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The Lived Experience of being a Speech-Language Therapist in the Western Cape public health service

By

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Abstract

The Lived Experience of being a Speech-Language Therapist in the Western Cape public health service

Speech-Language Therapy is a health and education profession assisting in the promotion of normal communication, as well as in the identification, prevention, treatment and management of a variety of developmental or acquired speech, language and oral disorders. In the Western Cape Public Health service (South Africa), Speech-Language Therapy posts exist in the three tertiary hospitals, in two district hospitals, one psychiatric facility, one rehabilitation hospital, and one community site. The paucity of available research on the lived experience of Speech-Language Therapists in the public service has informed this study.

This study explores the lived experience of being a Speech-Language Therapist in the Western Cape public health service. A qualitative hermeneutic phenomenological design was used, purposive sampling was undertaken and in-depth interviews carried out with seven Speech-Language Therapists working in the three Western Cape tertiary hospitals. Field notes and reflective memos were also kept by the researcher. Interviews were audiotape recorded, transcribed verbatim and analysed. Follow-up interviews were carried out in order to discuss and expand on preliminary study findings.

Five key themes characterised each therapist's experience: expectations of practice and practice realities; being part of the "underdog" profession: role definition and status; being connected; the holistic nature of the Speech-Language Therapist's practice; and erosion or promotion.

This research provides insight about the lived experience of the public service Speech-Language Therapist and provides a comprehensive description of it. The final description transforms this particular lived experience into a textual expression of its essence, and highlights specific recommendations that should be considered by educators, therapists, colleagues, managers and policy makers.

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Disclaimer

I *Jocelyn Amy Warden* declare that this thesis is a presentation of my original research work and has not been submitted in any form for another degree or diploma at any university or other institution of tertiary education. Information derived from the published or unpublished work of others has been acknowledged in the text and a list of references given.

Signed by candidate

Jocelyn A. Warden

12·11·07

Date

Dedication

To each and every Speech-Language Therapist, but especially to those who dedicate themselves to the public service.

> Help Wanted: Individuals who are enthusiastic, intelligent, energetic, and personable to work in challenging situations with challenging individuals. Extrinsic rewards minimal. Intrinsic rewards unlimited.
>
> Mastropieri, M.A. 2001, p. 66

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My seven participants. Thank you for being so willing to give up the time to share your experiences with me. Your stories truly "lead me to the most unexpected places" and confirmed the reasons I chose this profession.

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My colleagues at Groote Schuur Hospital. Thank you for bearing with me through the good times and the bad, for always being interested and supportive, and for jumping in at the end when I was not at work.

My Lord and Saviour Jesus Christ for sustaining and strengthening my soul throughout this process.

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Definition of terms

Lived experience

Individual experiences of people as conscious human beings.

Speech-Language Therapist (S-L Therapist)

A person who has completed an accredited B. degree, who has registered with the Health Professions Council of South Africa and who is able to practice in their trained field as a S-L Therapist. S-L Therapists address people's speech production, vocal production, swallowing difficulties and language needs through speech therapy in a variety of different contexts including schools, hospitals, and through private practice. The scope of practice also includes the rehabilitative or corrective treatment of physical and/or cognitive deficits/disorders resulting in difficulty with communication and/or swallowing.

Phenomenology

The study of a phenomenon, the way things appear to us in experience or consciousness; a discipline that endeavours to describe how the world is constituted and experienced through conscious acts (Phenomenology Online Glossary, 2004).

Speech

The oral medium of transmission for langauge; the process of information exchange through spoken language; the manner of articualtion where the body parts involved in making speech are manipulated (Crystal, 1995. p. 458).

Language

The systematic, conventional use of sounds, signs, or written symbols in a human society for communication and self-expression (Crystal, 1995, p. 454).

Communication

The transmission and reception of information between a signaller and receiver; a process that allows organisms to exchange information by several methods requring all parties understand a common language that is exchanged with each other. Common modes of commucnaition can include speaking,singing and sometimes tone of voice, and nonverbal, physical means, such as body language, sign language, paralanguage, touch, eye contact, or the use of writing (Crystal, 1995, p. 450).

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Experience

Experience as a general concept comprises knowledge of or skill in or observation of some thing or some event gained through involvement in or exposure to that thing or event; not inside us but instead how we behave towards the world and act towards others (Wikipedia, 2007a).

Western Cape public service

Used to describe the Western Cape government department as a whole.

Western Cape public health service

Health services under the oversight of the Provincial Government of the Western Cape.

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CHAPTER ONE
Introduction

1.1 Introduction and background

Speech-Language (S-L) Therapy, previously known as Speech Therapy, is a health and education profession assisting in the promotion of normal communication, as well as in the identification, prevention, treatment and management of a variety of developmental or acquired speech, language and oral disorders (Speech-Language Therapy Scope of Practice, 2005). The S-L Therapist provides assessment and management of cognitive and social aspects of communication, counselling for individuals with communication impairments and their families, as well as education and prevention programmes to communities. Further functions include the making of appropriate referrals to other professionals; the undertaking of training and provision of support to family members; the development and establishment of effective augmentative and alternative communication techniques; and the selection, fitting and effective use of appropriate prosthetic devices (Lubinski & Frattali, 2001, p.12).

This chapter will present an historical outline of the profession of S-L Therapy[1] worldwide and in South Africa. It will describe the process of training, registering and practising as a S-L Therapist in South Africa, and then focus on the structure of the S-L Therapy services in the Western Cape public service. This will be followed by a description of the researcher's personal experience of being a S-L Therapist in the public service, which frames the problem statement and provides a rationale for the need for research in this area. The current study aims will then be presented.

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[1] The professions of S-L Therapy and Audiology are closely related and although were initially viewed as a single profession, now constitute two separate registrations with the Health Professions Council of South Africa (HPCSA). In this chapter, both the historical background of S-L Therapy and information about training, registering and practising as a S-L Therapist in South Africa includes that of Audiology, however for the purposes of this study from section 1.5 onwards reference is made only to the profession of S-L Therapy.

1.2 The History of Speech-Language Therapy and Audiology[2] Worldwide

The history of the formal profession of S-L Therapy and Audiology as we know it commenced in the 1920s in the United Kingdom (UK), the United States of America (USA), and several parts of Europe (Aron, 1991). Prior to this, a British physician had begun to focus on certain areas of speech and its disorders, and in 1894 Scotsman Dr John Wylie published his famous book Disorders of Speech "which marked a definite stage in the development of speech therapy as it is known today" (MacLeod, 1991, p. 10). Dr Wylie as well as other British doctors became highly interested in the areas of speech and its disorders and employed the help of singing and elocution teachers and teachers of the deaf to assist them. Although both parties felt "fairly ignorant" in the field, they pooled their ideas and knowledge and "gradually became more experienced in the diagnosis and treatment of speech defects and disorders" (MacLeod, 1991, p. 10), with the first hospital clinics for the treatment of speech defects in children being opened in 1913. The Second World War presented medical doctors with patients suffering from "shell-shock" who again enlisted the services of the "speech specialists" to deal with speech disorders resulting from war injuries even though they were limited in the help they could provide (MacLeod, 1991, p. 10).

Aron (1991) reports that by the mid 18th century, education for the deaf had become widespread in Europe and moved from Europe to the USA by the beginning of the 1900s. In the USA speech correction became recognised in 1908 as a function of the public school system with many schools establishing speech correction training programmes. By the late 1920s many universities had established speech clinics and various courses in speech pathology had emerged in psychology departments and

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[2] Audiology is an "autonomous health care and educational profession that deals with the prevention, identification, treatment and management of organic disorders of the auditory and balance system, auditory processing disorders and developmental or acquired speech disorders caused by hearing loss" (Audiology Scope of Practice, 2005). It provides aural rehabilitation to children and adults across the entire age span. Audiologists select, fit and dispense amplification systems such as hearing aids and related devices. They prevent hearing loss through the provision and fitting of hearing protective devices, consultation on the effects of noise on hearing, and consumer education (Lubinski & Frattali, 2001, p.18). South Africa (HPCSA). In this chapter, both the historical background of S-L Therapy and information about training, registering and practising as a S-L Therapist in South Africa includes that of Audiology, however for the purposes of this study from section 1.5 onwards reference is made only to the profession of S-L Therapy.

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departments of speech and drama and education As research in the area grew, so did the need for advanced training (Aron, 1991). The Association of Teachers of Speech became the American Academy of Speech Correction in 1926, and finally the American Speech and Hearing Association in 1936. The first academic training programmes were offered within the faculties of art or science or in schools of graduate studies, and included basic courses on the structures and processes underlying human communication, courses on specific communication disorders and mainly observation of therapy.

In the UK during the early 1900s, speech therapy was established in various private schools for speech training or elocution. From the 1930s, formal diploma courses in speech therapy were offered which were later extended to Australia and New Zealand. As the profession developed within the UK, professional training was moved to the university setting (Aron, 1991). In Europe, during the 1920s and 1930s, speech therapy was approached from a different position and was introduced by phoneticians (phoniatrists) and medically trained voice experts who studied normal speech voice.

1.3 What's in a name?

'Speech therapy' as the preferred profession nomenclature was voted in during a UK referendum in 1973 and again in 1983, as this nomenclature was favoured by the British College of Speech Therapists. Those in opposition to this stated that it was "too simplistic and did not convey the extent of our work" (Aron, 1991, p. 5) due to the fact that the SLT's scope of practice exceeds that of speech correction.

1.4 The History of Speech-Language Therapy and Audiology in South Africa

The first Speech, Voice and Hearing Clinic in South Africa was established at the University of the Witwatersrand (WITS) in 1936 by Professor Pierre de Villiers Pienaar (a phonetician) who had completed his doctoral studies in voice science at the University of Hamburg. The purpose for establishing the clinic was to train Speech Therapists, with the first Speech Therapists completing their two-year diploma in Logopaedics in the Faculty of Arts in 1939 (Aron, 1991). Five years prior to the establishment of this clinic, a speech and drama teacher, Mrs Elsie Salamon-Burns, had been providing "speech therapy" for children hospitalized in the Transvaal Memorial Hospital for Sick Children.

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In 1942, the WITS diploma was extended to a three-year degree and in 1946, a four-year degree was introduced. The training programme was structured around the close inter-relationship of hearing with the speech and language processes. As a result, the anatomy of the ear, hearing process and basic audiometric procedures were taught in the speech science course with aural rehabilitation being introduced as a subject in 1946 (Aron, 1991). In 1959 a similar training programme commenced at the University of Pretoria, followed by the University of Durban-Westville in 1973, University of Cape Town (UCT) in 1975, and University of Stellenbosch in 1989.

The Speech Clinic at Groote Schuur Hospital had, however, been in existence thirty years prior to the establishment of the UCT programme, with services at the time also available at Red Cross Children's Hospital. This is due to the fact that both Groote Schuur and Red Cross Children's Hospital are teaching hospitals and therefore functioned and still do function as primary training sites for the training of students. Groote Schuur Hospital's service was established by Mary Kihn in 1941 followed by the establishment of a one-year course leading to a certificate for teachers of children handicapped in speech and hearing as well as the speech correction and hard of hearing service of the Cape Education Department. The certificate curriculum included courses in psychology of the deviate child, English and Afrikaans phonetics, voice production and anatomy and physiology of speech and hearing (Aron, Bauman, & Whiting, 1967).

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1.5 Training, registering and practising as a Speech-Language Therapist and/or Audiologist in South Africa

At time of study six of 23 South African universities offer a four-year Bachelor degree programme, namely the University of Cape Town, University of KwaZulu Natal, Medunsa (Medical University of South Africa, now a campus of the University of Limpopo), University of Pretoria, University of Stellenbosch and the University of the Witwatersrand. Postgraduate programmes are offered at most of these institutions. Entrance requirements vary from institution to institution, but most have a point system minimum, require mathematics and science and/or biology subjects, and conduct group or individual interviews with prospective students.

Until 1999, following completion of the B. degree, students registered with the Health Professions Council of South Africa (HPCSA) on a dual register (S-L Therapy and Audiology) enabling them to practice within both disciplines. Since this date

graduates Of the B. Degree register with the HPCSA on a single register and practice as either a S-L Therapist or an Audiologist . The University of the Witwatersrand remains the only university which offers the dual registration option.

In most countries, the disciplines of Speech-Language Therapy and Audiology are considered to be separate professions (Soer, 2003; Tuomi, 1994). As already stated, until recently graduates from all South African Universities studied both S-L Therapy and Audiology disciplines in their degree programme. Reasons for separating S-L Therapy from Audiology was the desire to align South African programmes with international standards, and to better equip graduates in light of the rapidly expanding knowledge base in both professions (Tuomi, 1994). While the history of the S-L and Hearing professions in South Africa has been recognised as an intricate and somewhat uncoordinated one, both professions have come a long way in creating better defined professional identities (Andanda, Bonaretti, & Wemmer, 2003).

The HPCSA's membership register contains the details of all qualified South African S-L Therapists and Audiologists even if they are not currently practising in the profession. As of 31 May 2007, it was confirmed that South Africa had 190 qualified single register S-L Therapists (7 male and 183 female) with 62 of these having postal addresses in the Western Cape (2 male and 60 female). At this time there were 1428 therapists registered on both S-L Therapy and Audiology registers (35 male and 1393 female), with 238 of those having postal addresses in the Western Cape (2 male and 257 female) (Y. Daffue, personal communication, June 4, 2007). These figures indicate that the Western Cape is home to 32% of the total number of South African S-L Therapists with single registration and 16% of the total number of South African S-L Therapists/Audiologists with dual registration. The small number of single register S-L Therapists compared to dual register S-L Therapists/Audiologists is most likely due to the recent shift in graduates registering on a single register.

Since 01 January 2003, all graduates of both S-L Therapy and Audiology holding South African citizenship have been required to complete a year of Community Service in a government setting in South Africa (Regulations in terms of Health Professions Act, 1974). A Community Service S-L Therapist may be placed at primary-level, secondary-level or tertiary-level and during the year carry out the same clinical and administrative duties as that of a qualified S-L Therapist. In most cases and where

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available they are offered supervision by more experienced S-L Therapists. On completion of Community Service, the S-L Therapist and Audiologist are registered with the HPCSA in the category of a qualified S-L Therapist or Audiologist and may practise within the South African public or private sector. As of 30 June 2007, 884 of a possible 1428 South African dual register S-L Therapists and Audiologists and 50 of a possible 190 single register S-L Therapists were registered as private practitioners (H. Ball, personal communication, July 6, 2007). The remainder of therapists within each registration group constitute those either working in the public service or registered, but for unknown reasons at the time of study not practising.

1.6 Speech-Language Therapy in the Western Cape public service

At time of study S-L Therapists in the Western Cape public service were employed by either the Western Cape Health Department or the Western Cape Education Department (WCED). Although both services employ S-L Therapists, they are administered by separate departments, have separate directorates, budgets and carry out different functions. As it is the focus of this study, a detailed description of the public health S-L Therapy service is outlined below, as is a brief outline of public education S-L Therapy services for the purpose of providing background information.

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1.6.1 Speech-Language Therapy services available in the Western Cape public health service

Within the Western Cape Health Department, the three tertiary hospitals, namely Red Cross Children's War Memorial Hospital (RXH), Groote Schuur Hospital (GSH) and Tygerberg Hospital (TBH), have established Speech Therapy and Audiology departments. Although these departments offer both speech-language and audiology services, for the scope of this study only speech-language services will be described. The three tertiary hospitals in which current study participants work are teaching hospitals, have links to all Universities in the Western Cape who have a Health Sciences Faculty, and function as primary training sites for undergraduate and postgraduate students (locally and internationally).

The Speech Therapy department at RXH has three full-time permanent posts and two Community Service posts (described in 1.2). Children aged naught to seven years presenting with speech, language or communication delays or difficulties are seen e.g. oral motor, articulation and phonology, dysfluency, language and learning, and acquired

speech and language disorders. Infants and children with swallowing and or feeding difficulties are also seen. The department offers these services on an in and outpatient basis. A combined specialist Cleft Lip and Palate Clinic services children from birth through to adolescence. Due to an internal decision by the RXH S-L Therapy department, children who have started primary school are referred to GSH or TBH. Special arrangements are made for school-aged children with difficulties of a tertiary/specialist nature or those needing to attend multiple RXH clinics to receive S-L Therapy at RXH (e.g. children with traumatic brain injury attending occupational therapy and physiotherapy at RHX) (Red Cross War Memorial Children's Hospital Outpatient Clinic Information Brochure, 2005).

GSH has four full-time permanent posts, two part-time permanent posts and one Community Service post within its Speech Therapy and Audiology department. S-L Therapy services include in and outpatient assessment and treatment of adult and child neurological and structural swallowing and or feeding difficulties (including neonates), developmental and acquired speech and language disorders, cognitive-linguistic and social communication difficulties, voice and resonance disorders, language-learning disability, and dysfluency. Further specialist services include Modified Barium Swallow evaluation (MBS), tracheo-esophageal voice restoration as well as services to Intensive Care Units. Due to an internal decision by the GSH S-L Therapy department, children not in primary school are referred to RXH for S-L Therapy (R. Lentin, personal communication, March 13, 2006).

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The Speech Therapy and Audiology department at TBH has nine full-time permanent posts, one sessional post and one Community Service post. S-L Therapy services include in and outpatient assessment and treatment of adult and child neurological and structural swallowing and/or feeding difficulties (including neonates), developmental and acquired speech and language disorders, cognitive-linguistic and social communication difficulties, voice and resonance disorders, language-learning disability for children, tracheo-esophageal voice restoration, cleft lip and palate, dysfluency, and MBS evaluation (H. Elliot, personal communication, June 04, 2007).

At time of study there was one S-L Therapy Community Service post at Lentegeur Hospital (as of January 2007) and two S-L Therapy posts at the Western Cape Rehabilitation Centre. Two S-L Therapy posts exist at Eben Donges Hospital in

Worcester (Boland health district), one at the Paarl Hospital (Westcoast Winelands district) and one new post at the Caledon Hospital as of January 2006 (Overberg health district) (F. Baradien, personal communication, January 20, 2006). S-L Therapists in the Boland, Westcoast Winelands and Overberg districts are classified as community S-L Therapists who serve the surrounding clinics, community health centres, schools and communities. As well as carrying out S-L Therapy intervention, their responsibilities include the promotion of professional services, the carrying out of hearing screening and the establishment of referral pathways between surrounding clinics and health centres. Presently, no S-L Therapists are placed at primary health facilities such as clinic or Community Health Centres anywhere in the Western Cape.

During 2002, the Western Cape Department of Health produced a strategic plan for the reshaping of public health services throughout the Western Cape. This initiative, Healthcare 2010, describes the proposed plan that will "substantially improve the quality of care of the health service and simultaneously bring expenditure to within budget" (Healthcare 2010, 2003, p. 7). Based on the primary health care approach, Healthcare 2010 proposes a shift of patients to "more appropriate levels of care with commensurate cost savings" (Healthcare 2010, 2003, p. 7). The Healthcare 2010 Human Resource Plan aims to revise the existing staff establishments to enable facilities to be more appropriately staffed (Healthcare 2010, 2003). Although the implementation of the Healthcare 2010 plan is anticipated to bring about changes to S-L Therapy services within the public health service, a plan outlining the specific changes to S-L Therapy services has not as yet been presented (R. Lentin, personal communication, July 04, 2007).

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1.6.2 Speech-Language Therapy services available in the Western Cape Education Department

At time of study S-L Therapists (called Health Therapists in this context), were employed in a limited number of schools providing Education for Learners with Special Educational Needs (ELSEN schools, previously known as 'Special Schools') throughout the Western Cape. These schools fall under the management of the Western Cape Education Department's Directorate of Specialised Education Support Services, and accommodate learners who require a high level of support (Education Support Team Manual, 2003). ELSEN schools are classified according to the disorder or disability of the children attending them and include schools dedicated to the education

and training of children with Autism, Cerebral Palsy, Physical Disability, Visual Disability, Hearing Impairment, Severe Mental Handicap and Epilepsy (Dr. Bolton, personal communication, March 16, 2006). The number of S-L Therapy posts allocated to each school is constantly re-evaluated according to a weighting system prescribed in the Employment of Educators Act 76 of 1998 (M. Delo, Western Cape Directorate of Education Research, personal communication, July 16, 2007).

At time of study there were 22 S-L Therapy posts in 14 ELSEN schools (except those serving children with Physical Disabilities, Visual Disabilities and Epilepsy) throughout the Western Cape. In 2001 the National Department of Education released the Education White Paper 6 "Special Needs Education: Building an Inclusive Education and Training System" (EWP 6). The publication of the EWP 6 followed investigations into all aspects of special needs and support services in education and training in South Africa. It stipulates a new policy framework for the support of learners with special education needs (learners who experience learning and developmental barriers), and outlines the support structures that must be put in place to support the above-mentioned learners.

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1.7 My personal experience of being a Speech-Language Therapist

Growing up, I was always intrigued and interested in people with disabilities and handicaps. I always chose books and movies about children with conditions such as spina bifida and autism, and was intensely affected by the story of Helen Keller, the well known deaf-blind mute, and would always imagine myself to be her tutor, Anne Sullivan. I became interested in the profession of S-L Therapy in High School, and because of my past experiences, pursued it with little investigation into other career options. After completing my undergraduate degree at the University of Cape Town in 2003 (registering on the S-L Therapy register), I completed my Community Service at Groote Schuur Hospital followed by in a one-year contract post at this hospital. I currently work as a Senior S-L Therapist at the same hospital in a permanent post.

In my first year as a professional, I observed my S-L Therapy colleagues who had worked in the public health service for between 5 and 26 years and became increasingly interested in the way they experienced their work. I wondered what being an S-L Therapist meant to them and what meaning it held for them. Through informal discussions it became clear that being a S-L Therapist holds different meanings for

different individuals. Some view it as merely a job to be done, while others described it as being an integral part of who they are as human beings and found it difficult to just "leave it behind" when they went home. These views challenged me to re-evaluate my own feelings about being a S-L Therapist and the meanings I attached to it. I started to reflect on who I am as a person, who I am as a professional and how those roles are linked to the work and activities I do on a daily basis.

I entered the profession with great expectations and over time have been surprised to find out that it is at once very different and yet the same as I expected. The basic execution of clinical activities is much the way I expected it would be and draw on the knowledge I was taught at university. I consider these the mechanics of the profession which have measurable guidelines and outcomes. However a large portion of "non-clinical" activities and experiences exist for which I was largely unprepared. These are the more human elements of S-L Therapy, which are not reliant on clinical skills or the ability to carry out an assessment battery.

I have learned about the whole-ness of my patients, that each is mind, body and spirit, and not mere objects to be "worked on" or "therapy-ed" as if they have no ideas and preferences. I have consciously become deeply respectful of the "human-ness" of my patients despite their communication disability, education level, race, religion or attitude towards me or the world. I have had to learn how to become a catalyst in helping each of them to find and achieve the best and most effective way to communicate. It is only through adopting this attitude of deep respect and understanding, that I have been able to assist them participate in their community, feel accepted and make a meaningful contribution to their world.

Despite the government commitment to a primary health care approach in public health services, the medical model of health care remains evident in many sectors of the services. The *process* of rehabilitation is often not fully understood by health professionals and patients and in my experience, many doctors, nurses and patients expect a rapid medical approach to treatment. Similarly to other health and rehabilitative services, S-L Therapy does not rely solely on the biomedical model (Engel, 1977) and has shown a shift towards a more holistic approach referred to as a social model or biopsychosocial model of healthcare (Engel, 1977). This model is now commonly understood and implemented in the realm of S-L Therapy and provides a

better understanding of disability as it includes the individual's family, social context and belief system. Much of my experience so far has involved engaging with patients and their communication disorders in order to change the way they perceive it, and help them make peace with the loss whether it be temporary or permanent. Being a part of these processes has challenged my view of how I understood life and the way in which I thought people functioned. I have realised that not all people think about the world in the same way nor have the same inner and outer resources to deal with and process tragedy, loss, temporary and permanent disablement and life in general.

My knowledge and skills offer the potential for me to do something unique and worthwhile, and to improve the communication status of my patients and advocate for those who are not able to communicate as they wish to.

1.8 The significance of the study

Initial research questions always come from real-world observations, dilemmas and questions, and often emerge from "the interplay of the researcher's direct experience and growing scholarly interests" (Marshall & Rossman, 1995, p. 16). As I was forming *my* identity as a S-L Therapist and verbalising what the experience of "being a S-L Therapist" meant to me, I did not know what "being a S-L Therapist" meant to other S-L Therapists of different ages, cultures and personalities, and how they relate *their* experience of being a S-L Therapist to their own humanness. I suspected that their experiences may be very different to mine and I wished to gain a deeper understanding of the nature and meaning of the everyday experiences of other S-L Therapists. Understanding this, would in turn help me understand the way in which they experience the world (van Manen, 1984).

The purpose of doing a study of this nature according to van Manen (1984), is not to "reduce the phenomenon of being a S-L Therapist into a clearly defined object so as to dispel its mystery, but rather to bring the mystery more fully into the presence of the reader" (p. 11). By doing this, language will be used in such a way as to make present to us what is inherently transparent and obvious, yet hidden by context. These processes will capture of the phenomenon of being a S-L Therapist in a linguistic description that is holistic and true to itself and to explore the issues and experiences that are observed and experienced in the lives of S-L Therapists.

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1.9 The research question and the research objectives

The aim of this study is to explore and describe the lived experience of being a S-L Therapist in the Western Cape public health service. Originally the study was planned to include S-L Therapist's working in both the public health service and public education service (ELSEN schools). Following the poor response from ELSEN school S-L Therapists and the sufficient response from public health service S-L Therapists, in consultation with my supervisor I decided to include only S-L Therapists working in the public health service. The study was limited to the Western Cape Province, not because it was anticipated that SLTs working in the province would have different lived experience to SLTs working in other provinces, rather that the researcher has knowledge of the presenting issues as she is a resident and works in the a Western Cape public service hospital. It is for this reason that the province, political issues and demographics, will not be discussed in much depth.

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1.10 Conclusion

A review of the literature is presented in Chapter two. The literature seeks to link the current study with previous research and ideas on the topic, and to present previous research that relates specifically to how the S-L Therapist may experience his or her work. Chapter three describes the study design and discusses relevant methodological issues. Chapter four presents the five themes that emerged from the analysis and chapter five presents a discussion on these themes as they relate to van Manen's four lifeworld themes (1990, p. 101), and to the literature. The final chapter (chapter six) concludes this research report by describing the significance and implications of the study, presenting recommendations and outlining the strengths and limitations of the research.

2.3 Search strategies

A database search of all internationally published research and of dissertations from all South African Universities was done. Specific search engines used included MEDLINE, Ebscohost and Science Direct as well as the University of Cape Town's

electronic and print journal database. Key words used focussed on the lived experience in Speech and Language Pathology/Therapy; phenomenology/phenomenological research in Speech and Language Pathology/Therapy; the profession of Speech and Language Pathology/Therapy in South Africa; gender; socio-economic class and ethnicity and Speech and Language Pathologists/Therapists in South Africa and worldwide; Speech and Language Pathology/Therapy as a helping and rehabilitation profession; helping and rehabilitation professions; stress and professional burnout in Speech and Language Pathology/Therapy; stress and professional burnout in healthcare professions. A national library search for relevant books was also carried out using similar keywords to the database search. The Health Professions Council of South Africa and the Board of Health Care Funders were consulted with regard to South African statistics.

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The journal search failed to source any locally or internationally published phenomenological research in the field of S-L Therapy, although numerous qualitative studies looking at *patients* with certain communication disorders such as aphasia and dysfluency have been published. While research has been conducted around professional issues in S-L Therapy, this has focussed mainly on professional stress and burnout. A preliminary search revealed the existence of related research on the lived experience in professions such as occupational therapy, nursing, social work, physiotherapy and teaching.

2.4 Speech-Language Therapy as an expanding profession in South Africa

"The dynamic expanding field of Speech-Language Therapy has produced significant theoretical, clinical and technological advances which require special knowledge, skills and experience to effect them competently" (Aron, 1991, p. 7). In recent years the demography of the client population and variety of settings in which S-L Therapists provide services has continued to evolve with the S-L Therapist's clients now extending across the age span from newborns with feeding difficulties to geriatric clients with dementia-related communication disorders (Lubinski & Masters, 2001).

With each new client group and setting providing a new avenue for service delivery, the development and update of new professional skills, continual self-evaluation and continuing education to best meet the needs of clients, families, educators and caregivers is required (Lubinski & Masters, 2001). Aron (1991) states that with the development of the profession comes the challenge for universities "to maintain academic and clinical curricula to reflect change" (p. 8), as qualified S-L Therapists are required to display clinical competency in a wide variety of clinical areas.

2.5 Speech-Language Therapy and South Africa's changing political history

Writing in 1991 Aron predicted that with the "significant social and political changes" (p. 8) that were about to take place in South Africa, both the training and delivery of S-L Therapy services would be significantly affected. He stated that the changes in South Africa would most likely "bring about substantial demands on health and education systems with significant shifts occurring along linguistic, cultural and socio-economic changes" (p. 8). These changes would very directly affect the nature, demand and delivery of S-L Therapy's professional service. In order to make provision for the changes, he suggested an increase in the professional S-L Therapy workforce and training of Community Speech and Hearing Workers to assist professionals. He advised universities to encourage research that would identify health needs, provide data and schemes to meet the needs, and provide the authorities with hard facts on which to base their decisions (Aron, 1991). Due to the limited research output in South Africa at that time, he encouraged clinicians as well as academic staff "to carry out research and publish their findings as the lack of research in the S-L Therapy field potentially weaken our viability as a science and discipline" (p. 8). Jacobson's (2002) statement that the Audiologist is an ambassador representing Audiology to the world is also true of S-L Therapists in that those who practise it are primarily responsible for its accreditation.

Aron further criticised the lack of locally designed and standardised assessment and therapy procedures, and stated that those which are used are not constructed for use in the South African context and therefore raise ethical accountability issues. He made suggestions regarding the need for training programmes to be made more appropriate for the South African context. Although he stated that the profession could not hope to cater for all the challenges, planning and projecting plans to meet anticipated challenges would place the profession in a much stronger position. Lastly he emphasised a

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proactive stance from the profession and a generally increased commitment from its members.

In response to this article by Aron, and following the democraticization of South Africa, an article entitled "Speech-Language Pathology in South Africa: A Profession in Transition", reported both the profession and professional to be showing "signs of strain" (Tuomi, 1994, p. 6). Tuomi ascribed the low morale of S-L Therapists, as well as their general concern and uncertainty regarding their future and the future of the profession, to rapidly changing political, economic, social, and educational situations. He explained how prior to the democratization of South Africa, S-L Therapists centred their services around the "First World population", however as a result of the rapid democratization of the country, services were changing to include all the people of South Africa. Challenges for the profession that these changes projected included "the diverse collection of people, cultures and language groups" (p. 6). Many of the suggestions Tuomi proposed were identical to those cited in Aron's 1991 report, and included the need for research outputs, government collaboration, initiation of lobbying action for more posts, the need for locally normed assessment tools, and modification of university training curricula (Tuomi, 1994).

2.6 Speech-Language Therapy - a profession under threat

Henri and Hallowell (2001) state that worldwide the provision of S-L Therapy services to people in need of them is under threat. In the private setting, the greatest identified barrier to adequate provision of these services is funding. Many medical aids refuse to pay claims for S-L Therapy services viewing them as "low priority" and services which should be provided by the education department. Even though historically S-L Therapists have had "little experience and often little inclination to participate in the arena of political advocacy and lobbying" (Lubinski & Frattali, 2001 p. 344), in all countries there has been an increasing need for advocacy. Lubinski & Frattali (2001) argue that given the dramatic challenges S-L Therapists face in providing access for clients, they can no longer afford to remain passive, adopting a "let them do it attitude" (p. 344). These authors urge S-L Therapists to collaborate in co-ordinated efforts aimed at educating and influencing decision makers about the value of S-L Therapy services and about the societal consequences of not providing these services. Because most individuals take communication for granted and are frequently unaware of the link between one's communication abilities and success in life, S-L

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Therapists should take more seriously a professional advocacy role. This is due not only to the expanding nature of their service as their job no longer only includes remediation of speech and language deficits, but also the fact that the lack of their services will inevitably affect the way people function in society (Lubinski & Frattali, 2001, p. 356).

2.8 Lack of diversity in the South African Speech-Language Therapy profession

In his doctoral thesis, Pillay (2003) described the S-L Therapist by considering his or her social constructions, otherwise referred to as his or her Community Biographical profile. This allows for the "*collective* positioning of an individual *within a* community so as to represent the various social, political, and cultural systems in which the individual may be situated" (Pillay, 2003, p. 58). One of the topics addressed in Pillay's thesis was that of the power relationship between the South African S-L Therapist and his or her patient, which was done by using the social Triumvirate of Race-Class-Gender to explain the S-L Therapist's possession of power in the relationship. The elements of this triumvirate will be addressed below in order to describe the current lack of diversity in the South African S-L Therapy profession.

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2.8.1 Ethnicity

According to Pillay (2003, p 65) "South African Speech-Language Therapists and Audiologists have been and still are predominantly white". In previous work by Pillay (1997), it was found that approximately 99% of South African S-L Therapists and Audiologists were White (as cited in Pillay, 2003, p. 65). An unpublished thesis by Beecham (as cited in Pillay, 2003, p. 65) showed that by 2002 this number had decreased to 98.5%. Between 1936 and 1988, 1.54% of S-L Therapists and Audiologists were Black Africans while the rest were White (Parshotam, as cited in Pillay, 2003). The racial descriptor of South African S-L Therapists is similar to that of countries which have a predominantly white population (Pillay, 2003, p. 65). Sheridan (1999) states that in the UK "people from ethnic minorities are under-represented" (p. 3) and that the USA also shows an under-representation of black/ethnic professionals in the S-L Therapy workforce.

The 2007 statistics for the professions indicate that approximately 60% of South African single register S-L Therapists are White, 23.6% are Black African, 4.3% are Indian, 2.1% are Coloured and 9.4% are not racially identified. Currently in the dual

register category, 52.38% are White, 3.7% are Black African, 6.7% are Indian, 0.84% are Coloured and 36,2% are not racially identified (Y. Daffue, personal communication, July 9, 2007).

2.8.2 Socio-economic class

Most S-L Therapists are located in urban areas which, when translated into economic terms, "usually implies that the Speech-Language Therapist is of a middle-income population" (Pillay, 2003, p. 65). In 1997, of the total number of registered South African S-L Therapists and Audiologists, most (approximately 82%) worked in private practices which were primarily urban-based and by 2002 this situation had not changed (Pillay, 2003, p. 60). It is impossible to calculate the current percentage of S-L Therapists working in private practice, as private business partnerships are registered as private practices and do not specify individual registrations. However, it is possible to identify the provinces which currently have the highest concentration of South African S-L Therapists and dual register S-L Therapists and Audiologists. These are (in descending order), Gauteng, Western Cape, Kwa-Zulu Natal, and Free State, with the smallest being in the Northern Cape, North West Province and Northern Province (Y. Daffue, personal communication, July 9, 2007). The provinces which currently have the highest concentration of private practices are (in descending order), Gauteng, Western Cape, and Kwa-Zulu Natal (H. Ball, personal communication, The Board of Health Care Funders, July 10, 2007). The existence of urban-based private practices "translates into services provided mainly to urban residents who are (still) predominantly White (and English or Afrikaans speaking people). Being urban residents, the potential (and actual) clientele may be mainly middle-income earners" (Pillay, 2003, p. 60). This situation is most likely very similar to other parts of the world where S-L Therapy services are mainly provided from urban centres. Pillay continues by stating that "although a contestable factor, it may be argued that the global community of Practitioners - by virtue of their status as professionals, as middle-income earners, *and* as urban-based service providers - may be members of the middle-classes which further assists in promoting privilege to the privileged" (2003, p. 60).

2.8.3 Gender

Although many professions are reporting greater gender neutrality, the opposite appears to be the case in S-L Therapy [and Audiology] (Werven, 1994). Worldwide the number of male S-L Therapists has always been small, and presently the S-L Therapists

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in South Africa are predominantly women (Y. Daffue, personal communication, June 4, 2007; Pillay, 2003, p. 65). Men in the profession are under-represented in management and related high-status posts, e.g. research and or academic posts (Sheridan, 1999). In the UK during 1999, 1.9% of the total S-L Therapy workforce was male (Sheridan, 1999) in Australia during 2001, 3.6% of the total S-L Therapy workforce was male (Meade, Brown, & Trevan-Hawke, 2005) and as of 31 May 2007, 3.6% of single register South African S-L Therapists and 2.4% of dual register S-L Therapist and Audiologists respectively were male. Currently 16.8% of single register South African Audiologists are male (Y. Daffue, personal communication, July 9, 2007).

Historically the pioneers of S-L Therapy in South Africa and internationally have been male. In South Africa, the declared "Father" (Aron, Bauman, & Whiting, 1967, p. 78) of the profession was Professor Pierre de V. Pienaar (Aron, 1991). The induction process of female S-L Therapists by male pioneers also seems to be true for places like the USA and the UK. In the late 1800s male pioneers such as Kussmaul, Potter, Wiley, and Goldstein introduced mainly American and British women to the field of Communication Disorders with some starting female-only schools for training S-L Therapists (MacLeod, 1991). In South Africa up to and including 1992, three of the five university professional programmes were headed by male S-L Therapists (Pillay, 2003, p. 62).

Female dominance within the health and welfare professions is not isolated to S-L Therapy and is described in professions such as occupational therapy, physiotherapy, dietetics, and nursing. In Australia during 2001, only 6.8% of the total occupational therapy workforce was male, 9.1% of the total dietetics workforce was male, and 27% of the total physiotherapy workforce was male (Meade, Brown, & Trevan-Hawke, 2005). In the USA during 2001, only 7.9% of the total nursing workforce was male (Bernard Becker Medical Library, 2004) and in 2002 30% of American physiotherapists and 13% of American occupational therapists were male (Bernard Becker Medical Library, 2004). As of 30 June 2007, 4.4% of registered South African occupational therapists and 15.8% of physiotherapists are male.

Reasons for the gender imbalance within the profession of S-L Therapy are not clear, although numerous explanations have been offered. Werven (1994) suggests that this is largely the result of "generations of gender stereotyping that relates not only to

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the attributes men and women should possess, but also the tasks they should perform" (p. 43). It has also been suggested that the qualities traditionally associated with the caring or helping professions, of which S-L Therapy is one, are those thought to be a natural extension of the woman's domestic role (Bernard Becker Medical Library, 2004). The nursing literature reports that men have been involved in the field of nursing since the fourth and fifth centuries. However in the mid-1800s Florence Nightingale postulated that "every woman was a nurse, and those women who sought training as nurses were doing what came naturally to them as women" (Bernard Becker Medical Library, 2004). Her schools for training excluded men, thus making it difficult for them to access nursing education.

A UK study of 27 male S-L Therapists found that the career choices of these S-L Therapists were "wanting to work with people, job security, satisfaction, and professional autonomy" (Boyd & Hewlett, 2001, p. 170). Just under one third of respondents reported difficulties relating to their gender, specifically issues pertaining to "being made aware of males working with children" (Boyd & Hewlett, 2001, p. 171). Hostility from female colleagues was also reported.

