questions about their care, telling about pain and calling for a nurse.

Administration of the IFCI includes 1) documenting information about the patient's medical history, current medical status and health management plans (this information is compared with the patient's responses to the interview for accuracy); 2) interviewing the patient; 3) supplementing the information from the patient by interviewing relevant staff members, and 4) writing an overall summary. Step 1 would be necessary for any patient evaluation and step 3 (interviewing staff) would only be required if the patient interview did not yield all pertinent information, so administration time for the IFCI is quite reasonable. During the patient interview, the clinician may use a variety of strategies to facilitate the patient's comprehension and/or expression. Scoring of the patient's responses is based on effectiveness of the communication with respect to adequacy and accuracy.

The IFCI is certainly a unique tool given that it is based on the patient's communication skills during functional situations frequently found in the inpatient setting. The use of facilitative communication techniques that make the patient better able to understand and respond is also unique in an assessment tool. However, for experienced clinicians this information can often be extracted from an informal bedside conversation in addition to informal discussion with hospital personnel and family members. For clinicians new to an inpatient setting, the IFCI would provide a good framework for the initial contact with a patient.

Information gathered by the IFCI is very useful in determining what future testing may be needed. For example, with the patients assessed for this review, concerns were detected regarding word-retrieval abilities, high level comprehension skills and memory. The tool was equally effective with a non-fluent aphasic patient, a patient with cognitive-communication deficits and two patients with right hemispheric strokes. Facilitative techniques and environmental adaptations were identified for staff and family to use to increase the effectiveness of communication with the patients. Again, an experienced clinician could extract much of this information from a less formal interview with the patient.

One criticism of the IFCI is that it does not collect information from the patient's family/caregivers. While family members may provide biased and subjective information, they can also provide useful information concerning the patient's pre-morbid communication skills that would be unavailable from staff and the chart. Additionally, they may already have found strategies that facilitate communication with their loved one.

On the positive side, the authors provide a comprehensive list of communication strategies that can be used by the patient and/or clinician to facilitate comprehension and/or expression. Many of these strategies are readily used by experienced clinicians but may not be clearly communicated to staff and family members because they seem too obvious or because of oversight. With all the techniques laid out so clearly, all of the ones that are helpful can easily be copied for communication partners to use with the patient.

In summary, the IFCI is a unique assessment tool that provides structure and standardization to an initial interview with patients that is highly functional for an inpatient setting. This tool would be especially useful to clinicians new to the inpatient situation in helping establish rapport with the client, determining appropriate facilitative communication strategies and planning future assessment needs. As a result, it meets the goals set out by the authors. However, for an experienced clinician the same goals can be accomplished using an unstructured interview with inpatients in a shorter amount of time (approximately 20 minutes). I do very much like the listing of facilitative communication strategies and feel these would be very beneficial in my setting in providing staff and family members with a more complete set of techniques to enhance communication with the patient. I also like the fact that staff members are interviewed in this assessment. While again this is something that many clinicians already do, it highlights the importance of teamwork during the assessment phase.