

**“CLIENT EXPECTATIONS OF SPEECH AND LANGUAGE THERAPY SERVICES
AT THE KORLE BU TEACHING HOSPITAL”**

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**THIS DISSERTATION IS SUBMITTED TO THE UNIVERSITY OF GHANA,
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DECLARATION

I **MALAIKA ABIGAIL ADDAI-SUNDIATA** do hereby declare that this thesis which is being submitted in fulfilment of the requirements for the Master degree of MSc in Speech and Language Therapy is the result of my own research performed under supervision, and that except where otherwise other sources are acknowledged and duly referenced, this work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree.

I hereby give permission for the Department of Audiology, Speech and Language Therapy to seek dissemination/publication of the dissertation in any appropriate format. Authorship in such circumstances should be jointly held between me as the first author and the project supervisors as subsequent authors.

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DEDICATION

This work is dedicated firstly to the Almighty God, who has been my rock in times past. It is also dedicated to my parents who encouraged me in the course of the work.

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ABSTRACT

Background: Speech and language therapy is a profession which is slowly beginning to develop in a number of sub-Saharan African countries. In Ghana, there are currently limited speech and language therapy services. There are only three (3) speech and language therapists serving the rehabilitation needs of people with communication disabilities in Ghana. The development of speech and language therapy training in Ghana means that services will grow and families of children with communication disabilities will have more access to speech and language therapy across the coming years. Research from developed countries has shown that families seeking services have high expectations of speech and language therapy services. There is no research within Ghana on the expectations of families who access speech and language therapy. This research aims to explore the expectations of families when they see a speech and language therapist for the first time.

Aim: This research aimed to explore parents' expectations and experiences of speech and language therapy, during their first contact with the speech and language therapy service at a teaching hospital in Accra, Ghana.

Methodology: A two-part oral mixed methods survey was used to explore the expectations and experiences of families, both before and after accessing speech and language therapy services. The survey included both categorical and qualitative data. Convenience sampling method was used. Participants were parents of children who were seeking services for communication delay or disability at the Korle Bu Teaching Hospital. The sample consisted of thirty (30) participants whose children were between the ages of one (1) year and ten (10) years. Descriptive analysis of categorical data of text based qualitative data was employed.

Results: The study revealed that parents have various expectancies, as well as various impressions of the job of a speech and language therapist. All parents were however satisfied with the services they received and were certain to return for the review appointments.

Conclusion: The study established that parents who come to the speech therapy clinic for the first time need more education on the job description of a speech and language therapist.

CHAPTER ONE

INTRODUCTION

1.1 Background

Expectancies are suppositions that clients have about treatment procedures, outcomes of therapy, therapists, or any other area of intervention (Nock & Kazdin, 2001). In spite of increasing parental participation in speech-language therapy (Glogowska, Campbell, Peters, Roulstone & Enderby, 2001) and encouragement to research parents' viewpoints about treatments (Barnes, McGuire; Stein & Rosenberg, 1997), there is little information about parent expectancies and perceptions in the field of speech and language therapy (Abell, 1998).

In the Majority World, which comprises developing countries across the regions of Asia, Africa, South and Central America and the Caribbean (Hopper & Lowe, 2005), some headways are being made in identifying and measuring disability.(World Health Organization, world report on disability, 2011). However rates of communication disability are not well documented (World Health Organization, world report on disability, 2011)

There is minimal data clearly identifying the rates of communication disability in Majority World countries (Wylie, McAllister, Davidson & Marshall, 2013), however some limited information is available. In a household study in a rural area which explored disability prevalence in children in Ghana, 25% of all children presenting with disabilities were found to have a communication disability (Biritwum, DeVres, Ofosu-Amaah, Marfo, & Essah, 2001).

There is strong evidence that growth in the workforce providing rehabilitation services for people with disabilities are urgently required (World Health Organization 2015). Speech and language therapists are professionals with specialised skills in therapy and rehabilitation for people with communication disabilities. Sub-Saharan Africa has an extremely limited workforce of speech and language therapists. An informal review of the speech and language therapy workforce in 4 sub-Saharan countries revealed an estimated ratio of 1 speech and language therapist per 2 – 4 million people (Wylie, McAllister, Marshall, & Davidson, 2013). This study indicated the small numbers of speech and language therapists in some countries

such as Uganda, Kenya, Zambia and Ghana (Wylie, et al., 2013). These data support the work of Fagan and Jacobs (2009) which used a key informant method to report on availability of speech and language therapists. These studies confirm the limitations in the availability of Speech and Language Therapists (SLTs) services across many sub-Saharan African countries including Ghana.

1.2 Problem Statement

As the profession of speech and language therapy has been extremely limited in Ghana, it is likely that the general public has limited awareness of the profession and the services it provides. Limited public awareness of speech therapy services for communication disability has been previously documented in Ghana (Wylie et al. 2017). To date, there has been no research published on the expectations that Ghanaian parents have from speech and language therapy services.

1.3 Significance of the study

This study provided information about what families seeking services for speech and language therapy know about, and want from, SLT services. It also considered if the expectations of families were met with services provided. Information obtained in this research may contribute to shaping public education on speech and language therapy services, and inform the practices of speech and language therapists in Ghana to ensure they address the needs of people seeking services for communication disability.

1.4 Research Questions

- What are the expectations of parents who have children with communication difficulties when they access speech and language therapy services for the first time?
- To what extent do parents of children with communication difficulties report that their expectations are when they meet the speech and language therapist for the first time?
- What issues do parents of children with communication difficulties experience in accessing speech and language therapy services?

1.5 Aim

The aim of this study was to explore the expectations of parents of the kind of services provided by the speech and language therapists.

1.6 Objectives

The following were the objectives of the study;

- To explore first time parents' expectations of speech and language therapy services.
- To discover the extent to which parents report that their expectations have been met.
- To explore barriers parents face in accessing speech and language therapy services, reported by parents.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presents information gathered from other studies related to the topic of interest. The literature was reviewed from books, articles and journals. This literature review includes a broad definition of communication and communication disabilities. It considers the nature of help seeking behaviours among parents, the role and importance of early intervention, barriers faced in accessing health care services and parent expectations of speech and language therapy services.

2.2 Communication

Communication is the avenue by which individuals receive and express language. It is an important element for community integration, economic well-being and socialization (Reuben, 2000). It is important for human interaction as well as a basic human right (McLeod, 2008). Communication refers to any verbal or non-verbal behaviour that influences the attitudes or behaviour of others (Knapp, Hall & Horgan, 2013). Verbal communicative behaviour represents the spoken words used in communication. Non-verbal behaviour represents the other ways by which we get our points across, including gestures, eye-contact and touch. Verbal communication encompasses both speech and language. Speech refers to the production of sounds that allow humans to express themselves. Language is a shared set of knowledge and rules about the meaning, forms and use of words, sign language or pictures (American Speech-Language-Hearing Association 2003). Hartley and Wirz (2002) define communication as a process of interaction, incorporating modes including speaking, gesture, writing, signed communication, among others. Hartley and Wirz

(2002) further explain that people may need difference modes of communication. For instance, a person with a low literacy level, will not be able to use written communication; and an individual without a hearing impairment is unlikely to use signed communication. Effective communication is a core skill which results from learning and social interaction (Guralnick, 2001; Barnett and Hustedt, 2005; American Speech–Language Association, 2008). Communication is an important aspect of human existence, essential for participation in the activities of society. An individual’s inability to communicate in a relevant and required modality may result in a communication disability (Wylie et al, 2013).

2.3 Communication Disabilities

Individuals with communication disabilities may be defined as a “group of people whose ability to communicate is affected by their response to impairments or contextual and social factors which interconnect with each other and the person themselves”. This results in hampered communication skills and abilities (Hartley, 1998). Communication disabilities may be from birth and experienced in different ways at different points across the lifespan. Communication disabilities may also be acquired as a result of a disease or trauma, affecting people for part of their lives (Wylie et al, 2016). A communication disability may effect participation in social, educational, family, work and community roles (Wylie et al, 2016). This is usually as a result of societies’ perception of individuals who are unable to communicate in the socially accepted manner. Individuals who have communication disabilities are therefore reluctant to take part in activities in the society for fear of stigmatisation. In Ghana, it is evident that most individuals with communication disabilities are also not able to attain optimal academic achievements. This may be attributed to the inability of the education system to recognize and nurture individuals who have difficulties with communication and cannot get their message across (Botts & Owusu, 2013). For instance in a class of forty (40) pupils with one teacher, a child who has a learning disability

may be ignored and branded as blockheaded and as the teacher may not know how to deal with the needs of this child. In some families, a child with a communication disability may be left out of most family gatherings or family days out.

People experience communication disabilities in various ways (Wylie et al 2013). Some people's communication disabilities may exist alone, as in the case of a language disorder. Other people may have a communication disability secondary to another condition, as in the case of a child with cerebral palsy (Geytenbeek, 2011), or an adult with a stroke (Dickey et.al.2010). These conditions affect the person's ability to communicate. People who suffer from any of these communication disabilities may experience difficulties trying to get their message across, trying to make requests or making refusals. There is also evidence that supports the fact that having a communication disability alone, with no other disabilities, is associated with poor educational, social and employment outcomes (Davidson et. al., 2008).

There appears to be limited awareness of communication disabilities in Ghana (Owusu, 2016). Public awareness of other forms of disability, such as physical disabilities, visual or hearing impairment. Communication disabilities are often referred to as hidden disabilities. This is because they are unobserved until a person attempts to communicate. Hidden disability may include language disorders, speech and/or language delay, stammering, and are often given less priority when thinking about services and service development (Zhang & Tomblin, 2000).

2.3.1 Communication Disabilities and Spirituality

Spirituality in Ghana is something that is taken very seriously. Individuals who give birth to children with one form of disability or another, be it a physical or communication disability is viewed as having given birth to a child belonging to the 'sea'. In the local dialect they are referred to as "nsuo ba".