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2.9 Thoughts about the profession's future

Considering S-L Therapy's history and the changes that have and are still taking place both politically and within the public health service, the fact remains that as Tuomi (1994, p. 6) argued "in order for Speech-Language Pathologists to have a future in South Africa, services have to be valuable and necessary with both the government and the people perceiving their value and necessity". Currently there are 934 private practices throughout South Africa [which as already mentioned serve mainly white, middle income/class residents (Pillay, 2003, p. 60)], which may well have contributed in the past as well as presently contribute to the profession being viewed as a luxury for the privileged and not relevant for the majority (Tuomi, 1994). From the statistics it is thus clear that the vast majority of the population do not receive basic S-L Therapy intervention due to the urban distribution of S-L Therapy services throughout the country, reinforcing Tuomi's (1994) reflection that S-L Therapy primarily services the first world population. In order to meet the needs of the whole South African population the issues which need to be addressed include increased recruitment of indigenous mother tongue speakers, (Xhosa in the Western Cape), into training programmes, clinical training in appropriate settings, and the production of locally normed

assessment tools. Further to this, the use of an alternative service delivery model which includes family members needs to be developed and there needs to be a more deliberate focus on prevention and early communication intervention (Bortz, Jardine, & Tshule, 1996).

2.10 Speech-Language Therapy as a helping profession

The profession of S-L Therapy is described as one of the helping professions along with teaching, nursing, counselling and social work among others, with those drawn to it tending to be more people-orientated than object-oriented (Lubinski & Frattali, 2001, p. 189). Purtilo (1990) describes health professionals as being "first and foremost helpers" (p. 18) as they benefit the individual in society, and patients' lives are directly or indirectly affected by his or her activities. Helping is further defined as person assisting another in exploring feelings, gaining insight, and making changes in her or his life (Hill, 2004).

The importance of personal relationships is reflected in people's choice for entering the profession of S-L Therapy, for which helping other people is a primary motivation (Byng, Cairns, and Duchan, 2002). A 1995 survey in the USA, of undergraduate and graduate S-L Therapy students showed that 75% chose the profession because they wanted to help others (Lass and Ruscello, 1995). Helping professions such as S-L Therapy involve more than just helping, but require "an investment of knowledge and skill blended with facilitating interpersonal qualities to effect change in another individual" (Lubinski & Frattali, 2001, p. 189). Hill (2004) states that while helping seems to be a natural tendency in many people who have a natural innate desire to assist others, "helpers can sometimes be motivated to work with people for less than healthy reasons" (p. 13). Such motivations can include seeing themselves as a saviour, helping others because of being needy themselves, helping to work through unresolved personal issues (Hill, 2004, p. 14).

In his book entitled "The Skilled Helper" (Egan, 2002) presents two principle goals of helping: the first being to help clients manage their problems in living more effectively and develop unused resources and missed opportunities more fully; and the second being to help clients become better at helping themselves in their everyday lives (Egan, 2002, p. 7). Although Egan's work is based primarily in psychotherapy, these goals may be adapted to any helping relationship, including that of the S-L Therapist-

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patient interaction. Egan (2002) states that helpers "are only successful to the degree to which their clients, through the client-helper interaction are better able to manage specific problems and develop specific unused resources and missed opportunities more effectively" (p. 7). He also states that although the helper assists the client in achieving valued outcomes, he or she does not control that outcome, and in the end the client makes the choices. Since helping is a two-way collaboration, clients are successful to the degree to which they commit themselves to the helping process and capitalize on what they learn from the helping interaction. This is true for the S-L Therapist-client interaction where the S-L Therapist's helping attempts are only as successful as the client's willingness to collaborate and response to his or her assistance. When looking at the second goal, Egan states that clients "are often poor problem-solvers", or "whatever problem-solving abilities they do have disappear in times of crisis" (Egan, 2002, p. 8). In many cases clients are not able to generalize learnt skills to other situations, and so the goal of the helping relationship is often "to equip the client not only to manage a specific situation, but become more capable of managing subsequent ones in living more effectively" (Egan, 2002, p. 8). In this way the most effective helpers are those who assist clients in determining goals that are consistent with their dreams, values and abilities (Hill, 2004, p. 5).

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Counselling in S-L Therapy practice is a highly utilised therapeutic tool, and has been described as both an art and a science (Nystul, 2003, p. 4). Describing it as an art suggests it is a flexible and creative process whereby the therapist adjusts his or her approach to the specific and emerging needs of the client (Nystul, 2003, p. 5). The science of counselling provides a balance to the art by "creating an objective dimension to the process" with sound technical understanding of different therapies and skills (Nystul, 2003, p. 6). The specific set of skills and knowledge which is unique to each different profession emphasises objective observations and inferences, testing of hypotheses and formulating theories about our clients and patients, while the artistic aspects suggest that it is a process with timing being a creative example where the S-L Therapist may need to say the right thing at the right time while offering empathy, support, modelling, interpretation and comfort. The artistic aspect also includes the concept of "giving oneself, such as concern, support and empathy" (Flasher & Fogle, 2004, p. 7). This "giving of oneself" (p. 7) is a delicately balanced process that is learned over time and in includes issues of when to give, how much to give, in what way to give, and in what way to hold back from giving. A person with a communication

difficulty usually exists within a family context and therefore the communication disorder will usually affect more than a single individual. This means that effective clinicians will deal with the patient and at least some of the important people in his or her life. In dealing with more than the patient, the focus is always the communication problem and how it is affecting the patient and the family's coping abilities (Flasher & Fogle, 2004, p. 9).

2.11 Speech-Language Therapy as an autonomous and a collaborative profession

In a chapter entitled "Professional Autonomy and Collaboration" Frattali (2001) explains how "throughout history, the discipline of human communication sciences and disorders as well as Speech-Language Pathologists have worked aggressively to form an identity that is unique from other disciplines and have earned a reputation of being specialists in the field of communication and related disorders" (p. 173). Yet at the same time she warns that a professional identity that is so separate from other professions can become a professional liability "if pursued as propriety and at the exclusion of other professionals" (p. 173).

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The word "autonomy" is derived from the Greek word *autonomia*, meaning "'to have its own laws" (Frattali, 2001, p. 174). Definitions of autonomy include self-government, personal independence and the capacity to make decisions and act on them (Dictionary Tools, 2004). The notion of autonomy is supported in that S-L Therapists worldwide are awarded certification based of their ability to provide independent clinical services to persons who have disorders of communication (American Speech-Language-Hearing Association, 1993). However, in his reflections on autonomy and independence for health professionals, Grinnell (1989) maintains that although professionals have always held to the ideal of independent work, these ideals need to be reviewed within the realities of the current health care system. He states that in early days when professionals were few in number, communities were small and expertise was limited, the individual professional could function in a highly independent manner. However, as society has grown in size and complexity, Grinnell (1989, p. 115) argues that the independent professional has became less viable and traditional notrions about autonomy are dispelled as a consequence of the reforms and changes taking place in the health and education systems.

Grinnell (1989) identified four possible ways in which health professionals can experience autonomy and independence. The four identified modes that provide different opportunities for autonomy are: collaboration by command; collaboration by specialist division of labour; competitive cold war; and collegial collaboration. He suggests collegial collaboration as being perhaps the most suitable model as it is associated with high performance and "enhances rather than compromises autonomy" (p. 119). This type of collaboration relies on the professional's ability to develop open and two-way communication among all participants in order to sustain collegial working relationships. In turn, these communication processes depend on the existence of "attitudes of mutual respect, trust and interdependence among professionals" (p. 120).

The terms "interdisciplinary", "multidisciplinary" and "transdisciplinary" are well-documented in healthcare literature. The terms "multidisciplinary" and "interdisciplinary" are often used interchangeably (Wilson & Pirrie, 2000, p.1), although distinct differences do exist. Frattali (2001, p. 179) describes the interdisciplinary approach as one where the S-L Therapist is required to address an integrated plan of care, rather than a specific isolated need of the patient. In this approach, two disciplines may work simultaneously to achieve an integrated goal as specified in the treatment plan by fully integrating activities. A difficulty with this approach is the aspect of "crossing into another space" (Wilson & Pirrie, 2000, p. 2) as clear territorial boundaries between professionals are not established in this approach (Wilson & Pirrie, 2000).

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Different to the interdisciplinary approach is the multidisciplinary approach where each professional in the team is only responsible for the activities related to his or her field, with separately formulated goals for each patient. There is a definite focus on co-ordination and communication between members as by bringing together diverse skills achievement of goals is more likely as the group's performance will exceed that of numerous professionals working independently. In this approach, issues of territory and professional boundaries impact greatly on multidisciplinary working with role clarification being a hallmark of this approach (Wilson & Pirrie, 2000).

Furthermore the transdisciplinary approach results in one professional taking over the role of another which both threatens professional autonomy and jeopardises

scope of practice. S-L Therapists are encouraged to adopt either an interdisciplinary or multidisciplinary approach to treatment (Frattali (2001, p. 179).

2.12 The Speech-Language Therapist as a communication and rehabilitation therapist

S-L Therapy is one of the health and educational professions (previously known as professions allied to medicine). It has its own unique culture, dynamics, areas of challenge, scope of practice and characteristics which set it apart from other health professions. Although the profession is now well known as S-L Therapy, it was previously known as 'Speech Therapy' which may have contributed to the misconception that S-L Therapists deal only with speech difficulties such as stuttering, lisping, mispronunciation of speech sounds, or individuals who are completely unable to speak (such as a child with autism or mutism). Although the remediation of specific speech difficulties does indeed fall within the S-L Therapist's scope of practice, S-L Therapy is largely concerned with *communication*, (hence the appropriate inclusion of the 'language' component in the profession's name). The word 'communication' is derived from the Latin root 'to share' with similar words such as 'commune' and 'communion' having 'sharing' at their core (Reynolds, 2005, p. 4). To communicate well is both to give and receive information in an interchange between persons, a central aspect of the S-L Therapists work with patients across the human lifespan.

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The word 'rehabilitation' is defined as "training, therapy, or other help given to somebody that will enable him or her to live a healthy and productive life" (Dictionary Tools, 2004). This definition explains, at least in part, the role of the S-L Therapist in that he or she often engages in a prolonged therapeutic relationship with a patient in order to restore lost function and work towards obtaining a functional outcome. Other definitions include "the restoration of somebody's former position, rank, rights and privileges, influence, or good reputation" (Dictionary Tools, 2004).

2.13 Speech-Language Therapist – patient relationship

The clinical relationship is a key element in effective service delivery in communication disorders and other helping professions (Stone, 1992). As previously stated, S-L Therapy is described as a "people-orientated" profession (Lubinski & Frattali, 2001, p. 189) with the importance of personal relationships being reflected in people's choice for entering the profession (Byng et al., 2002). S-L Therapy

intervention, as well as other healthcare interventions, take place in a context of an interaction between the patient and professional - a relationship documented as early as 1937 (Bloom & Summey, 1978). Since the S-L Therapist's interaction with his or her patient is the cornerstone on which the remediation of the presenting communication difficulty is set, some documented professional-patient models and theories are now briefly presented.

2.13.1 The Parsonian model of the "ideal" sick role and professional role

In 1951 Talcott Parsons presented a distinctly asymmetrical model of the professional-patient relationship, stating that there was a "built-in institutionalized superiority of the professional roles, grounded in responsibility, competence, and occupational concern" (Parsons, as cited in Bloom & Summey, 1978, p. 23). In this model, the professional is expected to apply a high degree of achieved skill and knowledge while being objective and emotionally detached from his or her patient. Further, the model assigns specific privileges to the professional such as professional self-regulation, access to physical and personal intimacy with the patient, autonomy and professional dominance. The model assigns a far less powerful "sick role" to the patient, in which he or she is expected to be motivated to get well, to seek technically competent help from a professional, trust the doctor and accept the competence gap. The patient is also exempt from performing normal social obligations and being responsible for his or her own state.

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2.13.2 Developing the Parsonian model

The Parsonian model was later reviewed and further developed by Szasz and Hollender (as cited in Bloom & Summey, 1978, p. 25) who stated that in contrast to the original Parsonian model which assigned a far less powerful role to the patient, as long as the patient was able to participate in his or her treatment, he or she must be an active partner and mutually involved in his or her own treatment. The clinical application for the notion of mutual participation was for chronic illnesses and therapeutic interventions such as psychotherapy. In contrast to the previous model, mutual participation suggested that the professional's role was to help the patient help him or herself, while the patient acted in partnership with the professional. The three basic models in the Szasz-Hollender conceptualization of the doctor-patient relationship are tabulated below.

Table 1. The Three Basic Models in the Szasz-Hollender Conceptualization of the Doctor-patient relationship

Model	Physician's role	Patient's role	Clinical application of model
1. Activity-passivity	Does something to patient	Recipient (unable to respond)	Acute trauma, coma, delirium
2. Guidance-co-operation	Tells patients what to do	Co-operator (obeys)	Acute infectious processes
3. Mutual participation	Helps patients to help himself	Participant in "partnership" (uses expert's help)	Most chronic illnesses, therapy

2.13.3 A mutually participative model of interaction

Fadlon and Werner (1999) suggest that in order to understand the health professional-patient relationship it must be viewed in the context of both micro and macro sociology. Micro sociology being "the understanding of the mechanisms which construct situations such as symbolic interaction, verbal exchanges, and perceptions of status and role"; and macro sociology being "the sense that each situation is embedded in a social and cultural context" (Fadlon & Werner, 1999, p. 197). These elements borrowed from sociology, as well as contributions from psychotherapy, social psychology and anthropology have been described in Bloom's (1963) total transactional model (as cited in Bloom & Summey, 1976, p. 29). Although the model was primarily devised for medical doctors, it is suitable for use by all healthcare professionals. Bloom's model describes the intricate social situation which encompasses the doctor-patient interaction. It is described as being an interaction not only between someone seeking help and another giving it (as in the Parsonian model), but an encounter of cultures, background, families, and aspirations, where the patient contributes actively to the encounter and the doctor responds to his or her cues, suggestions and reservations. This model differs greatly to those previously described as it integrates the surrounding social context with the exchange taking place between professional and patient and does not present the exchange to be an isolated relationship without context.

Figure 1 is a diagrammatic representation of Bloom's (1963) total transactional model (as cited in Bloom & Summey, 1976, p. 29). The model shows the Doctor (A)

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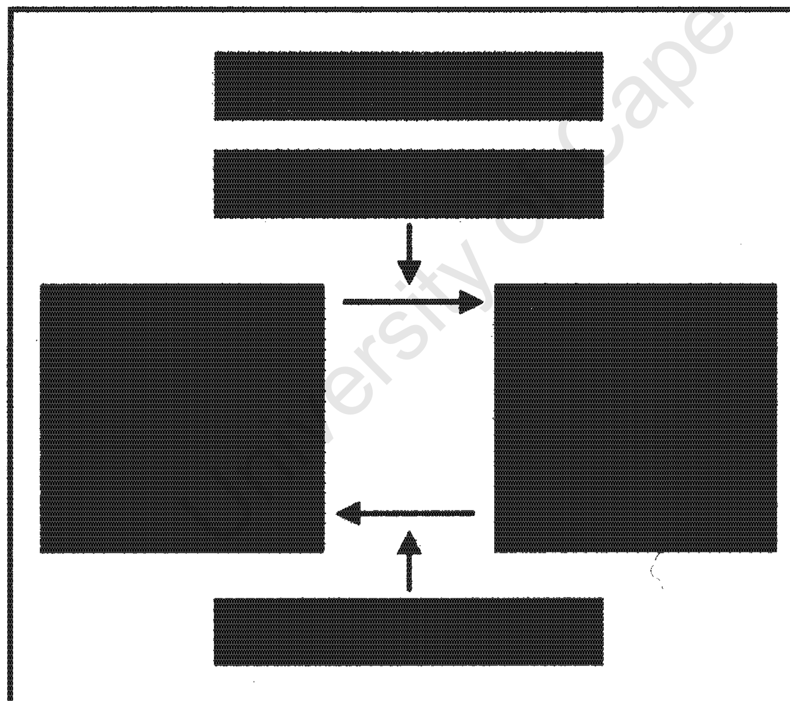
and the Patient (B) acting in their respective roles (A and B) in a transactional social system (x + y). The internal environment of the relationship is contained within the four elements A + B and x + y. The interpretation of roles A and B is initially dependent upon a series of social forces. For the doctor, the major source of reference for his behaviour as a physician is the medical profession (Aa); for the patient it is the family (Bb). Both Aa and Bb are based in the dominant culture (C), and together these three (Aa + Bb + C) form the comprehensive external environment in which the group itself (A + B) exists. Further subdivision of the cultural factor is included as subcultural reference groups (D and E). These refer to factors such as class, race, religion and ethnicity which function in particular cases as the significant sources of value-orientation for either or both the doctor and his or her patient (Bloom, 1963, p. 30).

Figure 1. Bloom's (1963) total transactional model



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In order to relate the theory of Bloom's total transactional model to S-L Therapy, it has been suggested that it is not only the S-L Therapist's knowledge of his or her profession and therapeutic techniques that define what he or she does, but the S-L Therapist's ability to "enter into the person's world and to develop a therapeutic relationship" (Flasher & Fogle, 2004, p. 87). "Entering into the person's world" clearly suggests that the S-L Therapist considers the patient as an individual (B) and how he or she is located and positioned within his or her family (Bb). As communication is such

an integral part of social interaction, understanding and considering the subcultural reference group (E) to which the patient and his or her family belong is vital. Similarly, the manner in which the S-L Therapist (A) positions him or herself in the S-L Therapy profession (Aa), and in his or her subcultural reference group (D) affects the way the S-L Therapist will relate to his or her patient.

As the S-L Therapist-patient relationship develops, it creates its own "dynamic quality that is affected by what the Speech-Language Therapist and client bring to it" (Flasher & Fogle, 2004, p. 87). The trust which develops between the S-L Therapist and his or her patient has been referred to as "professional closeness" (Purtilo, 1990, p. 22) and the way in which the client behaves toward the S-L Therapist is suggested to be directly linked to how the S-L Therapist thinks, feels and behaves towards the client (Flasher & Fogle, 2004, p. 88). The following section (2.12.4) presents an expansion on the S-L Therapist-patient interaction by considering the role of the S-L Therapist as "the Powerful Expert", and the patient as "the Sick Person" (Pillay, 2003, 19).

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2.13.4 "The Powerful Expert and the Sick Person: The practitioner and the patient"

Pillay's (2003) doctoral thesis entitled "The Powerful Expert and the Sick Person: The practitioner and the patient" presented an analysis of the *relationship* between the practitioner [S-L Therapist and Audiologist] and his or her patient. The two biographical identities ('the S-L Therapist' and 'the patient') formed the focus of his study in which he merged an empirical and theoretical design that derived data which he used to perform a critical analysis of the Practitioner-patient relationship's ideological basis. Questions asked in the study were those such as: what it is about the practitioner that has made him or her a powerful expert?; how it is possible to have developed this identity?; is the practitioner in fact powerful?; is he or she even an expert?; what qualifies one as a powerful expert?; is it a 'bad' thing that the practitioner is a powerful expert?; and why is identity of the practitioner even referred to as an 'expert'? Questions he asked in relation to the patient were: how did the person with a communication disorder become the patient?; what processes have assisted the development of this biography?; what ideological positions have enabled the practitioner to construct the sick person? (p. 19).

Pillay (2003) describes the space in which the interaction takes place as "The Clinical Moment" (p.19). He uses the term "clinical" as it highlights the reason for the existence of the moment [in which that interaction occurs], is derived from the medical/health context of the profession, and refers to the medicalised nature of S-L Therapy practice. He states that S-L Therapy exists only because it presents itself as a medically oriented or clinical profession, and because the profession orients itself relative to clinical care/practice i.e. the treatment of the patient. Describing this interaction as a "moment" locates professional practice within a temporal framework which includes the past, the present and the future. The Clinical Moment is further described as "an animated moment, an open system and not closed off from a host of related social, cultural, and political systems" (p.19).

Pillay (2003) states that different roles are assigned to the S-L Therapist and patient respectively. Through the interview the S-L Therapist discovers how "...the person came to be what he or she is today" (Darley and Spriestersbach, as cited in Pillay, 2003, p. 8). The S-L Therapist then decides through a standardised procedure how the patient will be "seen", and through the use of professional language-jargon what the diagnosis will be. Knowledge of the classification of diseases and disorders helps the S-L Therapist to manage the case all the while providing the patient with information regarding his or her disorder, often by rating the severity. Even simpler, Pillay describes how the S-L Therapist states what is wrong, how wrong it is, and how well he or she thinks the patient will get with the question of "wellness" (p. 19) depending almost entirely on the help he or she gives the patient.

2.14 Evolving models of healthcare

The manner in which the medical profession has approached and addressed illness, disease and disability has changed significantly over the last few decades. As more medical professionals have begun to appreciate the patient's right and desire to participate in the management of his or her illness, the patient is no longer seen as a passive victim of medical science. This has lead to professionals taking a more whole-body approach which recognizes other aspects of the person as possible contributing factors to the presenting problem. As the professional seeks to manage the whole person, treatment may take the form of behaviour change and encouraging a change in beliefs, and coping strategies. The shift in the management of patients, illness and

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disease is described below, followed by a short description of how this shift has impacted on the S-L Therapy context and practice.

2.14.1 The Western Scientific Medical Model of Health and Disability

The Western Scientific Medical Model of Health, also known as the Biomedical model, has been a dominant perspective across all sectors of health care both in training and practice. This scientific model is thought to have arose in Western Europe where the body was viewed by the Christian Church as "a weak and imperfect vessel for the transfer of the soul from this world to the next" (Engel, 1977, p. 131). According to Engel, the Church's permission to study the human body included "a tacit interdiction against corresponding scientific investigation of man's mind and behaviour" (p. 131) as the Church viewed these aspects to have more to do with religion and the soul and hence properly remained the church's domain. This author further argues that the notion of mind-body dualism, defined as physical and psychosocial processes being separate and disease not being influenced by psychological aspects, became firmly established and that medical science soon presented the idea of the body being a machine, of disease as the consequence of breakdown of the machine, and of the doctor's task being to repair the machine. The scientific approach to disease therefore focussed primarily on biological (somatic) processes as the cause of disease while ignoring behavioural and psychosocial aspects (Engel, 1977).

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2.14.2 The Social Model of Health and Disability

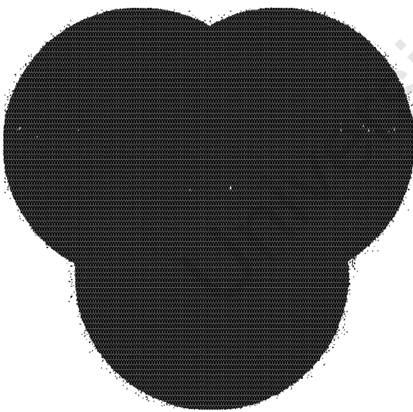
The origins of this approach can be traced to the 1960s and the Civil Rights Movement, with the term emerging from the UK in the 1980s (Wikipedia, 2007b). Intervention according to this model requires a philosophical shift away from the traditional medical model (Simmons-Mackie, 2000). Theorists who have begun to challenge the medical model of disability argue that disability is largely socially constructed, that it is a function of social practices and attitudes rather than actual physical impairment (Social Model of Disability, 2006). From this perspective, one can conclude that this model understands disability to be socially constructed rather than defined by medical assessments of impairment. The parameters of disability are to a greater extent constructed by social practices, and the attitudes and conceptions that inform those practices, rather than by actual physical impairments (Social Model of Disability, 2006). This model rejects the "fix-it" mentality (a core value of the medical model) as the effort to fix or correct the disability is a continuation of the same rejection

and invalidation of the worthiness of living as a person with a disability (Social Model of Disability, 2006).

2.14.3 The Biopsychosocial Model of Health

In 1977 psychiatrist George Engel also began to contest the traditional medical model stating that it "assumes disease to be fully accounted for by deviations from the norm of measurable biological (somatic) variables, leaving no room within its framework for the social, psychological, and behavioural dimensions of illness" (Engel, 1977, p. 129). In an article titled "The Need for a New Medical Model: A Challenge for Biomedicine", Engel presented the biopsychosocial model of healthcare (Engel, 1977). The model stated that firstly, there are multiple determinants in the development of disease and the resultant illness process; secondly, there is a hierarchical organization of biologic and social aspects that contribute to the disease and illness experience; and thirdly, the psychologic and social sciences are equally as important as the natural sciences in understanding the determinants of illness (Sahler, 2002).

Figure 2. Biopsychosocial Model of Health and Illness (Sahler, 2002).



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2.14.4 Speech-Language Therapy and the evolving models of healthcare

Holland (2001) describes the core values of S-L Therapists worldwide as the unique commitment to understand the process of communication and find ways to help people across the age span communicate more effectively. It is her premise that, as a body of professionals, S-L Therapists believe that the ability to communicate more effectively is intrinsic to quality of life, be it at home, school, in the workplace, or community setting (Holland, 2001). The fact that the profession is described as a hybrid, using elements from fields such as neurology, psychology, anatomy,

physiology, physics, education and computer science makes S-L Therapy a highly integrated profession which is not limited to one approach or thinking about patients and their disorders. S-L Therapy practice is consistent with the principles which guide the biopsychosocial model of healthcare in the following ways: firstly, it recognises the presence of multiple determinants in the development and maintenance of a communication disorder; secondly, it recognises that there is a hierarchical organization of biologic and social aspects that contribute to the experience of disease and having a communication disorder; and thirdly, that psychologic and social aspects are equally as important as the natural sciences in understanding communication disorders.

Wilkinson (2007) states that the traditional medical model of S-L Therapy practice in one-to-one clinical settings has limited value in the current South African sociopolitical and multilingual context. She highlights that access to basic, inclusive education and healthcare is a democratic right of all South Africans regardless of culture, language and disability. This right demands that S-L Therapy systems of practice move towards inclusive, collaborative and socially based approaches in order to access greater numbers of South Africans. In S-L Therapy, the use of a social model approach views communication disorders from the long-term perspective. There is sensitivity to the chronicity of the difficulty with no clear termination point. Intervention is likely to be along a continuum along which various forms of intervention are available. Using the social model reduces the social consequences of having a communication disorder and promotes social communication within natural contexts. Using this approach reduces the barriers that may prevent someone with a communication disorder participating in his or her social world, and in so doing, improve a person's quality of life.

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2.15 Stress and professional burnout in Speech-Language Therapy

2.15.1 Stress in Speech-Language Therapy

Although there are many definitions of stress, Monet and Lazarus (as cited in Lubinski & Frattali, 2001) apply one of these definitions specifically to professionals dealing with communicative disorders. They state that stress for the S-L Therapist is "any event in which environmental demands, internal demands or both, tax or exceed the adaptive resources of an individual, social system or tissue system" (p. 184). They also state that stress may "emanate from some combination of professional and/or

personal events of our own environment, our own personal makeup to cope with stressors and their effect, and our individual perception of the situation" (p. 184). Even though most individuals are able to cope with stress, if for some reason a person's internal and external coping resources become overly depleted, his or her ability to adapt may become affected. Due to the nature of the helping professions being highly emotional (Reynolds, 2005, p 167) those involved in caring for sick and disabled individuals are especially susceptible to stress.

Human services, of which S-L Therapy is one, is "people work" which includes a number of inherently stressful factors (Farmer, Monaham, & Hekeler, 1984, p. 43). Factors which have been identified as being inherently stressful within human service professions include the complexity of clients and their needs, the difficulty in evaluating success, the poor perceptions of the helping relationship by others, lack of support from the organization, ambiguous decision-making processes, and tension of client needs and organization demands (Farmer et al., 1984, p. 45). Maslach (1982, p. 18) stated of health professions that "because by definition the recipients of most helping relationships are people with problems, the health professional inevitably sees the part of her patient that is negative or needing intervention". The healthcare professional [S-L Therapist] has also been described as facing an occupational stressor that is not part of most other occupations in that he or she deals with people in situations involving death and suffering that have a profound effect on them (Payne & Frith-Cozen, 1987, p. xi)

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A recent USA study which aimed to determine the causes and effects of stress levels experienced by S-L Therapists who work in either a medical or educational setting identified those in medical settings to have high levels of stress with specific stressors being (in order of severity) paperwork, co-workers, caseload and families. The types of patients identified to cause the highest levels of stress were those with severe disabilities and those with uncooperative families. Even though stress was noted to have a negative effect on collegial relationships, it was not identified as a factor in reducing job performance (Whites et al., 2005). Numerous surveys looking to identify levels of occupational stress and proneness to professional burnout, indicate that due to the type of work S-L Therapists do, they are among the most at risk when compared to other health professionals (Fimian, Lieberman, & Fastenau, 1991; Swindler and Ross, 1993). Conflicting priorities in situations where S-L Therapy

intervention is viewed as merely playing a supportive role within the hospital team has been raised as a major issue of stress for professionals (Byng et al., 2002).

2.15.2 Stress in other health professions

Stress is not unique to the profession of S-L Therapy, as other human service professionals are reported to experience similar issues to those experienced by S-L Therapists. Public health system occupational therapists described how they perceive colleagues and non-occupational therapy managers to have little regard for the role of occupational therapy, and often fail to recognise the value of the profession (Moore, Cruikshank, & Haas, 2006b). The same group of participants stated an additional source of stress to be the belief that the health budget was not adequate to meet the needs of staff or patients. A survey of 696 American occupational therapists showed therapists to experience high levels of stress caused by dealing with patients' "trauma", "pain" and the "chronicity and severity of patients' illnesses" (Bailey, 1990, p. 25). Occupational therapists also report a high patient caseload as being a contributing factor to feeling unable to adequately serve their clients (Hasselkus & Dickie, 1994; Lloyd, & King, 2001), excessive paperwork and statistics as sources of major stress (Bailey, 1990; Freda, 1992; Pringle, 1996). In a study investigating the influence of managers on the stress levels of occupational therapists, results showed therapists to experience increased stress by having managers who did not show the same level of care and consideration to all staff members and who were unsupportive and inconsistent (Moore, et al., 2006b). In an older study, 45% of newly graduated occupational therapists reported working with doctors, nurses and other health professionals as a major source of stress and at times felt that they were not accepted by these colleagues (Nordholm & Westbrook, 1981).

Studies of stress and burnout amongst social workers have consistently reported moderate to high levels of burnout resulting in the conclusion that social workers are more vulnerable to high levels of stress and burnout than other health professionals (Lloyd & King, 2004, p. 753). Like occupational therapists, social workers also state that their role is misunderstood, which leads to feelings of frustration (Moore, Cruikshank, & Haas., 2006a; Reid et al, 1999) and that that their role is often misinterpreted as "just being nice or doing the common sense things that anyone can do" (Dillon, as cited in Lloyd, King, & Chenoweth, 2002, p. 257). Another major

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feature of client-related stress is feeling unable to answer or solve specific client problems due to societal circumstances especially in the face of the public's perception of their ability to do so (Collings & Murray, 1996).

In a study looking at stress, burnout and social support in nursing (Jenkins & Elliott, 2004), the main stressor cited by qualified nurses was lack of adequate staffing followed by physically threatening, difficult or demanding patients. Having to cope with a high workload also showed to be particularly stressful. A study by McNeese-Smith (1997) showed nurses to experience increased stress levels when managers fail to advocate for the needs of their staff, support their staff and provide them with professional development opportunities.

2.15.3 Professional burnout

The term "burnout" was originally suggested by Freudenberger in 1974 (Farber, 1983, p. 1) and was subsequently defined by Maslach (1982) as "a syndrome of emotional exhaustion, depersonalization and reduced personal accomplishment that can occur among individuals who do 'people work' of some type" (p. 3). It is a complex phenomenon in which staff members feel that they are unable to give of themselves at a psychological level, develop a negative attitude about their clients, evaluate themselves negatively and feel dissatisfied with their accomplishments on the job (Maslach, Jackson, & Leiter, 1996). Literature on the topic has revealed an increasing awareness of the existence of professional burnout within numerous professional disciplines, especially human service disciplines. Felton (1998) proposes that people in certain occupations are at a distinct risk for the development of burnout. These include individuals who work with the public or special populations such as those persons with "disabilities, the severely ill, children, prisoners, or the impoverished" (p. 239). This phenomenon is therefore assumed to be directly related to the relationship between the caregiver and the person receiving the care, and has serious implications for both the professional giving care and the client receiving it (Lloyd & King, 2004). Common responses to burnout according to Lloyd & King (2001) include changing jobs, moving to administrative work or even leaving the profession entirely. Burnout has also been correlated with indices of personal dysfunction including "increased use of alcohol and drugs and increased marital and family conflict" (p. 228).

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Other factors continuing to burnout include patients becoming heavily dependent on the health professional for support due to the limited support they receive from their own families; patients who are unmotivated or non-compliant in following therapy instructions; and limited or no appreciation for the professional's skills and support, leaving the professional feeling unappreciated (Reynolds, 2005, p. 166). Burnout can occur in even the strongest personality type where stress is prolonged, intense or unresolved (Maslach, 1982, p. 3) and personal factors which may co-exist with professional issues exacerbating the situation include family commitments, health problems, and involvement in hobbies outside of work.

2.15.4 Burnout in Speech-Language Therapy

The literature search revealed a paucity of recent studies dealing specifically with burnout in S-L Therapy, however literature that was sourced is discussed below.

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Fimian et al. (1991) reports that emotional fatigue can affect S-L Therapists to such an extent that they may experience the same amount of tension, stress and negative attitudes as professionals with seemingly more stressful jobs do. In their study the factors that lead to burnout amongst S-L Therapists working in schools included (a) bureaucratic restrictions limiting growth and effectiveness, and little emotional and intellectual stimulation on the job; (b) emotional-fatigue manifestations such as procrastination, and calling in sick; (c) time and workload management resulting in little time for preparation and personal priorities, over-commitment, and excessive paperwork; (d) bio-behavioural manifestations such as respiratory, cardiac, and gastrointestinal problems, and the use of drugs and alcohol; and (e) lack of professional support including lack of recognition, feeling alienated from school staff, feeling misunderstood by the public, and having poor consultation opportunities.

Miller and Potter (1982) carried out a study investigating job satisfaction of American S-L Therapists. Therapists experienced moderate levels of burnout which was related to reduced job satisfaction and effectiveness and lack of support services. Results showed that burnout was not related to setting, years of employment, caseload, patient severity level, paperwork demands or collegial relationships. Potter and Rudensey (1984) investigated how S-L Therapists coped with burnout, and revealed that although coping strategies included changing job setting within the field, establishing realistic job goals, self-reflection about reasons for being in the profession

and increasing communications with managers, 16% were leaving the profession due to burnout.

Only one published South African study (an undergraduate research dissertation from the University of the Witwatersrand) was sourced on burnout among S-L Therapists (Swindler & Ross, 1993). The study reported findings from a national survey of all South African S-L Therapists and Audiologists on the frequency of burnout and possible work situation factors that may be correlated with burnout. Findings were reported for the whole group of S-L Therapists and Audiologists who were at that time experiencing moderate levels of emotional exhaustion[3], low levels of depersonalization[4], and high levels of personal accomplishment[5]. In particular, hospital therapists with large caseloads and extensive paperwork perceived themselves as being under large amounts of pressure and susceptible to burnout.

Depending on the clinical area in which the S-L Therapist works, he or she is exposed to a degree of his or her patient's grief, anger and frustration connected to the communication difficulty. While some patients and their families are engaged in a process of mourning the loss of function and valued roles, the engagement of the therapist in these feelings is a relatively unrecognised aspect of practice within the biomedical context (Reynolds, 2005, p. 166). Reynolds further argues that the difficulties the healthcare therapist may face in dealing with such emotions may go mostly unnoticed leaving him or her feeling largely unsupported and vulnerable to emotional burnout. Further training in counselling skills has been recommended for therapists working in environments which have the potential to be of a highly emotional nature. This is anticipated to equip the therapist in his or her role, and enable him or her to take better care of his or her own mental health (Reynolds, 2005, p. 167).

2.16 The Speech-Language Therapist's work environment

2.16.1 Examining the organization in which the Speech-Language Therapist works

Organizations create motivation through factors that are either intrinsic or extrinsic to the work itself (Bratten, Callinan, Forshaw, & Sawchuk 2007, p. 250). In

[3] excessive and lengthy levels of job stress leading to feelings of extreme tension, irritability and fatigue

[4] psychological detachment from work, becoming apathetic, cynical and rigid towards client

[5] adequately relating to clients and a sense of having success in work tasks

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1995, as part of a master's degree thesis, Barnes conducted a study with hospital-based occupational therapists, physiotherapists and S-L Therapists in order to determine which extrinsic and intrinsic factors correlated with career satisfaction and desire to stay in the job (Barnes, as cited in Randolph, 1995, p. 50). Extrinsic factors are defined as external benefits provided to the professional by the facility or organization. These may include competitive pay, continuing education, flexible work hours, sick leave and vacation leave allowances, medical aid benefits, pension benefits and bonus payment (Barnes, as cited in Randolph, 2005, p. 50). Intrinsic-context factors are defined as less tangible but inherent to the job, and although are controlled by outside forces, affect the professional's internal satisfaction. These may include adequate staffing, realistic workload, stable environment, and balance between work and home (Barnes, as cited in Randolph, 2005, p. 50). Intrinsic-content factors are primarily controlled by the professional and affect his or her sense of self-efficacy and competency. Such factors may include having diversity of practice, providing direct patient care, having meaningful work, and providing quality care (Barnes, as cited in Randolph, 2005, p. 50). When people are intrinsically motivated, they will seek to perform well as they enjoy performing the task or enjoy the challenge of successfully completing it and when they are extrinsically motivated, they do not particularly enjoy the task but are motivated to perform well to receive some type of reward or to avoid negative consequences (Aamodt, 2007, p. 304).

Results from Barnes' study showed that the only significant extrinsic factors that positively correlated with desire to stay in the job were productivity expectations and flexible work schedule (Randolph, 2005). Intrinsic factors that positively correlated with job satisfaction *and* desire to stay in the job were stable work environment, opportunity for professional growth, input into departmental decisions, and practising in an environment that was in line with the professional's values. Intrinsic factors that positively correlated with job satisfaction only, were opportunity for direct patient care, feeling competent, accomplishing career objectives, and meaningful work. Intrinsic factors that positively correlated with desire to stay in the job only, were fair policies, and closeness with co-workers. Barnes' study was repeated by Randolph in 2004 with a group consisting of the same type of professionals. Again, results showed intrinsic rather than extrinsic factors to be predictive of job satisfaction and desire to stay in the job (Randolph, 2005). Extrinsic factors not being predictive of job satisfaction in either study is consistent with the Industrial/Organizational Psychology literature. Such

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literature states that high achievers are intrinsically motivated and that extrinsic factors are less important to most employees than intrinsic ones (Bratten et al., 2007, p. 254). In terms of remuneration, Bratten postulates that while money (extrinsic factor) can motivate people, current research has shown that for money to motivate an employee's performance, certain conditions must be met. These conditions include the employee regarding money as valuable, and perceiving that the money is "a direct reward for performance" (p. 254).

As already mentioned, in South Africa, the settings in which S-L Therapists work are hospitals (government and private), community-based services, ELSEN schools, and private practice. Some are supportive, others oppressive, and the resources to do the tasks at hand may or may not be present in the setting. The only South African published research on hospital S-L Therapists, reported that hospital therapists (S-L Therapists and Audiologists) were under a large amount of pressure due to poor extrinsic motivation such as having to cope with large caseloads and extensive paperwork (Swindler & Ross, 1993, 81).

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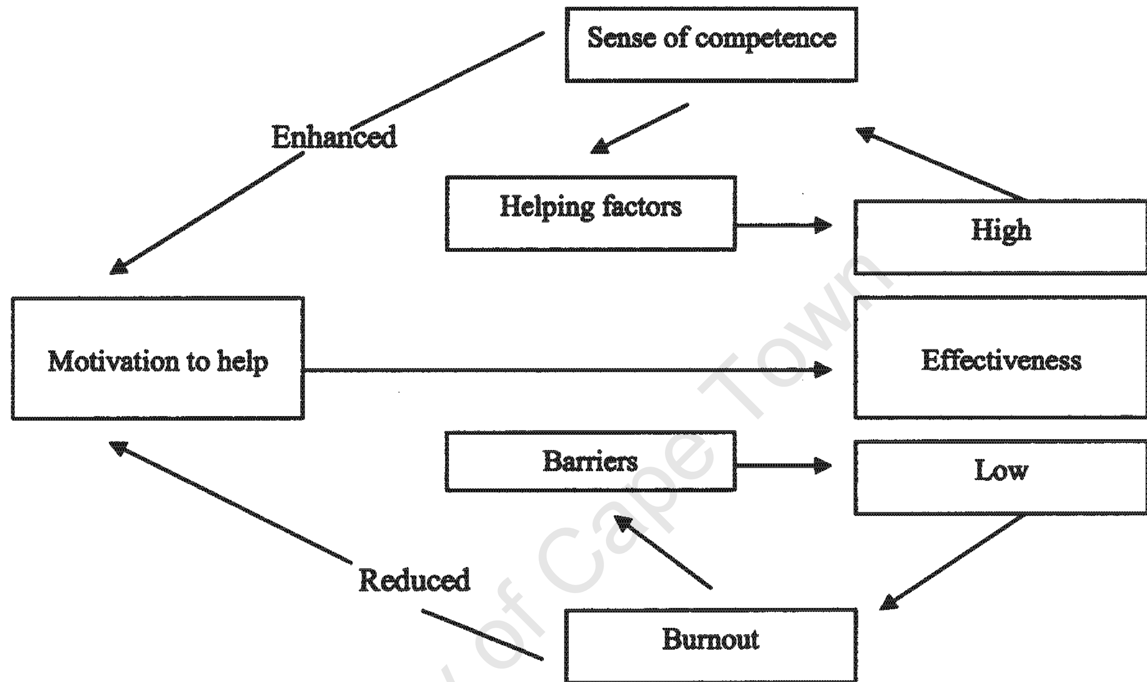
2.16.2 The Speech-Language Therapist's response to his or her work environment

Harrison (1983, p. 224) stated that "a sense of competence and a feeling of efficacy are the results of being able to affect the environment and meet its challenges". It has been proposed that significance is a core motive for all people, especially those engaged in a profession, and that people in the helping professions want to feel that they're making a difference in others people's lives (Cherniss, 1995, p. 122). Professionals will develop positive affective responses to their jobs if they believe that what they are doing is valuable and makes a difference to the lives of their patient. Work that gives them this opportunity is "meaningful" (p. 122) while a lack of perceived competence and effectiveness is closely related to professional burnout. Harrison's social competence model of burnout (1983, p. 224) although developed over twenty years ago and originally to describe the process of stress and burnout, illustrates very clearly the nature of transactions between the individual and his or her work environment. For the purposes of this project, the approach is discussed using current literature as it relates to S-L Therapy and other healthcare professions. The approach demonstrates that while the motivation to help and serve others is an important pre-requisite for the professional, the presence of supportive aspects (helping factors) significantly affect the professional's sense of competence and resultant motivational

enhancement. Likewise, the presence of non-supportive aspects (barriers) significantly decreases the professional's sense of effectiveness leading to burnout and a reduced motivation to help others.

Figure 3. Harrison's social competence model of burnout (1983)



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Across the professions of S-L Therapy, occupational therapy, physiotherapy, nursing, social work, clinical counselling and teaching, the literature describes supportive aspects (helping factors) to include: participation in peer counselling and support from colleagues (Collings & Murray, 1996; Culbreth, Scarborough, Banks-Johnson, & Solomon, 2005; Jenkins, 1991; Jenkins & Elliott, 2004; Kilfedder, Powers, & Wells, 2001; Lloyd & King, 2001; Reid et al., 1999; Um & Harrison, 1998); feeling supported by managers (Collings & Murray, 1996; Lloyd & King, 2001; Moore, et al., 2006b); feeling training had prepared them for the working environment (Culbreth et al., 2005); feeling their expectations of the job had been satisfied (Culbreth et al., 2005; Moore, et al., 2006a; Reid et al., 1999); feeling a sense of pride and achievement when goals were attained (Hasselkus & Dickie, 1994; Lloyd et al., 2002; Moore, et al., 2006a); and experiencing work as interesting and rewarding (Akroyd, Wilson, Painter, & Figuers, 1994; Jenkins, 1991; Moore, et al., 2006a).

It follows from the literature that should the professional feel supported by colleagues and his or her manager; feel adequately prepared for the work he or she is expected to do; that most of his or her goals for patients are met and that his or her work is interesting, challenging and rewarding, the professional will consequently feel a sense of increased motivation as the proof of competence and effectiveness becomes evident.

The literature has described non-supportive aspects (barriers) to include high job demands and work overload (Austin, Shah, & Muncer, 2005; Cheng, Kawachi, Coakley, Schwart, & Colditz, 2000; Lloyd & King, 2001; McGibbon, 1997; Moore, et al., 2006a; Murray, 1998; Smith & Nursten, 1998; van Wijk, 1997; Webster & Hackett, 1999); low supportive work relationships with supervisors and co-workers (Cheng et al., 2000; Decker, 1997; Lloyd & King, 2001; Pope, Nel, & Poggenpoel, 1998; van Wijk, 1997; Webster & Hackett, 1999); dealing with death and dying (Carson, Wood, White, & Thomas, 1997; Murray, 1998;); lack of essential resources (Jenkins & Elliott, 2003; Murray, 1998; Smith & Nursten, 1998; Tovey & Adams, 1999); uncooperative family members and clients (Austin et al., 2005; Jenkins & Elliott, 2003; Smith & Nursten, 1998); time constraints (Austin et al., 2005; Lee & Henderson, 1996; Lloyd & King, 2001); unpredictable staffing and understaffing (Carson et al., 1997; Jenkins & Elliott, 2003; Lloyd & King, 2001); not having adequate referral pathways (Coffey, 1999; Smith & Nursten, 1998); poor or unfair remuneration (Moore, et al., 2006a; Pope et al., 1998); disregard for professional worth (Lloyd & King, 2001; Moore, et al., 2006a; Pope et al., 1998; Smith & Nursten, 1998); lack of patient progress (Hasselkus & Dickie, 1994; Moore, et al., 2006a; Smith & Nursten, 1998;); and role stress and role ambiguity (Chang & Hancock, 2005; Chang, Hancock, Johnson, Daly, & Jackson, 2005; Smith & Nursten, 1998).

It also follows from the literature that should the professional feel unsupported by colleagues and his or her manager; overloaded and inadequately prepared for the work he or she is expected to do; disregarded as a professional; receive unfair remuneration and reward for his or her work; and experience a lack patient progress, the professional will consequently feel a sense of decreased motivation and burnout as she experienced low effectiveness is experienced.

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2.17 Conclusion

This research as I have already mentioned is interested in the lived experience of being a S-L Therapist in the Western Cape public health service. In the reviewed literature I have shown the paucity of research in this particular area while outlining certain issues relating to the profession. I have described the profession's history in light of the political changes that have taken place in South Africa, and the lack of ethnic diversity within the profession which has been a consequence. Gender issues were also described. Using the literature, S-L Therapy was described as a helping profession, a profession which seeks to be both professionally autonomous and collaborative in nature and which seeks to focus on communication. The S-L Therapist's relationship with his or her patient was described in detail according to different models of interaction. The traditional medical model of healthcare, the social model of health and disability, and the biopsychosocial model of health were described and critically compared. Professional stress and burnout was discussed in relation to S-L Therapy and health professions. Lastly the S-L Therapist's work environment was examined.

This study therefore aimed to describe the lived experience of the S-L Therapist the public health service in relation to already existing literature, while contributing to and expanding the body of knowledge in this field.

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CHAPTER THREE
Methodology

3.1 Introduction

This chapter outlines the methodological approach taken in this study. The study aimed to describe the lived experience of being a S-L Therapist in the Western Cape public health service and was thus interested in the lived experience of a small group of people. A qualitative design was therefore selected and was located within the tradition of phenomenological hermeneutics as described by van Manen (1990, p. 180). This chapter is written in the first person to emphasise my close involvement in the process.

3.2 The use of a qualitative research design

The two major paradigms that guide scientific enquiry are quantitative and qualitative research (Maxwell & Satake, 2006, p. 29). Quantitative research is based on the positivist paradigm (also called traditional, experimental or empirical) whereby formalised tests and measuring instruments are applied to precisely and objectively specify the characteristics of data in numerical terms. Typically such data is used to compare an experimental group with a control group (Maxwell & Satake, 2006, p. 29). Qualitative research is based on the naturalist paradigm (also called interpretivist, constructivist or interactionist) and is centred on "interpretation and creation of meaning by human beings and their subjective reality" (Holloway & Wheeler, 1996, p. 12). In qualitative studies, the aim generally seeks to answer questions about the "what", "why" or "how" of a phenomenon rather than questions about "how many" or "how much" as in the quantitative approach (Green & Thorogood, 2004, p. 5). In qualitative studies there is no initial hypothesis, and ideas and theories are generated primarily through the gathered data. Qualitative research is viewed as being more holistic and subjective in orientation, with the ultimate goal of describing, understanding and interpreting the phenomenon under investigation, rather than controlling behaviour or determining its statistical probability as in quantitative research (Maxwell & Satake, 2006, p. 248). In qualitative research the researcher's involvement in the process is vital since he or she is the main data gathering tool. Data is gathered from individuals who have experienced the phenomenon under investigation, typically through long interviews which seek to discover the feelings, thoughts and perceptions of the participants (Cresswell, 1994, p. 62; Maxwell & Satake, 2006, p. 32;). The data gathering and analysis process is

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iterative in that the processes constantly interact and analysis relies on both rigour and imagination and is guided by the specific approach used.

A qualitative approach is therefore most appropriate for the current study to gain insight into the lived experience of S-L Therapists and the interpretations and meaning these professionals attach to their experiences. Qualitative research methods are also able to provide a systematic way of exploring complex issues, such as communication, that cannot be separated from the context in which they occur. Within the qualitative paradigm various methodologies exist (biographical, phenomenology, grounded theory, ethnography and case study), each attempting to satisfy different research aims and purposes.

3.3 The phenomenological approach

A phenomenological methodology is best suited to the study of lived experience. Brink (2002, p. 119), describes phenomenological studies as those that "examine human experience through the descriptions that are provided by the people involved". "Phenomenologists study people's experiences of everyday life within a definite philosophical context that generates specific assumptions about human nature and human living" (Becker, 1992, p. 9). The purpose of phenomenological research is to describe how people experience a specific phenomenon, how they interpret those experiences and what meaning the experiences hold for them. Phenomenology focuses on a participant's actual experience rather than merely on the participant or object, and describes the participant's experience of a phenomenon as different to their knowledge of it. Colaizzi (1978) describes human experience as "not closed off inside the human person, but always how we behave towards the world and act towards others" (p. 52). Phenomenology is described by Patton (1990, p. 70) as "the study of experiences and the way in which we put them together to develop a worldview; carrying an assumption that there is a 'structure and essence' to shared experiences that can be determined", and by Cresswell (1998, p. 51) as "a study which describes the meaning of experiences of a phenomenon for several individuals". In a phenomenological research approach the researcher attempts to "enter the world of the participants to the greatest extent possible, in order to understand their thoughts, attitudes, feelings, and beliefs about various aspects of existence" (Maxwell & Satake, 2006, p. 33).

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Phenomenology has its roots in philosophy and three phases in its movement have been described, namely preparatory, German, and French (Moustakas, 1994, p. 48). The early history of phenomenology (preparatory phase) was influenced by Franz Brentano (1838-1917) whose central theme was intentionality. He believed that when an individual perceptually experiences an object the object always exists (Moustakas, 1994, p. 28). In the German phase, Edmund Husserl (1859-1938) held the position that the object may be imaginary and may not exist at all (Moustakas, 1994, p. 28) and in his search for rigour and criticism of positivism, centred around intentionality, essences and phenomenological reduction (bracketing), and the use of phenomenology to describe how the world is constituted and experienced through conscious acts (van Manen, 1990, p. 184). Heidegger and Merleau- Ponty, philosophers in the French phase, focussed on perception and the creation of a science of human being (Holloway & Wheeler, 1996, p. 120). Heidegger engaged with the concept of being-in-the-world that refers to the way human beings exist, act, or are involved in the world (van Manen, 1990, p. 175), and Merleau-Ponty described phenomenology as "the study of essences" where phenomenology always asks the question of what is the nature or meaning of something (van Manen, 1990, p. 184).

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The purpose of a phenomenological study is that the person reading it may have a better understanding of the "essence" of the described experience and better understand what it is like for someone to experience that phenomenon. Van Manen (1990, p. 36) describes it as a means "to transform lived experience into a textual expression of its essence". In phenomenological research the researcher brackets his or her preconceived ideas about the experience or phenomenon in order to understand it through the voices of the informants. This is especially important if the researcher shares the experience with those whom he or she is interviewing. Data is gathered from participants who have experienced the phenomenon, usually through in-depth interviews which are conversational in nature, with participant numbers ranging from 5 to 15 (Holloway & Wheeler, 1996, p. 124; van Manen, 1990, p. 66).

3.4 Hermeneutical-phenomenology

Phenomenological research is typically classified as either empirical or hermeneutical (Becker, 1992, p. 32). Empirical phenomenologists ask people to describe life events and then use the descriptions to understand the general structure or nature of a phenomenon, or show the essential features of a process. Hermeneutical-

phenomenologists take a broader view, where essential meaning is studied and revealed in the interpretation of text (Becker, 1992, p. 32; Lindseth & Norberg, 2004). Hermeneutics is described by van Manen (1990, p. 179) as "the theory and practice of interpretation". This particular study makes use of a descriptive phenomenological methodology as at the same time as allowing things speak for themselves and allowing essences to be "'uncontaminated' by interpretation" (Lindseth & Norberg, 2004, p. 147; van Manen, 1990, p. 180), it is interpretive (hermeneutic) as it claims that there are no such things as uninterpreted phenomena (van Manen, 1990, p. 180). In hermeneutical-phenomenology, "it is not only the interpreter that interprets the text, but the text that also interprets the interpreter" (Lindseth & Norberg, 2004, p.151), which provides new insight about the world and those living in it. It is proposed that when our outlook on phenomena changes, our behaviour will also change, and when we have gained a new perspective and insights about new possibilities to relate to ourselves and others, the challenge is to help others to also gain new insights by writing research reports in a way that can affect people (Lindseth & Norberg, 2004).

Lindseth and Norberg (2004) describe the phenomenological hermeneutical method of interpretation as having the aim of "affecting people's perception of reality and helping them become aware of possibilities such as alternative ways of being in the world" (p. 152). They state that "only when the reader can make the interpretation integrated into her or his world, that it can become productive in human life" (p. 151).

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3.5 Research Processes

The remainder of this chapter outlines the research processes that were followed. It also seeks to describe how the research process is related to the philosophical premises described in 3.3 and 3.4. Brink's (2002) definition of phenomenological research as being "to examine human experience through the descriptions that are provided by the people involved" (p. 119) will be realized through the close examination of the participants' verbal descriptions. Becker (1992) states that "the phenomenologist studies people's experiences of everyday life within a definite philosophical context that generates specific assumptions about human nature and human living" (p. 9). This will be realized through the way in which the research question is presented, data is collected, analysed and through the specific use of van Manen's (1990) four lifeworld themes in the discussion of the findings.

3.5.1.1 Sampling and sampling procedures

Participants were purposefully selected using the following criteria:

- at least 2 years work experience in and currently practising as a full-time or part-time S-L Therapist in the Western Cape public health service (hospital or community)
- if on a dual register (S-L Therapy and Audiology as described in 1.2), dedicating 50% of her[6] weekly activities to S-L Therapy
- at any stage of her professional career in order to provide a diverse range of experiences
- be willing to reflect on her experience of being a S-L Therapist

Purposive sampling was selected as I sought to explore the participants' experience of a particular phenomenon and not to measure it. Another motivation for using this method was my desire to interview individuals who reflect different stages of experience e.g. years practicing as a S-L Therapist (Brink, 2002, p. 141). A complete list of all S-L Therapists employed by the Western Cape Department of Health was compiled and entered into a database.

Van Manen (1990, p. 98) suggests that the participant in an hermeneutic phenomenological project "becomes the co-investigator of the study" in that he or she usually has more than "a mere passing interest" in the topic and through the process "begins to care about the subject and research question". In light of this it was necessary that I took care when recruiting participants, and did so in a sensitive manner to ensure as far as possible that participants were those who had a vested interest in the study and its outcome.

3.5.1.2 Access to participants

- I contacted the hospital superintendents of Red Cross Children's War Memorial Hospital, Groote Schuur Hospital and Tygerberg Hospital for permission to approach the relevant head of each Speech Therapy Department (Appendix B).
- Once permission was granted, I contacted the head of each Speech Therapy Department (HOD) via e-mail and follow-up telephone call (Appendix C). I

[6] 'her' will be used in the text as all S-L Therapists in the Western Cape public service are currently female

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informed the HOD about the study aims, how I anticipated the department's S-L Therapists would be able to assist me, and offered to address staff as a group in order to explain the study aims and rationale, discuss issues of time, commitment, tape recording of interviews, and voluntary participation. I also requested permission to make contact with all S-L Therapists via e-mail, inviting them to participate should they meet the selection criteria. None of the HODs requested that I address the staff as a group, and agreed to inform them of the study and that they would be contacted.

- I contacted each S-L Therapist individually via e-mail (Appendix D and E) and requested a response indicating either willingness or unwillingness to participate in the even that the selection. Should the therapist not satisfy the selection criteria, no reply was necessary. Each therapist was informed that should she satisfy the selection criteria but expressed her wish not to participate, she would not be contacted again and would not have her decision disclosed to her HOD or colleagues. I chose this method of contacting individual S-L Therapists in order to uphold anonymity and minimise the pressure to participate by allowing the S-L Therapist to decline participation without needing to give a verbal explanation. E-mail contact (to e-mail addresses) also maintained confidentiality. At Red Cross Hospital, three S-L Therapists met the criteria and two of those three agreed to participate. At Groote Schuur Hospital, five S-L Therapists met the criteria and four of those five agreed to participate. At Tygerberg Hospital, two S-L Therapists met the criteria and one agreed to participate.
- I contacted willing participants again via e-mail informing them that they would be contacted shortly for an interview.
- Upon commencement of the data collection phase, I contacted each S-L Therapist telephonically in order to arrange an interview time where the consent form was completed (Appendix F).

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3.5.1.3 Description of the sample

Participant biographical information is presented in a format that protects the identity of each participant. The group comprised seven female S-L Therapists ranging in age from 26 to 52 years with a mean age of 36 years. The number of years work experience ranged between three and 27 years, with three participants holding Bachelor degrees and four holding Masters degrees. They graduated from two different universities in Cape Town and are currently working at three different tertiary hospitals

in the Western Cape. Five participants have dual registration while the remaining two have single S-L Therapy registration. Five out of 7 have a predominantly paediatric S-L Therapy caseload.

3.5.2 Data Generation

The term 'data generation' is suggested by Mason (1996, p. 36) as a more suitable term in qualitative studies than the quantitative term 'data collection', as qualitative studies actively seek to "construct knowledge about the phenomenon". In hermeneutic phenomenological research, data gathering is described as "a kind of conversational relation that the researcher develops with the notion he or she wishes to explore and understand (van Manen, 1990, p. 98). For this study data was generated through:

- conducting 7 individual in-depth qualitative research interviews with selected S-L Therapists
- the keeping of field notes and reflective memos
- conducting 7 follow-up interviews to discuss preliminary study findings

3.5.2.1 Qualitative research interviews

Kvale (1996) describes the qualitative research interview as "an interpersonal situation, a conversation between two partners about a theme of mutual interest.... a specific form of human interaction in which knowledge evolves through a dialogue" (p. 125) and Brink (2002, p. 158) describes it as being almost like a normal conversation, but with purpose. In phenomenological research this conversation has "a hermeneutic thrust in that it is orientated to sense-making and interpreting of the notion that drives or stimulates the conversation" (van Manen, 1990, p. 98). Phenomenological interviewing relies on skilled listening without prejudice by the interviewer, and encouraging and allowing the interviewee to describe her experience without interruption by questions from the interviewer. Although qualitative research often describes the researcher as the primary tool for data generation, the participant is actively involved in the gathering process of discovery and interpretation (van Manen, 1990, p. 98). Hermeneutic phenomenological research relies on interpretation taking place during and after the formal data gathering phase. In this tradition, interviews deliberately do not contain a set of pre-formulated questions which allows the researcher to remain open to new and unexpected views and ideas. I opened each interview with an initial question, and due to the open-ended nature of the research methodology, probes were used during all of the

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interviews. A helpful introductory probe used in all interviews was the reason for the participants' choice of profession as this was a general and non-threatening question which facilitated further discussion about their experiences (Appendix G). The frequency of probe use increased towards the end of each interview.

Three interview techniques in qualitative interviewing are outlined by Meulenberg-Buskens (1996), as summarising (giving back to the interviewee his or her feelings and opinions in his or her own words to validate the interviewee's words), clarifying (finding out more about something which was mentioned), and pause or silence (an effective tool in giving the interviewee time to consider, process and reflect upon what he or she just said and to add any additional information).

An example of the *summarising technique* is given below using an excerpt from one of the interviews.

Excerpt from participant 7 (Interviewer in bold)

> **What I'm hearing from you, need to reflect back. Is just, um, ja, that sense of ja being very passionate about it, but then having a very balanced view, and you were saying things don't get to you, things don't, you don't get depressed about it** No **Um, that's what I'm hearing and that are aware of the barriers and of the good things and that you just make do with, with it** And try and solve it **Ja** [yes]**, and a pro-activeness** Ja, rather than a complacency **Ja** am I suppose to say something more now? **no, no is that** yes, yes, that's what you're hearing

An example of the *clarifying technique* is given below using an excerpt from one of the interviews.

Excerpt from participant 1 (Interviewer in bold)

> you know you, you can't, you have to give them everything, you know your all, **(mm)** you can't be, type of thing (pause) **tell me more about giving them everything** (laughs) you can't (pause) what, you know you, if like I assess a child I'm not gonna, my whole heart is there ok, type of thing, it's not ok, I'm doing this but my mind is somewhere else, I don't know, I mean **(mm...mm)**

An example of the *pause or silence technique* is given below using an excerpt from one of the interviews.

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Excerpt from participant 3 (Interviewer in bold)

> **So what what have been the things that have made you stay?** Um (long pause) the lack of job opportunities (**mm**), just generally (**mm**), um, I mean as a Speech Therapist again that's one of the frustrating things I think there's a lot more opportunities for Physios [physiotherapists] and even OTs [occupational therapists] maybe not as much OTs, but, it's still more than there is for Speech especially in Cape Town.

3.5.2.2 Framing the interview

Briefing and debriefing occurred at the start and end of each interview. Briefing defined the situation for the participant and informed her of the interview purpose and use of tape recorder. The participant was also given the opportunity to ask any additional questions. Debriefing involved reassuring the participant that she may feel "empty" after having opening herself up and exposing thoughts and feelings (Kvale, 1996, p. 128).

3.5.2.3 Interview setting

The interview setting impacts on the kind of data generated and so I attempted to seek as much privacy for each interview as possible (Brink, 2002, p.159). Prior to the interview I discussed an appropriate and suitable venue with each individual S-L Therapist. One interviewee requested to be interviewed at her home and the remaining six requested that the interview be conducted in their offices during their lunchtime. Those interviewed at work were asked to switch off their cellphones and unplug their landline for the duration of the interview. Consequently no telephone interruptions were experienced. Although I highlighted that being interviewed in their departments in full view of fellow colleagues would jeopardize the confidentiality of their participation in the study, participants did not consider it to be an issue. Although participants did not appear to be anxious about colleagues entering their office during an interview I was acutely aware of this risk.

3.5.2.4 Tape recording

All interviews were recorded on a digital recorder, after permission from the participant had been obtained. Advantages of tape recording included allowing me to maintain eye contact with the interviewee and give her my undivided attention

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throughout the interview. It also assisted me in remaining focussed on the question and participant's responses without having to "balance" note taking and questioning. It also enabled me to capture pauses, and changes in voice tone. Tape recording the interviews enabled me to listen to the interview after the interview, making further understanding and rich analysis possible (Kvale, 1996, p. 160). Prior to the commencement of the interview, the audio recorder was checked on site to ensure it was in working order. After the interview, the data was downloaded onto my personal computer as a wave file, dated and labelled with the participant's number. The list of matching participant names and numbers were stored separately to the data to achieve participant confidentiality. A disadvantage of tape recording interviews is that body language, gesture and facial expressions of the participant were not captured and therefore had to be informally recorded in my field notes.

3.5.2.5 Field notes

Field notes were written straight after each interview. These captured the "flavour of the interview" (Holloway & Wheeler, 1996, p. 70) as well as participants' behaviours, attitudes and non-verbal information and were used during analysis (Mason, 1996, p. 68).

3.5.2.6 Reflective memos

The writing of reflective memos was not part of the direct data collection process although did contribute to the analysis phase and enhanced rigour. These were written at various points in the research process and captured my views, thoughts, feelings and opinions (see more detail in 3.4.5)

Excerpts from my reflective memos:

21 July 2006

Well, I thought this interview was going to be "easy"!!! But by 10 minutes into the interview I was feeling really awkward and just wanted to leave! But I persevered. I felt that many of her responses were "textbook" ones eg. Multidisciplinary team approach ect. and that she was telling me what she thought I wanted to hear. She "um-ed and ah-ed" a lot with lots of silences which made it difficult to follow. She used lots and lots of fillers which made following her train of thought really hard for me. She didn't always finish her sentences and so it was hard to follow what she was going to say and know if

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what she was going to say was significant or just a filler. On the way home I felt exhausted from trying to "get the information out of her" and almost like I had not heard anything. She was however very relaxed about what she said. The overall feeling I got was that she loves her work and that it takes up a lot of her time (mental and practical). She was not forthcoming with any "extra" information which I found frustrating. I found I had to prompt a lot and probably lead her quite a lot in the questioning which was not optimal.

23 October 2006

I am finding myself talking about "our" job with all participants which I shouldn't do. Each person's experiences are very different to mine, which makes me sit up and take note and then prepare better mentally for following interviews.

02 March 2007

The vast amount of data I have is overwhelming. I can't even make sense of it anymore. Just when I think I have a moment of clarity, I realise that I am not even near to where I should be in this analysis.

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3.5.2.7 Follow-up interviews

This process was both a data generation tool and a measure of rigour. Following preliminary analysis, a summary of the themes, categories, and clusters with a short description of these was given to each participant to read. A thirty to forty minute discussion was held with six of the seven participants in order to discuss the findings and participants were given the opportunity to comment, clarify issues and expand on the interpretation (see detail in 3.4.3.4 number 5 and 3.4.5.3).

3.5.3 Data Analysis

The challenge of qualitative data analysis is "to make sense of massive amounts of data, reduce the volume of information, identify significant patterns, and construct a framework of communicating the essence of what the data revealed" (Patton, 1990, p. 372). In particular, phenomenological data analysis is not a set of instructions to be followed, but more an approach or attitude with the goal of constructing a thick description of the lived experience under investigation. It also aims to produce a description that is a correct and reliable interpretation of what participants said.

3.5.3.1 Transcription

After each interview the recording was transcribed verbatim. Transcriptions reflected reliably the precise words of the interviewee, including slang words, stutters, hesitation, silences with as much significant non-verbal and para-linguistic communication noted (Hycner, 1985). I used consistent transcription conventions for non-verbal cues, and removed identifiers (name and specific location) from the transcript e.g. pause = [pause].

3.5.3.2 Phenomenological reduction and bracketing

Hycner (1985) describes phenomenological reduction as a process rather than a point in time which involves the researcher bracketing or suspending any presuppositions with which he or she may approach the data. By approaching the data with openness to whatever meanings emerge, an understanding of the phenomenon in

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its pure form and of what the person has said, rather than what the researcher expected the person to have said, is made possible. The phenomenologist "must refrain from making judgements about the factual as they are not interested in stating facts, but in relating what has been experienced" (Lindseth & Norberg, 2004, p. 147). As part of the process of phenomenological analysis, I had to identify any biases and presuppositions I had about the phenomenon under investigation and set them aside. These included the positive way I view my profession, the advantages I feel SLTs experience by working in the state service, some of the negative experiences I have had with privately employed SLTs, and elements of the relationships I have with my colleagues whom I interviewed. The process of doing this was described as Epoche by Moustakas (1994, p. 85). Although the processes of bracketing and epoche were challenging, they were conscious and continuous throughout the research process. Throughout the research process regular discussion and feedback sessions were held with my supervisor who acted as a neutral person in the process. This enhanced rigour as she was able to point out issues that I had overlooked due to my deep involvement in the study. Although impossible to do completely, these processes reduced as far as possible any inappropriate or personal over involvement in the phenomenon being studied.

3.5.3.3 Listening to the interview tapes for a sense of the whole

Following transcription of the interviews, I listened to the recordings and read the data a number of times before commencing the analysis process as this provided the

context for the emergence of meaning. I paid particular attention to para-linguistic levels of communication (intonation, pauses, silences and emphases) and achieved a deeper sense of the whole meaning, while making notes of my impressions, thoughts and questions as they arose attempting as far as possible to "stay true to the interviewee's meaning" (Hycner, 1985, p. 281).

3.5.3.4 Stages of analysis

The steps involved in conducing data analysis, described by Colaizzi (1978) and Hycner (1985) were used, and although described in detail below, were approached with flexibility and openness.

1) Step one involved reading the entire set of transcripts a number of times in order for me to acquire feeling for and better understand them.

2) Step two was to re-read each transcript and extract significant statements which were directly related to the phenomenon under investigation. These were tabulated and in an adjacent column, the statement was re-written in the 3rd person which

assisted in personalising the statement. Duplicate statements (those that contained the same or nearly the same information) were eliminated. An example of a significant statement is tabulated below with the 3rd person version.

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Table 2. Significant statements and corresponding formulated meanings

Verbatim transcript Units of general meaning "SIGNIFICANT STATEMENTS"	**Units of relevant meaning to the research question** "what does this tell me about the experience of being a Speech-Language Therapist in the public sector?" "FORMULATED MEANING" in 3rd person
so um, it, it's, maybe also being around for so long, I felt secure, it's felt like home, **[mm]** really, I've felt nurtured,	P7 says that maybe being around for so long has made her feel secure, and like it's home, so really she's felt nurtured.

I've felt respected, I guess I've earned it, worked *hard,* **[mm]** but we were uh, [pause] we were *appreciated.*	P7 says that she's always felt respected, but says that she's had to earn it through working h*ard*
I think its in the more recent times where, cos in our time there was also rank promotion, **[mm]** so you *did*, you, you worked hard, but there *was* room for, for *progression*	She says that in previous years S-Therapists were *appreciated* and were rewarded by rank promotion allowing room for financial progression

3) In step three each significant statement was coded. Meaning was formulated from each statement and this 'discovered' or brought out the meaning in the description. This process demanded creative insight, as I explicated the underlying meaning of the participant's words. Colaizzi (1978) describes this process as "going beyond what is given in the original text while staying with it" (p. 59). Meanings which were formulated connected with the original data.

Table 3. Significant statements and assigned codes

Verbatim transcript Units of general meaning "SIGNIFICANT STATEMENTS"	**CODES** what does this tell me about the experience of being a Speech-Language Therapist in the public sector?"
so um, it, it's, maybe also being around for so long [P7 25]	feels secure from a long time in the service
I felt secure, it's felt like home, **[mm]** [P7 26]	feeling secure makes work feel like home
really, I've felt nurtured [P7 27]	has felt nurtured
I've felt respected, I guess I've earned it, worked *hard,* **[mm]** but we were uh, [pause] we were *appreciated* [P7 28]	has felt respected has earned respect through working hard S-L Therapists have been appreciated in the past
I think its in the more recent times where, cos in our time there was also rank promotion, **[mm]** so you *did*, you, you worked hard, but there *was* room for, for *progression*	rank promotion in the past was an incentive to work hard

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4) Step four involved grouping similar codes from each interview together into clusters e.g. 'desire to make a difference in people's lives'; the 'unfixable' nature of S-L Therapy disorders'. These clusters were grouped across all transcripts into categories eg. 'moving from idealism to realism' of which there were finally 27. These categories were then assigned to one of five final themes. The themes as well as the categories were checked against each original transcript to ensure that all information from the transcript was contained in the themes and vice versa. My research supervisor was utilised to verify my data categorization into clusters and themes which enhanced trustworthiness. A summary of the clusters, categories and themes is presented in Appendix H.

5) In step five I wrote exhaustive thick descriptions of the findings in paragraph form under each theme, substantiating the analysis through the use of interview excerpts. van Manen (1990) describes the identified themes as being "objects for further reflection in follow-up hermeneutic conversations in which both the researcher and the interviewee collaborate" (p. 99). This was achieved by returning the themes and a short description of each to the participants to read, and then conducting a thirty to 30 - 40 minute discussion in which the researcher and interviewee "attempted to interpret the significance of the preliminary themes in light of the original phenomenological question" (van Manen, 1990, p. 99). In each of these conversations, the participant was asked, "is this what the experience is really like?", and was given the opportunity to comment on the findings, clarify issues and expand on the interpretation.

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6) In step six, an exhaustive description of the actual phenomenon i.e. the experience of being a S-L Therapist was written and was highly reliant on context and the research question.

3.6 Ethical Issues

3.6.1 Entry into health facilities and access to staff

Approval and permissions were obtained as follows:

- Approval by the School of Health and Rehabilitation Sciences and UCT Faculty Research Ethics Committees (Appendix A)
- Approval by the relevant hospital Medical Superintendent (Appendix B) and/or Speech Therapy and Audiology Head of Department (Appendix C)

- Initial e-mail contact with S-L Therapists (Appendix D)
- Provision of an information sheet (Appendix E)
- Signed consent by participating S-L Therapists (Appendix F)

3.6.2 Voluntary participation

Participation in the study was voluntary and was stated as such in the initial e-mail contact with S-L Therapists as well as in the information sheet and consent form. S-L Therapists who declined to participate were respected and were not contacted again in connection with the study.

3.6.3 Informed consent

Once a S-L Therapist had indicated her willingness to participate in the study, an interview time was negotiated during which the consent form was signed (Appendix E). Again the overall study purpose, main features of the design, possible risks and benefits of participation, demands on time, details about tape recording, and withdrawal procedure were explained. Consent to the agreement assumed the participant to be in agreement to participate fully in the interview process and gave me licence to interpret, analyse and use generated verbal and non-verbal data as I saw fit (Mason, 1996, p. 58). The agreement also highlighted the possibility of a second interview if needed.

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3.6.4 Anonymity and Confidentiality

Due to the relatively limited pool of S-L Therapists working in the Western Cape public health service[7], the names and other identifying information about the participating S-L Therapist were kept strictly secure and was not made available to any persons other than myself and my supervisor. Each S-L Therapist was allocated a number which appeared on all her transcripts and wave files, and the list of corresponding names and numbers was not located anywhere near the transcripts. Identifying information about the S-L Therapist has not been used in the final report and every effort has been made to select unidentifiable quotes that still support the thick description. Neither the department head nor colleagues of the participating S-L Therapists had access to the identities of those who were participating in the study, unless those who participated chose to make it known. As S-L Therapy departments in

[7] total anticipated number of public health service S-L Therapists meeting the criteria was 12

the Western Cape public service are small, all correspondence between myself and each S-L Therapist was via personal e-mail to increase anonymity. Confidentiality implies that information that the participant does not want disclosed is kept confidential, and had the participant made such a request, the information would not have been divulged or used for analysis even if the information was considered to be useful for the study.

3.6.5 Beneficence and non-maleficence

Beneficence implies that the risk of harm to a participant is minimal, all efforts are made to reduce risk, and "the potential benefits to and importance of the knowledge gained outweigh the risk of harm to them" (Kvale, 1996, p. 114). Both the consequences and anticipated benefits of participating in the study were contained in the consent form and were discussed with each participant. Non-maleficence is described as "not doing harm" (Green & Thorogood, 2005, p. 53), and was achieved by giving accurate and sufficient information about the study to each S-L Therapist, giving the S-L Therapist the opportunity to ask questions, assuring her of voluntary participation, and giving her information about her choice to withdraw at any time without needing to supply an explanation. Even though the topic of "the lived experience of being a S-L Therapist" was not considered to be particularly emotional, had the S-L Therapist felt the need for support after the interview, I would have referred her to a professional counsellor of her choice.

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3.6.6 Issues with interviewing colleagues

Prior to the commencement of the study I anticipated that I would be conducting interviews with both present work colleagues as well as with S-L Therapists from other hospitals that I know. Elimination of all the S-L Therapists I knew would have resulted in an inadequate sample size and would have compromised the feasibility of the study and so this was not done.

Advantages of interviewing a colleague include shared language, shared level of education and norms, and possibility of issues and ideas being more easily understood by a researcher who is involved in the culture of the participant (Holloway & Wheeler, 1996, p. 58). Disadvantages include the assumption of common values and beliefs between the researcher and interviewee, which may cause misunderstandings where thoughts that are uncovered during the interview process might not be questioned as they would have been if the interviewer and interviewee did not share a common work

"culture". In this study, I knew most S-L Therapists being interviewed as colleagues or acquaintances, which placed me in a position of equality with the S-L Therapists and made them neither distant nor anonymous (Platt, 1981). Although this may have encouraged the S-L Therapist to be more open in the interview, the danger of over-involvement and identification with the S-L Therapist existed. The following techniques were employed to minimise this risk:

- I offered to address the entire S-L Therapy department prior to participant selection and interviewing in order to openly discuss the study and possible difficulties with interviewing colleagues.
- I used my personal home e-mail address as the mode of all research-related communication as opposed to telephonic or face to face discussion. This was anticipated to achieve anonymity and confidentiality and create appropriate boundaries between myself and participating S-L Therapists in my workplace.
- I avoided discussion with present work colleagues (whether they were participating or not) about the specifics of the research, which was anticipated to encourage trust and privacy between myself and participating S-L Therapists, where they were assured that information was not being openly discussed and analysed with colleagues.
- The S-L Therapy participant was requested not to discuss the content of her interview with fellow colleagues.
- Interviews were conducted while I was on study leave to create distance during that research phase.
- Each interview began with me [the researcher] formally assuring the participant that I was conducting the study from the point of a researcher and not a SLT or colleague and that I would not be assuming or drawing on prior conversations we may have had. The information obtained during the interview was all I would use for the study.
- Continuous self-reflection and bracketing of presuppositions or attitudes with which I approached the participating S-L Therapist.
- Ongoing discussion with my supervisor regarding methodological issues.

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3.7 Rigour and Trustworthiness

3.7.1 Credibility

Credibility refers to the truthfulness, believability, and value of the researcher's findings in representing the "real world" as perceived by the participants (Maxwell & Satake, 2006, p. 270). One strategy includes accurately identifying and describing the study participants, the researcher and research process. To ensure that the findings were valid and believable, I described, declared and interpreted my own experience of being a S-L Therapist and clearly outlined my level of involvement in the study, i.e. that I conducted all interviews and transcribed them (Holloway & Wheeler, 1996, p. 164).