Communication disabilities are often associated with spiritual causes. In both Christian and Muslim traditions, individuals with Intellectual disabilities are seen as ‘gifts from God’, sent to challenge the faith and strength of the members of their families (Rohleder et al, 2009; McKenzie et al, 2011). Gara (2007) argues that on the one hand, this belief will lead the individual with Intellectual disability to be neglected, and lose opportunities made available to them like education. In addition however, this view can serve as a coping mechanism as well as a source of strength and support in difficult situations for families of these individuals. For some, giving birth to a child with autism is an indication that God has counted them worthy to bestow upon them a child with special needs (Skinner & Bailey, 2001). Jagatheesan et al (2010) conducted a study among 3 Muslim families to find out how parents made sense of having a child with autism, as well as to find out what they believed about autism. One theme that run through all six parents was that having a child with autism meant that ‘Allah’ had found them worthy to send them his ‘special child’ to care for. Also, in an interview of 60 parents from the Republic of Ireland about the impact of having a child with autism, Coulthard and Fitzgerald (1999) found that 45% reported that this event in their lives had prompted them to distance themselves from God and their religion. However, some parents reported that they trusted God to take care of their situation. In Ghana as well, reports from parents indicate that some of them feel angry with God for giving them a child with any kind of disability and as such they cease praying, going to church or engaging in any God-related activity. Other parents, after realising their child may have a communication disability like autism tend to seek the face of God in their situation by moving from one church to the other, as well as visiting prayer camps. In 2004, Gabel conducted a 2-year ethnographic study using 20 Asian, Indian and Hindu families who had children with intellectual disabilities in the United States. As a result of them keeping with Hindu beliefs about karma and reincarnation, parents considered the disability as being a gift from God,

given to parents because of some sins they had committed in their previous life. It was their belief that the person with the disability or their family had lessons to learn in their present life as a result of past life actions. Giving birth to a child with a disability was also a way to release them from the cycle of death and rebirth. In some situations in East Africa, a child born deaf and non-verbal signifies one who is to keep the family secrets (Omiegbe, 2001). In research undertaken by Stone-McDonald (2014), families who had children with any form of disability were seen to be punished by the gods for various offences they may have committed, including women having sex with their husband whiles pregnant, engaging in incestuous relationships, or failing to render the appropriate sacrifices to the gods. In Tanzania, there is a saying that “mental illness can be cured; stupidity or foolishness cannot”. This refers to the fact that an intellectual impairment affects understanding and so the community considers it to be more serious than a mental illness (Kisanji, 1993). In countries such as South Africa, Tanzania, Uganda and Zambia, Intellectual disability has been identified as being caused by divine retribution or witchcraft (Kisanji, 1995; Kromberg et al, 2008; Mulatu, 1995; Hartley et al 2005 & Mung’omba, 2008). This leads to a lack of exposure to Intellectual disability with the wider society, which in turn adds to continuous stigma and discrimination (Mung’omba, 2008). In Ghana, the story is not any different. With extensive evidence about stigma of disabilities including communication disabilities, families experiencing this frequently do not receive services (Odoom & Weelan, 2001). Many families are hiding their children who have disabilities like cerebral palsy, cleft lip and/or palate, for fear of being ridiculed, or in extreme cases, estranged from their families (Stephens & Owusu, 2015).

Traditional beliefs in Zambia cause families to hide their children with Intellectual disabilities because of shame. As a result of this, people seldom seek help for their relatives with communication disabilities.

2.4 Help Seeking Behaviours

Children depend on adults to recognise their problems, to decide whether they require services, and then seek help on their behalf (Sayal et al, 2010). Families who seek help regarding their children with communication difficulties may do so in different ways. For a family to actively seek help, they first need to be aware that their child has a communication difficulty. In the Western world, where there is more awareness of communication disabilities, parents may seek help from various places including maternal and child nurses, speech and language therapists, and also from the internet (Skeat et al, 2010). According to research done by McAllister et al (2011), parents were more inclined to look for help if they were advised by others or if they had heard success stories from other parents. The idea that a particular method has worked for someone, especially someone we share certain characteristics with, is motivation enough to try the same method. Certain situations however may serve as facilitators or barriers to help seeking

2.4.1 Factors that Determine Help-Seeking Behaviours

Research from developed countries indicates that there are many factors that will lead a parent to seek help about their children's communication difficulty. The age of a child is one important factor that determines when a parent will seek help (Skeat et al., 2010). For some parents, it is not until their children are at a school age that they realize that their child's communication is different from that of their peers or siblings, and so begin to seek help. A family's financial status is also a determiner of help seeking. Families with enough financial resources are more likely to find help concerning their child's communication difficulty than a less affluent family (Gulliford et al., 2002). Another pertinent issue about communication disabilities which may influence help seeking is that some types of communication disabilities are more noticeable than others. The nature of a communication disability is also relevant (Zhang & Tomblin, 2000). The pattern of speech of a child with a stammer will not

go unnoticed, but language characteristics of a child with a subtle communication difficulty such as a language disorder or social communication disorder may be less obvious, or clearly identifiable as a communication disability. Features of the stammer such as prolongations, repetitions and blocks, will make it obvious that a person has a stammer. Also, some people, when they stammer may blink rapidly, tap their feet or even tap the next person. These behaviours make other people aware that the person with a stammer is struggling with their speech. On the other hand, children with difficulties such as language disorders have a hard time being identified as needing help, and are very rarely the subject of ridicule. This is because it is only a trained ear that will be able to make out the errors that these children make. However, until they have been brought to see this trained ear, they, and all those around them will be unaware that the child needs help.

In a study done by Patil et al (2016), about parents' help seeking behaviours for their children with mental health problems, they listed factors such as large family size, gender of the child in question and unemployment as hindering the help seeking behaviour of parents. Of the 38 parents who were interviewed, only 12 had sought help. The 26 who failed to seek help gave reasons such as not being aware of available services, or had hesitated because of lack of money and time, as well as the stigma associated with mental health problems. This is not so different when it comes to help seeking for communication disabilities. Money, time and availability of services all serve as barriers to accessing help for children with communication disabilities.

In Ghana, anecdotal evidence supports this submission, in that, most families that have a lot of children may ignore the needs of the one that has any form of disability, be it a physical or a communication disability. This could stem from the fact that there are many mouths to feed, and as such, parents are unwilling to spend some money on the child with the disability, with regards to health care or education. However the blame is not to be pushed on parents

alone. This is because there is not a lot of awareness among Ghanaians when it comes to seeking help for communication disabilities, and there are not a lot of available services.

Another reason parents do not seek help for their children with communication disabilities is as a result of societal attitudes. The fear of their child being ridiculed will prevent a parent from taking their child to see a specialist who can help with their situation. Some parents do not even send their children with severe physical as well as communication disabilities like a child with cerebral palsy for instance to the hospital, but would rather buy over the counter drugs for them primarily because of their fear of how other people as well as some health professionals would treat them.

In a 2009 examination of data from a national study to explore families' use of speech therapy services, Harrison and McLeod discovered that about two-thirds of families, who had been identified as having children with speech impairment, did not access speech therapy services. Some said they couldn't access services because of distance, while other families were capable of accessing services but had not done so. It was therefore not clear if they did not know the benefits of speech and therapy or how to access services. In this study, two issues came up, that is, knowing where services can be accessed and failing to do so, or distance serving as a barrier to accessing services. Because the profession is quite new and now growing in Ghana, we cannot draw such conclusions about parents' help seeking behaviours.

Sayal et al. (2010) conducted a qualitative study in which they had eight focus group discussions consisting of parents who were worried about their children's mental health and emotional behaviour. The study also sought to find out parents' help seeking behaviours. The ages of the children ranged between two and seventeen years. At the end of the study it was revealed that parents sought help for their children depending on a number of factors.

These factors included; 1) what they perceived to be the child's difficulty, 2) what they know about mental health, and 3) the availability of services. Parents in this same study also shared the fact that a couple of attitudes from people around them made it unnecessary for them to seek help for their children. These attitudes included short appointment times, their children being ridiculed and feelings of shame.

2.5 Early Intervention

Intervention for children with disabilities during the early childhood years is often referred to as early intervention by families and service providers (Royal Australasian College of Physicians, Paediatric & Child Health Division, 2013). It has been well documented that for children with communication difficulties, early intervention is critical. Early intervention gives families the opportunity to make judgments about their child's needs and treatment plan (Tomasello, 2010). When early intervention is provided, especially for young children, they are most likely to be able to settle into education successfully, and this will make them less of a liability to the state (Lyons et al., 2010). The importance of early intervention for children with communication disabilities is universally acknowledged (National Research Council, 2001; Klinger & Dawson, 1996; Powers, 1992). Powers (1992) for instance, notes the advantage of intervention before maladaptive patterns of behaviour and communication are firmly instituted. Early intervention programs also have benefits on child functioning, and often lead to full inclusion programs in elementary school (Dawson & Osterling, 1997).

Early intervention is not solely the job of the speech and language therapist. Parents are also required to do part of the work in helping their child obtain optimum language abilities. Early intervention is not only about "treatment" for the child, it's also about providing education, support and guidance for parents (Bailey et al, 2004). Parents' interaction styles, for instance plays a significant role in the early language development of their children, and this can also be viewed as early intervention. In their study, Lyons et al. (2010) gave parents

opportunities to support with the early intervention program with their children, using activities given to them by the speech therapist. Findings suggested that there was no significant difference in the results the parents got and what the speech therapist would have achieved with the child. Similarly, the speech and language therapists in the Korle Bu Teaching Hospital work with parents to ensure the optimum development of their children's speech. Parents who come in, sit in the session with the therapist in order to observe what the therapist is doing with their child and then together with the therapist, a plan is drawn, and activities are given to parents to do at home with their children. It is the desire of most parents to do right by their children and so this impels them to seek early intervention for their children (Watts, 2008). Research shows that not only do some children not grow out of their pre-school language difficulties (Leitao & Fletcher, 2004; Roulstone, Miller, Wren & Peters, 2009), but that failure to begin intervention before the child is 5 years means that they would have passed the crucial time for proficiency in language (Nathan, Stackhouse, Goulandris & Snowling, 2004). Further importance of early intervention is provided by studies that have found huge differences between children for who services was sought before age 5, and children who began an intervention program after age 5 (Fenske, Zalenski, Krantz, & McClannahan, 1985).