3.7.2 Applicability and Transferability

Applicability refers to the degree to which the findings can be applied to other contexts and settings or with other groups (Krefting, 1991). It is also described as the ability to generalise findings to the greater population. Krefting (1991) suggests that "the ability to generalise is not relevant in many qualitative research projects" (p. 216) as the aim is to discover a certain phenomenon within a specific context rather than generalise the results to the wider population. However if the researcher would like to make generalizations about the subject of the research, specific strategies to enhance transferability must be made. One such strategy is to increase the diversity of the informants.

From the outset, I stated my assumption that the findings would reflect the lived experience of the particular group of S-L Therapists interviewed and not the greater population of S-L Therapists. While findings may be helpful and interesting to similar groups of S-L Therapists in the public service, it was never assumed that their situation would be exactly the same as the one which was described in this study. Purposive sampling does not facilitate transferability as participants are selected based on their experience of the specific phenomenon being explored, however there was a range of diverse public service S-L Therapists in the sample with respect to age, experience level and area of practice.

3.7.3 Confirmability and the use of an audit trail

Confirmability implies that the final data which is presented is linked to its source and that findings come directly from the data (Holloway & Wheeler, 1996, p. 168). The establishment and presentation of an audit trail is regarded as one of the

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principal techniques for establishing the confirmability of qualitative findings (Lincoln & Guba, 1985, p. 318). This enables the reader to understand and evaluate how methodological, analytical and theoretical decisions were made. If carefully and critically presented, the reader will be able to ascertain whether the findings are "grounded in the data", "reach a judgement about whether inferences based on the data are logical, looking carefully at analytical techniques used, appropriateness of category labels, quality of interpretations", and "assist the auditor in making an assessment of the degree and incidence of inquirer bias" (Lincoln & Guba, 1985, p. 323). "Member checking" (where transcripts are returned to participants to read and comment on whether findings are true to their experience), is a suggested method to ensure confirmability in much research literature (Holloway & Wheeler, 1996, p. 168). Due to the collaborative and iterative nature of hermeneutic phenomenology, individual member checks were not carried out, and were replaced with individual follow-up conversations as described in 3.4.3.4.

3.8 Conclusion

This chapter has addressed issues of study design, sampling, data generation and analysis, ethics and rigour and trustworthiness. The methodological processes that were used have been described and form the basis on which the remaining chapters are set.

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CHAPTER FOUR
Analysis

4.1 Introduction

In this chapter I present the five themes that emerged from the analysis of the interview transcripts. I have included the most descriptive excerpts from participants' interviews as quotes which serve as exemplars of the participants' experience. Quotes which may have made it possible to identify a participant have been excluded and words which may identify the participant have been replaced by brackets e.g. [...]. In places the researcher has added words to clarify the text which have been placed in brackets e.g. [...].

Five main themes were generated namely: expectations of practice and practice realities; being part of the "underdog" profession; being connected; the holistic nature of the S-L Therapist's practice; and erosion or promotion. Themes and theme categories are presented below:

4.2 Theme One: Expectations of practice and practice realities

This theme deals with the S-L Therapist's initial expectations of practice being fairly idealistic, and how over time and with experience become more realistic. It gives insight into how she moves from being a novice therapist to a more experienced one realizing that she is not able to solve everyone's problems. The content describes how she learns that although there are times she can bring about significant change, situations exist where she is not able to help at all. The theme provides evidence of how the speed at which patients progress and recover is slower than what the S-L Therapist had initially anticipated, making it difficult or even impossible to predict whether recovery will take place at all. Underpinning the S-L Therapist's work is always the expectation from self and others to know more, learn more, do more and strive to achieve better results.

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4.2.1 Moving from idealism to realism

The S-L Therapist enters the treatment setting with the expectation that she will be able to make significant contributions to her patients and in some cases even "change the world" (P7). Her motivation is that "you *want* to help people" (P1) because "you concerned about their speech and language" (P1).

> ...I think, sort of wanting to be able to, to help people, um, you know an underlying desire to, to be able to try and make a difference somewhere ....you know we *want* to be able to, to help everyone make a big difference, make their lives better and, help them to cope at school and help them to, be a success in life, and make their social circumstances easier... (P2)

Working as an S-L Therapist is very different to her anticipations and she soon realises that, contrary to her expectations, she is not able to help every patient she sees. Furthermore, she feels "let down" (P3) that the public health system is not as organised and efficient as it was portrayed during her training, and struggles to gain the same level of control she had as a student therapist:

> ...I think in, in the beginning it's a bit harder 'cos you, you come in into the profession and it's very *different* to what you were prepared for as a student. As a student, I mean everything is like *in order* and you know it looks like there's this whole system in place to deal with people coming in with speech problems, with hearing problems and you know everything looks good on paper, but when you actually start, start working...it's a lot *messier* than what I think you expect and I think *that* is a bit of a, a *let down* in a way, um, and a bit frustrating... (P3).

Realising that some things are beyond her personal capacity to change, she becomes less idealistic and more realistic about what she can and cannot achieve. She begins to establish more realistic goals and expectations, adapting her therapy to her setting and patients. By being less idealistic about her work, her patients and therapeutic outcome, she experiences less anxiety about needing to 'fix' (P5) every patient's problem and feels released from feeling solely responsible for every patient's progress:

> ...I'm just more realistic in my *goals*, and my expectations, um, and I'm more realistic about the population I *work with*, um, what they *can*, what, what I can expect *them to want* to do...I mean you know when you're 20, you think you

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can change the world, now I know I can just change my *corner* of the world! so that's fine!... (P7)

Being free of idealistic expectations helps her to accept difficulties which arise and helps her to view them as being part of the job rather than crises to be managed. She expects obstacles but is able to focus on both positive and negative aspects instead of only negative ones:

> ...so that's just something that you accept that you're going to um, take on as a challenge, I mean those are things you just have to *work* with um, and if you're going in work in the public service you *know* you're going to struggle with posts, and with money, and with resources... (P6)

Although she is initially anxious about her professional competency, as she matures and gains professional experience, she settles as a therapist and becomes aware of her clinical strengths and weaknesses and becomes more realistic about what she is able to expect from her patients. Participant 6 describes her journey:

> ...you become more accepting of oneself and so I think it's the maturity too....I've *matured*, I *know* what I *know*, I don't touch what I *don't* know, and what I know, I know well and I know I make a difference, I'm not prepared to take on a patient if I can't fix them in inverted comma's...and I think it was kind of like a bit mushy with something and maybe *now* it's more, more [pause] what colour now – *yellow*... (P6)

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4.2.2 Not always being able to fix what's 'broken'

4.2.2.1 Helping to a point and then no further

> ...the *nature* of language disorders, *never, never fixed, seldom*, it's, it's a *life-long* disability... (P5).

She is seldom able to completely "fix" (P5) her patient's difficulty. Although she experiences successes in facilitating a better level of communicative functioning for some of her patients, she is only able to assist others up to a point. Communication disorders are seldom as clear cut as many medical conditions and she seldom experiences a definitive end to her intervention or a point where her patient shows a

complete recovery. This can leave her feeling that her work is unfinished, unresolved and incomplete.

The typical patient accessing public service healthcare is not able to access private services due to financial or other reasons. The social climate in which many of her patients live, and the negative social elements which are rife in their communities "perpetuate the current situation" (P5) and are barriers to progress:

> ...*sweet*, a *sweet flavour*, um, but sometimes the bitterness around the edge ja [yes] definitely, I guess that would kind of represent the aspects of society that are *beyond me* as an individual to affect any change in... (P5)

To counteract these limitations, she acknowledges the pressures her patients face and seeks to use her skills and knowledge to "help people [patients] to understand *how* they [social elements] are related to the language problem" (P5). Examining the environmental stressors at play in her patient's life assists her in understanding his or her difficulty more fully:

> ...um, but I think ultimately if things in their home situation or *community* situation are *affecting* the specific speech and language *difficulty*, one needs to address them otherwise dealing with the underlying speech and language disability can be a bit of a waste of time... (P2)

She focuses on "looking at what's most valuable that you *can* change" (P2), and acknowledges where S-L Therapy fits into the big picture which in some cases means terminating therapy and referring her patient to a more appropriate service:

> ...I know that, that often happens when you, you *counselling* and, but then it actually, it actually it goes *beyond* what you can do.....and then you, you actually have like to think, "you know what, you just listening, you actually not getting anything done", you're gonna need to kind of refer on... (P1)

When she is no longer able to help her patient there are different responses. On the one hand there is a sense that she has been honest with her patient and done everything she is able:

> ...I say I can't help you or this that and the other, I feel *absolutely fine with it*, I feel a *sadness that I can't*, but not that I haven't performed... (P6)

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On the other hand, there is a sense of disappointment that she cannot do more. She may even feel guilty that she has let her patient down as he or she has "come to you with all this *hope*" (P3).

In other cases where she experiences repeatedly unsuccessful attempts to help her patient, she may start to give up on the possibility of a positive outcome, may withdraw, or "become almost *accepting* of, 'well, ok, this is what's going to happen'" (P7)

She is significantly limited in providing therapy to a patient who speaks a language in which she cannot communicate. This is a barrier to her service provision and a denial of access to readily available services due to a lack of appropriately trained staff. Not being able to communicate with Xhosa-speaking patients means that she is "treating an exclusive *elite* group who can speak English or Afrikaans" (P2), and although she is usually able to conduct a cursory assessment, cannot perform formal assessments, obtain accurate results or provide adequate intervention beyond this point.

Most of her patients cannot attend as often as needed to due to the distance they have to travel to attend therapy. Consequently, she adapts her therapy plan to suit her patient's attendance capabilities by training a parent or family member to continue intervention at home, and planning therapy more effectively to reduce the pressure on her to achieve results from limited therapy attendance:

> ...in a different kind of setup you'd be getting therapy twice a week or once a week and things like that, whereas we need to really make a difference in our client's lives or in, in the *parents*, and we need to *empower* them, so I feel like um, I'm *enabling* people *more* than I would if I was just doing regular twice a week therapy... (P7)

4.2.2.2 Not being able to help at all

Working with patients living with serious or terminal medical conditions means that there are times when S-L Therapy is not indicated due to the disease progression. Managing a patient, giving bad news or a poor prognosis leaves her "lost for words" (P6). One participant related her experience of not being able to help, where all she could say to her patient was:

> ...I just feel so sad that I don't know what to say to you... (P6)

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> ...I mean if someone's *dying*, it's really *hard*, you can't *swallow*, you know I had a man the other day, wanting to know about why he couldn't, it was a tumour...I said 'I don't know if they can pass a tube, but if not it's surgical, but you know if you don't eat, this is what's going to happen. Sorry that I've got to be the bearer of bad news, it's all I can offer you...' (P6)

The same participant described how humbled and strengthened she is by the way her terminal patients often offer *her* comfort even when they are very ill or on hearing bad news about their condition:

> ...that's why I say *humbled*, but these are you know mentally fine, and they say 'you know it's ok (name)' [laughs] and I sit there crying [laughs] and they actually say 'it's ok'... (P6)

4.2.3 Slow and steady rather than rapid and immediate

> ...it's not the kind of work where you get a quick fix and like a sudden, very *warm* response and a, you know like a fire 'I'm cured', it's not like that at alll... (P4)

These words reflect the sometimes slow and steady rather than rapid and immediate nature of progress. The S-L Therapist makes large investments of time and emotional and mental energy into each patient's management and may work with a patient for a long time before seeing any improvement:

> ...it's a long *road* you walk with a patient as a Speech Therapist and you've got to put in a *lot* to get out not so much always, sometimes *nothing* up to a point and then finally you realise, 'yes, ok it was worth the, it was *worth* the effort eventually'... (P4)

Intervention is rarely once-off, and when she "takes on a speech patient, perhaps more so a, a *child*, you, you know they're going to be around for a good length of time, you're looking probably a year plus" (P2). It is difficult to make predictions about outcome and measure progress due to her intervention as opposed to spontaneous recovery as participant 6 describes:

> ...and even if you can't predict, you know strokes – I say, 'I don't *know* if it's ever going to come right, I don't think it'll *ever* be 100%, but I *do believe that together we can make some difference, together*... (P6)

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She feels a sense of success and accomplishment when her patient progresses quickly. In treating long-term rehabilitative patients who are not usually "imm*ediately* rewarding cases" (P2), she experiences less control over his or her progress and at times a reduced sense of accomplishment which can be frustrating. If a lack of progress continues for some time, she becomes demotivated and feels that her efforts are pointless:

> ...I can make an impact in a short period of time, so the therapy's been *intensive*, and you've seen a change and then they can go, whereas I think it must be, you know not, not helping, patients aren't coming, not ever fixing and the frustration of feeling a bit, *lost* and 'what am I *doing* here'... (P6)

In treating certain medically-based communication and feeding disorders, intervention may last a few years as different stages of her intervention depend on the patient's age as opposed to more acute difficulties which she can resolve relatively quickly:

> ...I enjoy having long term patients, I have a lot of, in fact all my [specific disorder] patients are long term, so, I see them for *years and years and years*... so, I'm not only about the here and now [laughs] I can do both [laughs]. And I enjoy that [long term cases] *too*, but I think I didn't enjoy doing only that [long term cases], I enjoy the fact that there are *short*, acute problems that can be sorted out... (P7)

4.2.4 The challenge to know more and do better

She is on a constant learning curve and is continually challenged to increase her theoretical knowledge and refine her clinical skills. She finds it daunting and uncomfortable when making management decisions about patients with complicated or unfamiliar diagnoses. In these cases, feeling out of her depth due to lack of knowledge frustrates her and so invigorates her to acquire new techniques to the point of clinical competency:

> ...I think you know there is a constant challenge of being on a learning curve, um, which at *times* can be very *frustrating* but at other times is rewarding...continuing to be increasing one's knowledge... (P2)

The novice therapist experiences a dichotomy of high expectations of what she wishes to achieve, and feelings of insecurity about her raw clinical abilities. She feels "a tremendous amount of *discomfort* and anxiety" (P6) when she is unsure of a case, and

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should her patient not improve as she anticipated he or she would, takes it personally considering critically what she could possibly have done wrong or differently:

> …as a younger, less experienced therapist you feel you know you *must* just make some more impact, 'what did you do *wrong*' whatever… (P4)

> …I think as a new therapist, I was always *very* insecure… I thought 'I know *nothing*', and 'how can I treat it', kind of 'what am I *doing* here, I don't *know* anything'… (P6)

The therapist in the tertiary hospital setting is rarely designated to one clinical area and so simultaneously manages patients with a variety of clinical disorders. This is taxing even for the experienced therapist as she has to "change gears" (P6) between disorder groups a number of times during one day, and she rarely feels that she has comfortably got to grips with one clinical area. For the novice therapist these pressures are added to the fast pace and pressure of the hospital setting which makes huge demands on her to perform equally well across all clinical areas and exhibit the same level of clinical competency as an experienced therapist:

> …I think it's just become more *pressurised*, you're expected to do it all, and it's kind of like mothers, you're expected to *do it all* and you're expected to *be good at it all* and I think it's really *hard*. I think it's hard, on any, *managers* are managing and treating, on *young therapists* still finding their feet… (P6)

She is called on to present cases during ward rounds and is put on the spot to explain her rationale, thus it is essential she has a clear understanding of her patient's disorder and rationale for her management choice. In her interactions with other professionals and patients, she is required to have the relevant knowledge and exhibit confidence when giving feedback:

> …if there's been a tension or I could see that they thought that we were talking *rubbish*, I think it's always just *prompted* me to *go away, get* to *really be smart* and come back with a smart answer to show him….and when I didn't quite know what was going on I've always been uncomfortable, so now if I don't know I make it my business so that if I say I can't help you or this that and the other, I feel *absolutely fine with it*… (P6)

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She is challenged daily to develop a fuller and deeper understanding of her patients' difficulties and is constantly involved in a process of evaluating and adjusting her intervention approach:

> ...one has to start off by peeling off the outside layer to find out what's going on inside, and just like one doesn't *know* necessarily from looking at the *outside* of an orange whether it's going to be sweet or sour...if it's going to be firm and juicy or squishy and mushy...some of the cases are perhaps more, *definitive* and easier to see in their individual segments where some of them are more complicated and different areas blurr into each other... (P2)

Throughout the therapy process, as one facet of her patient's disorder improves a new aspect may emerge and at times she may be temporarily flawed regarding her next step. This experience makes her cautious about the way she approaches the assessment and treatment of most communication disorders. How a disorder initially presents may be very different to how it later manifests.

Unlike more anatomically or physiologically-based disorders which typically have more predictable outcomes e.g. the repair of a cleft lip and palate or insertion of a gastrostomy tube for a feeding difficulty; the abstract nature of most language or cognitively-based communication disorders makes it difficult for her to measure the outcome of her intervention or predict how fast her patient will progress:

> ...you can fix the cleft, you help with the swallowing, some one has their tongue removed, it takes two weeks and if nothing happens, there's a PEG and you know like that, it's not these, these *hidden* cognitive things that take *long* and *do* you make a difference, and how do you measure it, and is it *spontaneous recovery*?... (P6)

This lack of predictability means that her intervention approach needs to be flexible, she needs to be open to "trying new, or alternative ways of establishing behaviour" (P5), and "looking at lots of different possibilities and ways of doing things" (P5). Her approach to clinical challenges needs to be pro-active and one of taking the initiative to ensure she reaches a solution. Understanding and viewing her work from a solid scientific basis and thinking about therapy analytically also assists her in solving clinical challenges:

> ...I like there to be a *problem* and I can fix it or I *can't*, or someone else can fix it... (P7)

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> …with manipulating people's behaviour one has to have a very sound understanding of people's *psychology* um, ja [yes], so what makes people tick… (P5)

She rarely treats the same group of disorders year after year, and over time moves through various clinical areas which enables her to fine-tune her skills, develop new skills and combat boredom. It is important for her to always feel like she is giving something to her patients and so as her enjoyment of a certain clinical area decreases, she moves into an area she anticipates will be more enjoyable and as her interests change, a change in focus is initiated:

> …then I started doing what I enjoyed doing and then I didn't *enjoy* it so much anymore so I moved on to something *else,* maybe that repeated a few, few times, so I think I've moved through *quite* a lot of areas in the, the years I've been here and that's been, it's, it's been nice not to have to do the same therapy over and over, to sort of select the areas that you like and get more experience in, maybe I'm just, I just got a bit *bored* with language therapy and ja [yes], 'cos it's not a field where there's so much, *change*, there's not much *new* really, and also I think when you reach that point you realise that it's time for a, a change, if you're *not*, if you don't feel like you're *giving*, the best you *could* then you must take a *break*, or do something else… (P4)

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When undertaking to set up a new S-L Therapy service in this setting, even though the infrastructure, equipment and personnel are "on tap" (P6) the task is time-consuming and getting the service to run independently takes time. She is wary to embark on new projects due to the investment of time required, especially as this is in addition to her existing caseload and already pressurised clinical schedule:

> …*new* areas come up that you start focussing on and things and it's, it's always such a *challenge* to get things, um, sorted… (P3)

Experienced therapists generally spend a great deal of time and energy training and helping novice therapists. This leaves her with little time to develop her own clinical skills, and even with her years of experience she too desires to be mentored. However, in this setting few mentorship options are available to her:

> …uh, even way back then, you had the *support* of your colleagues…so I'm now *tired* of *learning* on my own, I would love to be mentored, I would love

> to have someone I could chat with, I think I really enjoy it, like with (name), that's why I *love* chatting to her, it's someone who knows more than me in something, so *that's* what I miss, I miss some brain power…I kind of, I miss looking up to someone, someone who's smart, someone who can *share*… (P6)

With a lack of mentorship available to more experienced therapists, they spend enormous amounts of time learning through reading textbooks as opposed to having it demonstrated:

> …but a lot of it is that I had to do *hard work*, a lot of the things I've learnt, I learned by myself…and maybe that's also been, it's been *frustrating*, as I said we've had no one to look up to and *I'm tired* of doing it all on my own. But by doing it on your own you also get a, a, an edge that others *don't* have. That haven't 'sukkeled' [struggled] through it…I mean *no-one* goes and reads a book cover to cover now-a-days…but I had two books, I think I read *every single line* in it. I might not have remembered it, but I know what *every chapter in every book about to cover* and I think that's because there was *nothing...and yes* it's *tiring* and you do miss things that you would like to have taught to you, kind of take the short cut, and then develop… (P6)

4.3 Theme Two: Being part of the "underdog" profession: role definition and status

This theme deals with the significant ignorance and misperception which surrounds the profession of S-L Therapy. It describes possible reasons for this misperception which include S-L Therapy services being absent in locations where they are needed, and the fact that communication disorders lack a concrete and tangible nature by which they would possibly be better understood. Patients are presented as misunderstood individuals by the mere fact that they are subject to misunderstood pathologies. The theme highlights the existing ignorance and misperception that surrounds the public service S-L Therapist's physical workplace and also describes how she perceives herself to be unimportant and to play a trivial professional role in her setting. It lastly deals with the challenges of addressing the existing ignorance and misperceptions.

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4.3.1 Ignorance and misperception about Speech-Language Therapy roles and function

One of her greatest frustrations is the misperception that the public and fellow health professionals have about what her job involves and what she does on a daily basis. Participants made mention of the fact that existing perceptions about the profession are incorrect and mostly highly simplistic. These misperceptions make her feel underestimated and underrated as a professional as she knows and understands her work to be far more complex and intricate than commonly understood:

> ...ja, [yes] there's always the perception that you, you work mostly with children, that you work in a school...that you work with stutterers...uh, what else, ja [yes], I find people don't *ask* - how can I say it? I wouldn't say they not *interested*, but it's, it's almost like its something they know too little about to actually *engage* in conversation with you about the topic maybe... (P4)
>
> "...but I think from *my* experience people generally look at Speech Therapy and say "oh you treat people who *stutter* and have phonology problems", they're not *aware* of the *diverse range* in age groups that we, see, I mean the diverse range of disorders and age groups, and um, ja [yes] types of things that we deal with..." (P2)
>
> "...ja [yes], perhaps that's a part of the profession that people are not – they think if you're doing *speech* it's about *speech production!*, it's not about language and cognitive and interaction..." (P4)

Comments such as "oh you teach *elocution,* and people to speak *well*" (P4) highlight how her profession's name contributes to the misperception surrounding it and that having the title of 'Speech Therapist' is unclear and misleading. The title 'Speech Therapist' makes her feel misnamed and even *under*named as it is limited to speech, neglects language and makes no reference to the relationship between speech, language, cognition and learning:

> ...you know especially the term "speech therapist", I mean, I think a lot of us refer to ourselves as speech and *language* therapists, which gives a *better* overview if what we do... (P2)

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"If *only* you knew what I *really do"* (P3) was a strongly expressed feeling. "N*obody* asks the Physio [physiotherapist], 'Oh so what, what *is it* that you do?', but when people hear that you're a Speech Therapist, they go 'So what *is it* that you do?' or 'So what's that about?" (P3). She is frustrated by constantly needing to explain and defend what it is she does and the fact that the level of acknowledgement and respect she receives as a professional is directly related to how well-known her profession is to the public, disheartens her:

> ...you know you *always* having to, explain it or *justify* it and *defend* it and things like that, which, which is a bit *hard*, you know you just wish like that it can be out there and *known* and *respected* and things can just work... (P3)

> "...if you say "Physiotherapist" people have a better, just a better idea of what you, what you do...you know people with a little *backache* or this or that, they all know 'Ah, we can go to a Physio [physiotherapist]' or 'I fell and I need a little bit of Physio [physiotherapist]' stuff like that, but *somehow* people just *don't know* so much about Speech Therapy... (P3)

Misperceptions about what she does exist even amongst medical personnel and other health and rehabilitation professionals, which impacts on referrals to S-L Therapy. The need for an S-L Therapy referral may not be recognised or a patient may be inappropriately referred:

> ...I think there's a a certain amount of *frustration* because I think the general lack of *knowledge* of Speech Therapy as a *profession* in a community and especially at, you know at a community *health* level, nurses and doctors and other *professionals* I think are often *not* fully aware of what our role is - what we do – who we see, um why we see them – what we can offer, you know all those types of things... so there just isn't a lot of *knowledge* about Speech Therapy... (P2)

> ... I think because people don't *know* of what Speech Therapists *can do,* um, they don't use us *enough* and so therefore what we *do* um, is very much *isolated unless* we make the attempt to, to reach out to other professions... (P5)

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Her interactions with community-level health professionals such as doctors, clinic sisters and social workers also reveal a lack of knowledge about what she is able to offer patients as participant 2 describes:

> … I think there's a a certain amount of *frustration* because I think the general lack of *knowledge* of Speech Therapy as a *profession* in a community and especially at, you know at a community *health* level, nurses and doctors and other *professionals* I think are often *not* fully aware of what our role is - what we do – who we see - why we see them – what we can offer, you know all those types of things….so I think there just isn't a lot of *knowledge* about Speech Therapy… (P2)

She attributes most misperceptions about the profession to the difficulty she has in defining her role and putting it into words. She doesn't enjoy trying to explain what she does to other people and when she does, she uses examples of the types of patients she sees in an attempt to make it easier for them to understand. Dual S-L Therapy and Audiology qualified therapists usually focus more on the Audiology aspect of their work as hearing difficulties are easier to explain and are better understood by lay people:

> …and sometimes I'll *decide* on what I'll be, depending on the company I'm in – am I an Audiologist tonight or am I a Speech Therapist!" what, what, what'll be *easier* for these people to, to *explain* this to you know…when it comes to hearing I think it's easier, everyone knows about hearing aids… (P4)

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Her role is also not well understood by education professionals and as there are currently no government S-L Therapy posts in mainstream education, she has few opportunities to train mainstream educators about language and associated difficulties from her perspective.

4.3.2 Not reaching those who require the services

Unlike Physiotherapy, Occupational Therapy and Social Work, S-L Therapy services are significantly under represented at community health level, secondary hospital level and in mainstream education. Due to this, patients have no choice but to access S-L Therapy services at a tertiary level even if it is geographically and logistically very difficult to do so:

> ...often clients can receive the medical help they need at a community level, but not the rehab at a community level... (P2)

While some S-L Therapy services require the medical support which the tertiary level hospital offers, a large proportion of the services she offers to both adults and children are not suited to this setting, and would be far more effective if offered at a community level or in mainstream classrooms:

> ...*my particular* area of *expertise* is not suited to that type of environment [tertiary hospital], and ideally would be perhaps more effective if I was in the *community*... (P5)

> ...and I think that's, that's an area of, where our profession *really* needs to be to be *working* at is at a level of, um...*communities*, but also educators, doctors... (P2)

She is concerned that the failure to recognise the role S-L Therapists can play in mainstream education means that many children who could benefit, will continue to fail in the school system:

> ...the *main one* being that there, the need for posts, in, uh, in the school environment is not well recognised at the moment... (P5)

> ...but I think with the lack of resources especially from my side in *education*, a lot of these kids are going to sit failing in the school system... (P2)

She is usually the first health professional the patient sees after being identified by the community health clinic sister or classroom educator. She feels pressured to make management decisions without the support of a medical diagnosis or developmental assessment which can make her feel isolated and helpless to intervene most effectively as participant 1 relates:

> ...you know because often the clinics they say the child can't *speak* and they send, uh, send them to you, so you kind of like the *first person*, before they go to see the *doctor*, the first, before they see the *OT* [occupational therapist] and things... (P1)

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Complementary rehabilitation services such as Physiotherapy, Occupational Therapy and Social Work services are available at community level and so are not offered routinely at tertiary level. With no available community-based S-L Therapy services she is not able to re-direct the patient back into the community for multiple interventions that will include S-L Therapy. With no choice but to offer S-L Therapy intervention at tertiary level, she becomes increasingly overcommitted. Community-based S-L Therapy services would provide patients with a more holistic service and allow her more time to offer tertiary-level S-L Therapy services to those requiring them:

> ...I think then one would also then be able to take a bit more of a *holistic* approach, um, you know given the support from other professionals whereas often you are treating a child as an island and you *can't* provide them with everything they need and Speech Therapy is often not *enough*, um, whereas if they had sort of *academic* support or support from Occupational Therapy, Social Workers, um, you know that were easier to *access*, I think a lot of the clients would be able to benefit a lot *more* our services... (P2)

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As the complementary services are offered primarily in the community and not at tertiary level, seeing a patient for S-L Therapy intervention at tertiary level means that she intervenes often in areas outside of her skill set. This impacts on the potential to achieve the optimal outcome for the patient, as the services of other health and rehabilitation professionals need to be offered in conjunction with those of S-L Therapy:

> .... I think one's got to be *careful* not to cross boundaries over to what we can and *should* be doing and what can't and *shouldn't* be doing and finding that boundary is sometimes be quite *difficult* especially *without*, and I mentioned before *without* the referral pathways and people to refer them *to*... (P2)

It is difficult to manage the number of patients needing "run-of-the-mill" (P5) S-L Therapy services. She works in isolation, feels overwhelmed by the magnitude of the task she faces and becomes disillusioned and experiences feelings of hopelessness regarding her effectiveness as a service provider:

> ...and I think you know with the number of professionals in the public service compared to the *size* of the community and the and, ja [yes] the vast *areas* which one *covers* and whatever, it almost feels like it's almost an impossible task... (P2)

> ....one wonders 'what for' um, particularly when if you're *working* in *isolation* um, and it becomes a catch 22 *situation* 'cos you've got to get the work *done*, and yet *making connections* and *networking* is *enormously time consuming* and obviously in a facility like this, one isn't in the *community* so geographical distance is also a part of that... (P5)

4.3.3 The invisibility of communication disorders

Due to the abstract nature of language and communication, in many cases her patient does not even appear to have a difficulty, and "*because* these difficulties are *not* visible, they're *not* well *understood*" (P2):

> ...speech and communication disorders are not as concrete or as *visible* as more *physical* disorders, as treated by a Physio [physiotherapist] or an Occupational Therapist, um, you know if someone's got a, had a stroke and one side of their body is weak, you can automatically see it, um, whereas speech and language is, not as *visible*... (P2).

Her experience is that the more visible a communication difficulty is, the more it is prioritised, and so patients with more "invisible" difficulties are generally viewed as less of a priority:

> ...it relates to the *visibility* of a disorder – so a disorder like perhaps like *fluency*, is more *visible* than a learning disability or, um, sort of a *language* problem, you can't pi, pick it out as such, whereas something like *stuttering* can be observed and heard by the listener um, so it's more a *visible* or overt disorder and more like to be picked up, whereas a lot of the *underlying difficulties* perhaps aren't as easy to detect, um, in a once-off observation or once-off interaction... (P2)

A patient is more likely to seek her help for a problem that is negatively impacting his or her occupation or quality of life as with adult stroke survivors who generally value walking over communicative competency:

> ...the limited amount of work that I've done with the elderly who have *lost* their ability to *communicate* as well as they used to, um, for many of *them*, *it is* about getting back to *walking* um, the types of skills that, um, that Physio's [physiotherapists] and OT's [occupational therapists] would deal with sometimes much *more* than communication... (P5)

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For many of her paediatric patients with less visible or overt learning difficulties, she notices a pattern of them attending "a short period of speech therapy, defaulting, and then returning some time later" when it becomes concrete or starts affecting his or her academic performance. As parents tend to prioritise and address the difficulty once it becomes visible, the child is usually older on entering therapy which significantly reduces her effectiveness in offering intervention:

> ...I think also one of the other problems is, um, the late referrals we often get, you know clients don't, aren't always picked up early as kids perhaps in early intervention or, you know even other cases where it waits until the problem has become so *severe* that they *have to* kind of get help especially with the school kids, a lot of them have perhaps even *had* previous therapy when they were *younger* um, couldn't maintain it and have come back when the child's failing or just not succeeding at school and often then its kind of too *late* to give the best intervention possible [sighs]... (P2)

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4.3.4 The misunderstood patient

Not only is her profession and the disorders she treats misunderstood, but so are the patients she treats:

> ...people with communication *difficulties* as I prefer to call them *whatever they are*, *whatever* their nature, is that *because* these difficulties are *not* visible, they're *not* well *understood* um, *people*, the *public* think that people who can't communicate properly are *stupid* are *worthless* are um, they become the butt-end of *jokes*... (P5)

> ...I think often the kid especially with learning disabilities are just considered as being *stupid* or *dumb*... (P2)

She experiences "the *lay person's attitude to* people with communication problems as one of, of, of *ridicule*" (P5), and has on more than one occasion been "a recipient of the casualties of the lay person's attitude and actions towards them" (P5). In her interactions with her patient, and his or her family or educator, she is frequently alone in her understanding of the underlying difficulty as "things which may have certain meanings or interpretations for *us* [S-L Therapists] may be interpreted and seen differently in a different sort of culture or environment" (P2).

4.3.5 The existing ignorance and misperception about where the Speech-Language Therapist works

The public have numerous misperceptions regarding state hospitals. She experiences her work environment as "nurturing" (P6), a unique "community" (P3) and almost "like home" (P6) which is contrary to the way lay people seem to view it:

> …ja [yes], I think they, people just don't have any idea of this *context* even that you're working in or you know it, it, I think this *hospital*, it's like a little *world* on it's own, sort of a *community* in a way and ja [yes], if you haven't *been* here you don't quite… (P4)

Her experience of feeling secure and being "nurtured" (P6) by her environment makes the tension between her experience and the public's misperceptions difficult to reconcile:

> …people just come in here, they see the, the *dirt* the everything peeling off the walls, the whatever!.. the first impression's here are not very positive I think for many people ja [yes]……ja [yes], but it's a home away from *home* sometimes in a way [laughs] now…. I think it's, it's, if you've been here a *long time*, one, you, you *know* how things work here, so I think that's just a negative perception we really have… (P4)

4.3.6 Feeling unimportant and trivial

"I do think we get *side-lined* quite a lot" (P7) is a common experience participants described. Although the multidisciplinary team approach is a principle to which health professionals subscribe, she does not consistently feel recognised as an equal member of the team:

> …there's still a lot of, um, *ignorance* about, even in the medical profession, and *that* makes it also very hard, I mean sometimes I think that it would actually have been so much easier to have been a Physio [physiotherapist] or an OT [occupational therapist]… (P3)

She feels stupid and that her intervention techniques are not academic enough when receiving comments from medical doctors that belittle her therapy:

> …you know you do *swallow* assessments *all the time*, and they [doctors] start *mocking* you because you walk around with the yoghurt! They say 'I've seen

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> you this whole day, and every time I see you you're walking around with the yogurt' and *that* like, you know, and then you think is *that* the impression that our profession leaves in their mind, and in *that way* it can also sometimes be a bit, um, sort of *draining* because there I think sometimes it doesn't get the respect you want it to get and *that* is also something I'm, I'm um, ja [yes] that's a bit hard... (P3)

4.3.7 Challenging ignorance and misperception

Raising awareness about the profession is a time-consuming activity requiring a large amount of after hours work. One participant explained how even though she would like to do more, with her family commitments and after a full and taxing day of therapy she has little time and energy to be involved in large-scale after-hours commitments:

> ...I mean it requires a lot of *effort over and above* ones regular *job description*, I think um the, *nature* of the work in the public service is *quite taxing* and time consuming as I say so maybe people, *don't* have the *energy or motivation*, um to work outside of those hours...it's largely a woman's profession, and so, people who *might* be taking a leadership role *like that* would have *families* um, ja [yes], so split loyalties I think and not enough *time*... (P5)

She is overwhelmed by the amount of advocacy that needs to be done and the existing barriers which need to be overcome:

> "...one does want to create awareness and one *does* want to promote the profession, but I think at *times* one gets into a, kind of a *despondency* as to the *amount* of work which is needed to be done, and an *the lack* of personnel and the of lack *resources* to do that work. I think there's definitely an *awareness* that the profession needs to be promoted and *acknowledged* as a profession, um, but I think at times one can become so bogged down with the, sort of nitty gritty of what you're *doing*, um, and the *amount* of work sort of needed *out* there just gets too huge to consider how, *how* one goes about doing it..." (P5)

In terms of professional advocacy, participants described the profession as being "historically inert", and people involved in the profession being "generally silent" (P5) and "complacent" (P7), and as one participant described, "we like to *moan a lot* but we don't like to *do a lot...*" (P7). Despite the profession having the lowest ratio of health therapists

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to the population, and public ignorance of the profession, "there are few active people who *are* involved in promotion of the profession and public *relations*" (P5). The "silence" (P5) of S-L Therapists "is a *contradiction*" as the profession is "one of *communication* and yet professionals communicate very *poorly* or *inadequately*" (P5):

> ...You know, if you're *not happy* about the post situation then write letters to the *Minister of Health*, don't sit in your office drinking tea and *moan* about it, if, you know, oh, your patients don't come, if you're not busy 'cos people don't know what you do, well we're busy, but if you're not busy 'cos you don't, well who's fault is that, then *go* and do education, *go* and speak to doctors, go and find where you can do outreach and who you can train... (P7)

For the therapist who is motivated to change the status quo and who recognises that her role is under threat if she does not express her unhappiness at the current situation, the small efforts she does make to communicate her role to others are positively received:

> ... so if one's working with children, starting to make contact with teachers, is kind of a start in the right direction, and when one starts to *do* a bit of awareness, whether it be in a school or with a doctor in a certain clinic or whatever, one *does* tend to see how *they* try and hear what we're saying and, and in *their* small environment there is a greater awareness of the profession, so they more likely to perhaps refer children or um, ja [yes], within their environment spread sort of what we do so I think that is a small step... (P2)

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4.4 Theme three: Being connected

This theme deals with the broad range of relationships the S-L Therapist engages in. It describes the intricate collaboration the S-L Therapist has with her patients and their families and what she perceives her role in these relationships to be. It describes the connection she has with members of the healthcare team and how these relationships function in her setting. The S-L Therapist's relationship with her fellow S-L Therapists is portrayed in depth as well as the mentoring relationships she engages in. Lastly, the theme addresses and describes some of the poor collaborative relationships she experiences and how those affect her and her work.

4.4.1 Collaborating with patients and families

Intervention as a collaborative process between herself and her patient and his or her family. Therapy involves "a *tremendous* amount of give and take" (P5) where she and her patient are continuously interacting with each other and requires that she is "really getting to know them beyond the *superficial* level, to just go a bit deeper" (P4). She initiates this reciprocal partnership on initial contact with her patient and his or her family by describing the therapeutic process as an active two-way partnership, and clearly outlining her expectations of them. She does not accept mere therapy attendance as sufficient to bring about improvement in communicative function, and requires total commitment to the process:

> ...with Speech Therapy, it's not, a hour *a day*, is *not* going to do it, I mean an hour *a month* is not going to do anything...they actually need to try to fit Speech Therapy *into* the daily routine. It doesn't have to be um, a *isolated* thing of "they bring their child to Speech Therapy... (P1)

She places her patient and his or her family at the centre of the process, giving them permission to state their priorities and expectations of therapy. In order to build an effective partnership, she attempts to meet their immediate needs first and allow them to feel heard before moving ahead with her own agenda:

> ...maybe they're concerned about schooling....you just have to kind of see, *go with* what, kind of get those needs *first*... (P1)

She recognises her patient and his or her family as incredibly important and useful resources for change and not as passive recipients of her services. By "*appealing* to the *parent's own sense of worth* and in their abilities" (P5), she explores different options to solve the child's difficulty. She strategically looks to what her patient and his or her family are able to contribute to the process. Many times a patient presents to her having "got very stuck into a rut of doing things and thinking *about* things" (P5) and require her to mobilise and empower them "to make changes for *themselves*" as participant 6 explains:

> ...by simply *suggesting* changes um, it's not going to work, you can't really *only encourage* people to do x, y and z, it is *not going to work* until you've *shown them*, until you've *got them in there* and they got their hands dirty with you in *doing the job*...