Finding early intervention services is not an easy feat for a lot of parents. In a research conducted by Bailey et al (2000), parents were concerned about their children's difficulties at 7.4 months and sought early intervention services when the child was 11.9 months of age. Parents in the study however reported that they were only able to get a referral to early intervention services when the child was about 14 months old. It is advised that families who have toddlers and infants (from birth to 36 months) who are at risk for or who have communication disabilities receive developmentally supportive care that addresses priorities and concerns as early as possible (Bailey et al, 2000). The positive outcomes of early-

intervention programmes are well established. By providing early intervention at the appropriate time, professionals increase the likelihood of their clients being able to attend mainstream schools, which will in turn reduce societal cost (Guralnick, 2001; Barnett and Hustedt, 2005; American Speech–Language Association, 2008). Although a lot of studies have been done on the outcomes of early-intervention programmes (Girolametto, Pearce, and Weitzman, 1996; Almost and Rosenbaum, 1998; Glogowska, Roulstone, Enderby, and Peters, 2000), there have been even less studies that have sought to explore parents’ experiences of speech and language therapy services (Glogowska and Campbell, 2000; Paradice and Adewusi, 2002; Marshall, Goldbart, and Phillips, 2007). In one such study, Glogowska and Campbell (2000) found that there was a need for collaboration between parents and clinicians particularly in the early stages of intervention, where acknowledgement of parents’ perspective could impact on future decision-making and negotiation of treatment. More so, this study indicated that a lot of parents expected to be a part of the therapy process and that the responsibility for what took place would be shared between parents and the therapist (Glogowska and Campbell, 2000). While there may be some similarities between speech and language therapists and parents in their impressions about language development and intervention (Marshall et al., 2007), extensive research indicates that parents’ perceptions of the content and aims of therapy, and their expectations of what therapy entails, are often very different from those of the therapist (Brett, 2002).

Law et al. (2004), did a study in which they sought to find the outcome of a parent whose child had benefited from early intervention, leading the discussion in a focus group with other parents who had children with communication disabilities. In other words she was to take on the role of the expert. The job of this parent was to share what her experiences had been as well as sharing what she had done to support her child in therapy. This showcases the importance of having parents who have some experience in certain early intervention

programs support other parents who are yet to get on any of those programs and assuage the apprehensions of these other parents. Knowing that someone you share certain characteristics with has found a solution that has worked for them is likely to get you to find that same solution. Evidence from this study revealed that when interventions were spearheaded by experienced parents for other parents, the results were not so different from the results a therapist would have had if they had delivered that intervention (Law et al., 2004). Parents in this study had the expectation that they would be observers while the speech therapist did all the work. This is therefore a call to therapists and parents to share their thoughts on what exact role each is supposed to play so as to be on the same page when it comes to delivery of early intervention.

2.6 Barriers in Accessing Health Care

There are numerous barriers that may impede the ability of families to receive adequate health care. In accessing speech and language therapy services, parents are faced with a number of barriers which may lessen their enthusiasm about seeking help for their child. In the Western world, a major barrier to accessing speech and language therapy is a long waiting list (Short, Woolfenden, Blackmore, Best and Croft, 2010). Long wait times for therapy, or difficulty accessing services, results in the failure of some general practitioners to make referrals to speech therapy (Short, et al, 2010). Cost of receiving services and the limited availability of speech therapists in rural areas (McAllister et al, 2011) are also documented barriers to service access in the Western world. Generally, access and usage of health care is limited in sub-Saharan Africa (Say, 2007) and studies have attributed this to many reasons. For instance, long distance to health care facilities has long been established as one of the barriers to health care utilization (Kadobera et al 2012). Ghana has very few speech and language therapists, three (3) local, and about 3 expatriates who are all practicing in Accra (Owusu, 2016). With few service locations, clients are likely have to travel long distances to

receive services. This is challenging for families. Many of such families, at a point give up and stop coming to therapy altogether (Owusu, 2016). Another issue in Ghana is that many medical professionals are unaware of the role of a speech and language therapist, and so fail to make appropriate referrals. Parents' attitudes towards referrals and their involvement in treatment can serve both as a facilitator or barrier to receiving speech and language therapy services (McAllister et al 2011). Informal observations in the speech and language therapy clinic at the Korle Bu teaching hospital have shown that parents who engage very well in their children's therapy sessions, and who do homework given to them see improvement in their children's communication. On the other hand, parents whose behaviours are nonchalant, who do not turn up on their appointment days, or who misplace their children's folders and so stop coming for therapy report less improvement in their children's communication. With regards to socioeconomic status, individuals with disabilities are less likely to be able to work, more likely to have low household incomes, and more likely to be dependent on federal and state-funded health insurance programs such as Medicare and Medicaid as compared to those without disabilities (De- Jong et al., 2002; KFF, 2003b).

Parents may experience financial barriers in that they may be restricted from gaining access to health care because of failure or inability to pay for needed medical services (Drainoni et al 2006). In their study, (Kadobera et al 2012) found physical barriers to accessing health care to be a causal factor of child mortality in rural Tanzania. Frankenberg (1995) noted that being close to a health care facility reduces child mortality a great deal while being slightly far from a health care facility leads to a comparable increase in the risk of child mortality. Personal and cultural barriers which are related to the type of service given by the provider stems from some providers not having sufficient knowledge, as well as having some misconceptions about people with disabilities, or instances when they are insensitive and

have no respect for patients and fail to take them or their caregivers seriously. There are also instances when providers are reluctant or unwilling to provide care.

There are some hindrances that impede people's ability to access health care services. These types of barriers are referred to as structural barriers. These have no financial bearings but equally have the ability to serve as obstacles to people seeking health services. Examples of structural barriers include when policies or procedures are not appropriately put in place for patients to ensure their safety or insure their health, or if the physical environment is not patient friendly and they do not receive the right amount of care they (Baron et al. 2008). Individuals in almost all of the focus groups mentioned transportation problems as a barrier to finding health care. Persons with disabilities who lived in geographic areas that did not have providers specializing in their specific condition usually had to travel great distances in order to receive treatment (McAllister et al. 2011).

2.7 Parent Expectations of Speech and Language Therapy Services

Expectancies are suppositions that clients have about treatment procedures, therapeutic outcomes, therapists, or any other aspect of intervention (Nock & Kazdin, 2001). Most families or clients have various expectations when they meet various professionals, and speech and language therapy is no exception. They are likely to have their own expectations for the type and outcome of services they receive. Client expectations and preferences have the tendency to impact on been thought by many to influence willingness or readiness to engage in the process of therapy (Glass, Arnkoff, & Shapiro, 2001). The ability of the professional to meet a client's expectation may serve as a contributing factor to successful interventions. In a study done by McAllister (2011) to find out parents' expectations of speech and language therapy services, parents stated that they expected their children's teachers to alert them if they realized the children's pattern of communication was different

in any way. Participants in the Auert et al. (2012) study, in Australia, stated that they would prefer it if the speech and language therapist worked in partnership with them in order to resolve the communication difficulties of their children. Parents also indicated that they expected the therapist to treat them as experts since they spend more time with their children and know what they need. Parents further stated that a quality they expected to find in a speech and language therapist was the ability to develop a good relationship with the children they worked with and their families. Bachner et al (2006) discovered that parents were able to cope better when the therapist showed a caring attitude and when they the parents were also involved in the intervention process. They laid more emphasis on the fact that professionals need in-depth information to ensure that interventions are in agreement with families' daily lives. It is imperative that clinicians find out the roles of those relatives who are involved in the intervention process, so as to tailor rehabilitation in a way and manner which will encourage the family to assist the child at home where there is no speech and language therapist. In their study, Lyons et al (2010) parents expected that they would be given homework and that the focus of therapy would mainly be on making their children's speech better. That however was not the case since the clinical team was more interested in changing parental interaction style, as well as focusing on required skills for the development of speech and language e.g. attention and listening skills. This could therefore be seen as a mismatch between parents' expectations of therapy and what the clinical team delivered.

2.8 Research gap

Although parent expectations of speech and language therapy have been studied in most parts of the world, there is no data on this in Ghana. Such a study has not been conducted in Ghana and as such it is necessary that this study is done to improve the nature of services that speech therapists provide in the country.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter presents the methods and techniques used in carrying out the study and include the research method, research design, population, sample, sampling technique, data collection tool and procedure and data analysis.

3.2 Research Method

A mixed methods approach was used in this survey. Mixed methods refers to research that integrates both qualitative and quantitative data using a single study (Wisdom et al, 2012). It provides an alternative methodology for the researcher to address complex issues in a more holistic way than would be achieved by using only quantitative or qualitative research (Andrew & Halcomb, 2012; Simons & Lathlean, 2010). Mixed methods were used in this survey because data required to answer the research questions included both categorical and qualitative data. Categorical data here refers to all information that was put in groups. Examples of these include communication difficulties of the children, where parents have sought help and area of residence of the clients, to mention a few. Using a mixed method approach ensures that all areas that are under scrutiny in the survey are covered, and as such there are no loop holes. This buttresses the point of Zhang & Creswell (2013), who say that mixed methods provide a fuller account of the research problem under study.

3.3 Study Design

This survey used a descriptive study to undertake an early exploration of a little-known topic. Descriptive studies are a useful approach to begin to explore areas with minimal existing information (Grimes & Schulz, 2002). Qualitative description may also be used within mixed methods studies, particularly surveys, to explore elements of an event or an experience

(Neergaard, Olesen, Andersen & Sondergaard, 2009). This survey therefore utilized a mixed methods survey, which included both qualitative and quantitative data. The survey was largely focussed on qualitative data which aimed to explore the experiences and perceptions of families of children with communication disabilities. Quantitative data aimed to describe the characteristics of a sample of people seeking speech and language therapy services. The survey aimed to survey a cross-section of people who use speech and language therapy services for the first time.

In this case, a survey containing both qualitative and quantitative data was selected to find out what expectations parents had when they came in to the speech therapy clinic for the first time, whether those expectations were met, and whether parents faced any difficulties accessing the speech and language therapy services. Doing this enabled a more complete representation of the characteristics and experiences of people attending speech therapy for the first time.

3.4 Study Site

The survey was conducted in the Speech and Language Therapy clinic in the Korle Bu Teaching Hospital. A proposal about the scope of the survey was written, permission was also sought to conduct the data collection in the hospital, and this was vetted and approved by the Ethics Committee. To ensure privacy, participants were taken to an unoccupied room to complete the survey.

3.5 Population

There is currently no population-based data on the prevalence of communication disabilities in children within Ghana.

The population for the survey consisted of parents who have children with communication disabilities between the ages of one (1) and ten (10) years, who were visiting the study site

for management. As the first of its kind, this survey focused only on children with communication disabilities, excluding adults. This population was chosen also because many families that come through the speech and language therapy clinic have children within this age range with communication disabilities, and this made data collection easy.

3.6 Sample Size and Sampling Techniques

As little is known about the population of children with communication disabilities in Ghana, and due to the descriptive nature of this research, the research did not aim to obtain a representative sample of the wider population. This research aimed to sample from the population of new cases seen by speech and language therapy at the data collection site. The speech and language therapy clinic at KBTH sees approximately 30 new cases of children with communication disabilities each month (Bampoe 2016). This research aims to provide an early exploration of this topic and describes the patterns evident within a small sample of this population. The sample size of thirty (30) participants was selected as this represents approximately a month of new cases, and the survey was extensive in describing both qualitative and quantitative data. Surveying a larger sample of the new clients seen by speech and language therapy was beyond the scope of this research, as it would require data collection over a longer period of time. The limitations and lack of generalizability of the results were discussed in the limitations section of this thesis. However this research sought to inform the basis for development of more robust studies on this population, which is a useful outcome of small-scale descriptive studies (Grimes & Schulz, 2002).

Convenience sampling technique was used in selecting the participants. According to Cohen (2007); Vanderstoep and Johnson (2009), convenience sampling – also called accidental or opportunity sampling involves choosing the nearest individuals to serve as respondents and continuing that process until the required sample size has been obtained. Therefore

participants were drawn from the parent population who came through the speech and language therapy clinic and were interested to take part in the study.

Before the start of the study, the researcher explained the contents of the Participant Information sheet (Appendix A) to the participants. The participant information sheet contained information about what the survey was about, and the purpose for which the information was being taken. It was explained to participants that the researcher was conducting this survey as part of the course requirement. Participants were also assured that they could drop out of the survey at any time, and that this would not affect the quality of service they would receive. They then signed a Consent Form (Appendix B), which showed that they had accepted to take part in the survey. The researcher sat with the participants and read the questions to the participants while recording. This was to ensure that participants with low literacy, and who for some reason found it difficult to read and understand were also included in the study. To ensure confidentiality and anonymity, each sheet was numbered, as there was no need for names.

The questionnaire was piloted using three (3) participants. This was to enable the investigator to make sure that items on the survey were suitable for the general public. Issues identified from piloting, in layout, wording or organisation of the questionnaire, were sorted in response to the piloting process to ensure the questionnaire was easily understood by participants. The wording was therefore changed after the pilot study to make it more participant-friendly. Questions asked in the survey were also made straighter to the point to make it easier for participants to understand. The questionnaire consisted of two parts. The first part, which was to be filled out before the participant met the therapist, sought to find out what he or she knows about speech and language therapy, and what kind of service they expected to receive when they met the speech therapist, and the second part which was filled out after their session with the therapist, asked how they found the session and if it their

expectations had been met. Parental levels of satisfaction were measured using a likert scale, rating from “very unsatisfied” to “very satisfied”.

3.7 Inclusion and Exclusion Criteria

3.7.1 Inclusion Criteria

All participants in the study met the following criteria;

- They were visiting the speech and language therapy clinic for the first time.
- They had a child less than 11 years with a communication disability.
- They were able to provide informed consent.

3.7.2 Exclusion Criteria

The following were used to exclude non-participants;

- Parents who had a child aged eleven (11) years or older with a communication disorder.
- Parents who had previously accessed speech and language therapy at Korle Bu Teaching Hospital or any other speech and language therapy service.

3.8 Data Collection

Parents who had come to the clinic were spoken to, to find out if it was their first visit. If it was, the researcher then gave a brief overview about the research and asked parents if they were interested in taking part of the study. If parents were, they were then given a Participant Information Sheet (Appendix A) which explained the nature of the research to parents. The researcher then answered any questions parents may have had, after which they were given a Consent form (Appendix B) to sign. Parents were then sent to a private room, where the survey was taken. The researcher was with the participants in the private room to ask parents the questions while recording. Recording the interview made it easier for the researcher to

transcribe responses. This also made it possible for participants to ask questions or seek clarifications while they were filling the survey.

3.9 Data Handling

Collected surveys were placed into a locked box. Data were transferred onto an excel spread sheet which is purpose designed within forty-eight (48) hours of data collection.

Participant identification numbers were used to identify the source of the data. No names or other identifying information were collected. Responses to the questionnaires were transferred to an excel spread sheet. The spread sheet was password protected and the data held securely. Original surveys were stored in a locked cabinet. Only the researcher and her supervisors had access to the original data and the excel sheet. Data collected was kept for a month, after which they were disposed of by being shredded.

3.10 Data Analysis

Quantitative and categorical data will be analysed descriptively, using both simple descriptive statistics (mean, median, mode) and presented graphically. Text based qualitative data will be analysed using content analysis. Content analysis can be described as a research technique for making replicable and valid inferences from data to their content. Analysis was done using the steps in the Erlingsson & Brysiewicz (2017) hands on guide to doing content analysis. The steps are as follows;

1. Familiarization: The researcher immersed herself in the data and read it over and over to get an idea of what the participants were discussing, and then divided the texts into meaning units
2. Formulation of codes: The researcher then developed codes that described certain ideas in the text. These codes were then grouped into categories. A category is a group of codes that are related to a particular idea.

3. Category development: Finally categories were developed.

Content analysis usually emphasises data reduction (Leadbeater & Litosselli, 2014). However, the current study was more interested in providing an interpreted account of the expectations of parents who were visiting the speech and language therapy clinic for the first time and thus used this approach. During the analysis, the data was constantly subjected to rigorous review and reorganization, to come up with themes that relate to the research questions. Views of parents were put under suitable categories and sub-categories with some interpretation to explain the findings in relation to the expectations parents have of speech and language therapy.

Responses that were received from participants were put into various categories and the researcher analysed the categories selected and related them to the analysis of their research questions.

3.11 Trustworthiness and Rigour

Trustworthiness is important in a qualitative data to ensure its authenticity. To ensure trustworthiness, four procedures (credibility, transferability, dependability and confirmability) should be taken into consideration. Trustworthiness in this study was ensured by checking data repeatedly and using peer review and consensus during category development to minimize bias and maximize transparency of coding decisions. Peer review means to subject the research work to the scrutiny of other experts in the field to check its validity and evaluate its suitability for publication. In the case of this survey, the work was given to colleagues of the researcher to read through and find loop holes which could be addressed.

3.12 Ethics

Ethical approval was sought from the Ethics and Protocol of the School of Biomedical and Allied Health Sciences (SBAHS) of the University of Ghana. This was done by writing a proposal to SBAHS, which was then approved, and permission was thus granted for this project to be done. A letter was also written to the Head of the Speech and Language Therapy Clinic to seek permission to carry out the study.

CHAPTER FOUR

RESULTS

4.1 Introduction

This chapter presents findings from this study. Thirty (30) questionnaires were completed by thirty (30) parents who were attending the speech and language therapy clinic with their children for the first time. This number was chosen because consideration was given to the amount of time needed for the completion of this research. The aim of this study was to explore the expectations of parents who have children with communication disabilities of speech and language therapy. The research also sought to consider if parents reported feeling satisfied with the services they received. This chapter will be divided into two parts. The first part represents the demographics of the participants, and the second part represents results of the survey.

4.2 Demographics

Information on the respondents' gender, level of education, area of residence and concerns about their children's communication was collected. The questionnaire also collected data on their child's age, gender and communication difficulty.

4.2.1 Characteristics of Parent/Carer Participants

The study included thirty (30) parents or carers who were bringing their children to the speech and language therapy clinic for the first time. Of the thirty parents included in the study, twenty-three (n=23, 77%) were female, and seven (n=7, 23%) were male. The education level of the parents was broad, ranging from having not completed primary school to having attained a tertiary education, with the majority of parents reported having completed tertiary qualifications (n=18, 60%). Ninety per cent (n=27) of the participants indicated that they resided in the Greater Accra area. Of the participants residing outside

Greater Accra, one (n=1, 3.3%) was from the Western region, one (n=1, 3.3%) from the Volta region and one (n=1, 3.3%) from the Brong Ahafo region.

The majority of participants were concerned about their child's communication skills (n=29, 96.67%), whilst one participant was not concerned. Duration of parental concern is further examined in the following section.

Table 4.1: Demographic characteristics of parents

| | Variables | Number | Percentage |
|----------------------------|-------------------------|----------------|-------------------|
| Gender | Male | 7 | 23.33% |
| | Female | 23 | 76.67% |
| | TOTAL | 30 | 100.00% |
| Educational level | Tertiary | 18 | 60.00% |
| | O'level | 3 | 10.00% |
| | Senior High School | 3 | 10.00% |
| | Technical School | 1 | 3.33% |
| | Junior High School | 3 | 10.00% |
| | Primary School | 1 | 3.33% |
| | Primary School drop-out | 1 | 3.33% |
| TOTAL | 30 | 100.00% | |
| Area of residence | Greater Accra Region | 27 | 90% |
| | Volta Region | 1 | 3.33% |
| | Brong Ahafo Region | 1 | 3.33% |
| | Western Region | 1 | 3.33% |
| TOTAL | 30 | 100.00% | |
| Duration of concern | Less than 6 months | 2 | 6.67% |
| | 7-12 months | 5 | 16.67% |
| | 12-18 months | 6 | 20.00% |
| | 19-24 months | 7 | 23.33% |
| | More than 2 years | 9 | 30.00% |
| | Not worried | 1 | 3.33% |
| TOTAL | 30 | 100.00% | |

4.2.2 Characteristics of the Children Of Participants

Parents and carers who were participants in this study reported on their perceptions of, and experiences with, their children. This section describes the characteristics of the children with communication difficulties that parents discussed.

Nineteen (n=19, 63%) boys and eleven (n=11, 36.67%) girls were considered during the survey. Their ages ranged from twelve (12) months to nine (9) years. The distribution of ages is presented in figure 1.1. Half of the children were three years or under (n=15, 50%), whilst thirteen per cent were aged seven (7) years or older (n=4, 13.33%). The mean age of the children was 3.9 years, the median age was 3.5 years, and the mode age was 2 years.