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She aims to help her patient and his or her family see where they are being successful which helps them to come to an "*acknowledgment, acceptance* and *nurturance of* the *person* with the disorder" (P2). She helps them to start expecting success rather than failure which minimises the amount of attention they give to what he or she is unable to do. In this way, her primary focus is not only to carry out specific clinical activities, but to facilitate a process that leads to change:

> …not always *about* "fixing" a problem, it's about the steps, each step on the way is a challenge and reward… (P2)

She regards her role of educating and providing information to her patient and his or her family as a vital one. Empowering her patient and his or her family to meaningfully understand the communication difficulty and what is required to change it enables them to contribute as active participants in the therapy process. She faces the challenge of "trying to put things as simply as possible, so that they do understand, and translating jargon or technological language to simple lay terms" (P2):

> …the way that you counsel or educate, I actually *do feel determines* whether they're going to come back or not, I think that's *your one shot*, at, at making an impression with a patient… (P6)

> …if they've come for *stuttering* and that's the main reason unless one can get them to see, *see* the difficulty and *why* we're doing what we're *doing* it's not going to be meaningful for them… (P2)

A primary responsibility is informing her patient and his or her family what she is *able* to do as well as what she is *not* able to do to help. Her own discomfort may tempt her to "soften the blow" (P6) by not being completely clear about what she is, and is not able to offer them, but resists making idle promises about recovery and rather uses honesty to gain their trust:

> …the trick is 'it's this, this, this, this' and 'I can do this, this and this and I can't do that' 'cos I think that's when it will instil confidence... (P6)

She invites all involved parties to contribute to discussions around management as "it's not a case of *telling* them what to do, it's a case of advising them on what we think would work, and asking them *what they* think and then drawing up a plan *together*" (P7). She does

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not force her patient or family into making a decision and respects their need for time to consider the options and ask for further information:

> ...I won't ignore the parent's opinion or feelings or whatever...if we feel there's a problem and they don't, then we won't push them for therapy, we will say well come back in 3 months or come back in 6 months when they're ready to address it if we've given them a diagnosis like *autism or global delay* and they're not ready to accept that then, um, we give them information and we give them the opportunity to repeatedly come for counselling... (P7)

One participant described how, when discussing invasive procedures or severe diagnoses with parents of her patients, she is deeply respectful of their feelings and emotions and does not ignore or minimise the emotional consequences attached to the issues under discussion:

> ...it's not something that we can just *prescribe*, because it's a very *invasive* procedure for a parent to accept and there are all the *emotional* issues attached to not being able to feed your child anymore and have they failed because of something they didn't do and that kind of thing...(P7)

Her patient and his or her family lead the therapy process and her aim is that by working collaboratively with them, they will ultimately be able to continue the process at home and in the school environment.

She works predominately with parents of children for whom S-L Therapy is not a "*top priority* considering their circumstances" (P2). Although she knows how much some of her patients urgently need S-L Therapy intervention, she is not ignorant about the daily struggles her patients experience, and being more realistic about the population she works with helps her to adjust her expectations of her patients and reduce her frustration:

> ...if you can't put food on the table, do you care if your child can say /s/? so I think I've had a priority shift... (P7)

A parent's understanding and appreciation of the value of S-L Therapy affects his or her expectation of what it can offer the child. Parents expect the S-L Therapy to provide a "quick fix" (P2) during the initial consultation, or without needing to attend weekly therapy sessions and participate in therapy. She is frustrated by the parents' perceptions

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that a communication difficulty can be treated in a similar manner to an acute medical condition, when communication difficulties are complex, as is her role in treating them. This is illustrated in her experiences of parents of her patients being physically present in therapy, but not cognitively understanding or grasping the goals:

> …when you try to introduce a *different pattern* and it just like goes completely over, over people's heads, it's just, just doesn't, you don't get *through* to some people…and especially with children…sometimes you have parents who are *with* you, but maybe not *understanding* everything… (P4)

> …*obviously* there are people, or are parents who *don't want to* take that responsibility and there is the perception that the therapist will fix all, will be able to, you know do some [pause] *wonder cure!* in a *limited* amount of time, and that, ja [yes], that makes for enormous problems for *me,* for all of us I think.. (P5)

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She feels frustrated when a patient or his or her family "*don't* perhaps *allow* themselves to understand fully *or,* don't take the responsibility that they *could*" (P5).

4.4.2 Collaborating with the healthcare team and fellow Speech-Language Therapists

"…treating a child as an island means you *can't* provide everything they need" (P2) and a reality she faces is that often Speech Therapy is not enough:

> …you actually have to see that this *is* actually where Speech Therapy fits in, in the bigger picture…and if the child needs medical attention, they need *that,* they need OT [occupational therapy], they need to go to *dentist,* type of thing… (P1)

Being a member of a multidisciplinary health team helps her offer more effective and holistic patient management and teaches her to depend on fellow team members:

> ...also *seeing* that you can't just do things by yourself, you know the *team work,* working with *other people,* you know it's all very important, so that's like why personally I've grown, definitely… (P1)

Her role is complemented by other members who bring their specific skills to the team,

reinforce her decisions and give advice and assistance. This reduces the pressure and expectation she feels to meet all her patient's needs, as participant 7 describes:

> ...when we run multidisciplinary clinics we provide a much *better* service for a patient because it's *one-stop-shop*, it's less time for them, it's less schlepping [walking] around less waiting, less stress...everyone's in one *place*, so that we work together at the same time with the parent and the child and we *can* give them feedback together and we have *one* plan...which is just a more *efficient* way of doing things... (P7)

Working together makes it possible to accomplish more in less time. Fellow team members are willing to collaborate with her making the task more enjoyable:

> ...as professionals *everyone's* interested and wants to participate, so it's not like there's a professional, an individual who doesn't want to *collaborate*... (P7)

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As well as good mentorship opportunities, she experiences support from fellow therapists and other healthcare staff. Fellow S-L Therapy colleagues offer backup, and as a departmental team member she has a sense of community in a setting where discussion and support is readily available. Opportunities to discuss difficult patients and brainstorm therapy ideas with colleagues prevent her from feeling isolated and "completely stranded" (P1):

> ...Ja [yes], I think *that's* where there's lots of *support*, I mean I'm not the *only* Speech Therapist here, I think maybe *then* it would be difficult, so, I mean there's 4 others *so* you can always *ask* somebody if you don't, if you're not sure of things, so there's always that *support*, um, and that's important, um so there, ja [yes], so if you have difficulties, there's always that support that you can go to, it's not like you're completely stranded... (P1)

> ...if you've got someone to go and *talk* to about that, that child afterwards or, makes a huge difference and ja [yes], perhaps that's also one of the *benefits* here, you can always go and discuss it with whoever... (P4)

Having a supportive team to call on also increases her sense of accomplishment:

> ...you could go to a doctor, he was on tap, you had the equipment on tap and it was hard enough setting it up, but you had all the *resources*. In private I

> think it's harder 'cos then you'd have to *sell* yourself, you don't have it within your environment... (P6)

4.4.3 Being mentored

The tertiary hospital provides ample opportunity for inexperienced therapist to learn from and assist more experienced therapists. Having a platform from which to learn from others encourages her to remain in this setting for as long as she is still gaining new knowledge and expertise:

> ...it's a nice place to get *experience* and get like a *wide variety* of you know *professional knowledge* and you know they've got the best of equipment and this and that, if you come in for a *short period* you know it could be the best place, and you could leave with the best of... (P3)

> ...I *was* influenced as I said before by (name) and I would accompany her, so, we *had* a lot of [disorder], like we still do, so it was an area we had to learn in, plus I would help her, and then uh, I was terrified of [disorder], but uh, I had to step in and do it... (P6)

4.4.4 Experiencing poor collaborative partnerships

Participants described a noticeable tension between public and privately employed S-L Therapists. She receives negative comments from privately employed S-L Therapists about working in the public service and is questioned about having more ambition for her career. Even though her decision to work in the pubic service is one of choice, such comments make her feel inferior to a privately employed S-L Therapist as participant 4 relates:

> ...we do get quite a lot of negative comments, it's, it's, especially (name) and I who've been here for many years, um, you go to any gathering of therapists and they say "oh, you're *still* at (name) - shame!" and it's kind of like "can't you do anything *better* for yourselves, that you, you're still *landed* here". I think that the perception is that you *start off* in the public sector when you don't know very much to, to *learn* and, which is true to a certain extent, it *is* a very good place to start but, um, it's almost the perception that perhaps you *graduate* to private practice!... (P4)

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On the whole, she experiences a lack of knowledge and resource sharing from privately employed S-L Therapists and is seldom freely offered help and assistance:

> ...I don't feel that anyone tries to help anyone else really, I think it's all get as much as you can and keep it to yourself... (P7)

Her partnership with school educators is not always a collaborative one and although there seems to have been a recent positive shift in educator interest and in their willingness to assist children with communication difficulties, she feels that the historical lack of collaboration between the Western Cape Department of Education and the Western Cape Department of Health still exists:

> ... all these many years *later* after what, 25 years close that I've been working um, *is* the *tension* between *public health* and *public education* facilities for school-age children um, historically there have been, you know sort of different fields or *guarded* um, uh, fields, and *both* guarded quite jealously or indeed *misunderstood* and I think the liaison um, between health and education in this *particular area* is, is very poor and makes for a lot of difficulties for working in that situation... (P5)

This lack of collaboration makes "effective management of these clients very difficult" (P5) and creates a barrier for the development and maintenance of good working relationships between professionals from each department.

4.5 Theme Four: The holistic nature of the Speech-Language Therapist's practice

This theme encompasses the elements of the S-L Therapist's work that are not easily seen or concretely visible. It describes from the S-L Therapist's point of view, what intervention is and what it provides her patient with, and explains where S-L Therapy intervention fits into the larger picture of the patient's overall medical management. The S-L Therapist's realization of not being able to solve everyone's problems is described in this theme where intervention is presented as "just being there". It addresses the personal investments the S-L Therapist makes into the lives of her patients and their families, how this comes about and what exactly these investments entail. Lastly, it describes the S-L Therapist's experience of "bouncing back" after having invested so

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extensively into her patients. Ways in which she does this are presented as well as her coping strategies described.

4.5.1 Focussing on more than the presenting problem

The therapist is more than a clinician employed to remediate the communication difficulty. She is a committed friend and support to her patient and his or her family and constantly operates from a place of "enormous empathy" (P5). Aware of the impact she can have on her patient means that she uses her influence and power delicately. She values the relational aspect of her work and endeavours to be the friend as well as the therapist as participants 5 and 6 explain:

> ...I think the *obvious* ones are that one needs to have an enormous amount of *patience*...*along* with that *perseverance*...*And* another quality would be an enormous degree of *empathy*... (P5)

> ...it's like a doctor, I might go to a doctor who's *brilliant*, but if *I can't ask him to* explain to me and tell me, or I know that I could phone him if I was in trouble, screw him! I'll find someone who's just not quite as good, but that I know I can phone......so if *I like that*, then that's what I *give*... (P6)

The therapy process involves much more than direct therapeutic intervention and in order to better understand the needs of her patient, she needs to consciously engage with him or her:

> ...but it's also about *hearing them*, it's about *having the humility* to *hear them without* judging them... (P6)

Although the presence of a communication difficulty is what brings the patient to her, her primary focus is on the 'person' and her role requires that she consciously address his or her salient needs with the same amount of respect and rapidity as she does his or her communication difficulty:

> ...it *feels* like you're giving more than just that [therapy]... but you end up having to, to just make, *make* their lives neat and tidy from *other* aspects so you can actually – you know, if all that is in a mess then somehow the therapy is not, *they can't* focus on therapy because they too stressed about blah blah blah and something else, so it's almost like you *have to* focus on all

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> the little bits and pieces as part of like a like a holistic sort of management that you're doing… (P3)

4.5.2 Providing a tool for life

She understands how speech and language are used to carry out daily interactions between her patient and his or her significant others and community and the severely limiting impact of the communication difficulty on her patient's ability to interact effectively with his or her world:

> …speech and language is a part of *interaction* which is a part of the child's *family*, which is a part of their *society*… (P5)

She places high value on the way her patient uses speech and language functions to gain communicative power, and not by the way they are defined by individual grammatical structures. Her aim is to assist her patient to use language as a tool for everyday life and to facilitate successful social integration:

> …I mean I think one of the most *important* things is not only focussing on sort of *specific* language things but looking at more lifestyle communication and *pragmatic* skills which are going to help them later on in life as opposed to being able to say something that's syntactically correct! or whatever, and you know it might be *more* of a priority to deal with, get them *coping* at a certain level which is functionally going to be useful for them as opposed to what would be perhaps *ideal*… (P2)

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She experiences a sense of having made a lasting investment into her patient's life by helping the patient use language and communication to achieve his or her goals and create a better life:

> …perhaps what one can achieve in a *few* sessions around social communication skills and help a child or support an adult as well a lot more than spending 4 sessions of drilling work and then they leave and don't come back and they haven't gained anything in the *long run*, whereas if you *provide* them with something *functional* and *practical*, it's more likely, even if they *can't* continue to come, to have provided them with *some* sort of a support… (P2)

4.5.3 Helping by just being there

At times her role entails not doing anything, but just being there for her patient and consciously assuming the role of supporter, advisor, or counsellor:

> ...they come to Speech Therapy and that's where they can basically, you know, *express* whatever they, they were *feeling* and things like that which is *good*, it's *important* and then... you kind of just have to be *there* for them... (P1)

One of her most important roles is the ability to provide emotional support, recognising that her patient needs encouragement and reassurance in order to achieve success. This is crucial to motivate the required change activities in therapy. Giving her patient permission to be open about how he or she is feeling helps release some of the overwhelming emotions patients experience. She puts words to her patient's feelings and verbalises what she suspects he or she is thinking but is too afraid to say aloud:

> ...I just *know* that, that it looks *bad* for them to say that they can't come, 'I don't have the money' or something. Um, and I think if I've said, '*it costs a lot of money*, I don't think you can', I've almost seen the *relief* with them. I think I've even seen it now with my [disorder] patients where I've said 'how are you doing' and they say 'fine, I'm fine, everything's ok'. And I'll say, 'mm, you know I, it's *not* all well. If you're telling me it's all well I'm a really little bit suspicious because you've just lost your [function], your bottom's dropped out of your world'. And when I say the relief, I see the eyes well up and the wide starts crying and then everything crumbles... (P6)

> ...just to be supportive, I think it's kind of to acknowledge what you're feeling, it *is a* process, it *does take* time... and certainly with my adults if I cry with them, I just think it adds a dimension, they *do* know that you feel, and why should I hide it? If I'm going to cry and fall apart and I can't *help him*, that's a different story, but if you're helping him and feeling for him... (P6)

4.5.4 Making personal investments

She makes large daily investments into the lives of her patients as the therapeutic process involves more than doing specific activities, but an emotional giving of herself:

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> ...you know you spend a whole *day* investing in a lot of, ja [yes], you're *communicating* all the time with people who are not communicating *easily* back to you... (P4)

> ...you *could* just go through the motions of, of doing one by one with the patient, but I think it *feels* like you're giving more than just that, there goes I think a lot of *personal* sort of *concern* and things of the patient into that, sort of every patient is um, ja [yes], I think, that sort of *worry* and *concern* that goes sort of along with the session... (P3)

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She is fully present in the session with her patient and consciously focuses her mind, thoughts, attention and energy during that time, not allowing herself to wander from that moment or become distracted:

> ...it's to *do with* one's *concentrated attention* on [pause] *on* the client, um, be it the child, or, *or* their *parent*, ja [yes], I, I'm *amazed* at, at what amount of concentration uh, I *use*... *(P5)*

> ...you know you, you *can't*, you have to give them *everything*, you know your all...if like I assess a child I'm not gonna, my *whole* heart is there ok, type of thing, it's *not* ok, I'm doing this but my *mind* is somewhere else, I don't know, I mean...you can't be...you are going to try to put 110% in... (P1)

As she offers herself and her skills fully in the therapeutic process, her own needs as therapist are subservient to the greater needs of the patient:

> ...so no matter how *busy* your day is, no matter *what's* happened before, no matter what's *coming*, you have to, you just put on your therapist's hat and off you go...it's like, you know a child comes *running*, *smiling* and you've got to, you've just pull out what you *need* and you know deliver the goods!... and sometimes that's a natural thing, other times you dig deep!... (P4)

She is emotionally drained after a day of making such intense investments into the lives of her patients. Her working day is much more than "just a job" (P3):

> …so in that way I feel it, it's not just a job, it takes a lot of yourself also as well and it can be *emotionally draining* ...if I'm *treating* the whole day and you're in the *hospital* and *here and there* and coming and then there's outpatients and walk-in's with a [specific need] and this and that and then at the end of *that* day you're actually, you just feel like *finished*! So, and I think it's *not because* you were, it's *not* because it's just an activity, you actually have to give more than that… (P3)

The responsibility of managing patients with serious communication difficulties can be a heavy load to carry. A participant compared the task of managing even an average patient to "trying to eat spaghetti" (P3), in that it is "hard to manage" (P3). Doing more than specific therapy activities with her patient requires a deeper level of interaction which allows an emotional bond to develop with attached expectations:

> …they come to you with all this *hope* and I think because we *are* in a profession that gives people a little more time – it's not you know quick consultations, they have a a lot of one on one time with you and because it's – it's not just *so medical* but so - *therapeutic* - there's a lot of *counselling* and stuff that goes on, that, I think it doesn't just affect the *patient*, you know somehow you also become involved, in their *lives*, in what it means for them… you know it becomes *your, your* problem *as well*… (P3)

She shares in the emotions her patient and his or her family experience, as described by one participant where she hoped test results would not return positive, as she suspected:

> … you like 'I hope it's *not* that', you know, you kind of hope like you made a *mistake*, maybe, you know, maybe the doctors, you know you *do* kind of or like just say *before* they even get the diagnosis and maybe they came to you first and then you refer them to the doctor but you, you kind of think you know, I mean you *know* what the diagnosis, but you kind of like hope 'ok well maybe I was *wrong*', um, so you do go through that… (P1)

Another participant described how, in giving her patient and his or her family the freedom to express grief and disappointment at the birth of a disabled child, diagnosis of a terminal illness or life-altering procedure, she physically and emotionally shares their journey:

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> … mother's are *devastated*, bilateral clefts, you know, wanted this perfect baby, they d*evastated a*nd they're very brave when they come to you… they've *got to mourn*… (P6).

Sharing in her patients' emotions and taking on the responsibility of managing patients with serious medical conditions and chronic disabilities requires a significant amount of emotional maturity. One participant described how over time she has developed stamina and "s*taying power* which takes more *maturity* than your *years*" (P4):

> …you take on responsibility um, you know, you're still a *teenager*, you're 19, 20 and you're *treating* people with um, ja [yes], I think the *demands* on you from that side are quite, quite steep… (P4)

The repeated exposure to illness and suffering can make her hardened, no longer sensitive to the shocking reality of her first experience. Certain sights, sounds and smells become so much a part of her daily activities that they no longer have any impact P4 recalls relating a story to a family member which concerned one of her patients. The shocked response alerts her to how much less she is affected by sadness and tragedy of her patients' lives than she used to be:

> …my [certain family member] came home [from a visit to a state hospital] *completely shocked*, and said 'can this be happening out there' whereas to *me* that is pretty much, it's, well there's nothing funny about that it's where we *work*… (P4)

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As she witnesses the same scenarios repeating themselves, she begins to "rate" (P4) the severity of a problem by comparing it to other patients with the same disorder, and gradually over time her baseline assessment of the severity of a disorder changes and is more pessimistic. Severity for her is very different to the perception of a lay person – she may assess the severity as only "bad", whereas to a lay person, the same disorder will be seen as "devastating". She easily loses her sense of what normal is, sees disorders as the norm, thus seldom expects anything more. She loses hope that miracles *do* happen and that recoveries *can* occur. She finds herself approaching her patient from an aspect of "deficit", thinking only about what he or she cannot do, instead of what he or she is still able to do:

> …I mean I remember when I was a student, just seeing *pictures* of children with cleft lip and palate thinking this is *terrible*, I mean now you think "oh is

> that all that's wrong with you!" "oh, that'll be fixed, I mean the brain's working *fine*" and you've seen people with so much worse than that that your, you sort of *rate* your degree of how *bad* something is... (P4)

Her level of shock and surprise at patients who against all odds make unbelievable recoveries makes her realise just how pragmatic and matter-of-fact she has become:

> ...and then in the last year or two I've had patients that have just *shocked* me which is good, because now, I'm back to thinking, well, within reason, you know I know how much of the brain needs to be there for it to work and things like that, but, but you must never just write someone off, um, you must never think, there's nothing more I can do, um, you mustn't give people *false hope*, but, um, I think that maybe after a couple of years, I had perhaps become, um, *too realistic*, you know you have to be realistic, but maybe I wasn't, maybe I just didn't have that extra bit of hope, so I've go my hope back... (P7)

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4.5.5 Bouncing back

Being exposed to illness and suffering on a daily basis calls for a restoration of her emotional balance which she does in a variety of ways. By choosing to adopt an optimistic outlook towards her work and her patients, she is able to counteract her feelings of hopelessness:

> ...yes it's horrible that this has happened to a child, but you're *helping* them, you're actually making a difference, if you weren't here, they would be worse off, so that helps me as well to think that 'yes it is terrible, but I'm actually helping them and I'm making it better for them, not *completely*, but they're better off because I'm here than if I wasn't', so I think that's how I deal with it... (P7)

> ...*you can*, you can make *the best* out of every situation, you can, you can try to *solve*, not *solve anything* that, things you can *overcome* some things, um, you don't have to just sit with it...there's *always* hope... (P1)

Although patients with communication disorders as a consequence of a medical condition cause her to question why he or she is ill, she protects herself by not being

adamant to find a reason, and accepts that reasons for illness are not always obvious and definitive:

> ...I *do* struggle, um it's not that I struggle with, but I mean you do always think, why has this happened and you know why would it happen to a child or a baby, um, but I don't think I necessarily try to look for answers or have a reason for why things have happened... (P7)

Most of the time she is able to switch off emotionally from her work when going home, although occasionally she has a patient who remains in her thoughts. One participant described that, while out shopping or with friends, she may suddenly think about a patient and a technique she could possibly try in therapy. Another participant experienced intrusive thoughts of a patient; she 'carries her patients around with her' and is often surrounded by thoughts of them:

> ...I think you have to be a very strong person to, to, to sort of hold your head above water, um, I think, I *try* and separate sort of *work* and the, the, you know, from *after work*... (P3)

> ...you know one's constantly challenging how one can be helping a certain client or what one can be reading or what one can be, *creating* or what one can be *doing*, um, and ja [yes] it can be quite, quite *draining*, constantly dealing with clients, and um, *feeling for them*... (P2)

A participant described the importance for her of having "time-out alone" (P4) after work with no demands being made on her. This helps her to separate herself from work and recover; after giving to the needs of others during the day, doing something she enjoys helps her regain a sense of self and normalcy:

> ...I think you must make time to do the things that you enjoy, for your, for yourself, um, ja [yes], for me, I need to, I need to have some time-out *alone* at the end of, you know you spend a whole *day* investing in a lot of, ja [yes], you're *communicating* all the time with people who are not communicating *easily* back to you, and ja [yes], for me, I need to just take a bit of *time-out* where you don't have to have a conversation with anyone except perhaps the cat or the dog, that's the level I get to!... (P4)

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Going home and being away from the work environment is refreshing in itself and being able to clear her head helps her to refocus and gather strength for the next day:

> …it does get overwhelming *on a day*, and then, you'll either have to remove yourself [laughs] from the situation or go home and clear your head. It's never been like, I can't face it tomorrow again, it *does* get overwhelming on a day, and then you just deal with it and then tomorrow you're ok again, or tomorrow you just see some other patients and then the *next day* you're ok… (P7)

Verbalising her thoughts, feelings and daily experiences with family members and supportive friends also provides her with an emotional outlet:

> …at *home* I think that's all I talk about…I mean not the *whole confidentiality thing*…it *does come* up, I do speak about it and, and you kind of, you, not, not to speak but you relate it to, you know, this is the circumstances, this is what's happening type of thing, and oh yes, this is the case or this is the child that I, so, it does comes up… (P1)

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Common to all participants is the support they receive from their work colleagues. She is able talk to others about difficult, sad and frustrating experiences and being able to talk with people who experience similar challenges is very comforting for her:

> …I get sad, and um, or, or ja [yes], I may get *upset* and then I will talk about it or just *think about* it and then it's fine… (P7)

She puts preventative measures into place to ensure that her sense of self is well-defined and that as far as possible she maintains a consistently low level of stress. By maintaining a healthy emotional distance between herself and her patients she guards against becoming over-involved with them which will negatively affect her ability to help them. She has to remind herself that she is not responsible for the decisions her patients make, that her responsibility lies only in providing the best input she is able. This helps to reduce her anxiety. Self-discipline in taking leave in order to recharge and regain her equilibrium helps maintain a healthy mental, emotional and physical condition:

> ...I think heading towards the *end*, October, November, I guess for anyone is any job, you're kind of running out of steam, you need to recharge a bit... (P4)

One participant's deep compassion for her patients means that despite her intense connection with their pain, she is protected from becoming hard to their suffering. Although she may feel overwhelmed by a situation on a certain day, she uses her compassion as a raw material to continue to make a difference:

> ...yes you will cry sometimes and you will be upset and some things will upset you more than others, and you don't get hard and um, distance yourself like everyone tells you to because I think we're in this profession because we *care*... (P7)

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4.6 Theme Five: Erosion or Promotion

This theme deals with the S-L Therapist's constant debate to leave the public service or to stay in the setting. It describes the pressures and challenges of the public service as an organization and how these can lead her to consider leaving the service. Predictability and security are strong determiners to stay in the public service as they offer her safety and a sense of feeling settled. The diversity she experiences in her work makes the experience more enjoyable and challenges her professionally. The theme describes how her setting gives her opportunities to grow as a therapist both clinically and personally and how experiencing support from administrative systems makes her work more manageable. It addresses and describes participants' choice to work in the public service and how that choice has lead her to experience feelings of accomplishment and enrichment.

4.6.1 Working with systemic challenges

A constant pressure is the major tension she experiences due to the limited time she has to get through the workload. Coping with a large caseload, with the associated administration, is stressful and results in reduced productivity. She is pressured to discharge patients in order to take on new ones who are waiting to be seen:

> ...and I think that especially being in the *public service* where there's more, there's more of a *rush* to get things done, um, there's *numbers* that you have to get through, there's *waiting lists*...I think if there was time you could sort it

out better, um, but you in a bit of a hurry to, to sort out all the loose ends sort of move on so it does, I think the time and the *pressure* on, on numbers and things like that does, does affect how much you can actually do... (P3)

A large caseload results in less time and energy to focus on each individual patient especially with the extremely time-consuming administrative duties such as referrals and report writing:

> ....I think it also depends on your, your *workload* um, I think if you're *really* working hard you have less of that for each patient... (P4)
>
> ...'cos you've got to get the work *done*, and yet *making connections* and *networking* is *enormously time consuming*... (P5)

Her effectiveness teamwork is limited by the lack of sufficient time to effectively communicate with team members and conduct case discussions:

> ...*time,* because, um, everyone's busy, it's difficult to, to see patients together or to have time to *discuss* patients together, um, it's not like you can see a patient and then discuss them and then call them back for feedback, because financially that's not an option, you need to see them and give them feedback and something to *do now*... so I think the biggest obstacle is really *time*, for everyone...I mean it's not that people aren't *interested* or that we struggle to, um, you know as professionals *everyone's* interested and wants to participate, so it's not like there's a professional, a individual who doesn't want to *collaborate*, it's more, it's more *logistics*... (P7)

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Because of staff shortages, she is expected to see more patients within the same time frame. Although she gets through the work, she seldom feels that she is working fast enough and covering enough ground:

> ...probably the, the most negative time was when we were really short staffed you just felt you weren't on, you could never be on top of the work, there was just always a waiting list... (P4)

She feels demotivated by the fact that her salary does not increase proportionately to the general increase in her living expenses and that she enjoys no financial incentives other than her monthly salary. There is no promotion on the basis of work experience and year after year she remains on the same salary notch. She feels dissatisfied and

unappreciated as over time both her responsibilities and demands made on her increase, with no financial recognition:

> ...*now* money's an issue, but in the past the salaries were *adequate* um, as the cost of living *increased* so the salaries didn't keep pace, but in the beginning it wasn't as *shocking* a salary as it is now... (P6)

> ...but if you stay *long*, and I feel now like I'm qualified as someone who's been staying *long* um, ja [yes], I think the, the fact that there's *no* incentives *really*, I mean I think when I started working here there was a bit more, the whole sort of um, even the payment and in terms of rank and in terms of payment there was ways of at least working yourself up a bit and that all that fell away a few years ago and things, and I think *that's* also been very, *hard* *b*ecause I mean to be a few years in, basically on the *same level*... (P3)

Salary scales do not provide any incentive to work in the public service. In the absence of rank promotion and financial incentives, she relies on internal rewards to keep her motivated:

> ....in terms of *incentives*, and you know all the things that run the business world and the *corporate* world, well, I don't know what happens in private, but in state, you learn that it doesn't exist, you work for your own personal satisfaction so you've got to be happy with, with that level of, of functioning, some kind of intrinsic *motivation* maybe... (P4)

She is also expected to perform her function in a context where there are budget constraints and budget cuts which make it difficult to purchase appropriate therapy resources and assessment tools.

The therapist who manages her department bears the responsibility of constantly dealing with the difficult issues around posts:

> ...and *obviously* we have a huge problem with *posts* so we're always fighting to keep posts, to get *more* posts, to try to get posts at a more appropriate level... (P7)

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Promotion to management level usually involves "going to head office and becoming an administrator" (P6) as currently "there exists no opportunity for promotion in an exclusively clinical arm" (P6). She feels that the move into an exclusively administrative role as a management reward is a poor under sight on the part of provincial management:

> ...you should be able to be promoted in a *clinical arm* as well, because *really*, even nursing sisters, the minute they're worth something, they go and push papers and, and, and patients suffer, the service delivery suffers. So that's actually another frustration... (P6)

As a manager, she is responsible for managing staff, monitoring of their output, implementation of new protocols and has her own clinical caseload. This presents challenges as she is expected to perform duties without having received adequate training:

> ...like one day we were told 'do a business plan' – no training in a business plan and everybody rushes around asking someone else until you become assertive enough and say 'I'm not doing this, I haven't had training, you're the head, show me what to do', I think the sort of negative things for me have become uh, more apparent when, when *my* security was shaken, when *my* heads left and the people that *I'd* bonded with had left and then became head of department and um, and kind of like when I became head of department, and slowly more and more it became apparent that you had to be far more accountable, in terms of the *stats* [statistics], and the performance *appraisals*, accountable for the work being *done*, so *then*, then I started feeling um, *uncomfortable* because there hadn't *been* these systems.... (P6)

Even as a manager, she has limited decision-making power regarding which systems are appropriate for her staff, and is agitated by that fact that although she has been recognised as having leadership and managerial qualities, is not given any authority to make decisions regarding her staff. As she receives directives from management outside of her setting, she is burdened by political pressures which do not relate directly to the running of her department, and demand time and energy which decreases the time she has for her own patient care:

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> ...you had a head of department and she would manage you as she saw fit and devise her own thing so it was *different*...*so* like over the time I have seen a big change, where you were *more* of like a little micro management and now it's *out there* with people that know nothing about you, the department was cohesive, it was managed by your superior, one wasn't aware of all the *nonsense* at head office and people who didn't know what you were *doing*...here're all these outside influences that are *pressurising*... (P6)

The therapist in this setting is significantly affected by her immediate supervisor's leadership style and struggles to remain objective when she has differing opinions to how certain clinics should be run:

> ... in terms of *management* and ja [yes], there've been up's and down's here in the way that things have been, *been run* and, who you've been working under, there've been a few changes, some have been better than others! When *management* was not quite as you would like it to be, pressure from that side, frustrations... (P4)

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4.6.2 Predictability and security as determiners to stay

The S-L Therapist who is looking for security and safety is attracted to the public service setting and enjoys job security and predictability. She has the benefits of financial security in receiving a guaranteed and fixed salary at the end of each month with the attached benefits, high flexibility in terms of when she takes vacation leave and access to sufficient sick leave:

> ...you can be sick, you know "I don't feel good today, I'm going off, I'll cancel my patients" it's become *easy*... (P6)

The financial security makes it difficult for her to leave this setting as an equivalent salary with attached benefits is not readily available in many other settings, and eventually she becomes so comfortable and accustomed to the benefits, that leaving and moving on is almost impossible to consider:

> ...I like the, the *security* that the, that you know working for an *institution* offers you, there are some benefits to it like medical aid, your sick, your this your that, um, you know ...those things you don't *always* necessarily *get* if you set up a little room somewhere you're on your own and, also *money-wise*

> your income can fluctuate from the one month to the next and I don't know, I'm someone who likes *security*... (P3)

> ...I mean I've always had a job, I'm, I'm in quite a *secure environment*, which is maybe also why I'm *staying* here you reach a point where you, actually it's too comfortable maybe to [both laugh], to move on now ja [yes], also ja [yes], my career has been fairly safe *ground* for me... (P4)

Even though her salary is "*not* where it should be" and "it's difficult *to live on*" (P4), she is willing to settle for a lower salary in exchange for the benefit of security:

> ...the benefits of staying here, of staying here have been bigger than, the benefits of, of private sector... (P4)

She fears the loss of general security should she leave and not only does she feel safe where she is, but is familiar with the systems and has become accustomed to the stability and predictability:

> ...it it's quite a risk, I think and maybe I'm just not brave enough to to do it, um, and I think like I said, maybe it's, it's in a way *nice* – I think also partly because I'm *single* and you kind of feel completely responsible for yourself it's a bit harder to take that sort of risk financially, um, I mean if it doesn't work out then what? Will I have to trade my *car*, do this do that you know what do you fall back on? So I like that um, ja [yes], something that offers some security... (P3)

The high level of predictability she experiences emanates from the relative sameness of her day to day work. This allows her to feel settled, grounded and in control. She is familiar with the way in which systems and procedures operate and even her daily frustrations and challenges become predictable. Over time she becomes more accepting of the status quo, complains less about poor service delivery and becomes resigned to the ways things operate:

> ...and you have like a base, so you'll always have your lettuce, cucumber and tomato and those are the things like that stay the same... (P7)

She experiences high levels of predictability in her clinical work which enables her to "emotionally prepare" (P4) for commonly occurring situations such as poor attendance.

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Her familiarity with the ways in which her patients think and respond to various situations means that the initial frustration she experienced from their responses has become the norm:

> ...I think it's, it's, if you've been here a *long time,* one, you, you *know* how things work here, you know the *system,* the *frustrations* are predictable... (P4)

The recent abolishment of rank promotion as a reward for professional development has resulted in a reduction in pressure on her to improve her clinical skills. One participant highlighted how therapists can thus remain safely in this setting enjoying the benefits even if they acquire no new skills, perform poorly and produce sub-standard outputs. The absence of financial incentives based on patient statistics further reduces the pressure she feels to do more than what is expected for her to get by:

> ...you know, some people just get stuck in public service and they do become negative and complacent... 'cos it's a salary and you know, you can just get by... I think it *can* happen. It's a... it *can* be an easy job if you choose to make it that... it's a salary at the end of the month and so as long as you do your *work,* you won't get fired, so I *do* think, I do think there's complacency *definitely.* I think it's like an easy option for a lot of people... (P7)

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There is a rise in the intake of S-L Therapy students in the university programmes, and this, combined with the limited number of posts in the public service, makes her cautious to leave stable employment. Although from time to time she considers other employment opportunities, she feels trapped into staying due to few other viable options unless she is willing to take large financial risks. Over time, she finds it easier to identify reasons to stay rather than reasons to leave:

> ... I think there's a lot more opportunities for Physios [physiotherapists] and even OTs [occupational therapists],... than there is for Speech especially in Cape Town...I've been working in a hospital setup for years and now I don't want to go into the education setup so there's not *other* positions unless you want to go onto the private sector... (P3)

> ....there're more therapists around and less *jobs.* When I first started there weren't all the training problems, uh, uh, programmes, there weren't the *numbers* weren't big, we were *12,* there were 10 or 12 that graduated. So um,

> there wasn't (name) university, there wasn't (name) university in my day, but look at the amount of therapists that are graduating. So there's a scramble for posts… (P6)

4.6.3 Diversity gives opportunities to grow as a therapist

She is encouraged to stay as the setting provides opportunities to treat patients from a wide variety of disorder groups. This keeps her work dynamic and stimulating as she "would get bored with the same old things all the time" (P4). There is a large "on tap" (P6) supply of patients should she wish to improve a specific clinical skill or develop a new area of expertise, and is able to do so at her own convenience without overwhelming time pressures:

> …um, and I think some of the more *positive* things about working in the public service are as I mentioned, one's able to get a good range of experience, um, an understanding of much *wider* range of disorders than I think one would see in the private sector… (P2)

> …I think also there's a lot of *potential* for *growth* in certain areas for example running groups um, ja [yes], reaching out to, to certain sort of *populations* and trying to tailor a service to a group of, of people and their, their needs… (P4)

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Her diverse caseload including patients with multiple disorders demands flexibility, creativity and sound knowledge and understanding of different methods of treatment. Offering both habilitative and rehabilitative intervention requires that she prioritise treatment goals and setting of realistic aims:

> …a lot of the kids *we* see have a *range* of problems um, and so one's got to look at kind of, *all* their difficulties and, and try and work on either *prioritizing* them or kind of working on them all together at different levels… (P2)

Although her days are busy, they are diverse in nature as described by two participants who compare their experiences to that of a salad and a rainbow to illustrate how many diverse elements fit together to make a whole:

> …and to say that it's something more like a, a *salad* or even like, like a *casserole* [laughs] because it's lots of different things together, but I like a salad more because

it's crunchy! And so it's um, you know it's *fresh*! I think that's why I went for it...different flavours, different tastes, different textures, but all fresh!... (P7)

....I think it's like a rainbow in that there's so such *diversity*...bright to darker, um, I think there are sort of the brighter tones and then more murky sort of more murky, *blurred, blurred* tones, um of each shade... (P2)

The inexperienced therapist has the opportunity to develop firm and sound clinical foundations working in the tertiary service infrastructure and support networks. The freedom she has to "find her feet" (P6) is rarely available in other settings where providing services to paying clients is the priority from the outset:

...*Initially* you're pretty much finding you feet in the profession, you're doing, a little bit of everything, figuring out what you *like*, what you do *better*, what you *don't* do so well, so there's that initial kind of just almost *testing the waters* kind of thing... (P4)

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In the teaching hospital setting she is surrounded daily by an attitude of learning and clinical advancement, and she has unlimited accessibility to academic resources and support. She has the opportunity of being involved in student training which, although frustrating at times, challenges her and provides diverse experiences:

...I think perhaps what I enjoy *now* more is now *consulting* and *helping* other therapists, *tutoring students*, which I guess is a natural growth in the profession and just maybe, ja [yes], too much of a good thing, ja [yes], maybe something *new* now... (P4)

...part of the job is, is working with students which I always find *enormously* interesting and ja [yes], amongst the *frustrations*, there are *shining students* who really, ja [yes], make it *worth it*... (P5)

She feels an enormous sense of pride working in a tertiary institution that has academic, medical and historical credibility:

...I think that, that working in an institution like *this* with it's history, it, it, makes me proud actually when I walk up here and think "wow, what a

> place!" I am part of an institution um [pause] of *both* [pause] it, it, it's to do with international *renown* both academically and medically… (P5)

She enjoys being able to develop as an independent S-L Therapist by being given a choice of clinical work area. She has a sense of self-direction as she is able to select the areas she prefers and would like to gain more experience in; and being largely accountable for her own time is validating for her. Currently she experiences far greater autonomy than in previous years where "we were forced to do everything, it wasn't like now…our diaries were filled up, and you had voice [disorders] and this and that and you had to rotate through areas as well because if you didn't do that you couldn't get rank promotion" (P6).