Children presented with a range of communication difficulties as reported by parents. These are outlined in table 2 below and further examined by considering the age of the child as compared to the reported communication difficulty (table 3). The gender, age and reported communication difficulties of the children of the participants

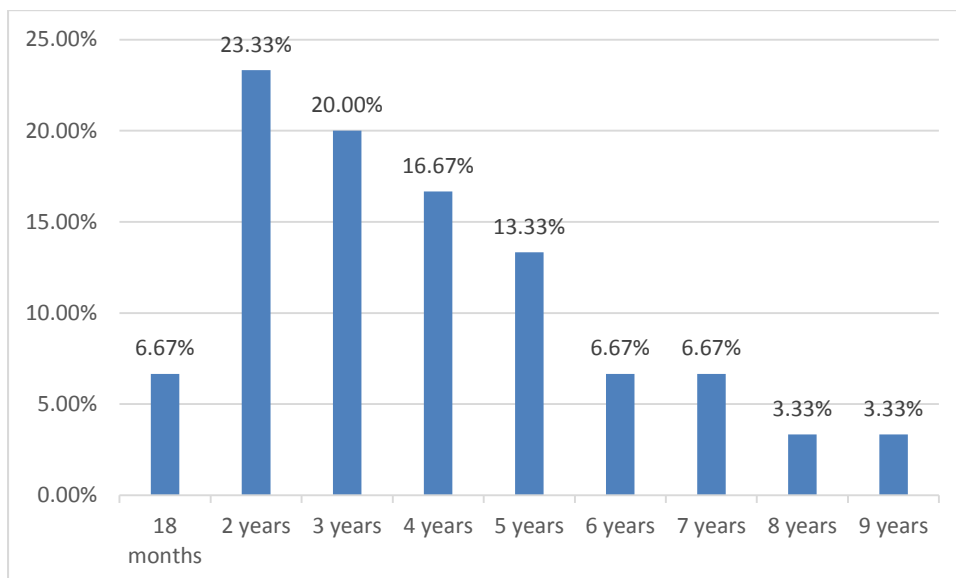


Figure 4.1: Age distribution of the children of participants

Table 4.2: Demographic characteristics of children

| | Variables | Number | Percentage |
|---------------------------------|----------------------------------|---------------|-------------------|
| Gender | Male | 19 | 63.33% |
| | Female | 11 | 36.67% |
| | TOTAL | 30 | 100.00% |
| Age | 18months | 2 | 6.67% |
| | 2 | 7 | 23.33% |
| | 3 | 6 | 20.00% |
| | 4 | 5 | 16.67% |
| | 5 | 4 | 13.33% |
| | 6 | 2 | 6.67% |
| | 7 | 2 | 6.67% |
| | 8 | 1 | 3.33% |
| | 9 | 1 | 3.33% |
| | TOTAL | 30 | 100.00% |
| Communication difficulty | Speech delay | 7 | 23.33% |
| | Unclear speech | 11 | 36.67% |
| | Expressive language difficulties | 6 | 20.00% |
| | No speech | 5 | 16.67% |
| | Stammering | 1 | 3.33% |
| | TOTAL | 30 | 100.00% |

4.3 Communication difficulty by age

From the figure below, it is apparent that majority of parents report that the speech of their children is unclear. Most of the younger children presented with a speech delay, but the older children presented with expressive language difficulties as well as unclear speech.

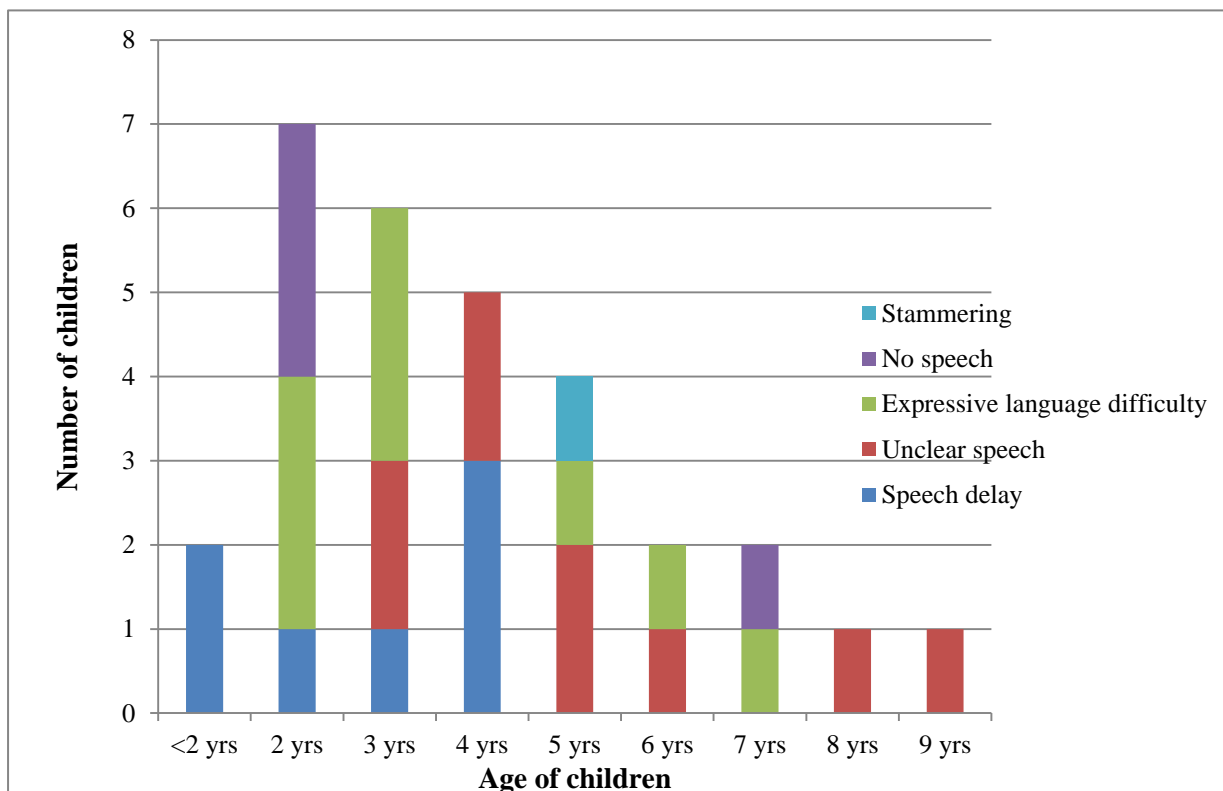


Figure 4.3: Distribution of children’s communication difficulty by age

4.4 Parental Concerns

Parents indicated that they had had concerns about their children for between six (6) months and two (2) years. Figure 4.4 below shows the duration of parents concerns, in comparison with the children’s ages.

Parents of older children (aged 4-9 years) appeared to have been concerned about their children’s communication difficulties for more than two (2) years. Sixty per cent (n=9, 60%) of parents of older children (n=15) reported being concerned for over two years. Unsurprisingly parents of children less than four years of age, however, indicated that they have been worried for a shorter period (n=15, 50%). One parent of a seven (7) year old boy reported that she had been worried about his communication difficulty between twelve (12) and eighteen (18) months.

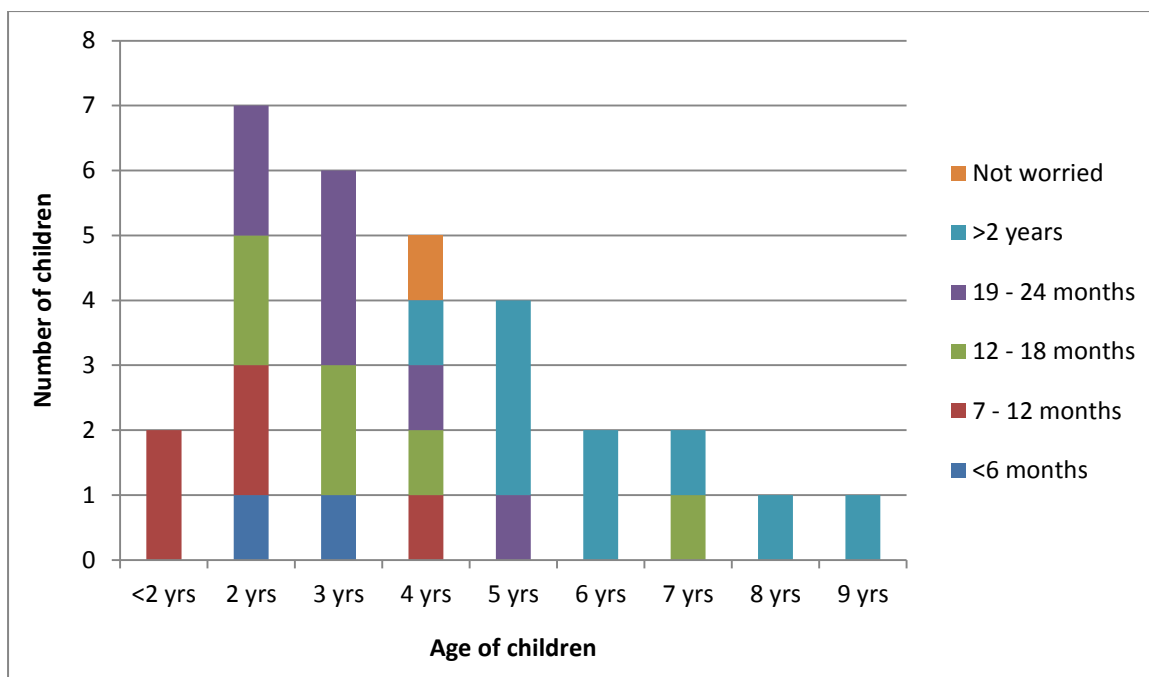


Figure 4.4: Duration of parents’ concern in comparison to children’s ages

4.5 Perceptions of Cause of Communication Difficulty

Parents were asked during the survey to share what they perceived to have caused their child’s communication difficulty. Some parents, (n=5, 16.67%) indicated that they perceived that their children’s communication difficulties developed because of some circumstances that occurred at birth. Some parents cited neonatal jaundice; others cited late delivery as a cause of their child’s communication difficulty;

“I think late delivery caused this” (Participant 5)

“She had neonatal jaundice at birth” (Participant 12)

Almost a quarter of parents (n= 7, 23.33%) indicated that their children had some secondary issues that were likely to be related to the communication difficulty. Conditions cited by the parents included cerebral palsy, Down syndrome and tongue tie.

“I think it’s because he has a tongue tie” (Participant 2)

“It’s possible the C.P caused it” (Participant 11)

Three parents (n=3, 10%) felt that their actions or their own family history were linked to the issue.

“I made him go to school early” (Participant 1)

“I myself had delayed speech so I think that is why” (Participant 3)

Almost one third of parents (n=10, 30%) reported to have no idea about the cause of their children’s communication difficulties

4.6 Seeking Help in other Places

With regards to seeking help, parents reported to have sought help from various places. The places they had reportedly sought help from included

- A range of health services including children hospitals, regional hospitals, private hospitals, polyclinics
- Specialised centres including: the speech and hearing centre where assessments are done and then children are referred for speech therapy services, from special schools where teachers are trained to handle children with special needs, and one family from a speech therapist in the United Kingdom

Parents also reported using phone applications (games and activities) which could improve the child’s speech, and seeking help from God through prayer.

In total, eighteen parents (n=18, 60%) reported that they had sought help from one or more of these places prior to coming to the speech and language therapy clinic. The remaining twelve parents (n=12, 40%) had not sought help from anywhere else.

4.7 Knowledge about Speech Therapy

Parents were asked in the survey to discuss what knowledge they have about speech therapy or the speech therapy professionals. Parents had varied views on speech and language therapy. Ten parents (n=10), representing thirty per cent (30%) of the sample reported they had some knowledge of the role of speech therapists, with descriptions including helping people with speech difficulties, improving the speech of children and giving professional advice about communication difficulties and explain why people have speech and language difficulties.

“It’s a stimulation process to aid people with speech difficulty to talk” (Participant 13)

“They explain why children have difficulty with speech” (Participant 16)

Parents were asked to identify their source of knowledge about speech therapy. Table 4.6 shows sources of information reported by parents to learn about speech therapy.

Table 4.6: Sources of information on speech and language therapy

-
- Doctors (G.Ps, surgeons, ENT specialist, paediatrician)
 - Media (television, radio and internet)
 - Audiologists
 - Family
 - Friends
-

4.8 Access to Services

In the survey, parents were asked about how difficult or easy it was to get to the speech clinic. Eleven parents (n=11, 36.67%) stated that they found it very easy to get to the speech clinic, five parents (n=5, 16.67%) reported to have found it easy, five parents (n=5, 16.67%)

said they found it difficult to get to the speech clinic, five (n=5, 16.67%) found it very difficult and four (n=4, 13.33%) said they found it neither easy or difficult to access speech therapy services.

Parents were then asked to describe any issues faced in accessing speech and language therapy services in an open-ended response. The question was not only related to geographical access, but it was extended to any situation that may have made accessing speech therapy services cumbersome. Content analysis was used to develop categories from the open-ended responses. Three categories of response emerged from the responses of participants and are described below;

4.8.1 Category 1: Distance

Distance was indicated to be an issue impacting access to services for parents, especially those parents who were not residing in the Greater Accra Region, where the speech and language therapy services can be accessed. This was primarily about how long it took them to get to the hospital

“We had to leave the house as early as three o’clock am (3:00 am), to join a bus for Korle Bu” (Participant 3)

“Because of the distance” (Participant 1)

4.8.2 Category 2: Directions

Four parents (n=4, 13.33%) described directions to the place as being a difficulty in accessing the SLT services even when you are in the hospital. This sub category refers to finding the actual speech and language therapy clinic, and not about finding the hospital in itself.

“We kept asking for directions, but it was not clear and people kept misleading us” (Participant 24)

“There are no directions to the place. I searched the whole hospital” (Participant 17)

4.8.3 Category 3: Waiting list

Five (n=5, 16.67%) parents indicated that one of the barriers or difficulties they experienced was the length of time they have been kept on the waiting list.

Five (n=5, 16.67%) also reported that being put on waiting lists for a long time made it difficult to access speech therapy services;

“We have been put on the waiting list for about four months” (P12)

“It took us six months to get an appointment” (P25)

4.9 Expectations of The Speech and Language Therapist

Parents were asked what they hoped the speech therapist might help them with. Eight (n=8, 26.67%) parents indicated that they expected the speech therapist to help develop their children’s speech. Six (n=6, 20.00%) parents reported they expected the speech therapist to help improve their children’s speech. Five (n=5, 16.67%) parents expected the speech therapist to use their knowledge to help their children. Three (n=3, 10.00%) parents expected the speech therapist to identify their children’s problem, and eight (n=8, 26.67%) parents reported to have no idea what expectations they had.

Parents were also asked about their expectation of what types of things the SLT might say or do, and they described practical activities they expected the speech therapist to engage them in. Seven (n=7, 23.33%) of the parents expected the speech therapist to teach them strategies to use with their children at home. Three (n=3, 10.00%) parents expected the speech therapist to give them encouragement about their children’s condition. One (n=1, 3.33%) parent reported to expect the speech therapist to give her a drug that could cure her child. Two (n=2, 6.67%) parents expected the speech therapist to provide explanations about what

was wrong with their children and seventeen (n=17, 56.67%) parents had no idea what activities they expected the speech therapist to give them.

4.10 Parental Level of Satisfaction With Speech and Language Consultation

Participants were asked to rate their level of satisfaction with their initial appointment immediately after they had seen the speech and language therapist using a five – point likert scale. Figure 1.3 shows the distribution of parents reported levels of satisfaction after their session with the speech and language therapist. The majority of parents (n=24, 80%) reported that they were either very satisfied or satisfied with the services they had received from the therapist. Two parents (n=2, 16.67%) reported being neither satisfied nor unsatisfied; none of the parents reported to be unsatisfied with services, and two (n=2, 16.67%) did not respond to this question.

In a similar vein, parents were asked to indicate how well the therapist met the needs of parents using a five-point liker scale (Figure 1.4). Eighty-seven per cent of parents (n=26, 86.66%) reported that the therapist had met their needs either well or very well. Four participants (n=4, 13.33%) did not respond to this question.

Table 4.10 Parental Perceptions of How Well Their Needs Were Met

| How needs were met | Number | Percentage |
|---------------------------|---------------|-------------------|
| Very well | 13 | 43.33% |
| Well | 13 | 43.33% |
| Neither | 20 | 0.00% |
| Poorly | 0 | 0.00% |
| Very poorly | 0 | 0.00% |
| No response | 4 | 13.33% |
| TOTAL | 30 | 100.00% |

4.10 Home Activities and Review In Clinic

Parents were asked if they had been given any activities to do with their children at home, and how likely they were to do them. Parents were asked about this because after a session with a client, the speech therapist usually gives some activities to parents to do with their children at home, and then come back to report on how it went whenever they came in for review. Speech and language therapists routinely give families follow up activities to do at home to promote learning. This is important as parents spend more time with their children at home and so it is important to have some activities which promote language and speech development for parents to engage their children in, until the next time they come into clinic. Twenty- five parents (n=25, 83.33%) reported that they had been given activities, one parent (n=1, 3.33%) indicated that she was not given any activities to do at home and four parents (n=4, 13.33%) did not respond to this question.

Parents were asked to indicate how likely they were to undertake the activities prescribed by the therapist. All participants (n=30, 100.00%) indicated they were either likely or very likely to undertake the activities.

4.12 Return Dates

Parents were asked during the survey if they had been given dates to return to see the speech and language therapist. This question was asked because parents who come through the speech and language therapy clinic are all given dates to return for a review of what progress their children have made since their last visit to the speech clinic. All parents reported that they had been given dates to return, and were certain they would return (n=30, 100%)

CHAPTER FIVE

DISCUSSION

5.1 Introduction

This study sought to explore the expectations the Ghanaian parent has about speech and language therapy. The overarching aim of this study was to explore first time parents' expectations of speech and language therapy services in Ghana, and measure their levels of satisfaction with the services they received. Findings revealed that some parents for instance, reported to expect the speech therapist to help develop, improve, and use their knowledge to help their children. Some others also reported to expect the speech therapist to teach them strategies, give them encouragement or give them drugs to help cure their children. This therefore showed that parents have varied expectations of the kind of services they were going to receive. The research questions that were answered are as follows;

5.2 Research Question 1

What are the expectations of parents of children with communication difficulties when they access speech and language therapy services for the first time?

Different parents have different expectancies of the kind of services they are to receive. Parents of children with communication difficulties are no exception. Parents participating in this study had children who had been identified with concerns about their communication. The written methodology used in this study did not enable exploration of whether parents were specifically concerned with the development of language (such as vocabulary development) or speech sound development. Interviews may have been more effective in collecting data on specific concerns of parents. Almost all parents in this study reported having concerns about their children's communication patterns, some for more than two (2) years yet data analysis revealed that only eighteen parents (n=18) had previously sought help

from other places. The data analysis shows some of the places where parents sought for help and this could therefore help the upcoming speech therapy practice in Ghana since there is a rough idea of the places the professionals can extend their education of speech and language development in children. When the community is educated, they can serve as sources of information for parents, and this will then foster communication development in children.

Results of this study revealed that the sample size is highly educated, as eighteen (18) participants, representing 60% of the sample had had a tertiary education. This raises the question of selection bias or whether the speech therapy clinic attracts people from more educated backgrounds. There is a possibility that people who have higher paying jobs will be more able to afford seeking help from the speech and language therapy clinic than people from a lower social economic status. More educated people may have access to information about services, such as through the internet. These factors may therefore have influenced bias in this sample population. This is an important issue requiring further research. Further research may seek to determine if people who access speech therapy services are from higher socioeconomic status, or come from more educated backgrounds. A larger service audit may provide evidence in this area. If a government speech therapy clinic disproportionately attracts educated families, then questions need to be raised about the equity of access to the service. This is discussed further later in this section. The educated nature of this sample must be taken into account when considering the results of the study. Further research could attempt to stratify the sample by education to determine if similar patterns were seen when educational levels varied.

In a first meeting with the speech therapist, the parent is often asked to give some information of the child's birth history, family history of a speech and language delay. The therapist also finds out from the parent what level of understanding their child has and what their child says. When this is done, the therapist assesses the child to find out the nature of the child's

speech and language difficulty, and then, together with the parent, decides on the best strategies that can be employed at home to help the child improve his speech and language difficulties. In this study, the majority of parents (50%), viewed the speech and language therapist as the expert on the child's speech and language development and relied on the therapist to directly treat the child. This resonates the study done by Carroll (2009), who also found parent expectations of the clinician as experts and to plan intervention. One parent in the current study for instance, perceived the therapist to be a skilled medical professional who was going to make her child's speech develop. Another parent reported that she expected the speech and language therapist to give her child a drug that could cure him. This could be interpreted as parents having a myriad of expectations of the speech and language therapists. Speech and language therapists typically work alongside parents to support the development of speech and language skills (Marshall, 2007). This study indicates that at least half of the parents in the sample may not appreciate their role in their own child's development. This is indicative of the need for greater community education about both the nature of communication development and how speech and language therapy is offered to support development of communication. In order for a child's communication to develop optimally, he or she must have been exposed to a language rich environment which will foster this development. The family is usually the first place a child should be exposed to language. Babies begin to recognize certain facial expressions as early as three (3) months old. This means that the human brain is primed for communication right from birth and as such this has to be stimulated. This therefore means that as children grow, there is the constant need for them to be engaged in various opportunities to communicate. It is therefore imperative that parents are made aware of their role in the development of their children's speech and language skills. This goes back to hammer on the need for community education on speech and language development.