4.6.4 Experiencing support from administrative systems

She is supported by established administrative systems which enable her to spend her time as therapist and not performing administrative duties such as booking appointments and managing patient payment:

> …to be part of an *institution* and *not* to have to carry the can, because I think that when one's working as a private practitioner in your *own* capacity you do *everything*, I mean *you are* the receptionist, *you are* the accountant, as well as the therapist……..so *that* was an enormous relief to, to be shot of the administrative duties like that…it *does cause* conflict, well, sort of *uncomfortable-ness* in fact when you are the money-gatherer and the *therapist*, it's not quite a conflict of interest, but it does make for awkwardness… (P5)

4.6.5 The choice to work in the public service

Participants described the motivation or reason they entered the pubic service to be a determining factor keeping them from leaving. Participants stated how they were socially motivated to enter the public service and recognised it as a platform on which to participate in "creating something new in South Africa's history" (P5) by serving patients who do not have the resources to access private healthcare:

> …just for *me personally*, is, I'm definitely not a business woman… and there's definitely *a place* for private sector people with medical aids who can pay…we leave space for those who *don't* have provision [private healthcare]… (P4)

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...um, and I think that's also especially if you work in the *public sector*, I don't know if it's more so, that you can do that, whereas privately you kind of working kind of for *yourself* whereas here you know you're working in the public sector, you're doing *your* bit for the community, um, you're working, you know there's, there's a *bigger*, you know there's a *bigger picture* type of thing, so, ja [yes] no definitely... (P1)

As a state employee she is part of something bigger than herself and able to "take part in South Africa's democracy" (P5). She regards her contribution as the change she brings about through her work and desires that it be meaningful and useful:

...*public service*, ok, I think um certainly *part* of it has to do with a *social conscience* um, my *background* is one of enormous *privilege*, um, and ja [yes], you could call it *pay back time*...I have a social *responsibility, um, pay back time* and to participate in, in the creation of something *new*... (P5)

The opportunities that initially attracted her to the public service continue to keep her motivated to stay:

...the ups in this context are the patients that we see... (P4)

...I enjoy, working with I mean, like the population that we see, kids, I think it's much different in the private [sector]... (P1)

Even though she experiences ups and downs in her work, positive experiences dominate and job satisfaction is a driving force for her to remain where she is:

...generally I can speak very positively about the, the public sector, and at the end of the day I *choose* to be here... (P4)

...it's been positive, I, I wouldn't um, I want to stay in the public service, in a *hospital setting*... I would say it's *palatable*, in other words it's not a *dreadful* taste or flavour um, obviously *very palatable*...*most palatable*, *most of the time*, let me put it that way... (P6)

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4.6.6 Feeling accomplished and enriched

One participant in particular described her experiences in this setting to be "very *nurturing*" (P6). She feels respected and appreciated by doctors, nurses and other health professionals, and recognised as having a role to play in the team. She reflects on how doctors in specialist clinics have always been "superb" in encouraging her to embark on ambitious projects, always offering her their support and guidance. The funding and support she has received to attend courses has made her feel affirmed and appreciated as a professional and as a valued member of the multidisciplinary team:

> ...*Very positive.* Very positive, *always* respectful. I've *never* had a problem that speech therapists weren't wanted, in fact the contrary, there's *never* for me personally been [a time] where I've felt that they [colleagues] thought I was an idiot... (P6)

The relationships this participant has formed with her colleagues have taken time to develop and have required commitment and humility on her part. Forging good working relationships with colleagues and having mutual respect for each other's clinical skill has enabled her to be confident and available enough to exchange knowledge and expertise.

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As a health professional the S-L Therapist travels both a professional and personal journey. The growing clinical challenges she faces and the types of patients she sees demand that she maintain an ever-increasing awareness of and reflective attitude about herself as a therapist:

> ...I think that, therapists *need* to have the sense of continuing development of *themselves* also, so that they, you know you've got to be pretty much in touch with *yourself*, or, be prepared to develop that um, if you are going to be changing *other* people's behaviours, uh, *in* flexible uh, suitable kind of way... (P5)

She is continually enriched by being exposed to the wide variety of people around her and has learned to accept others more, judge them less, and understand them more deeply. Engaging with patients and families on a daily basis requires her to go beyond a superficial level to "knowing where they're coming from" (P4) and "really *understand* the people you're working with" (P4). Having daily interactions with people from a different race, culture and socio-economic group to her own enriches and deepens her

understanding of the human race. Working in this setting has highlighted some of the social inequalities which exist in society making her passionate about revealing the barriers that many public service patients experience in attempting to achieve success:

> …I think um, people I work with, come out of a very different background to my own, I go home to a very different home to which they go home, *everyday*, and if I hadn't worked here, I would never have *known* much, as much about people who are not *different*, I mean we're all the same basically, live in *different* circumstances, have grown up *differently*, got different *priorities* perhaps um, I think it's made me more *tolerant* of people, more *understanding* of different ja [yes], just of different *belief systems* and *culture*… (P4)

> …it definitely helps you see things in perspective I think ja [yes], I mean you think, 'I mean it's cold this morning, I don't want to get out of my *bed*', but whoever's *coming* here probably had to get up two *hours* ago to catch the taxi in the *rain*'… (P4)

> …yes it's nice to have money and it's nice to have things, but it's just not *important* to me anymore because I see people with *nothing*…it's helped me *care* more for people, and be more *accepting of people*, not to judge people on how they look or how they dress, or where they live, or how much they earn, or what their education is…it's made me much more *socially aware*…(P7)

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She is challenged in the way she thinks about life and approaches situations by working with people with different worldviews. She realises that not everything is about *her* ideas and preferences, and so experiences freedom to embrace different views and over time grows into a more open and broad-minded individual and health professional:

> …and it's definitely opened, I, I'm definitely more *open* to different perspectives, you know sometimes you, you growing up and you're just in this *one little* nook, but now you're kind of, you're *out there*, um, you see what it's *actually like*…*and* you learn so much from *other* people as well, you know there's like a *whole different*, you know it's not just about you, it's not your perspective, you actually have to see that there are other people there with different views and you actually have to, you have to respect that and have this cultural what do you call it, cultural …*sensitivity*… (P1)

The therapist in this setting is greatly affected by her patients. She "loves her patients" (P7), "*loves* working with them" (P1) and has had "wonderful experiences with patients" (P6). Working and interacting with patients humbles her on a daily basis. Her experiences of crying with a patient, talking about his or her progress, how he or she has grown, or being thanked for help she has given patients, are all extremely rewarding and affirming experiences:

> ...my patients actually, because of the, the, the type of patients I see, I'm *humbled* by them, I'm, they, they, they make me feel *good* on a daily basis. I really do. I, I *cry* with them, they phone, "you saved my..."...*really,* I just *love* them and to see them grow it *great*... (P6)

As she interacts more and more with patients, they become an important part of her work and when she spends time away from work she "really misses the interaction with patients" (P4). One participant commented that she had refused to accept to a request to substantially increase her administrative tasks and decrease direct patient contact time:

> ...*patients,* I've, I've always enjoyed, and that's why I've refused to give up clinical work... (P6)

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She is humbled by and feels privileged to listen to the life stories and experiences of her patients, how they have experienced their past and how they think about their future. As her patients share their experiences with her, their dreams and fears, and reflections she feels enormously honoured that they choose to allow her to enter their reality:

> ...working with the *parents*, um, I'm always very *humbled by* the difficult *lives* that these parents have to *lead*, um, *financially,* I think particularly over the last few *years*, comes in waves, the *violence*, in the society in which they live um, so, when I am working with *parents* um it's almost like the opportunity that I've got *now,* you give them the opportunity to just *spend* a moment to reflect and to um, *see* the positive, to *see* a *different way*, *to see* that some things are going right... (P5)

She feels enriched and validated on seeing how or hearing that she has played a positive or significant role in her patient's journey. There is a sense of accomplishment as she sees her patient become empowered to succeed beyond the therapy setting. Victory for her patient is translated into renewed passion for what she does and why she does it:

> ...I love it when I have a "happy client". When I've been able to make a difference... (P3)

> ..."oh God, I've *really* helped this guy, he wouldn't have got it anywhere else... (P6)

> ...this is what I'm meant to do and *I love it!* And I um, I'm *passionate* about it and I *love* my patients and I feel alive when I'm at work!!!... (P7)

Seeing her patient succeed is almost like a personal victory, not because of the role she played in it, but because of the deep connection she feels to her patient and his or her rehabilitative journey:

> ...Yes, *obviously*, I mean getting, um, being successful or getting something *right*, or making some, making a *difference* in, in a patient's life, it, yes, it reaffirms you and it makes you feel, ok yes you want to do this again, you are making a difference... (P7)

> ... 'you're going to come to *love this little face*, take *lots* of photos, you're not going to *recognise* her when she comes out of, of surgery'. If one mother's told me, *101 have said* 'my child comes out, that's not my child, I've got to check the name badge' like just yesterday I said to her 'what's it like', she said 'it didn't look like my child, that little face', and those were just such nice experiences... (P6)

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Significant is the personal meaning and satisfaction she gains from physically "doing something" (P1) meaningful for her patient or solving a problem for a family. Literally being able "to do something" (P1) for her patient gives her a sense of usefulness, and sharing in her patient's victory not only affirms her intervention as being effective, but instils confidence in herself as a therapist:

> ...what I know, I know well, and I know I make a difference... (P6)

Having the skills and knowledge that her patient requires and being able to provide him or her with those skills makes her feel that she has a purpose and through feedback from her patients sees how "they really appreciate what you're doing and I think you *feel* like you really *are* delivering a meaningful service" (P4):

> …you're doing something *for the family*, you know you, I don't know, like if you just go home and you sorted out *one thing* for this family, then you, you, that's good… (P1)

> … it's not so much my desire to be *needed* as my desire to *help*…I like the fact that I can *help* someone and that, I don't think that it's even the fact that they *need me*, I like the fact that I can *help them*… (P7)

> …I think when one looks at the, the bigger picture of things, I think we *can* help most clients that we see and, ja [yes] that's rewarding… (P2)

The satisfaction she experiences from working with patients is a difficult one to match and as one participant described it, "it's illuminated, yellow, right, life-giving, warm" (P6). Her patient's success motivates her to believe that change is possible and feels rewarded by seeing her patient blossom, appreciate and acknowledge the success they have made:

> …and when you can get a parent to recognise *some* of that, um, or *to start* to reflect, that's enormously rewarding, and when a rather *frightened* and, and *withdrawn child*, starts to listen to *himself* um, and, and, and *appreciate*s their own successes and a*cknowledges* that success and the *delight* with which they do it, from a very rather sad child to watch that flicker of a smile as they give themselves thumbs up for a *attempt* [laughs], *that's* what makes it worth it… (P5)

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4.7 Reflections on initial themes with participants

I conducted a reflection session with 6 of 7 participants after having given each of them a summary of the initial themes to read. These sessions gave participants the opportunity to reflect on my interpretation of the data and comment, clarify or add to that interpretation.

Participant 3 reflected on the category of "the invisibility of communication disorders" by stating that not only are visible disorders generally given more attention by people, but are also viewed more compassionately. She gave the example of how in her opinion a member of the public would help a person with a leg amputation struggling to get through a door, before helping a person with a subtle communication disorder, following a head injury, struggling to ask for directions. She suggested a reason for this

may be that the public in general are more visibly-orientated, and therefore less sensitive to that which is not seen with the naked eye. In paying less attention to the disorder and showing it less respect they show their ignorance about how difficult having a communication disorder actually is and how it impacts on the person with that difficulty. She commented on how parents of children with communication disorders are guilty for not recognising communication disorders for what they are. She related experiences where parents would say to her, of their child: "hy is net ly" [he is just lazy], when in fact the child has a legitimate language and literacy disorder.

In reflecting on "feeling unimportant and trivial" participant 3 added how decisions to send a patient to a rehabilitation hospital are almost never left to the S-L Therapist. If a stroke survivor is left with both a physical and communication problem, rehabilitation is immediately recommended, whereas if the same patient is only left with a communication difficulty, referral to rehabilitation is not automatic and most times the S-L Therapist has to motivate strongly for that.

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Participant 3 added that S-L Therapy is not the only profession that is misunderstood and said that in her view occupational therapists face similar challenges, where people do not know what they do and mistake them for physiotherapists.

Reflecting on how "predictable" obstacles in the public service become, participant 3 shared how over time she has made peace with the fact that "that is just how it is", and has stopped trying to "fight the system" by accepting the challenges she has to deal with.

Participant 4 reflected on the theme "erosion or promotion" by saying that the decision to stay or to leave was a much more intense debate earlier on in her career than it currently is. She said that after so many years in the public service, the only reason she could think of for leaving would be to leave the profession completely, and would not at this stage leave to go into private practice. She also stated that she considers "looking around" for other employment possibilities to be a normal part of being in the workforce and thinks that most S-L Therapists do so even if they are happy in their setting. Participant 1 disagreed commenting that the S-L Therapist would probably only have continuous debates about leaving or staying if she was not completely happy in her

job. She said that for herself, other job opportunities do not interest her as she is happy where she is, but that in the future if she was no longer happy, she may consider it more.

Participant 4 reflected on the category "opportunities to grow as a therapist" and stated that although this setting does offer such opportunities, the opportunity to go on S-L Therapy-specific courses and take part in ongoing training is very limited. The cost of attending S-L Therapy conferences and courses is beyond her financial capacity as she has to pay for most such courses herself. She said that were she working for a private practice/company, they would be more likely to send her on such courses.

Participant 6 reflected on the theme "being part of the "underdog" profession", and stated how she thought S-L Therapy is definitely not disrespected, but rather misunderstood. She suggested that there is a fair amount of ignorance around it, but in her opinion, not a negative view of it. She explained this by stating that if doctors, health professionals and teachers did not respect S-L Therapists, they would not refer patients for services, and the fact that they do, implies respect for the profession.

For participant 1, the theme "doing more than just giving therapy" was significant as she experiences this on a daily basis, and always looks holistically at her patient playing various roles in their management.

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4.8 Conclusion

This chapter has provided a description of the themes which emerged through analysis. Reflections of initial themes with participants was included (section 4.7) as an introduction to chapter five in which I present a discussion of these themes as they relate to van Manen's four lifeworld themes (1990, p. 101), and to the existing literature.

CHAPTER FIVE

Discussion

5.1 Introduction

The previous chapter described the five themes that emerged from data analysis explicating the lived experience of a Speech-Language Therapist in the public health service:

1. expectations of practice and practice realities
2. being part of the "underdog" profession: role definition and status
3. being connected
4. the holistic nature of the S-L Therapist's practice
5. erosion or promotion

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In this chapter, the findings will be discussed in relation to the four lifeworld themes as described by van Manen (1990, p. 101), to the existing body of S-L Therapy literature, as well as to other human service professions including nursing, social work, occupational therapy, physiotherapy and teaching. Issues which arose from the follow-up discussions with participants will also be integrated into the discussion. Text presented in quotation marks ("...") has been taken from participant interview transcripts.

Husserl first introduced the concept of life-world as "the realm of original self-experience that we encounter in an everyday sense" (van Manen, 1990, p. 182) and describes the experience of the life-world as being a perceptual experience. Van Manen (1990, p. 101) states that all phenomenological research is an exploration into the structure of the human lifeworld - the lived world as experienced in everyday situations and relations. He identified four fundamental existential themes which he says "pervade the lifeworlds of all human beings regardless of their historical, cultural or social situated-ness" (p. 101). They are *lived space* (spatiality), *lived body* (corporeality), *lived time* (temporality), and *lived human relation* (relationality or communality). These four "existentials" (van Manen, 1990, p. 101) are very useful in guiding reflection in the phenomenological research process and presenting it in written form. Although these existentials are separate elements, the experience of being-in-the-world (Heidegger, in

van Manen, 1990, p. 175) cannot be explained exclusively through one with the exclusion of the others.

For this discussion I have identified the salient topics from the five themes which emerged and discuss them in this chapter as they relate to the four life-world themes.

5.2 Lived Space (spatiality)

van Manen (1990, p. 102) describes lived space as felt space and suggests that the space in which we find ourselves affects the way we feel and experience the world. The S-L Therapist's 'lived space' is not only the physical space she occupies such as the hospital building, hospital wards, Intensive Care Unit, and her therapy room, but is also her perceived or 'felt' space. It is a description of her experience as an S-L Therapist; how she engages with other people and situations in that space and how that interaction impacts on her sense of being. The 'lived space' lifeworld relates to theme two (being part of the "underdog" profession: role definition and status) and theme five (erosion or promotion) and is described as follows:

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5.2.1 Feeling proud, safe, secure and experiencing predictability

The study participants experience their working environment as "safe" (P4), "supportive" (P6), and highly "predictable" (P4). The physical size of the hospital, the established and time-honoured systems and procedures give her a sense of security and confidence. The historical evidence of the services that the institutions have provided and the professional competence creates a sense of dependability, constancy and familiarity. This results in her feeling settled, grounded and in control. She receives consistent and predictable administrative support which enables her to focus on service delivery rather than on administrative duties. Her familiarity with the way her environment functions, whether positive or negative, defuses much of her frustration over everyday challenges. This understanding prevents her from becoming unsettled when problems arise, and helps her to prepare mentally and emotionally for commonly occurring situations.

The environment further enables her to feel "nurtured" (P6), "reinforced" (P6) and part of a "community" (P$), making it feel "almost like home" (P4). Definitions of

"safe" include "being in a position or situation that offers protection, so that harm, damage, loss, or unwanted tampering is unlikely" and "able to be trusted or depended on" (Dictionary Tools 2004). The SLT perceives her environment to have protective and dependable qualities, and supportive of her professional development, thus contributing to professional success.

There is security and comfort in this "almost like home" space in which she can find refuge. It is a community that can only be understood by those who have experienced it firsthand. The hospital is empty without the people who work there and, whether cleaning, clerical or a fellow professional, hospital personnel play an integral role in making the environment what it is. They initiate and maintain systems that ensure its smooth running and play a supportive role to fellow professionals with regard to clinical duties. A community can be defined as "a group of people who share a common interest in society" (Dictionary Tools, 2004) and describing her environment as such reveals her identification with those working alongside her. Working amongst others who share her desire to care for people creates a shared purpose and strengthens the community bond.

The remuneration she receives and benefits she enjoys by working for the public service contribute to her experiencing her environment as secure and predictable. She is entitled to a guaranteed fixed monthly salary with attached benefits, no threat of being fired, high flexibility in terms of when she takes vacation leave, and access to sick leave. She is able to trust and depend on these benefits and does not have to worry about not being paid or being denied sick leave. Consistent with these views are the responses of participants from a study of occupational therapists working in the British National Health System who stated that they regarded themselves as having a job "for life" and reported valuing their pension and good conditions of service (Pringle, 1996, p. 405). For current study participants the benefits and security of this setting makes leaving a difficult choice as the equivalent salary with attached benefits may not exist elsewhere. Even though she considers the possibility of other employment opportunities, the fear and anxiety of losing her security and the large financial risk she would need to take in making a change are strong determiners for her to remain in this setting. Participants stated that the knowledge of having financial security acts as a trade-off for the fact that salaries are poor and less than what a privately-employed S-L Therapist typically would earn.

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5.2.2 A threat to safety, security and predictable experience

Despite the security provided in the public service environment, all study participants reported feeling highly dissatisfied with the lack of incentive and rank promotion in the system. No rank promotion on the basis of work experience, good performance or clinical achievement has a stagnating effect, a S-L Therapist remain in a salary notch with only the opportunity for advancement when a senior post is vacated. As the staff turn-over of S-L Therapists is minimal, such opportunities are few (R. Lentin, personal communication, July 9, 2007). In the absence of promotion opportunities she feels dissatisfied and unappreciated, particularly as with experience her responsibilities and the demands made of her increase without any financial recognition. This can act as a disincentive to improve her clinical skills through continuing professional development. One participant reported with no rank promotion incentive, an S-L Therapist could safely remain in the public service year after year, enjoying the benefits even if she acquires no new skills, performs poorly and produces sub-standard outputs. These views are consistent with the principles of Expectancy Theory (Aamodt, 2007, p. 327) where an employee will only be motivated if his or her work results in some specific consequence (in this case rank promotion). If an individual believes that no matter how hard they work they will never reach the necessary level, motivation is likely to be low. Again, the principles of Expectancy Theory (Aamodt, 2007, p. 327) explain the attitude of S-L Therapists in that if she works extra hours, sees large numbers of patients or acquires years of experience in a certain clinical area, she expects to be rewarded for that. She enjoys no financial incentives other than her monthly salary, and this can be demotivating. This finding is consistent with the occupational therapy literature in which studies report therapists to feel dissatisfied due to poor remuneration, the lack of promotional prospects (Greensmith & Blumfield, 1989) and limited rank advancement both professionally and financially (Bailey, 1990; Bordieri, 1988).

In the public service, quarterly performance reviews are conducted with all employees with a major performance review at the end of the cycle (1 April of each year). After the end of cycle Staff Performance Management System (SPMS) appraisals has taken place, should an S-L Therapist receive a performance award for good or above average performance, there is a once-off cash bonus depending on the available budget for that financial year and does not indicate a salary notch increase (Staff Performance Management System Collective Agreement, 2002).

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5.2.3 Expanding knowledge and expertise

The three tertiary hospitals in which current study participants work have been described as institutions of both healing and teaching (Groote Schuur Hospital Homepage, 2007). The environment is a healing space, and is also a training setting and the ethos of learning, teaching, research and clinical advancement is significant and ongoing. She has access to academic resources and staff which offers her opportunities to develop clinically in the course of her daily duties. She works alongside a team of health professionals in training [both undergraduate and postgraduate] and S-L Therapy students. The teaching environment is stimulating and rewarding and continues to be a source of significant job satisfaction.

The expectation of having exposure to valuable learning opportunities in specific contexts is common to other health professions. In a study looking at career choice, 55 percent of newly qualified Canadian physiotherapists reported having chosen a public service hospital setting due to the perceived learning opportunities and the anticipation of it being an appropriate environment to start as a novice therapist (Ohman, Solomon, & Finch, 2002). In another study novice physiotherapists chose the hospital setting because of the learning opportunities they believed it would offer them (Miller, Solomon, Giacomini, & Abelson, 2005). Respondents practicing in the hospital setting stated that while they enjoyed the learning environment, did not envisage staying in the hospital setting as they viewed it as a "stepping stone" (p. 148) to other practice settings. The sentiments of the public service hospital setting being a "stepping stone" (p. 128) and a good place to start as a novice therapist before moving on to other things was not shared by current study participants. It was however reported originally by one participant and then confirmed by remaining therapists during the second phase interviews, to be the attitude of some privately-employed S-L Therapists. Study participants described privately-employed S-L Therapists to most definitely have the perception that "you *start off* in the public sector when you don't know very much, *learn* as it's a very good place to start, and then *graduate* to private practice!" (P4).

The setting's training focus offers the S-L Therapist varied patient exposure and the opportunity to manage patients with a wide variety of communication disorders including those with multiple and / or rare conditions. This makes her experience dynamic, stimulating and challenging. It stretches her in terms of the knowledge, clinical skills and expertise she requires and demands flexibility, creativity

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and a sound knowledge and understanding of different treatment approaches. Even though the environment can be demanding, she experiences it as a safe and supportive setting in which to learn and develop skills at her own pace. Study participants reported this to be particularly advantageous for the inexperienced S-L Therapist as the infrastructure, support networks and personnel provide her with the opportunity to develop sound clinical foundations and the space to "find her feet" (P6) clinically. This is consistent with inexperienced physiotherapists who also described their setting as being supportive and encouraging while they got accustomed to how things operated (Miller, et al., 2005).

5.2.4 Not reaching those who require the services

The hospitals with skilled and available medical personnel available are geographically some distance from the majority of its clients. within the Western Cape, compared to physiotherapy, occupational therapy and social work services, S-L Therapy services are significantly under represented at a community health level, secondary hospital level and in mainstream education. Patients who require S-L Therapy services have no choice but to access them at tertiary hospital level even if it is logistically inconvenient and geographically very difficult for them to do so. This negatively affects patient attendance and frustrates the S-L Therapist who is all too aware of the difficulties patients face in accessing her services at a site so far from their homes. While certain S-L Therapy services require medical support which is offered by the hospital, a large proportion of the services she offers to both adults and children are not suited to this setting and would be "far more effective if offered at a community level or in mainstream classrooms" (P5). Although she knows and has seen firsthand how her services can make a difference to the lives of patients, she feels significantly limited by knowing how much more effective she could be in another location. She feels distant and detached from her patients because she is located so far from where they live and so does not share in community life as they know it. Feeling detached from her patients and intervening in the decontextualised way she does, makes her feel like a misplaced service provider.

5.2.5 A pressured environment

The hospitals in which study participants work, accommodate large numbers of patients in busy clinics. Large numbers of patients pass through the hospital wards, passages and clinics everyday. Waiting lists are long, referrals constantly being made to

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S-L Therapy and waiting rooms always full. There is rarely a time when there are no patients to be seen, no patients to contact and no administrative duties to complete. There is a constant pressure to get through the large case load in a limited time. The large caseload, when added to the associated administration, can result in reduced productivity and less time and energy to focus on each individual patient. She is pressured to discharge patients quickly in order to see new ones on the waiting list and keep up to date with time-consuming administrative duties such as making referrals and report writing. Participants stated feeling guilty about not being able to spend as much time with each patient as they would like to due to time constraints. This gives her a sense of dipping in here and there in an attempt to make some difference.

The lack of sufficient time for patient care is a consistent finding in other human service profession research. Occupational therapists are reported to feel unable to adequately serve clients when coping with a large caseload (Hasselkus & Dickie, 1994) and to experience excessive paperwork and statistics as a major source of stress (Bailey, 1990; Freda, 1992; Pringle, 1996). Teachers also experience restricted time in which to complete vast amounts of administration work (Austin, et al., 2005). The physiotherapy literature reveals similar findings in that "during periods of high demand for physical therapy" (Deckard & Present, 1989, p.116) therapists felt pressured and complained about the lack of time they had to give all their patients adequate treatment. Physiotherapists in the above study reported feeling "torn between providing service to everyone" (p. 116) which decreased the quality of care and amount of time they were able to devote to each treatment. Administrative duties were also problematic and were noted to "exacerbate the situation by cutting more and more into the time available to provide client service" (p.116).

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With these existing time constraints, even though the public service setting offers established and organised infrastructure, equipment and personnel, establishing a new S-L Therapy service to an area that is not currently serviced is difficult. It is time-consuming and getting the service to run independently takes time. Study participants stated that even though they have the desire to "do more" (P7) and develop S-L Therapy services within their environment, they felt wary to embark on new projects because of both its time-consuming nature, and their existing caseload and already pressurised schedule. This again could leave the S-L Therapist feeling that she is doing a lot (her existing duties), but not doing enough (what she would like to).

5.3 Lived Time (temporality)

'Lived time' is different to clock time and refers to the temporal way in which people are in the world with the temporal dimensions of past, present and future constituting a person's experience (van Manen, 1990, p. 104). The 'lived space' lifeworld relates to theme one (expectations of practice and practice realities), theme four (the holistic nature of the S-L Therapist's practice) and theme five (erosion or promotion).

5.3.1 The past

The S-L Therapist's past experiences, choices and expectations play a significant role in the way she experiences her present situation.

5.3.1.1 The choice to enter the profession of Speech-Language Therapy

All current study participants reported having originally chosen the profession of S-L Therapy due to an underlying concern for others, a desire to work with people, to help people in need, and to bring about change in the lives of others. This is consistent with a study looking at career choice among university students where 75% of undergraduate and graduate S-L Therapy students reported choosing the profession because they wanted to help other people (Lass and Ruscello, 1995). S-L Therapy has been described as being more people-orientated than object-oriented (Lubinski & Frattali, 2001, p. 189) with the importance of personal relationships being reflected in people's choice for entering the profession for which helping others is a primary motivation (Byng et al., 2002). Similarly a study of social workers reported that "the need to be helpful is a primary motive in their choice of profession" (Lloyd et al., 2002 p. 256). The fact that participants chose to enter a people-oriented helping profession indicates their desire to do "people work" (Maslach, 1982, p. 3) and creates a sense of underlying compassion and concern for humanity.

5.3.1.2 Past practice expectations

S-L Therapists during training and on entering the profession had great expectations of being able to solve every person's communication or swallowing difficulty. During their training the expectation of being able to help everyone was reinforced as a highly achievable goal. The undergraduate curriculum was divided into disorder groups with those only the most favourable outcomes described by lecturers,

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textbooks and supervisors. From having once been a student myself, it is my personal opinion that in order for student S-L Therapists to learn how to manage different communication disorders, rightly so the 'gold standard' or most commonly accepted treatment approaches are usually presented. The problem is not that such approaches are taught, but that students perhaps do not take cognisance of the fact that such approaches are developed in first world countries or in contexts very different to South Africa, and in particular the public service. Exposure to such approaches may cause the student to view her professional future through a narrow lens and mould her thinking, actions and expectations according to that view. One participant stated that in her opinion many new graduates go into their professional careers with a rather "glamorized version of Speech Therapy" (P2). They have developed a certain way of thinking about the future, fully anticipating their training and experience to be adequate for what lies ahead. Having such "glamorized" views is consistent with Harrison who stated that "idealism and enthusiasm characterize most people beginning careers as helpers" (1983, p. 207).

5.3.1.3 The choice to enter the public service

The choice to work in the public service has as impact on her daily experience. The S-L Therapist who was socially motivated to work in this setting or who chose it because of the role she wished to play in this context, experience it very differently to the S-L Therapist who did not have these same sentiments. Even after years in this setting, those who described themselves to have "chosen it" (P5) still describe it as being something they are fully committed to. This is illustrated in one participant's words who said "at the end of the day I *choose* to be here" (P4). Making a conscious choice to work in a setting which a participant described as "messy" (P3) illustrates a willingness to accept its challenges and shortcomings. Another study participant described her choice to work in this setting as "the desire to be a part of something bigger than myself" (P5). Although this choice was made some years previously, it still stands as a daily motivation and experience for her even after many years of practice i.e. this motivation seems to have transcended the passing of clock time. The negative comments study participants described receiving from the public and privately–employed S-L Therapists confirms that working in this setting is not desired by many people. This highlights the humanitarian-like drive and motivation S-L Therapists who choose to work here possess and reveals a sense of commitment to that which is not readily chosen by others.

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5.3.2 The present

The S-L Therapist does not experience the 'present' as an isolated entity. Her present experiences are influenced by her past ones and affect how she approaches future situations.

5.3.2.1 The transition from student to therapist and experiencing work as different to how it was anticipated to be

The processes involved in the transition from student to therapist was documented by Tryssenaar & Perkins (2001) who analysed the journal entries of physiotherapy and occupational therapy students in their final year of study and again in their first year of professional practice. They described four distinct chronologic stages experienced by new therapists, namely: the "transition stage" which is an eager "marking time" through a student's final months in training; the "euphoria and angst stage" as the therapist begins professional practice with both excitement and trepidation; the "reality of practice stage" where the therapist struggles through sometimes "unpleasant experiences"; and finally the "adaption stage" which marks the beginning of her "new world of professional practice" (p. 22).

Study participants found that working as qualified therapists was different to their expectations. This is aptly illustrated in one participant's words, "in the beginning it's a bit harder 'cos you come in into the profession and it's very *different* to what you were prepared for as a student. As a student, everything is like *in order,* and it looks like there's this whole system in place to deal with people coming in with speech problems…and everything looks good on paper, but when you actually start working…it's a lot *messier* than what I think you expect…" (P3).

Study participants described how after only a short time in professional practice they realised how their previously constructed ideas did not correspond with what they were experiencing in reality. Contrary to what she had originally believed and anticipated, the S-L Therapist is not able to help every patient she sees, and feels "let down" (P3) by the public health system which is not as organised and efficient as it was portrayed during her training. She struggles to gain the same amount of control she had as a student, realising that not all cases are clear-cut, and rarely resemble textbook examples. Clinical practice in this setting presents the S-L Therapist with more than an isolated communication disorder requiring intervention, but rather a set of challenges to

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be solved and new expectations and realities to adjust to. This is illustrated in a participant's words who stated "you want to be able to help everyone, make a big difference, make their lives better and, help them to cope at school, help them to be a success in life and make their social circumstances easier, but realistically that's not possible" (P2).

Research looking at professionals such as occupational therapists, physiotherapists, social workers, nurses, counsellors and teachers are consistent with the experiences of current study participants. Curtis and Martin (1993) reported physiotherapy graduates as having had "unrealistic expectations" (p. 588) on leaving student life and entering the professional world with expectations not having always been met or having been met in an unanticipated fashion. This is consistent with one current study participant who stated feeling "let down" (P3) when her expectations were no met. Lloyd et al. (2002) also reported social workers to have felt dissatisfied with the discrepancy between the ideals of social work they were trained in and what social workers actually do in practice. Participants stated that their profession "has a very idealistic and reforming philosophy which is not met by many social workers in practice" (p. 262). Specific ideals causing dissatisfaction amongst social workers were advocacy, social justice, client self-determination and empowerment, and the role she plays in reality (Lloyd et al., 2002).

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In a study by Madjar, McMillan, Sharke, and Cadd (as cited in Chang & Hancock, 2003, p. 156) nurses stated that the gap between the theory they had learned in training and what was expected of them in practice was significant. The mismatch between what this group of nurses had learned in the classroom and what actually occurred in the clinical setting was something they felt ill-prepared to deal with. In a study by Jasper (1996) which explored the experiences of nurses in their first year of professional work, particular difficulties identified were the sudden increase in responsibility and awareness of individual accountability, the "theory-practice gap" (p. 783) and dealing with the expectations of patients and other nurses who expected her to know exactly what to do. School counsellors reported to experience a discrepancy between the ideal role and the role that interns (novice teachers) experience in practice (Culbreth et al., 2005). This is reflected in the comment of a study participant who stated that in reality defining her role is a "continuous challenge" (P2).

5.3.2.2 Adopting a more realistic view of work to affect the future

The discrepancy between practice expectations and practice realities that has been described by study participants thus far is consistent with the "euphoria and angst stage" described by Tryssenaar and Perkins (2001, p. 22). It is followed by the "reality of practice stage" (p. 22) and the "adaption stage" (p. 22) which brings her to a place of increased balance in her work.

After experiencing the reality that professional practice is different to how she anticipated it would be, the ideas and expectations she brought into her professional career begin to change. Study participants described a tangible sense of emerging realism as described by participant 3 who stated "I think often especially starting *off* as a Speech Therapist one does try to do *everything* and over time you learn that you *can't* and you've got to look at what's that most valuable that you *can* change, and realise that ja [yes], you can't conquer the world!". These words illustrate how by realising that some things are beyond her as an individual to change, she becomes less idealistic and more realistic about what she can and cannot achieve. She begins to establish more realistic goals and expectations and adapts her therapy approach to her setting and individual patients.

Study participants described another significant realisation as being the fact that the nature of language disorders means that often the person's difficulty is "never, never, or seldom fixed" (P5) and that it remains a "life-long disability" (P5). Other realities she faces on a daily basis are those such as not being able to help at all, having to give bad news, feelings of having let a patient down, repeated unsuccessful attempts to help a patient, and working with patients living in poor social circumstances.

Learning to accept the reality of practice enables the S-L Therapist to become more realistic about future experiences. By being less idealistic about her work, her patients and therapeutic outcome, she experiences less anxiety about needing to "fix" (P2) every patient's problem. She is released from feeling solely responsible for every patient's progress, and being free from idealistic expectations enables her to accept difficulties which arise and view them as being part of the job rather than crises. Over time she begins to expect obstacles to occur rather than be shocked when they arise and makes a conscious effort to focus on both positive and negative aspects of her work instead of only negative ones. Current study participants described how through

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experience they have learned to counteract practice limitations and barriers by adapting their attitudes, theories and practices to best suit the individual patient. One participant stated how "if I can help just *one*, then it's been worth it" (P6). This shift in the way she experiences her work is most like the "adaption stage" as described by Trysenaar and Perkins (2001, p. 22).

5.4 Lived Human Relation (relationality or communality)

'Lived human relation' is the way in which people live in relation to others and share interpersonal space with them (van Manen, 1990, p. 104). The S-L Therapist does not function in isolation and is simultaneously involved in number of collaborations with people around her including patients, patients' families, S-L Therapy colleagues, the public, hospital staff and other health professionals, and educators. Stone (1992) states that the S-L Therapist must be able to sustain good working relationships with many different kinds of individuals in order to offer effective service delivery. For the purposes of this chapter, each of the relationships highlighted by participants will be discussed separately. The 'lived human relation' lifeworld relates to all five themes.

5.4.1 Speech-Language Therapist - patient relationship

Whether an infant, child, adolescent or adult the S-L Therapist's relationship with her patient is a complex and interactive one (Holland, 2007, p. 1). Current study participants described a real sense of connectedness to their patients as they are intimately involved in a dynamic two-way helping relationship fuelled by a desire to help, remediate and improve the presenting communication or swallowing difficulty. Worrall & Frattali (2000) described the S-L Therapist's involvement with her patient as "entering into people's lives in a very real way and becoming involved in issues of human living" (p. 193). All therapeutic endeavours occur in cultural context with cultural factors demanding awareness and sensitivity (Holland, 2007, p. 67). This means that at the same time as feeling connected to his or her patient, the S-L Therapist may experience times of feeling disconnected from the patient if he or she comes from a different cultural, social and linguistic background. She may also have little in common with her patient other than a mutual interest in the presenting difficulty. This is described by Pillay (2003) who stated that the S-L Therapist exists only as "a pure Con-Sequence of the creation of people with communication disorders; and the Sub-Sequence of the relationship between them and us: without *them*, *we* cannot be" (p. 9).

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In relating to her patient the S-L Therapist is more than a therapist employed to remediate his or her communication difficulty. Although the presence of a communication barrier is what initially precipitates their meeting, the S-L Therapist's primary focus is on the *person* with the communication difficulty and not exclusively on the actual communication disorder. All study participants described their view of a patient as an individual within a greater system such as a family or community. Although the S-L Therapist's relationship with the patient's family will be discussed thoroughly in the next section, for this section it is important to note how, when managing her patient, the S-L Therapist carefully considers the patient's family or significant other, as the family usually becomes part of the intervention process whether directly or indirectly. When the S-L Therapist takes these things into consideration and starts to understand the patient's self-perceptions, needs, values, feelings, experiences and expectations, she can begin to tailor his or her strategies and behaviours so that the outcome is optimal (Flasher & Fogle, 2004, p. 89). Viewing the patient holistically is useful in that the therapy process most often involves more than direct therapeutic intervention. She is required to address issues which although are not directly related to the communication difficulty, if left unresolved will limit the change she can effect. This requires her to address other needs and concerns being able to intervene in the communication difficulty. While the S-L Therapist has her goals and expectations, so does his or her patient. At times the patient may be overly optimistic or have unrealistic expectations for his or her progress, and about the S-L Therapist's ability to facilitate those changes (Flasher & Fogle, 2004, p. 89). Mutual discussion between the patient and the S-L Therapist about goals and expectations can decrease anxiety and unrealistic expectations.