During the survey, parents described the knowledge they have about speech and language therapy. Some parents described it as a ‘stimulatory process that enhance speech, others described it as a diagnostic process, while still others said it was a process of professionals making adults or children speak again. Half of parents however reported to have no knowledge of what speech and language therapy entails. It is important to bear in mind that this sample is educated and likely to have access to technology such as the internet, although this does not necessarily mean that all educated parents know about speech and language therapy and what it entails. This could also stem from the fact that speech and language therapy is a new phenomenon in Ghana and therefore not a lot of public awareness has been created. Owusu (2016) describes how few speech therapists there are in Ghana and how this impact on services rendered to the population. She also cites the need for immense education for the public, such as going to ante natal and post natal clinics to speak to both mothers and nurses about communication. Speech and language therapists work by raising awareness on ways to promote optimum speech and language development. They also promote the health and well-being of individuals with communication difficulties by contributing to the overall public health agenda. This research indicates that there is need to create more public awareness to enable the community to understand more about the development of communication and the important role of family environment in the development of communication skills. Speech and language therapists working in Ghana will also need to take time with new families to educate them on the approaches used by the profession to build communication skills in children and create effective partnerships with families. Only once families understand how communication develops, will they be able to partner effectively with speech and language therapists to achieve the best outcomes for their child. Kulkarni (2014) in his study sought to find out what parents of children with autism thought about being educated by the speech therapist about what procedures were being used. Some

parents explained that being in the know of what the speech therapist was doing with their children gave them a sense of ownership and responsibility, as they felt they were a part of the process, while other parents who were not involved in their children's intervention felt out of place and as such did not see the need to continue with speech therapy. This is likely to happen in Ghana as well if speech therapists fail to explain the rationale behind engaging children in certain activities to parents. McLeod and Harrison (2009) in an investigation of the use of speech therapy services in Australia discovered that speech therapy services had not been patronized by at least two thirds of the families who had been identified as having children with communication disabilities. There were some parents who indicated accessibility to services as a barrier. However there were those families who had no problem accessing services but had refused to do so, and it was unclear if it was because they did not know the Benefits of speech therapy or if they did not know how to access the services. It is only if Ghanaian speech therapists educate families, will they understand the need to work in partnership for their children's benefit.

5.3 Research Question 2

To what extent do parents of children with communication disabilities report their expectations are met when they meet the speech and language therapist for the first time?

Parents in this study reported high levels of satisfaction when they were interviewed immediately after the session with the speech and language therapist. It is unsurprising that parents reported to be satisfied with the services they had received, especially if it was the first time they had met someone who understood what they and their children go through. Meeting with the speech and language therapist also assured parents that there was hope for their children. In their research, Bailey et al. (1999) discovered that parents reported satisfaction with services after they had been attending sessions for some time and had seen

improvement in their children's speech and language. The story is however different for this study, as parents were asked to judge their level of satisfaction immediately after the session with the speech and language therapist. This may be related to a range of possibilities: social response bias if the parents felt compelled to give a good review of the services they received (Paulhus, 2002); or be linked to finding support after a period of being concerned about their child. Social response bias is a recognisable error of measurement which occurs when a participant in a research provides a response which is more socially accepted than his or her actual behaviour (Kaminska & Foulsham, 2011). Another situation that has been considered to cause this social response bias is the wording of some survey questions. When these questions are posed in less threatening ways, then there is the likelihood for participants to respond truthfully (Holbrook & Krosnick, 2010). Ways that the social response bias could be curbed include making sure the wording on survey questions are clear enough. In addition to wording the questions, the context in which the questions are being asked should be taken into consideration (Krumpal, 2013).

Other ways that satisfaction with speech and language therapy services with first time attendance may be more robustly considered would include tracking patterns of return visits and follow up with non-attenders. Using independent surveyors, or anonymous systems of feedback may also be useful may reduce the high risk of social response bias (Krumpal, 2013). For satisfaction of on-going families, a survey may be done for parents who have been receiving speech and language therapy services for some time (between three and six months), to find out if they are satisfied with services they have been receiving, and if they have noticed any improvements in their children's communication. Another way to measure satisfaction may be to hold open forums periodically for parents to discuss how they find the services and what could be done in addition to what they are already receiving. However it is also important to measure satisfaction of first time service users, because if service users are

unsatisfied, they are likely to disengage with services, limiting the ability of their child to receive intervention.

Parents indicated that they were likely to return to the speech clinic as requested; however, as discussed above, this methodology runs a high risk of bias. Future research could track the proportion of first time clients who attend on going appointments and follow up with those who are non-attendees to explore some of the factors which may influence non-attendance, including satisfaction levels.

5.4 Research Question 3

What issues do parents of children with communication disabilities experience in accessing speech and language therapy services?

Parents in the study listed **distance, being on a waiting list** and **difficulties finding the speech clinic** as being barriers they faced in accessing speech therapy services. Although about 90% of the participants in this study reside in Greater Accra, they, as well as those participants who reside outside the Greater Accra Region both cited the distance from their houses to the hospital as a cumbersome feat. The impact of distance to accessing speech and language therapy services is one that constantly appears in discussions about speech and language therapy services (O’Callaghan et al. 2005). McAllister et al. (2011) in their study reported that mothers revealed that when they had to consider the distance it took to take their children to see the speech therapist as well as taking care of the needs of the family, mothers said that they tended to neglect the needs of the child with a communication disability.

Analysis of data revealed that none of the participants in the study came in from a rural area. The few parents who came in from outside Accra came from the regional capitals. It comes as no surprise that when access to services is unequal among members of a community, inequities tend to exist (Dunkley, Pattie, Wilson & McAllister, 2010). There appear to be

fewer speech and language therapists for residents in rural Australia than for those in the urban areas (Winslow, Lincoln & Onslow, 2002). Lambier and Atherton (2003), in their study reported that there were only about 3% of the workforce of speech and language therapists in Australia who provide services for people in the rural areas. This is very different from the situation in Ghana because there are no services at all for people in the rural areas. The entire country can boast only of three practicing Ghanaian speech and language therapists as well as some expatriates who come in occasionally to work, but are not permanent workers. This entire workforce work from Accra, in the Korle Bu teaching hospital precisely, and thus this makes it difficult to get a lot of people coming in from places which are extremely far from Accra.

The American Speech and Hearing Association (2005) are of the view that telepractice and telehealth is the best way to deliver services for the profession of speech and language therapy especially in places where there is no SLT workforce, in order to overcome barriers of accessing services which are caused by distance or impaired mobility (Mashima & Doarn, 2008). This may be a service delivery approach that speech and language therapists in Ghana could consider, in order to reach as many families in need of speech and language therapy as possible. However it will require investment in telecommunication infrastructure that is not yet available. Future SLTs in Ghana could consider the use of apps, SMS messaging and other technology based solutions to at least in part, address the needs for clients. If this is not done, the population of people with communication disabilities may increase and create more problems for the now growing profession.

Another way speech therapists can make an impact is to spread their services across Accra and into other rural areas as the profession grows. Presently, speech therapy is only present in one hospital in Accra and this makes it difficult for parents to access services. Alternatively professionals can do occasional visits to some rural communities probably to do

some health screening, or even liaise with other health professionals to do the health screenings. Finally, upcoming SLTs can train people as speech therapy assistants to help with delivery of services. Teachers, community based rehabilitation workers can all be trained to offer at least some kind of support for people with communication difficulties in the communities so as to lessen the burden on the speech therapists.

Parents in this current study indicated that they see the amount of time they had spent on the waiting list as a barrier to services. O'Callaghan et al. (2005) reported that waiting lists are a recurrent problem in paediatric speech and language therapy services in Australia. The growing numbers of waiting lists has led to the declination of people accessing speech and language therapy services (O'Callaghan et al. 2005). In addition to this there may be a lot of pressure on the speech and language therapists and they may experience burn-out (McLaughlin, Lincoln & Adamson, 2008). Speech and language therapy is new in Ghana and so is the concept of waiting lists is now developing. However, if waiting lists are not used, Ghanaian speech and language therapists may equally experience burn-out. Another thing waiting lists could lead to is the missing out of the critical period in children's language development (Bishop & Adams, 1990; Nathan et al 2004). The critical period in language development is the time at which a child is cognitively programmed to acquire language. This critical period occurs usually before age 5 and therefore if a child is not exposed to a rich language environment or if exposure to language is delayed until after 5 then there will be a break in the child's language development (Waterfall, Heidi, Sandbank, Onnis & Edelman, 2010). Intervention for children with disabilities during the early childhood years is often referred to as early intervention by families and service providers (Royal Australasian College of Physicians, Paediatric & Child Health Division, 2013). It basically involves ensuring that a child reaches optimal language abilities. Early intervention is not only about "treatment" for the child, but also about providing education, support and guidance for

parents. (Bailey et al. 2004). However, when intervention is late, for instance beginning in a child's school going year, it may have lifelong consequences for children with communication disabilities. A systematic review of the literature has revealed that difficulties may continue for at least 28 years (Law, Boyle, Harris, Harkness, & Nye, 1998). Early intervention is not just a job solely for the speech and language therapist, but for parents as well. In the Lyons et al. 2010 study, where they gave parents the opportunity to support with the early intervention program with their children, using activities given to them by the speech therapist, they found out that the impact was no different than it would have been if the speech therapist had done it.

Results from the data also revealed that parents had been concerned about their children's communication difficulties, some for a year, and others for more than two years, but had not received any help for them. It has been well documented that for children with communication difficulties, early intervention is critical. When early intervention is provided, especially for young children, they are most likely to be able to settle into education successfully, and this will make them less of a liability to the state (Lyons et al., 2010). Parents in the study also reported to have sought help from various places as a result of their concerns about their children's communication disabilities. About 50% of the parents reported to have sought help from hospitals and the other parents reported to have sought help from places such as special schools, from phone applications, and one parent reported to have sought help from God. Some parents usually resort to relying on a religious deity to draw strength from in times of difficulties, and parents who have children with communication difficulties fall within this category. However, in an interview of 60 parents from the Republic of Ireland about the impact of having a child with autism, Coulthard and Fitzgerald (1999) found that 45% reported that this event in their lives had prompted them to distance themselves from God and their religion.

Although it has been documented that not a lot of parents come in to the speech clinic, there is still the situation of parents being put on waiting lists. This could be because the workforce of speech and language therapists is not big enough and as such there are not enough speech therapists to meet the needs of the individuals with communication disabilities. As has been discussed above, early intervention is critical to a child's communication development and therefore it is imperative that parents seek and find help as soon as possible. However, results from this study have shown that some parents, although being concerned about their children's communication difficulties, have waited for some time before seeking help. This, coupled with being put on a waiting list as well does not bode well for these parents because this will mean that it is going to take longer for the child to receive the help he or she needs, and as such the longer it takes to get to this child, the longer it's going to take for there to be an impact in the intervention he will be receiving. There is therefore the need to train more therapists, as well as train more people in the community to help work with children with speech and language difficulties, as this might help reduce the incidence of a lot of people being kept on waiting lists for long periods of time.

CHAPTER SIX

CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS

6.1 Introduction

This study provided an early exploration of the expectations parents of children with communication disabilities have about speech and language therapy. Additionally the study considered their levels of satisfaction with the service. The study was done using a two part questionnaire.

This chapter, provides conclusions of the study and considers both the recommendations and for future research. The limitations of the study are presented.

6.2 Conclusion

The findings from the study showed that;

- The parents in this study expected the speech therapist to solve their problem for them rather than work alongside them and other parents expected a cure to make their children's difficulties go away.
- Parents reported to be satisfied with the services they received at their first meeting with the speech and language therapist and were certain to return on the dates they had been given. However this finding is subject to bias, and requires further research.
- Parents faced barriers to accessing the speech and language therapy services. These barriers to access included geographical barriers (distance and travel time), lack of service availability (being put on a waiting list) and service visibility (difficulty locating the speech and language therapy clinic in the hospital).

6.3 Recommendations for Practice

Speech and language therapists in Ghana could do the following;

- Educate the public about communication development, so that families understand that acquiring communication requires consistent stimulation and effort, and so that they understand the important role of the family in promoting communication.
- Educate other health professionals about the job description of speech and language therapy so as to enable them to make appropriate referrals, as well as explain to parents why they are being sent to see the speech therapist.
- Work on creating geographically diverse clinics, including perhaps visiting clinics to nursing outposts, to make services more accessible to families.
- Support the training and development of more SLTs so that services can grow quickly
- Train more speech therapists in the country to increase the workforce.

6.4 Recommendations for Future Research

In the future, research such as this one could be done with a larger sample size, could be done over a long period of time, with follow-up on clients. Interview guides should look for more in-depth information and have more follow-up questions especially about barriers to services. Also another research could employ the use of a focus group discussion with the participants of the study, as this would help to get more information.

6.5 Limitations

One limitation of this study is that the sample size was too small. Another is the fact that there could be a risk of response bias. The researcher is also inexperienced in formulating surveys and therefore survey questions were unable to capture rich data. The research is inexperienced in analysis of qualitative data as well.

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APPENDIX A



UNIVERSITY OF GHANA

Department of Audiology, Speech and Language Therapy
School of Allied Health Sciences
College of Health Sciences
The University of Ghana
PO Box KB 143
Korle Bu

CONSENT FORM

Igive my consent to be a part of this research project titled ‘CLIENT EXPECTATIONS OF SPEECH AND LANGUAGE THERAPY SERVICES’.

I confirm that;

1. I have read and understood the information about the project, as provided in the Information Sheet dated.
2. I have been given the opportunity to ask questions about the project and my participation
3. I understand I can withdraw at any time without giving reasons and that I will not be penalised for withdrawing nor will I be questioned on why I have withdrawn.
4. The procedures regarding confidentiality have been clearly explained (e.g. use of names, pseudonyms, anonymity of data, etc.) to me.
5. The use of the data in research, publications, sharing and archiving has been explained to me.
6. I understand that other researchers will have access to this data only if they agree to preserve the confidentiality of the data and if they agree to the terms I have specified in this form.
7. I, along with the Researcher, agree to sign and date this informed consent form.

Participant:

| | | |
|---------------------|-----------|-------|
| _____ | _____ | _____ |
| Name of Participant | Signature | Date |

Researcher:

| | | |
|--------------------|-----------|-------|
| _____ | _____ | _____ |
| Name of Researcher | Signature | Date |

APPENDIX B



UNIVERSITY OF GHANA

Department of Audiology, Speech and Language Therapy
School of Allied Health Sciences
College of Health Sciences
The University of Ghana
PO Box KB 143
Korle Bu

PARTICIPANT INFORMATION SHEET

My name is Malaika Abigail Addai-Sundiata, and I am a graduate student at the University of Ghana. I am inviting you to participate in a research study. Involvement in the study is voluntary, so you may choose to participate or not.

I am interested in learning more about what clients expect when they see the speech therapist for the first time. You will be asked to answer questions from a questionnaire. This will take 10 – 20 minutes of your time. You will be asked to complete half before you see the speech and language therapist, and half after you have finished your appointment.

All information will be kept anonymous and confidential. Your name will not appear anywhere and no one except me will know about your specific answers. I will assign a number to your responses, and only I will be able to indicate which number belongs to which participant. In any presentations that I make, I will use a pseudo name – a name that is made up for you, and I will not reveal details or I would change details on where you work, live, and any personal information about you.

This research will help us begin to understand what people want from speech and language therapy services. It should help us to begin to meet the expectations that clients have when they first see a speech and language therapist.

The study has received ethical approval from the University of Ghana and Korle Bu Teaching Hospital.

If you start but do not wish to continue, you have the right to withdraw from the study, without penalty, at any time. You will still receive services from the speech and language therapist if you withdraw and withdrawing will not affect your access to speech and language therapy services in any way.

This form is for you to keep. If you have any questions about the research, please contact:

(0264621286)

APPENDIX C



Department of Audiology, Speech and Language Therapy
School of Allied Health Sciences
College of Health Sciences
The University of Ghana
P.O Box KB 143
Korle Bu

QUESTIONNAIRE

1. Age of child.....
2. Gender of child: Male Female
3. Area of residence:
4. Child's communication difficulty:
5. Parent's education level:
 - Never schooled
 - Completed Primary
 - Did not complete primary education
 - Did not complete primary education
 - Completed middle/JHS
 - SHS graduate
 - Completed commercial / technical
 - Completed post-secondary (other)
 - Completed tertiary

SECTION 1

1. What concerns do you have about your child's communication?

.....

2. Why do you think your child has a problem with communication?

.....

3. Does your child have any other health or disability issues?

.....

4. How long have you been worried about your child's difficulty?

Less than 6 months

7-12 months

12-18 months

19 months-2 years

More than 2 years (specify if more than 2 years)

5. Have you tried to seek help from anywhere else?

Yes No

5a. If yes, where have you sought help from?

.....

6. What do you know about speech therapy?

.....

.....

.....

7. How did you hear about speech therapy?

.....

8. Was it that person who told you to come?

Yes No

9. How easy was it to get here?

Very difficult Difficult Neither Easy Very Easy

9a. If difficult, or very difficult, what made it difficult for you to bring your child to speech therapy?

.....
.....
.....

10. What do you hope the speech and language therapist might be able to help you with?

.....

11. What do you think the speech and language therapist might do to help you?

.....
.....

12. What other types of things do you think the SLT might do or say?

.....
.....
.....

SECTION 2

1. How satisfied are you with the session you had with the speech and language therapist?

Very Unsatisfied Unsatisfied Neither Satisfied Very Satisfied

2. Which statement seems most appropriate to describe how well the therapist met your needs?

The speech therapist met my needs;

Very poorly Poorly Neither Well Very well

3. Were you given any activities to go and do at home?

Yes No

4. How likely are you to do them?

Very likely Unlikely Neither Likely Very Likely

5. Were you given a date to return?

Yes No

6. How likely are you to come back?

Very likely Unlikely Neither Likely Very Likely

7. If unlikely or very unlikely, what are some of the reasons you think you may not come back?

.....

8. What do you think the therapist could have done differently to make the session more useful for you and your child?

.....

9. On the whole, did you find the session;

Very unhelpful Unhelpful Neither Helpful Very Helpful



UNIVERSITY OF GHANA
SCHOOL OF BIOMEDICAL AND ALLIED HEALTH SCIENCES

30th January, 2018.

Ref. No.:.....

Ms. Malaika Abigail Addai-Sundiata,
Dept. of Audiology, Speech and Language Therapy,
SBAHS,
Korle Bu.

Dear Ms. Addai-Sundiata,

ETHICS CLEARANCE

Ethics Identification Number: SBAHS – ASLT. /10272652/AA/5A/2017-2018.

Following a meeting of the Ethics and Protocol Review Committee of the School of Biomedical and Allied Health Sciences held on Tuesday 30th January, 2018. I write on behalf of the Committee to approve your research proposal as follows:

TITLE OF RESEARCH PROPOSAL: “CLIENT EXPECTATIONS OF SPEECH AND LANGUAGE THERAPY SERVICES-AT THE KORLE BU TEACHING HOSPITAL”

This approval requires that you submit three-monthly review reports of the protocol to the Committee and a final full review to the Committee on completion of the research. The Committee may observe the procedures and records of the research during and after implementation.

Please note that any significant modification of the research must be submitted to the Committee for review and approval before its implementation.

You are required to report all serious adverse events related to this research to the Committee within seven (7) days verbally and fourteen (14) days in writing.

As part of the review process, it is the Committee’s duty to review the ethical aspects of any manuscript that may be produced from this research. You will therefore, be required to furnish the Committee with any manuscript for publication.

This reviewed report is valid till 31st. August, 2018

Please always quote the ethical identification number in all future correspondence in relation to this protocol.

Thank you.

Yours sincerely,

Dr. S. D. Amanquah
(Chairman, Ethics and Protocol Review Committee)

Cc: Dean
School Administrator
Head, Dept. of Audiology, Speech and Language Therapy

COLLEGE OF HEALTH SCIENCES

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