The S-L Therapist-patient relationship focuses on empowerment and involves the provision of tools for improved communicative interaction. The S-L Therapist's understanding of the necessity for adequate speech and language, in order to carry out daily human interactions, informs her motivation and ability to provide precise and useful tools for each individual patient. Further, her intimate understanding of how a communication difficulty severely limits a person's ability to interact effectively with his or her world to gain communicative power inspires her to assist in whatever way she can. The importance she places on gaining communicative power, explains her strong motivation to equip her patient with highly effective communicative tools for everyday life to facilitate successful social integration. Of high priority to her is the ability to

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make long-lasting investments into the life of her patient in order for that patient to use communication to achieve his or her goals and create a better life for him or herself.

5.4.1.1 The question of "fixing" the problem

All study participants described a significant issue in the S-L Therapist-patient relationship as being that of "fixing" (P2) the communication or swallowing difficulty. Although she helps many patients to the point of improved communicative functioning, she seldom reaches a definitive end to her intervention or point where her patient shows a complete recovery. For the S-L Therapist, this issue raises questions about how much therapy is enough, when to stop intervention, and an examination of therapy goal-setting principles. As communication disorders are often "life long disabilities" (P5), the S-L Therapist needs to explore all possible avenues in her intervention approach to ensure that the patient has benefited in some way from her intervention. The S-L Therapist experiences pressure from the patient and/or family if they believe she is able to bring about a quick solution to the problem, as illustrated in the words of participant 2 who said "I think often when they [patients] arrive, they expect a quick fix, they don't expect sort of long term therapy, having to attend weekly sessions". This again raises the issue of whether S-L Therapy services should be offered at a tertiary level hospital. For the typical member of the public, a hospital visit is normally associated with medical doctors, medical conditions and medication. Thus one can understand why patients who have perhaps never accessed S-L Therapy services view therapy in the same way as a consultation with a medical doctor, and from my own personal experience refer to the S-L Therapist as "Doctor". The traditional medical model as we know it also contributes to this discussion in that if a patient views the S-L Therapist-patient relationship in the same way as the traditional doctor-patient relationship, he or she will view the S-L Therapist as all-knowing, in charge, in control and prescriptive. Further, he or she will view themselves as playing a passive role, and as being the recipient or co-operator in the relationship rather than mutually participating in the process as described in the bio-psychosocial model of healthcare which S-L Therapy ascribes to.

Helping in this relationship does not always involve physically doing something. Current study participants described "being there" (P1) for a patient in the role of supporter, advisor, or counsellor as equally valuable as actively carrying out therapy activities. Participants stated how offering their patients emotional support,

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APPENDIX G

Opening interview question

"Tell me as fully as you can about your experience of being a Speech-Language Therapist in the Western Cape public service. I'd like you to think of as many different aspects of being a Speech-Language Therapist as you can and describe them as fully as you can"

Probes

- choice of profession
- profession expectations
- personal change, growth and development
- characteristics of effective/ineffective SLTs
- professional challenges
- influence of personality on professional outcome
- health beliefs
- coping strategies

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encouragement and reassurance is an effective mobilising technique, as is offering them permission to be open about how they are feeling. This helps release some of the overwhelming emotions patients experience, builds trust between the therapist and patient, and allows the S-L Therapist to achieve results even through not carrying pout specific therapy activities.

Environmental stressors play a significant role in the development of communication difficulties, "perpetuate the current situation" (P5) and can act as barriers to therapeutic progress. The S-L Therapist counteracts these limitations by acknowledging the pressures her patients face in order to build trust by demonstrating to them her understanding of what they contend with on a daily basis. She also attempts to help patients and families understand how their social situation is related to the presenting difficulty in the hope that they will learn to identify the risks and make changes to their environment. In these cases, she focuses on the aspects of her patient's difficulty that she *can* change, always acknowledging when and in what situations she is *not* able to assist. The S-L Therapist remains mindful of the boundaries laid out by the S-L Therapy scope of practice, terminating therapy or referring on when a patient requires assistance outside of her skill set. Participants reported experiencing a sense of guilt at time of termination; when knowing that the help her patient requires will be difficult to access or will require co-operation and motivation from a person other than the patient which is not forthcoming.

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Managing patients from poor social circumstances is not new to the health professions and within the social work literature the currently accepted view is that the difficulties many patients face are linked in diverse ways to their social, economic, and political status in society (Lloyd et al., 2002). According to Jones and Novak (1993) for social workers, bringing about change in poor social circumstances is difficult as they are so overwhelmed and overloaded that they have "little time to reflect on what they are being asked to undertake" (p. 210). Collings and Murray (1996) reported how social workers in their study described the main feature of client-related stress to be feeling unable to answer or solve specific client problems due to societal circumstances especially in the face of the public's perception of their ability to do so. For current study participants, examining the environmental stressors at play in the patient's lives assists them to further understand his or her difficulty, although does not guarantee therapeutic progress. By explaining the environmental risk factors to her patients she is

also able to highlight perhaps why intervention will take the amount of time it will, require the amount of attention from them it will, and produce the results it will.

5.4.1.2 The question of language

Language is the tool S-L Therapists use to remediate communication difficulties. Speech, verbal language, written language and non-verbal cues are used both to assess which areas of communication are problematic for the patient. Thus the S-L Therapist-patient relationship is a highly communicative interaction in which the S-L Therapist is usually linguistically stronger than her patient. A significant barrier to this interaction arises when she does not understand or speak the same language as her patient, or when her patient cannot understand or speak a language in which she is comfortable. English and Afrikaans speaking patients were not reported to present any difficulty for current study participants, with Xhosa speaking patients in particular (as well as other official South African languages) presenting the greatest difficulty as none of the participants are competent in languages other than English and Afrikaans. In this situation although the S-L Therapist is usually able to conduct a basic assessment using gesture, pictures, or family members to interpret, she cannot perform formal assessments, obtain accurate results or provide adequate intervention beyond a basic level. This is a source of tension for the S-L Therapist, as although she has the knowledge and is trained to provide the required services, has no tools to do so. Perhaps this could be compared to a physiotherapist attempting to mobilize a patient with no arms or hands to lift him. Study participants described this issue as very frustrating, with one participant viewing it as the provision of S-L Therapy intervention to "an exclusive *elite* group who can speak English or Afrikaans" (P2) and who are perhaps "too financially impoverished and not as educated about what services are available to them" (P2). In my personal opinion this statement highlights the fact that if Xhosa speaking patients were informed that they have the right to receive S-L Therapy in their mother tongue, there would be increased pressure on S-L Therapists and the employer to provide it. Currently, the issue of why S-L Therapy intervention is not available in Xhosa is one not even questioned by Xhosa speakers accessing public service healthcare.

5.4.1.3 Intervening in isolation

Study participants working predominantly with children reported that their relationship with them as lacking adequate direction. The S-L Therapist is often the first health professional to see the child after identification of a speech or language difficulty

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by the community health clinic sister or classroom educator. This is problematic as she sees the child with possibly only a brief Day Hospital or school nurse referral letter and then is expected to diagnose the problem and set a management plan into action. Unless the referral letter or person accompanying the child is able to provide specific information, decisions are made without the support of a medical diagnosis, developmental assessment, or psycho-educational assessment. This can cause a great deal of wasted time if new information comes to light later, meaning the management plan has to be revised.

In the case of paediatric patients, complementary services that would assist her in making a diagnosis, such as medical services, physiotherapy and occupational therapy, are either not available even at tertiary level or take time to access. Where no services exist, accessing these services involves referring the patient to community services with no guarantee of him or her being seen due to long waiting lists and lack of adequate staffing. In the case of psychological and psychiatric services (Department of Education's school Psychologist and Department of Health's paediatric psychiatry and psychology services) which are only available at tertiary level, the waiting period can be up to six months. As no S-L Therapy services are currently available at community level, even if the patient is able to access support services such as occupational therapy in the community, he or she will not be able to receive multiple interventions that will include S-L Therapy. In such cases the S-L Therapist will either continue intervening from a tertiary level in the absence of complementary services, or alternatively refer to the community and run the risk that the patient will not be able to access both services concurrently choosing to access the logistically easier one (which is usually not S-L Therapy). Managing children at tertiary level means that she works in isolation with little or no input from other professionals and often intervenes in areas outside of her skill set e.g. addressing issues of handwriting which should be seen by an occupational therapist. There is therefore is minimal progress, in comparison with what may have been achieved if the patient was receiving the comprehensive package of intervention. The S-L Therapists experiences feelings of isolation and helpless as she attempts to intervene as best she can.

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Further, a large portion of the S-L Therapist's paediatric and adult caseload do not require any tertiary level support and are only seen for S-L Therapy intervention at the hospital level, as no suitable services exist in the community. Logistically the S-L

Therapist is not able to manage the number of such patients, and soon becomes overwhelmed by the magnitude of the task. This leads her to become disillusioned, hopeless, and seriously question her effectiveness as a service provider.

5.4.2 Speech-Language Therapist - family relationship

5.4.2.1 A family-centred approach

In relating to her patient's family members, whether it is a spouse, a parent or sibling, study participants described using a family-centred philosophy of service provision. The well-described family-centred philosophy emanates from family-systems theories and ecological theories of child development (Hammer, 1998).

The first assumes that an individual can only be understood in context because of the relationships that exist between that individual and the members of his or her system (Hammer, 1998). It also assumes that the behaviours of the individual are influenced by others within the system and that meaning is assigned to the behaviours, by the person observing the family. The family is assumed to be the recipient of the service and the larger context in which behaviours occur becomes the focus of therapy (Becvar & Becvar, as cited in Hammer, 1998, p. 6). The second, namely the ecological theory stresses the importance of exploring the context in which behaviours exists and looking beyond the immediate setting of the patient. Furthermore, like family systems and ecological theories, the ethnographic approach observes the individuals' behaviours in the contexts in which they occur and develops conclusions that arise from what is observed (Hammer, 1998).

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Within the family-centred philosophy, the approach used by current study participants appears to be more in line with ethnography where the S-L Therapist seeks to understand the family's particular values, priorities, interpretation of events and decision making processes (Hammer, 1998). The S-L Therapist aims to develop a perspective of the family as opposed to a mere understanding of it and as one study participant described, "really getting to know them beyond the *superficial* level, to just go a bit deeper" (P4). In doing this she reframes her approach by attempting to describe the family from their point of view and ascertaining the family's beliefs about the child and goals for intervention (Hammer, 1998). Although she does not give up on sharing her professional point of view, she does give the ultimate control for decision making to the parent (Jones, Garlow, Turnbull, & Barber, as cited in Hammer, 1998, p.19).

One participant described her approach as "it's not a case of *telling* them what to do, it's a case of advising them on what we think would work, and asking them *what they* think and then drawing up a plan *together"* (P7). The togetherness that is formed through this process allows the S-L Therapist to partner with the family rather than be in opposition to them. Her ability to build the partner ship within their values and beliefs facilitates the process of intervention and the family will be enabled to implement her suggestions. They will in turn view the service as better meeting their needs, which will lead to increased participation in collaboratively planned interventions. By placing them at the centre of the process, giving them the opportunity to state their goals and "be heard" (P6), she allows them to take the lead, which gives her the advantage of seeing how they operate and which approach she should take to obtain the best results. Excluding them from decisions and dictating to them will only make them defensive and leave them feeling unheard and dissatisfied. Through allowing the family space to make known their goals and expectations, she is able to make decisions about how to mobilise them and use their strengths to her advantage.

The participants in this study described how using the family as a "resource" (Briggs, 1998, p. 78) for the patient's progress is sustainable as they draw on what is already in place and add to it, instead of attempting to construct something brand new. An example of this is in the case of a child with a language delay, which may involve finding out when the family spend time together and making suggestions of how to improve those times, rather than trying to implement a new routine for family time that may be inappropriate. Listening to the family and allowing them to state their priorities for their child or family member helps the S-L Therapist to pitch her intervention at a level that will be acceptable to the family (Hammer, 1998). This will ensure her decisions and choice are well received and not dismissed by the family as being inappropriate and of little use to them.

The S-L Therapist needs to consider what constitutes a communication disorder in the particular family, what roles each family member play in decision-making, and the family's cultural expectations of acceptable intervention. This insight assists her in addressing the family's possible expectation for a "quick fix" (P2), and in understanding why a family "*don't* perhaps *allow* themselves to understand fully *or*, don't take the responsibility that they *could*" (P5). This is consistent with Friehe, Bloedow, and Hesse (2003) who describe an important aspect of the S-L Therapist's interaction with the

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family being to "take into consideration the context of the family's overall life" (p. 216).

5.4.2.2 Loss, grief and communication disorders

Current study participants described client intervention as fully involving the family. Her challenge in working with the family throughout diagnosis and intervention is to understand the communication disorder's impact on the family, the sense of loss that may accompany the diagnosis of a communication disorder, and how to best assist with coping strategies. Stone (1992) states that it is critical that the S-L Therapist is able to identify and examine both problematic relationships and situations and implement beneficial solutions. She keeps the communication lines between herself and the family open by acknowledging the emotions that are associated with communication disorders, as well as the family's grief process at a diagnosis of a disorder (Briggs, 1998). Another goal of the S-L Therapist is "to tap each family's resources in order to mobilize them for their own identified problems" (Briggs, 1998, p. 78). This means that the S-L Therapist no longer drives therapy but instead builds therapeutic alliances with the family and helps them help themselves.

The diagnosis of some communication and swallowing disorders can cause the family to experience a sense of loss as they adjust to major changes in habits, roles, relationships or environment (James & Cherry, as cited in Friehe, Bloedow, & Hesse, 2003). Powers (1993) states that loss is typically perceived when the "reality of life is changed in such a way as to make it less preferred than wanted or expected" (p. 121). "Episodic grief" (Friehe et al., 2003, p. 212) is the type of grief families experience at the loss of normal communication or ability in a family member. These authors go on to explain that families rarely anticipate that they may have a child diagnosed with a communication disorder and often have to learn to cope with the loss of the perfect child who is seen as an extension of themselves. Powers (1993) explains that the fact that loss is often experienced in response to the disability of a child or family member "is a reflection of predominant cultural norms that emphases health and abled-bodied-ness, as criteria for happiness and full acceptance within society" (p. 121). This is illustrated in the words of one study participant who described a mother's devastation at having a baby born with [disorder] when all she wanted was "a perfect baby" (P6). This mother's statement is consistent with other parents who grieve over the "original child who is changed forever" (Powers, 1993, p. 121).

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The S-L Therapist and family are often not well equipped to understand or deal with episodic grief and the recurring sense of loss inherent in a diagnosis of a significant and long-standing communication or swallowing disorder (Friehe et al., 2003). The grief over a communication or swallowing disorder is complex and appears to be dependent on family circumstances, cultural expectations, gender and the nature of the disorder. The complex process of coming to terms with a communication disorder and learning to live successfully with it requires a fully collaborative team approach.

The S-L Therapist's dealings with families can be of an extremely sensitive nature, for example, in the case of the diagnosis of a terminal disease or severe disability. These situations require her to have a great deal of wisdom and maturity as described by participant 4 when she said "I think it takes more *maturity* than your *years*". Another study participant described how in sensitive situations the S-L Therapist is able to give the family "more than mere intervention" (P1) and fill other gaps. In these situations she takes on the role of a friend and support, counsellor and advisor, is highly empathic, always respectful and appropriate in her use of power and influence.

5.4.3 The Speech-Language Therapist's relationship with fellow Speech-Language Therapists

5.4.3.1 Public service colleagues

Study participants described their relationship with fellow S-L Therapists as being vitally necessary and supportive. Participants stated that having a common background in terms of training, a shared desire to help others, a passion for communicative competence, patient well-being and clinical excellence builds a sense of community. Colleagues offer each other backup and a permanent platform where discussion and advice is freely available. The structure of the S-L Therapy departments within each of the tertiary hospitals where participants work were described as a space in which to discuss issues and brainstorm therapy ideas. This prevents the S-L Therapist from feeling isolated and "completely stranded" (P1) especially when managing difficult or complex cases. Study participants described their relationships with fellow S-L Therapists as safe and they feel free to ask for help and support which increases their sense of accomplishment and creates a sense of belonging.

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The issue of collegial support appears to be significant in other health professions. A study investigating role stress amongst school counsellors highlighted peer consultation as an important means of professional support (Culbreth et al., 2005). In a study investigating recruitment and retention of health professionals, adequate support from fellow staff was significant for professional satisfaction for physiotherapists, occupational therapists and S-L Therapists (Randolph, 2005, p. 55). Further, a study conducted amongst mental health professionals including community psychiatric nurses, ward nurses, psychiatrists, psychologists, occupational therapists and social workers, found contact with colleagues to be the most frequently mentioned source of satisfaction (Reid et al., 1999) with one current participant stating that "I look forward to work, I work with a really good team and I feel enthusiastic about coming to work" (p. 303).

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The S-L Therapist not only receives emotional support, experiences a sense of belonging and has access to advice from fellow S-L Therapists, but engages in mentoring relationships with colleagues. The inexperienced S-L Therapist is mentored through having opportunities to learn from and assist more experienced therapists. This facilitates skill transferral which in turn ensures that more than one S-L Therapist is able to practice in a certain clinical area. This becomes particularly useful when colleagues are on leave or involved in other activities. A consequence of mentoring junior S-L Therapists is that experienced therapists spend a great deal of their time and energy training, supervising and discussing cases which leaves them with little time for their own clinical development. One study participant stated that even with her level of experience she too desires to be mentored, although few mentorship opportunities are available to her.

Having an established S-L Therapy department also ensures that the patient load is shared evenly although S-L Therapist's usually have one or more areas of interest. The S-L Therapist is given a choice regarding the clinical areas she wishes to work in and is largely accountable for her own time. She controls her own professional development within that area, defines her own boundaries and therefore described feeling free to develop as an independent S-L Therapist without being held back by her superior. In an international study of public health system occupational therapists, participants described how autonomy as a clinician creates great job satisfaction, how being able to freely plan their day and treatment sessions increased their ability to solve

problems. Feeling trusted by their manager was highly re-enforcing (Moore et al., 2006b).

In the public health service setting, the process of filling vacated posts takes time, and so in times of staff shortages the S-L Therapist is expected to see more patients in the same amount of time previously allocated when she saw fewer patients. Patients waiting to be seen are also expected to be attended to as rapidly as they were when more staff members were available. Current study participants described how in times of staff shortages, even though they got through the work, they seldom felt that they were working fast enough and covering enough ground. One participant described feeling that "you could never be on top of the work, there was just always a waiting list" (P4).

5.4.3.2 Privately employed colleagues

Study participants described their relationship with privately employed S-L Therapists as one of intermittent tension with the definite existence of a divide between the 2 groups. Privately employed S-L Therapists make negative comments towards them about working in the public service, pitying them and questioning them about their career ambition. This is illustrated by one participant who stated, "you go to any gathering of therapists and they [privately employed S-L Therapists] say 'oh, you're *still* at [hospital's name] shame!' and it's like they're saying 'can't you do anything *better* for yourself…you're still *landed* here'". This participant described such comments as being difficult to reconcile. Even though her preference and personal choice had been to work in the pubic service, comments like these make her feel inferior. In addition there is a perceived lack of resource and knowledge sharing from privately employed S-L Therapists, although public service S-L Therapists are often contacted by privately employed S-L Therapists asking for help with patients.

One may wonder why such a divide exists since both groups of S-L Therapists have received the same training and perform the same functions (even though employed in different sectors). Pillay (2003) presented a model of how members of the S-L Therapy community may view one another as either "insiders" or "outsiders" (p. 54). This depends on how the individual positions himself or herself in relation to the greater S-L Therapy community. He described how the S-L Therapist belongs to a community of S-L Therapists and to a wider community of health practitioners (see figure 5 adapted

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from Pillay, 2003, p. 54). Pillay (2003) argues: "individual biographies are viewed relative to an assumption that we possess, ascribe to, and align ourselves with our communities' ideological-practical positions" (p. 54). Current study participants who work in the public service described aligning themselves with a certain position within the greater S-L Therapy profession. This position is that of choosing to work in a public service setting with all the issues and circumstances that go along with that. Likewise, privately-employed S-L Therapists have also aligned themselves with a certain position within the same S-L Therapy profession which is choosing to work in the private sector.

Figure 4. A community experience of public-employed and privately-employed S-L Therapists (Pillay, 2003)

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Pillay (2003) describes how membership of communities may incorporate (a) those who define themselves as members (an 'inside' membership), (b) those who are defined by others (e.g., professional associations) as members, and (c) those who are situated as 'outside' members to the community in question (p. 55). He also stated that "if a practitioner claims to operate outside of the dominant values of the professional community, such positions are valued as operating or existing in *relation* to the community of professional practitioners, and may be regarded as a type of insider-outsider membership" (p. 54). Relating this to the current study, privately-employed S-L Therapists who have positioned themselves differently (researcher's note: not incorrectly) to public service S-L Therapists within the greater S-L Therapy community,

can be described as "'outside' members to the community in question" (p. 55); and vice versa. This creates a sense of community within each of the 2 sectors (public service and private sector) and a definite sense of assignment and loyalty to one or the other group.

5.4.4 Speech-Language Therapist – public relationship

The S-L Therapist is frustrated by the public's ignorance and misperception about what her job involves. Study participants described how comments and remarks made by members of the public, about the profession, clearly show their ignorance. This is illustrated in the words of participant 4 who quoted a comment repeatedly heard throughout her career as "oh…you teach elocution, and teach people to speak well" (P5). The S-L Therapist experiences the lay person's perception of the profession to be simplistic, making her feel underestimated and underrated as she knows and understands her work to be far more complex and intricate than commonly understood. The profession's former title of 'Speech Therapy' has contributed to the misperceptions, as it is unclear and misleading, limited to speech, neglects the language component, and makes no reference to the relationship between speech, language, cognition and learning.

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Study participants highlighted feeling significantly misunderstood compared to other health professionals. They described a desire for the public to understand the S-L Therapist's role, with the same clarity they do of a physiotherapist. In a study of hospital occupational therapists (Moore et al., 2006a), having a role which is misunderstood by the public was a major source of job dissatisfaction. Participants reported that in comparison to physiotherapy, the public have a very poor understanding of the role of occupational therapy. This was reflected in one participant's words who quoted, "if someone asks you and you say 'occupational therapy'… you can see in their face that they don't know what you do… whereas if you said 'physiotherapy', they would know straight away" (p. 23). Current study participants described how having to constantly explain and "defend" (P5) the profession to others is frustrating and tiring. This findings is consistent with public health system occupational therapists who described having to constantly "market" themselves as a major frustration (Moore et al., 2006a, p. 23).

Significant to the current study's participants was the feeling that the acknowledgement and respect they receive as professionals is directly related to how well-known the profession is to the public. She finds it difficult to define her role and put into words what it is she does, and using examples of the types of patients she sees makes this task easier and less tiresome. One dual register (S-L Therapy and Audiology) study participant described how when talking to a lay person she will usually focus more on the Audiology aspect of her work, as hearing difficulties are easier to explain and better understood by lay people than speech and language disorders.

Not only do the public hold misperceptions about S-L Therapy as a profession, but also have their own ideas regarding the public service setting. While the S-L Therapist experiences her work environment as being "nurturing" (P6) and "almost like home" (P4), study participants reported the public to view it differently. They reported how people make assumptions based on the exterior appearance of the hospital or on what they have heard in the media about public service hospitals in general. One participant stated how "people just don't have any idea of this context" (P4) and "see only the dirt and things peeling off the walls" (P4). This particular participant felt disappointed by the perceived discrepancy and wished lay people would not make judgements about the public service without giving it a chance and perhaps learning more about what goes on inside.

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5.4.5 Speech-Language Therapist - Doctors, nursing staff and members of the multidisciplinary team

The S-L Therapist's relationship with doctors, nursing staff and members of the multidisciplinary team is highly affirming yet challenging. Study participants described feeling affirmed by team members who respect them and appreciate them as having a valuable role to play within the team context. Commitment to the team and humility on the part of the S-L Therapist helps to develop good working relationships. This results in mutual respect for each other's clinical skill and develops the freedom and confidence to exchange knowledge and expertise.

In the hospital setting, patients often require intervention in addition to that offered by the S-L Therapist. The availability of a multidisciplinary team means she is able to access the help of fellow professionals, which in turn enables her to offer more effective and holistic patient management. Lessons learned from working in a team

context were reported to include realising where S-L Therapy fits into the big picture and the importance of interdependence. The S-L Therapist's role is complimented and enhanced by the presence of team members who bring their specific skills to the team. One participant described how having others to reinforce her decisions and give her advice and assistance significantly reduces the pressure and expectation she feels to meet all her patient's needs. This illustrates the team's role in producing better quality service than its individual members working as solo practitioners (Benierakis, 1995). Due to time constraints, health professionals in this setting do not always accomplish the amount of work they would ideally like to. The team approach enables the professional to accomplish more in less time which increases his or her productivity and sense of accomplishment.

Benierakis (1995) states that a well-functioning multidisciplinary team is able to provide the most comprehensive way of assessing and responding to the complexity of issues affecting health and disease. Study participants described experiencing high levels of willingness from team members to work collaboratively making their daily experiences more enjoyable. This is consistent with a study of occupational therapists who reported that job satisfaction is derived from being part of a multidisciplinary team and that good communication and co-operation among team members increased their sense of fulfilment (de Wesley & Clemson, 1992).

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In contrast to the S-L Therapist's positive experience of teamwork, ignorance and misperceptions about her professional role exist even amongst medical personnel. Study participants described feeling "side-lined" (P7) compared to professionals from seemingly better understood professions. They also described not consistently feeling recognised as equal members of the team. Participant 3 commented specifically on how the remarks and actions of medical doctors in particular make her feel "stupid" and that her intervention techniques are not sufficiently academic. Although not specifically commented on by current study participants, the literature states the underlying presence of profession ignorance and misperception is seen in both an absence of referrals to the profession or as was found in an Australian study of occupational therapists, inappropriate referrals being made (Moore et al., 2006a).

In a study looking at how social workers experience their work, participants stated that their role is misinterpreted as "just being nice or doing the common sense

things that anyone can do" (Dillon, as cited in Lloyd et al., 2002, p. 257). The social work literature reveals a number of studies which have focussed on the public's view of the social worker, as being a source of stress resulting in challenges to the legitimacy and identity of social work (Collings & Murray, 1996; Gibson, McGrath, & Reid, 1989; Smith & Nursten, 1998). A group of occupational therapists also reported feeling "devalued" (Hasselkus & Dickie, 1994, p. 147) and having their skills "unused" (p. 147) or "blocked" (p. 147) by certain team members. Current study participants described similar experiences in that talking and swallowing are viewed as automatic processes that everyone can do, and are less of a priority than other more obvious impairments. This is illustrated in the words of one participant who said "for many of them, [stroke patients] it is about getting back to *walking*...sometimes much *more* than communication" (P4). The specific experience of having a skill "devalued" or "blocked" is consistent with the experience of one current participant as she related the repeated situation where the decision to send a patient to a rehabilitation hospital almost never considers the S-L Therapist's opinion. She reported that should a stroke survivor be left with both a physical and communication deficit rehabilitation would immediately be recommended, however if left only with a communication difficulty, the referral to rehabilitation would not be automatic. She further reported that in most cases even after strong motivation, her opinion is usually disregarded, leaving her feeling disrespected as a professional.

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5.4.6 Speech-Language Therapist – educator relationship

Study participants who work with the paediatric population described their relationship with school educators as a poorly collaborative one. They stated that while some educators make an asserted effort to forge collaborative partnerships with the S-L Therapist's who manage their learners, many still do not see the need for this partnership. There is a history of tension and guarded collaboration between the Western Cape Department of Education and the Western Cape Department of Health which is experienced by S-L Therapists. This lack of collaboration makes "effective management of these clients very difficult" (P5) and creates a barrier for the development of mutually effective working relationships between professionals from each department. Furthermore, both the historical and current absence of S-L Therapy posts in mainstream education limits her access and opportunity to train mainstream educators about language and associated difficulties from her perspective.

A lack of collaboration between S-L Therapists and educators is not an uncommon phenomenon. A study carried out in the UK looking at the barriers to collaboration between teachers and health department S-L Therapists revealed similar tensions to those expressed by current study participants. The study highlighted how children with communication disorders are "no doubt better served through close inter-professional co-operation and the joint planning of these two professions" (McCartney, 1999, p. 432). The study identified a functional barrier to collaboration as being the different ways professional collaboration is understood by teachers and S-L Therapists. The author stated that both teachers and S-L Therapists are accustomed to working as experts with their respective assistants, and not together. Although the S-L Therapist may be familiar with multidisciplinary teamwork, the teacher is less familiar with the concept and "where the assumptions of the S-L Therapist and teacher about the underlying nature of their working relationship differ, or are simply unexplored, barriers are likely to exist" (McCartney, 1999, p. 435). This finding can be related to the current situation in the Western Cape where although S-L Therapists are trained to collaborate closely with educators and other professionals, educators perhaps see their collaboration as existing only with remedial teachers and school psychologists within the Department of Education and not the Health Department. Overcrowded classes, multilingualism and poor social circumstances also present educators with barriers to the provision of education which can be overwhelmingly stressful and taxing.

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In another study looking at teacher-S-L Therapist collaboration (Hartas (2004), factors described to support collaboration between teachers and S-L Therapists were good communication flow, adequate time to collaborate, shared beliefs and values, willingness to contribute, and willingness to adapt to change. Hindering factors were described as lack of time, limited communication, professional status/hierarchies, lack of quality, clash of terminology, and lack of formal systems to support collaboration.

McCartney's (1999) study also revealed that education is largely viewed as an "allocating service" (p. 433) where children receive a fixed number of years of education, irrespective of their individual situations and irrespective of how they perceive they have benefited. S-L Therapy services on the other hand are "commissioning services" (p. 433) where intervention is only offered on request and if seen as a priority. The study concluded that due to these barriers and to the fact that the two contexts (education and health sectors) "differ so radically" (p 432), the two

systems will most likely proceed in parallel, with those working in them at times being confused by the assumptions and practices of the other. These findings are consistent with the views expressed by current study participants in that until the two departments can collaborate effectively in the best interest of the child, "children will continue to sit in mainstream schools and fail" (P2).

5.5 Lived Body (corporeality)

'Lived body' refers to the fact that people experience the world through being bodily present in it and experience others through bodily means (van Manen, 1990, p. 103). Other than in exceptional circumstances, it is impossible for humans to experience the world and personal relationships exclusively though their physical body, because human beings are complex and comprise more than anatomical structure. In order to describe the S-L Therapist's lived experience as it relates to being 'bodily present', an examination of her physical, mental, intellectual, emotional, and spiritual elements of 'being' is required. The 'lived body' lifeworld relates to all five themes and is described in the following way:

5.5.1 The physical experience

The S-L Therapist is physically active during her working day. Her work is not a passive desk job, but rather is a busy and dynamic one as she moves from location to location. She works in a variety of wards and clinics in the hospital. The design of the hospital buildings impacts other work as she has to move from one section to another over in some cases long distances. With the limited time to see and treat clients and complete the associated administration, she has little time for self reflection which is stressful and can result in reduced productivity. Consistent with this is the experience of nursing staff who stated that the pressure to keep up with a strict pace of getting everything done means that they have little time to spend with patients. This leads to disappointment as many of them entered nursing in order to care for patients which is not always possible in reality due to the chaotic nature of hospital work (Reid et al., 1999).

Promotion to management level involves becoming an administrator as "currently there exists no opportunity for promotion in an exclusively clinical arm" (P6). The S-L Therapist in a management position carries the responsibility of having to

simultaneously manage her staff, monitor their output, design new protocols and perform clinical duties, often without adequate One study participant reported how even after being recognised as having leadership and managerial qualities, she experiences limited decision-making power regarding staff matters. She described being burdened by hospital-level political pressures which do not ultimately relate to the running of her department. The time she spends on these types of issues decreases time for patient care.

Raising awareness about the profession is a time-consuming activity requiring a large amount of work outside of work hours. Even though study participants would like to do more in terms of professional advocacy, family commitments, relaxation activities and social activities outside of work take priority. In terms of professional advocacy the profession of S-L Therapy was described by more than one study participant as "inert" (P5), "silent" (P7) and "complacent" (P5). This is significant as, despite the profession having the fewest number of health therapy posts of health therapists and the obvious ignorance surrounding the profession, "there are few active people who are involved in promotion of the profession and public relations" (P5).

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5.5.2 The mental and intellectual experience

The S-L Therapist in the tertiary hospital setting is on a continual learning curve which requires a great deal of mental and intellectual energy. She has to refine her clinical skills and increase her theoretical knowledge, as she is rarely assigned to a single clinical practice area and so simultaneously manages patients with a variety of clinical disorders. This is taxing even for the experienced therapist. A study participant reflected that she had to "change gears" (P6) between disorder groups numerous times a day. This can leave her mentally drained and never feeling completely at ease and fully competent in one clinical area. Within each clinical area, the S-L Therapist is challenged to develop a fuller and deeper understanding of her patient's difficulty. She is constantly involved in a process of evaluating and adjusting her intervention approach. Throughout the therapy process, as one facet of her patient's disorder improves, a new aspect may emerge leaving her temporarily flawed regarding her next step, and has to constantly trouble-shoot and problem-solve.

The therapy process is not static, therefore the S-L Therapist needs to be prepared for every eventuality. The lack of predictability of outcome or therapeutic

progression requires a flexible intervention, an openness to "trying new, or alternative ways of establishing behaviour" (P2) and "looking at lots of different possibilities and ways of doing things" (P2). Her approach to clinical challenges needs to be pro-active and one of taking the initiative. This is to ensure she reaches a solution. It is important that she understands and views her work from a solid scientific basis as thinking about therapy analytically will assist her in solving clinical challenges. The varied ways in which patients progress and disorders change during the therapeutic process makes her theoretical approach to assessment and management all the more important. This raises the importance of continuing professional development known in South Africa as CPD. Continuing education is necessary regardless of whether or not it is mandatory and helps S-L Therapists to remain current in their practice and knowledge base (ASHA, 1994). Lubinski & Frattali, 2001) states that continuing education assist the S-L Therapist "gain new skills to work more effectively and efficiently, stimulates creative thinking, and opens networks with other professionals" (p. 193). Current study participants stated that although they would like to participate in such programmes, workshops and in-service sessions, very few such opportunities exist in Cape Town and those that do, need to be financed by herself personally. Attending national conferences and workshops is expensive, and again mostly require her to pay for herself to attend. This is consistent with occupational therapists who stated the lack of funds to engage in professional development was a great source of dissatisfaction (de Wesley & Clemson, 1992). From my personal experience as a S-L Therapist, the number of CPD events available are significantly less than those offered to occupational therapists and physiotherapists. Even amongst private sector S-L Therapists, there is a lack of such events. This may be due to a lack of expertise which prevents S-L Therapists presenting such workshops or lack of interest for S-L Therapists to attend these out of work hours for various reasons.

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Another motivation for S-L Therapists in this setting participating in CPD, is that S-L Therapists with all levels of experience are required to present cases during ward rounds and are asked to provide clinical insight, suggest a management approach or explain the management choice. She needs to have a clear scientific and evidence-based understanding of a wide range of communication-related disorders and management options, have relevant knowledge close at hand, and exhibit confidence when giving feedback. A participant described how she found it daunting and uncomfortable when asked to comment on, or make management decisions about

patients with complicated or unfamiliar diagnoses. In these cases, feeling out of her depth due to lack of knowledge encourages her to acquire new techniques to the point of clinical competency as one participant described "and if there's been a tension or I could see that they thought that I was talking *rubbish*, I think it's always just *prompted* me to *go away, get* to *really be smart* and come back with a smart answer to show him...we *are* smart, and they've turned the corner" (P6).

The novice therapist has the additional pressure of the hospital's fast pace which makes demands on her to perform equally well across all clinical areas. She is required to exhibit the same level of clinical competency as an experienced therapist. Novice physiotherapists reported the same experience in that although they viewed themselves as new gradates, other members of the health care team treated them as "a therapist" (p. 148) and expected her to perform equally to that of an experienced therapist (Miller, et al., 2005). The high academic thrust of the hospital setting means the novice S-L Therapist usually feels particularly anxious about her professional competency. Participants described in the early days of their careers they felt a great deal of pressure to perform. Novice S-L Therapists are not alone in feeling anxious about their clinical competence. A study of novice physiotherapists revealed how in the first few weeks of work they felt "exhausted", "terrified", "intimidated", "scattered", "disorganised", and "overwhelmed" (Miller et al., 2005, p. 148). These descriptions echo one current study participant's experience where as a novice she reported always feeling "very insecure" (P6), and felt as if she "knew nothing" (P6) questioning how she could possibly treat her patient with her lack of knowledge. This experience is consistent with findings of Tryssenaar & Perkins (2001) who reported how new physiotherapists had moments of self-doubt and had concerns about their competence, and about not being as fast or as skilful as experienced therapists.

A current study participant highlighted the imbalance in skill and expertise acquisition in this setting. She stated how this setting provides the novice or inexperienced therapist with excellent mentorship opportunities from both more experienced therapists and other professionals. However as previously mentioned, the experienced therapist spends a great deal of time training junior members of staff which leaves her with little time to develop her own clinical skills. Intellectually mentoring others is tiring as it compromises the time she is able to spend on her own clinical development. Experienced therapists involved in high volumes of mentorship and

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student training reported how they have to spend a great deal of time and energy learning from reading textbooks and literature as opposed to having it demonstrated by a more competent therapist.

5.5.3 The emotional experience

5.5.3.1 The question of "fixing" the problem revisited

The most emotionally draining experience of being an S-L Therapist was that of seldom being able to "fix" (P1) their patients' difficulties. Although she does experience success, in some cases it is limited. Communication disorders are complex and due to her underlying desire to help, not always being able to help her patient or physically do something to make a difference can be emotionally distressing. In a study exploring the levels of satisfaction experienced by occupational therapists (Hasselkus and Dickie, 1994), participants reported a decreased sense of satisfaction when their client did not show improvement subsequent to therapy. They also stated that at times they felt as if they are "making no difference" (p. 147). In another study occupational therapists described the pleasure generated from being able to help someone achieve a goal as being a major motivation for doing what they do (Moore et al., 2006a). This is consistent with current study participants who described the great sense of satisfaction from being able to assist someone achieve a goal, with one participant stating how implementing change in someone is what "spurs me on" (P5). These descriptions as well as highlighting the satisfaction felt at helping a patient achieve a goal, also highlights the dissatisfaction felt when goals are not achieved despite the S-L Therapist's desire to make a difference.

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S-L Therapy intervention is usually a prolonged process, and the S-L Therapist may work with a patient for a number of sessions before seeing any improvement. In treating long-term rehabilitative patients who are not usually "immediately rewarding cases" (P2), she experiences less control over his or her progress and a reduced sense of accomplishment which can be frustrating. If a lack of progress continues for some time, she becomes demotivated and feels that her efforts are pointless. One participant recalled such times and said "I think after you've tried and tried and you haven't succeeded you eventually… you start giving up…" (P7). The same participant described how in the past after experiencing repeated unsuccessful attempts to help a patient, she had begun to give up on the possibility of a positive outcome, may withdraw, and become almost accepting of the inevitable. Participants

described how in treating certain medically-based communication and feeding disorders, intervention may last up to a few years. This is due to different stages of her intervention depending on the patient's age as opposed to more acute difficulties which she can resolve relatively quickly. Unlike more anatomically or physiologically-based disorders which typically have more predictable outcomes, the abstract nature of most language or cognitively-based communication disorders makes it difficult for her to measure the outcome of her intervention. This is difficult for her as the environment in which she works is medically-based and operates very much on definite outcomes in comparison to the disorders she treats. In reflecting on the nature of therapy a participant stated that more medically-based difficulties such as swallowing problems are easier to manage than "these *hidden* cognitive things that take l*ong* and *do* you make a difference?...and how do you measure it...and is it *spontaneous recovery*?" (P6). The S-L Therapist cannot always predict how fast her patient will progress or if they will even progress at all which can be unsettling for her. On the other hand, patients who progress quickly give the S-L Therapist a sense of success and accomplishment.

There are situations where the S-L Therapist is not able to help her patient at all. In these situations study participants described feeling either completely at ease knowing they had been honest with the patient and done everything possible, or felt disappointed that they could not do more. Some participants described a sense of guilt and of having let her patient down especially as patients "come to you with all this *hope*" (P3). For one participant, the hope patients placed in her ability to help them was particularly significant leading to increased guilt when she is not able to help someone. She feels their hope, sees it on their faces and hears it in their voices.

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One of the S-L Therapist's primary responsibilities is to inform her patient and his or her family what she is *able* to do as well as what she is *not* able to do to help. She described how her own discomfort in the situation has in the past tempted her to "soften the blow" (P6) by not being completely clear about what is or is not possible. She stated how she has learned the value of being honest with a patient in telling them "it's this and this, I *can* do this, this and this and I *can't* do this and that" (P6). Over time, she has learned to resist making idle promises about recovery and rather use honesty to gain their trust. The novice therapist experiences a dichotomy of high expectations of what she wishes to achieve, and feelings of insecurity about her raw clinical abilities. She feels "a tremendous amount of *discomfort* and anxiety" (P6) when she is unsure of a

case, and should her patient not improve as she anticipated he or she would, takes it personally considering critically what she could possibly have done wrong or differently.

Working with patients living with serious or terminal medical conditions means that there are times when therapy is not indicated due to the disease progression. Informing patients and families that therapy is not indicated or giving bad news or a poor prognosis leaves her lost for words. One participant described feeling "incredibly humbled" (P6) and strengthened by the comfort her terminal patients often offer *her* even when they are very ill or on hearing bad news about their condition.

5.5.3.2 Becoming hardened

For this group of S-L Therapists, the repeated exposure to illness and suffering with the common sights, sounds and smells makes it easy to become hardened to the shocking reality of seeing people suffer "with even the most experienced professional feeling awkward and helpless" (Arbore, Katz, Therese, and Johnson, 2006, p. 17). A study participant described how when relating a story about a patient to a family member or friend, the person's shocked reaction alerts her to how much less she is affected by sad and tragic stories than she used to be. As the S-L Therapist witnesses the same scenarios repeating themselves day after day, she may "rate" (P4) the severity of a problem by comparing it to other patients with the same disorder. Gradually over time her baseline of how 'bad' a disorder is, gets lower and lower. She realises that she may rate a patient with a severe disorder as only 'bad', whereas to a lay person the same situation will be seen as 'devastating'. Another participant described how over time she has lost her sense of what normal is, and by seeing disorders as the norm, she seldom expects anything more. Arbore, Katz, Therese, and Johnson (2006, p. 25) describe how in such cases, the professional is often left to feel that there is nothing he or she can do for the patient except to *be* with the patient in their situation. One participant described at times having lost hope that miracles do happen and that recoveries can occur. The S-L Therapist may find herself approaching her patient from an aspect of 'deficit' thinking only about what he or she cannot do, instead of what he or she is still able to do. Health professionals have been described to react in different ways to seemingly hopeless situations. They either become over- or under involved which are described as unconscious counter transference feelings (Arbore, Katz, Therese, and Johnson, 2006, p. 22). The S-L Therapist's level of shock and surprise at patients who

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against all odds make unbelievable recoveries further alerts her to just how pragmatic and matter-of-fact she has become.

5.5.3.3 Being the 'underdog'

Continually having to explain what her work entails and what her role does and does not involve is exhausting. Being referred to as an elocution coach or "someone who helps people to speak well" (P5) frustrates her immensely. The existing ignorance surrounding her profession affects her to such an extent that one study participant stated feeling that it would have been so much easier to have chosen a different career.

Speech, language and communication disorders are not as concrete or as visible as physical ones is a difficult issue for the S-L Therapist. Participants stated that as people with communication disorders often do not visibly appear to have a problem, their difficulty is not well understood or acknowledged. Even in a group of people with different communication disorders, she is frustrated by the fact that the more visible the difficulty is, the more it is prioritised, and the more "invisible" (P2) it is, the less of a priority it is made. Along with this is the situation where a patient is only likely to seek her help for a communication problem that is negatively impacting on his or her occupation or quality of life. She struggles with the fact that a person with a communication difficulty is many times content to tolerate it for as long as it does not affect his or her life in a way that they cannot deal with it, rather that seeking help as soon as it appears. From participants' experiences, it appears that her passion for and understanding of communication as a necessary tool for life does not correspond with the way the public view it. Participants reported the pattern of children with learning disabilities attending a short period of S-L Therapy, defaulting, and then returning some time later when it becomes concrete or starts affecting his or her academic performance. By parents only prioritising and addressing the difficulty once it becomes visible, the child is usually older which significantly reduces her effectiveness in offering intervention. It is her intimate understanding of the magnitude and effect a communication difficulty can have on a person's life, (whether visible or not), that causes feelings of helplessness when it is not perceived in the same way by those taking responsibility for others. In her interactions with her patient, his or her family or educator, the S-L Therapist is frequently alone in her understanding of the underlying difficulty as "things which may have certain meanings or interpretations for *us* [S-L Therapists] may be interpreted and seen differently in a different sort of culture or

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environment" (P2). These views are consistent with the findings of Hartas (2004) who found shared beliefs and values as a supportive factor to collaboration between educators and S-L Therapists and hindering factors to be professional status/hierarchies, lack of equality, and clash of terminology.

Not only are her profession and the disorders she treats misunderstood, but so are the patients she treats. She experiences "the *lay person's attitude to* people with communication problems as one of *ridicule*" (P5) and she often experiences being "a recipient of the casualties of the lay person's attitude and actions towards them" (P5). By the time patients reach her they have tried numerous avenues to get help for their difficulty and have usually endured a significant amount of teasing and ridicule.

As already described, there are many advantages of working in this setting, however at the same time she struggles with the issues of lack of adequate posts, inappropriate salary levels, lack of career progression and lack of resources. Reflecting on this setting's shortcomings, one participant stated "I mean those are things you just have to work with, and if you're going in work in the public service you *know* you're going to struggle with posts, and with money, and with resources, so that's just something that you accept that you're going to take on as a challenge" (P7). Study participants reflected on the lack of role definition and status in that not all health professionals fully understand her role as she does. While in theory the multidisciplinary team comprises of a group of health professionals working together and contributing to the management of patients, she does not always feel like an equal member of the team. Adapting to this reality has entailed coming to accept that other professionals may not ever understand her role as well and intimately as she does and for this group of study participants it is this realisation that helps them understand why other professionals do certain things, behave in certain ways and make certain decisions.

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5.5.3.4 The experience of 'giving of oneself'

One study participant described how the S-L Therapist makes large daily investments into the lives of her patients. The therapeutic process involves more than doing specific activities, but an emotional giving of herself. She does not do things half-heartedly, but is "fully present" (P1), in the session with her patient and consciously focuses her mind, thoughts, attention and energy during that time. She does not allow

her mind to "wander off and become distracted" (P1) which takes a great deal of concentrated attention. Despite how she may be feeling, what kind of a day she has had, or what she is going through in her personal life, participants described how the patient always comes first with her taking second place. She is emotionally drained after a day of making such intense investments into the lives of her patients with a day at work described by one participant as "much more than just a job" (P3). The responsibility of managing patients with serious communication difficulties can be a heavy load to carry and one participant compared managing even an average patient to "trying to eat spaghetti"(P3) in that it is "hard to manage" (P3). Through this process she interacts with her patients on a deeper level which inevitably allows an emotional bond to develop with attached expectations.

She fully shares in the emotions of her patient and his or her family. One study participant described how in the past she had "hoped with the family" (P1) that test results would not return as suspected. Other participants described the emotional journeys they have taken with patients and families as together they express grief and disappointment at the birth of a disabled child, the diagnosis of a terminal illness or life-altering procedure. Taking on the responsibility of managing patients with serious medical conditions and chronic disabilities requires a significant amount of emotional maturity and stamina. One participant described her experiences as requiring "staying power which takes more maturity than your years" (P4).

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5.5.3.5 Knowing oneself

As a health professional the S-L Therapist travels both a professional and personal journey. The growing clinical challenges she faces and the types of patients she sees demand that she maintain an ever-increasing awareness of and reflective attitude about herself as a therapist and a person. Self-respect, self-esteem and self-knowledge have always been core issues for health professionals (Holland, 2008, p. 71). She is continually enriched by being exposed to the wide variety of people around her and has learned to accept others more, judge them less, and understand them more deeply. Engaging with patients and families on a daily basis requires her to go beyond a superficial level, to "knowing where they're coming from" (P1) and "really *understand* the people you're working with" (P4). Having daily interactions with people from different ethnic, cultural and socio-economic groups to her own enriches and deepens her understanding of the human race. By working with people with different

worldviews she is challenged in the way she thinks about life and approaches situations. She realises that not everything is about her ideas and preferences, and so experiences freedom to embrace different views and over time grows into a more open and broad-minded individual and health professional.

The value she places on material wealth is also challenged as working in this setting means interacting with patients who typically may have very little in terms of material wealth. One study participant described how working with such patients has made her so much more aware of how a large proportion of the population live. By comparing her upbringing and current lifestyle to that of some of her patients, the social inequalities which exist in society are highlighted which makes her passionate about revealing the barriers that many public service patients experience in attempting to achieve success.

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5.5.3.6 The joy of one's patients

The S-L Therapist in this setting is greatly affected by her patients. She "loves her patients" (P1), "*loves* working with them" (P7) and has had "wonderful experiences with patients" (P6). Working and interacting with them humbles her on a daily basis. Her experiences of crying with a patient, talking about his or her progress, how he or she has grown, or being thanked for help she has given, are all extremely rewarding and affirming experiences. As she interacts more and more with patients over her career, they become an important part of her work and when she spends time away from work she "really misses the interaction with patients" (P4). One participant described how when approached to do so, refused to substantially increase her administrative tasks and decrease direct patient contact time. These responses highlight the fulfilment she gains by working with her patients. A study investigating the satisfaction of occupational therapists (Moore et al., 2006) showed patient contact and working with patients to be a highly fulfilling part of their work. One participant stated "I don't think there's anything I'd rather be doing" (p. 22). Other participants described their relationships with patients as being meaningful and rewarding. Current study participants described feeling humbled by, and privileged to listen to the life stories and experiences of her patients, how they have experienced their past and how they think about their future. As her patients share their experiences, their dreams, fears and reflections, she feels honoured that they choose to allow her to enter their reality. She feels enriched and validated on seeing how, or hearing that she has played a positive or significant role in

her patient's journey. She further experiences an enormous sense of accomplishment from observing a patient become empowered to succeed beyond the therapy setting. Social workers, nurses and occupational therapists reported the opportunity to develop relationships with patients and see them progress as being a frequent source of satisfaction (Reid et al., 1999). For the current study participant, her experience of seeing a patient achieve victory in his or her attempt stirs her passion for what she does and why she does it. She experiences a patient's success as almost a personal victory, not because of the role she played in it, but because of the deep connection she feels to her patient and his or her rehabilitative journey. An occupational therapy participant stated how the role she is able to play in a patient's life gives her a sense of achievement and validates her as a person (Moore, et al., 2006).

Significant is the personal meaning and satisfaction she gains from physically "doing something" (P1) meaningful for her patient or solving a problem for a family. Literally being able "to do something" (P1) for her patient gives her a sense of usefulness, and sharing in her patient's victory not only affirms her intervention as being effective, but instils confidence in herself as a therapist. The skills and knowledge she is able to give to her patient makes her feel that she has a purpose and through feedback from her patients sees how "they really appreciate what you're doing and I think you *feel* like you really *are* delivering a meaningful service" (P4). The satisfaction she experiences from working with patients is a difficult one to match as "they [patients] make me feel *good* on a daily basis" (P6). One participant described this experience as "illuminated, yellow, right, life-giving, and warm" (P6). Patients' success motivates her that change is possible and she feels rewarded by seeing her patient blossom, appreciate and acknowledge the success they have made. At the centre of this experience is a sense of having made a lasting investment into her patient's life by helping them use language and communication to achieve his or her goals and create a better life. In essence, participants described their relationship with patients as being full of "up's and down's" (P4), being as joyful and fulfilling as limiting and challenging and as "leading them to unexpected places" (Byng et al., 2000, p. 93).

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5.5.4 Bouncing back

The illness and suffering that the S-L Therapist is exposed to on a daily basis calls for a restoration of her emotional balance which she does in a variety of ways. Craik (1988) suggested that activities which enhance an individual's ability to cope with

demanding situations also improve his or her control over events, which in turn decreases the effect of organizational stress. Participants described doing things such as having "time-out alone" (P4) after work with no demands being made of her, doing something she enjoys, and going home and being away from the work environment. These activities have been described as decompression activities (Lubinski & Frattali, 2001, p.192) which counterbalance a day of stress. Other examples of decompression activities which were not mentioned by current participants include exercise, relaxation activities such as deep breathing, systematic relaxation and yoga (Lubinski & Frattali, 2001, p.192). In a study by Lloyd & King (2001) occupational therapists reported engaging in decompression activities such as talking to others, having exercise and having a life outside of work.

For current study participants, verbalising thoughts, feelings and daily experiences with family members and supportive friends also provides her with an emotional outlet. Common to all participants is the support they receive from their work colleagues, as was the experience of being able to talk to others about difficult, sad and frustrating experiences. Being able to talk with people who experience similar challenges is very comforting for her. Support from colleagues has been reported to relieve stress across the occupational therapy, nursing and teaching literature (Austin et al., 2005; Hasselkus & Dickie, 1994; Lloyd & King, 2001; Moore et al., 2006; Reid et al., 1999). In a study of 30 mental health professional including nurses, social workers and occupational therapists, contact with colleagues was reported to be the single most enjoyable and satisfying part of their work (Reid et al., 1999).

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The study participants described how putting preventative measures into place ensures that her sense of self is well-defined and that as far as possible she maintains a consistently low level of stress. By maintaining a healthy emotional distance between herself and her patients she guards against becoming over-involved with them which will negatively affect her ability to help them. By reminding herself that she is not ultimately responsible for the decisions her patients make, and that her responsibility lies only in providing the best input she is able to, she reduces her anxiety about solving everyone's problems. Being self-disciplined in taking leave in order to recharge and regain her equilibrium helps maintain a consistently healthy mental, emotional and physical condition. One participant explained how being deeply compassionate for her patients means that although she may feel their pain more intensely, it protects her from

becoming hard to their suffering as although she may feel overwhelmed by a certain situation on a certain day, she uses her compassion as a raw material to continue making a difference.

5.6 Conclusion

This chapter discussed the five themes which emerged from the analysis as they relate to van Manen's four lifeworld themes of lived space, lived time, lived human relation and lived body (1990, p. 101). Existing literature in the Speech-Language Therapy field as well as literature from other human service professions was used to compare with, expand on and further explain current study findings.

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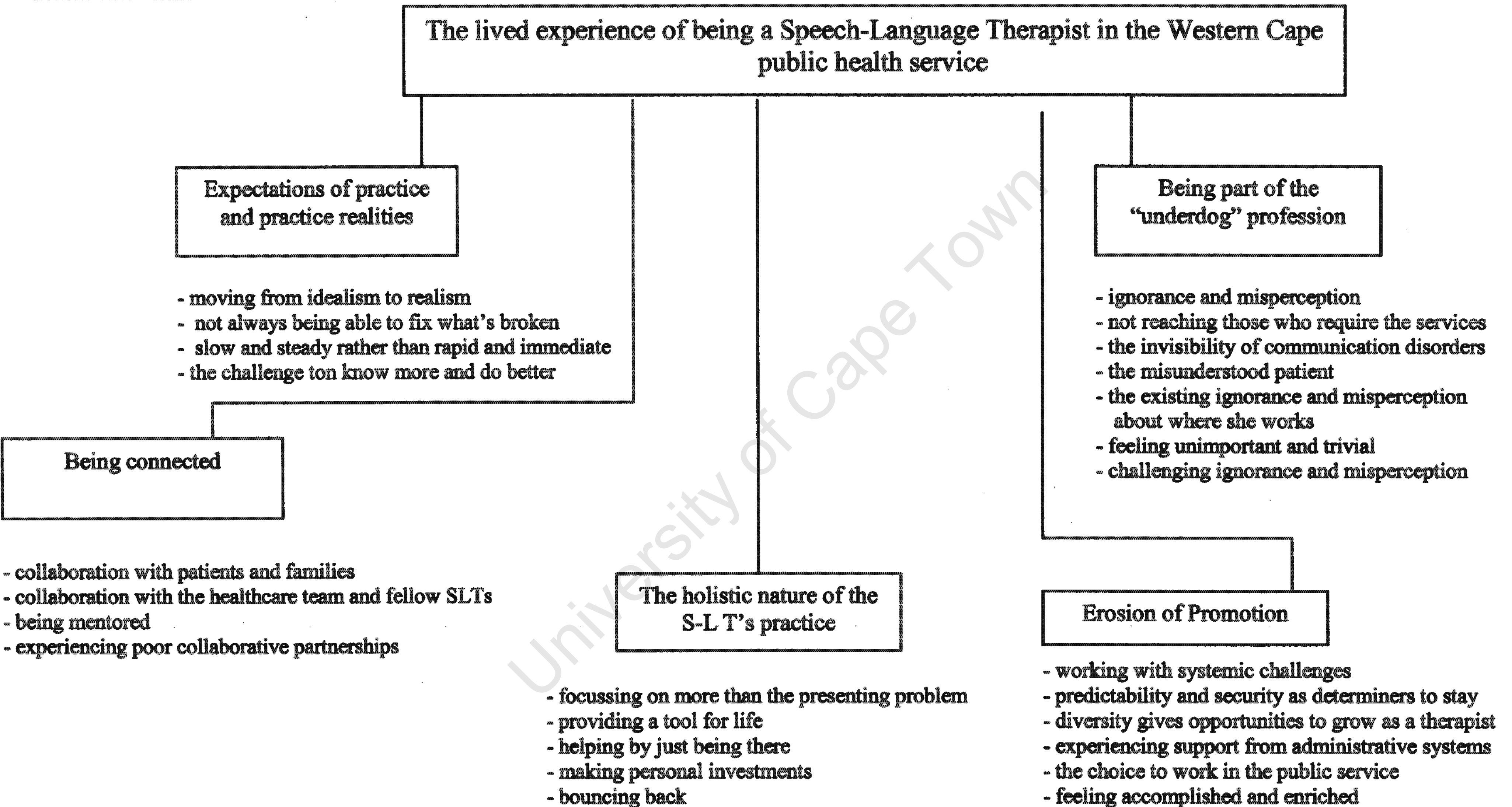
Conceptual summary of findings



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The following chapter (Chapter Six) will describe the significance and implications of the study, present recommendations and outline the strengths and limitations of the research.

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CHAPTER SIX

Conclusion

6.1 Significance and implications of research findings

This study has explicated the lived experience of being a S-L Therapist the public service health settings, in a field in which the experiences of S-L Therapists does not seem to have been studied in depth..

Phenomenological enquiry is a philosophy and approach which guides the methodology. It has defined goals and guiding principles with inductive analysis procedures as the means to interpret the findings. It is an appropriate methodology which guides the researcher's steps in the study of human lived experience and the scientific study of a specific phenomenon.

Although the public service is only one area in which the S-L Therapist may practise, the information which was gathered highlights issues specific to this context as well as to the profession of S-L Therapy in general. Findings provide thick descriptions of the S-L Therapist's experience and the meaning she attaches to this. The insight that was gleaned from interpreting the S-L Therapist's lived experience provides a closer introspection into professional issues pertaining to speech-language therapy. S-L Therapy is documented to be a particularly misunderstood profession with a paucity of research about professional issues (Byng et al., 2002). This study has focuses a lens on the profession and the professionals who work in a particular setting, describing their lived experience.

6.2 Recommendations

The research findings highlighted specific issues related to the way S-L Therapy students are trained and how training impacts the way they experience being a professional, identified issues which provide opportunities for further research. Issues related to policy were identified. The recommendations are discussed below:

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6.2.1 Recommendations for Speech-Language Therapy education

- Findings revealed how, after being in the profession for some time, S-L Therapists realised that the textbook examples differed from the presentation of disorders in patients who attend the services. As the management of communication disorders is not as clearly defined as textbooks and course notes describe, S-L Therapists need to continually adapt first world treatment approaches and concepts to the South African context.

- A major finding of the study was how novice S-L Therapists entered the profession with the idea that they would be able to "fix" every patient's communication difficulty. Participants stated how they were disappointed to learn that they were not able to do this, and that often therapy was not indicated due to the progression of the underlying disease process. They also described their role as supporter, friend, and referral source as well as clinician, which portrays a more holistic approach to patient management. As a practising S-L Therapist, it is my personal opinion that as well as being trained about when to initiate intervention, S-L Therapy students should be alert to situations that call for her to hold back from intervening, refer on, or merely offer support and reassurance.

- Practicing in a multi-cultural and multi-linguistic society means that the South African S-L Therapist will most certainly experience treating patients from different language and cultural groups to her own. Findings from this study revealed the frustration the S-L Therapy feels at not being able to communicate in the first language of her patient. In order to meet the needs of the all patients seeking S-L Therapy services, students should not only receive useful and functional instruction in at least one of the official South African languages (other than English and Afrikaans), but should actively use the language in clinical blocks during their training duration.

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6.2.2 Recommendations for public service Speech-Language Therapy practice

- Study participants stated that while the public service offers many benefits it also presents financial, personnel and systemic limitations which can prevent the S-L Therapist from supplying optimal intervention to her patients. As a public service S-

L Therapist, it is my personal opinion that, in accepting the challenges as early on in one's career as possible, S-L Therapist will be able to reduce her frustration. Novice S-L Therapists should be fully orientated to the structures and operations of the work setting and learn from more experienced therapists.

- Collegial support from fellow S-L Therapists and other health professionals was reported to be of great emotional and professional assistance to participants. The high number of patients seen and the nature of disorders managed calls for a supportive environment and opportunities for case discussion. Participants also reported mentorship as being a vital part of their personal and professional development. It appears that only the most junior staff members receive adequate mentorship opportunities. It is my opinion that no S-L Therapist is "old enough" or "experienced enough" not to require mentorship.

- Participants reported how even though they feel as though they do make a difference to their patients, greater difference could be made if they were located at community health centre level and not only at tertiary facility level. As far as possible, Speech Therapy departments from established hospitals should enquire about becoming involved in outreach projects in the community i.e. District hospitals. This would give communities the opportunity to access S-L Therapy services and also create a need in the community for a permanent service which could be motivated for. Partnering with, and developing a good relationship with an outreach site has the opportunity to develop into an indispensable service and encourage the possibility of permanent personnel being placed at the site.

- A significant finding of this research was the issue of professional role definition and status. Participants reported poor status and recognition to be a major source of job dissatisfaction. While this issue is not isolated to the field of S-L Therapy, professionals need to develop marketing strategies which are sustainable and adequately portray the profession in its entirety. Along with this finding was that of the "hidden" nature of communication disorders and the resultant ignorance which causes much frustration for the S-L Therapist and disadvantages particularly children in receiving intervention they require. Sustainable education and advocacy programmes should be initiated in communities, schools and places of work.

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- The poor relationship between the public health and public education departments continues to be an issue of great concern for public service S-L Therapists. For S-L Therapists working with the paediatric population in particular, greater effort needs to be made to bridge the gap between these two bodies and establish a good collaborative partnership between educators and S-L Therapists. Outreach programmes and information session to schools could facilitate this.

6.2.3 Recommendations for future research

- Currently no standardised assessment tools for non-English and non-Afrikaans speakers exist. This is a barrier to S-L Therapists being able to perform standardised assessments on clients and obtain accurate levels of language function. S-L Therapy students at both undergraduate and post graduate level should be encouraged to embark on research projects to devise and standardise assessment tools in languages other than English and Afrikaans.

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6.2.4 Recommendations for policy making

- In the Healthcare 2010 document, the Western Cape Department of Health plans to "shift patients to more appropriate levels of care" (Healthcare 2010, 2003, p. 7) by focussing on primary-level services, community-based care and preventative care; to "expand delivery of specialist services within the Regional Hospitals to make them more cost-effective and bring them nearer to communities who need them most" (Healthcare 2010, 2003, p. 7); and to "adequately supporting these services with well-equipped secondary, appropriately staffed and highly specialized tertiary services" (Healthcare 2010, 2003, p. 8). In anticipation of the implementation of the underlying principles of Healthcare 2010 which propose quality care at all levels; accessibility of care; efficiency; cost effectiveness; the primary health care approach; collaboration between all levels of care; and de-institutionalisation of chronic care, public service S-L Therapists should be willing to offer their assistance to those involved in the planning of such programmes.

6.3 Limitations of the study

- A limitation in this study is the specific nature of the study sample, which reflects on the lived experience of only one group of Western Cape public health service S-L Therapists, namely those working in the three tertiary hospitals. Findings do not reflect the lived experience of community S-L Therapists or S-L Therapists working in district hospitals (the one site which does exist). Although this issue may be viewed as a study limitation, while community and district hospital S-L Therapists may have similar experiences to those reported in this study, their inclusion in the current study is not felt to have been appropriate even if they had been willing to participate. S-L Therapists working in the public education setting may have different experiences, and this study cannot be generalised to SLTs outside of the tertiary hospital setting.

- A further possible limitation of the research is the fact that the researcher is a S-L Therapist at one of the tertiary hospitals that was used in the study. While this may be viewed as over-involvement and over-identification especially in the interviewing phase, studying colleagues is also viewed as an advantage (Holloway & Wheeler, 1996, p. 58). Qualitative research calls for the researcher to "immerse and involve him or herself in the setting and the culture under study" (Holloway & Wheeler, 1996, p. 3), having a "close" (p. 3) relationship with participants. In order to limit the possibility of criticism, the researcher kept reflective memos throughout the process and tried as far as possible to ask participants for clarification of their ideas and not assume to have a full understanding of what participants said before clarifying it with them.

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to limit the possibility of criticism, the researcher kept reflective memos throughout the process and tried as far as possible to ask participants for clarification of their ideas and not assume to have a full understanding of what participants said before clarifying it with them.

- A criticism of qualitative research is that studies with small samples (such as this one) prevent the research from being generalisable to the general population. From the outset current findings were not anticipated to be generalisable. Current study findings represent a description and analysis of reality that is typical for this particular setting by taking onto account the conditions and context under which the phenomenon occurs.

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6.4 Conclusion

The public service SLT works in a secure and predictable setting which has a fast pace and pressurised leaving little time for personal reflection. Being a teaching hospital as well as an institution of healing, her work environment has an academic focus requiring that she continually increase her knowledge, skill and expertise. Although an institution of historical and medical significance, it is geographically located far from its target population making it inaccessible to those who require its services. The SLT enters the profession with great expectations, some of which are soon disappointed. She progresses through a series of stages in her professional development which begins with both excitement and trepidation, progressing to not-always-pleasant experiences, and culminating in the adaptation stage marking the beginning of her new world of professional practice. Her work is highly relational and she is involved in numerous interpersonal interactions on a daily basis. These relationships are not fleeting, but deeply significant and meaningful. To some relationships she gives herself fully, in others she plays an equal role as the recipient and in others *she* is the recipient of what the other client and family offer her.

The profession of speech language therapy and the nature of the work impacts on her entire being – physical, mental and emotional. The joy of helping is contrasted with the exhaustion and despair where she does not feel that she makes a difference. Despite this, however, the SLT is committed to her chosen profession and to the clients and patients who need her.

List of personal communications

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APPENDIX A

UNIVERSITY OF CAPE TOWN

Health Sciences Faculty
Research Ethics Committee
Room E52-24 Groote Schuur Hospital Old Main Building
Observatory 7925
Telephone [021] 406 6338 • Facsimile [021] 406 6411
e-mail [illegible]

19 April 2006

REC REF: 122/2006

Miss JA Warden
Communication Sciences & Disorders
Health & Rehabilitation Sciences

Dear Miss Warden

PROJECT TITLE: THE LIVED EXPERIENCE OF BEING A SPEECH-LANGUAGE THERAPIST IN THE WESTERN CAPE PUBLIC SERVICE

Thank you for submitting your study to the Research Ethics Committee for review.

It is a pleasure to inform you that the Ethics Committee has **formally approved** the above-mentioned study on the 10 April 2006.

This serves to confirm that the University of Cape Town Research Ethics Committee complies to the Ethics Standards for Clinical Research with a new drug in patients, based on the Medical Research Council (MRC-SA), Food and Drug Administration (FDA-USA), International Convention on
Harmonisation Good Clinical Practice (ICH GCP) and Declaration of Helsinki guidelines.

The Research Ethics Committee granting this approval is in compliance with the ICH Harmonised Tripartite Guidelines E6: Note for Guidance on Good Clinical Practice (CPMP/ICH/135/95) and FDA Code Federal Regulation Part 50, 56 and 312.
Please quote the REC. REF in all your correspondence.

Yours sincerely

DR. M. BLOCKMAN
CHAIRPERSON, HSF HUMAN ETHICS

[illegible]

APPENDIX B

Medical Superintendent

________________________Hospital

Re: Permission to contact Speech-Language Therapists for research purposes

I am currently registered as a Masters student (WRDJOC001) in the Department of Communication Sciences and Disorders at the University of Cape Town doing a M.Sc in Speech-Language Pathology.

As part of my degree I am conducting a research project entitled **"The lived experience of being a Speech-Language Therapist in the Western Cape public service"**. *I have been granted approval by the UCT Research Ethics Committee (REC. REF. 122/2006) (see Ethics letter of approval) to conduct the study. 5-7 Speech-Language Therapists employed in the Western Cape Health Department will be interviewed about their experiences.*

The information gathered is anticipated to add to the existing body of knowledge about the occupation of Speech-Language Therapy (SLT) in general, as well as specifically to Speech-Language Therapists (SLTs) working in the Western Cape public health service. Results are anticipated to provide insight into how SLTs experience their work and locate themselves in the greater body of human service professionals. The results are also anticipated to be both interesting and useful to a wide variety of individuals, including academic staff training S-L Therapy students, students themselves, and qualified SLTs in various phases of their careers. By understanding the experience of a public service S-L Therapy and how she may make meaning of that experience, heads of S-L Therapy hospital departments, hospital management, special education settings and those involved in training S-L Therapists will hopefully be able to better assist S-L Therapists in making choices which will enrich and augment their professional development and amount of satisfaction experienced. Findings will also hopefully lead to the development of useful course material to be used in training S-L Therapy students.

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I request your permission to approach the Head of the Speech Therapy and Audiology Department (Ms. ......name......), in order to inform her of my research. Following her approval, I request your permission to approach the Speech-Language Therapists in the department in order to recruit study participants. Their participation will require them to take part in a 1-2 hour interview at a time convenient to them and which will not interfere with work activities. A follow up interview will also be carried out towards the end of the study process to discuss the preliminary findings. Participation is strictly voluntary and S-L Therapists may withdraw from the study at any time should they wish to do so without giving a reason. All names, identifying information, interview audiotape recordings and transcripts will be kept in a locked cupboard, not made available to any one else other than myself and my supervisor, and destroyed on study completion. No anticipated risks of participation or non-participation exist.

I have included the study synopsis and am willing to supply you with a copy of the full proposal if you so wish. Please contact me if you have any further questions or concerns.

I look forward to hearing form you at your earliest convenience.
Yours sincerely,

____
Jocelyn A. Warden

Contact details: Department of Speech Therapy and Audiology. E47 Old Main Building.
Ph: 404 6466 or 0832560484
Supervisor's contact details: Pat Mayers tel: 406 6464.
e-mail: pmayers@uctgsh1.uct.ac.za

University of Cape Town

APPENDIX C

Head of Speech Therapy and Audiology Department
_____________________ Hospital

Re: Permission to approach Speech-Language Therapists for research purposes

I am currently registered as a Masters student (WRDJOC001) in the Department of Communication Sciences and Disorders at the University of Cape Town doing a M.Sc in Speech-Language Pathology.

As part of my degree I am conducting a research project entitled **"The lived experience of being a Speech-Language Therapist in the Western Cape public service"**. *I have been granted approval by the UCT Research Ethics Committee (REC. REF. 122/2006) as well as the hospital superintendent to conduct the study (see attached Medical Superintendent's letter of approval). 5-7 Speech-Language Therapists employed in the Western Cape Health Department will be interviewed about their experiences.*

The information gathered is anticipated to add to the existing body of knowledge about the occupation of Speech-Language Therapy (SLT) in general, as well as specifically to Speech-Language Therapists (SLTs) working in the Western Cape public health service. Results are anticipated to provide insight into how SLTs experience their work and locate themselves in the greater body of human service professionals. The results are also anticipated to be both interesting and useful to a wide variety of individuals, including academic staff training SLT students, students themselves, and qualified SLTs in various phases of their careers. By understanding the experience of a public service SLT and how she may make meaning of that experience, heads of SLT hospital departments, hospital management, special education settings and those involved in training SLTs will hopefully be able to better assist SLTs in making choices which will enrich and augment their professional development and amount of satisfaction experienced. Findings will also hopefully lead to the development of useful course material to be used in training SLT students.

I request your permission to approach the SLTs in your department in order to recruit study participants. Their participation would require them to take part in a 1-2 hour interview at a time which is convenient to them and which will not interfere with work activities. A follow up interview will also be carried out towards the end of the study process to discuss the preliminary findings. Participation is strictly voluntary and SLTs may withdraw from the study at any time should they wish to do so without giving a reason. All names, identifying information, interview tape recordings and transcripts will be kept in a locked cupboard, not made available to any one else other than myself and my supervisor, and destroyed on study completion. No anticipated risks of participation or non-participation exist.

I have included the study synopsis and am willing to supply you with a copy of the full proposal of you so wish. I will be contacting you shortly by telephone to discuss the possibility of having a brief group information session with your staff members before contacting them. Please note that even though many of your staff may meet the selection criteria and be willing to participate, interviews will only take place until

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saturation point (until no new information is revealed). This means that not all initially interested SLTs will be interviewed. The selection criteria are:

- having at least 2 years work experience in and currently practising as a fulltime or part-time S-L Therapist in the Western Cape public health service
- if on a dual register (S-L Therapy and Audiology), dedicating 50% of her weekly activities to S-L Therapy
- in any stage of professional career to provide for a diverse range of experience
- be in agreement with all the conditions on the consent form
- be willing to reflect on her experience of being a S-L Therapy

Yours sincerely,

____

Jocelyn A. Warden

Contact details: Department of Speech Therapy and Audiology. E47 Old Main Building. Ph: 404 6466 or 0832560484
Supervisor's contact details: Pat Mayers tel: 406 6464.
e-mail:pmayers@uctgsh1.uct.ac.za

University of Cape Town

APPENDIX D

Dear _______________________ (name)

My name is Jocelyn Warden and I am currently registered at the University of Cape Town for a Masters degree in Speech-Language Pathology (WRDJOC001) entitled ***"The Lived Experience of being a Speech-Language Therapist in the Western Cape public health service"***. Your Head of department, (…name…..), agreed that she would inform you that I would be contacting you in with regard to my research study. I would very much like you to consider participating in the study and have attached an information sheet for you to read which should answer any questions you may have.

Below I have listed the selection criteria which I will be using for this study. Please would you read the list carefully and *should you meet the selection criteria*, kindly e-mail me at this address indicating either your willingness or unwillingness to participate. If you *do not* meet the selection criteria, you are *not* requested to reply. If you would like further information or are unclear about the contents of the letter please also e-mail me. Should you meet the criteria but *not be willing* to participate, no explanation is required, you will not be contacted again and your decision not to take part will not be made public to your Head of Department or fellow colleagues. If you indicate your willingness to participate, I will contact you shortly to arrange consent form signature and an interview time.

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Selection criteria:

- having at least 2 years work experience in, and currently practising as a fulltime or part-time SLT in the Western Cape public health service
- if on a dual register (SLT and Audiology), dedicating 50% of your weekly activities to SLT
- in any stage of your professional career to provide for a diverse range of experience
- be in agreement with all the conditions on the consent form
- be willing to reflect on your experience of being a SLT

I look forward to hearing from you at your earliest convenience.

Sincerely,

Jocelyn Warden

Tel: (w) 404 6458 (h) 674 6760 (cell) 083 2560484

Study supervisor: Pat Mayers tel: (w) 406 6464 e-mail: pmayers@uctgsh1.uct.ac.za

APPENDIX E

Research Ethics Committee
E53 Room 44.1, Old Main
Building
Groote Schuur Hospital
Observatory
7925
tel: 406 6492

INFORMATION SHEET

STUDY TITLE

"The Lived Experience of being a Speech-Language Therapist in the Western Cape public health service"

INFORMATION ABOUT THE RESEARCHER

My name is Jocelyn Warden and I am currently registered at the University of Cape Town for a Masters degree in Speech-Language Pathology (WRDJOC001). The information I am gathering will form the basis of my dissertation. I have been granted permission from the UCT Research Ethics Committee (REC. REF 122/2006) to conduct this study as well as the medical superintendent of this hospital and your Head of Department.

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AIM OF THE RESEARCH

The aim of this study is to explore the experiences of Speech-Language Therapists working in the Western Cape public health service. I would like to find out what it is like for you to be a Speech-Language Therapist, what meaning it has for you, and how you see yourself in the profession.

YOUR INVOLVEMENT IN THE STUDY

I will be conducting an informal in-depth interview as the method of data gathering. The interview will be one-to-one, should take no longer than 1-2 hours, and will be conducted at a convenient time and place for you. Following the initial analysis of the transcribed interview, I will probably need to interview you a second time in order to clarify any questions I may have and to ensure that I have correctly transcribed and understood the information you shared during the initial interview. Both interviews will be audiotape recorded for easy transcription.

CONFIDENTIALITY AND WITHDRAWAL FROM THE STUDY

Your name, all identifying information and interview audiotape recordings will be kept in a locked cupboard and not made available to any one else other than myself and my supervisor. Your name and identity will not be linked to your interview transcript and your tapes and transcript will be destroyed on study completion. Please note that you may withdraw from the research at any time without having to supply a reason for doing so.

University of Cape Town

APPENDIX F

Research Ethics Committee
E53 Room 44.1, Old Main
Building
Groote Schuur Hospital
Observatory
7925
tel: 406 6492

PARTICIPANT CONSENT FORM

I ……………………….. (full name) agree / disagree (please delete irrelevant one) to participate in the research study entitled ***"The lived experience of being a Speech-Language Therapist in the Western Cape public health service".*** I understand the study aims, processes, and possible risks and benefits which have been explained to me. I understand that the interview will be audiotape recorded for the purpose of verbatim transcription and analysis. I also understand that I am under no obligation to participate in this project and am able to withdraw from the study at any time without giving a reason. In addition, my participation or non-participation will not be disclosed to my Head of Department or colleagues by the researcher. By consenting to participate in this study, I agree to fully participate in the interview process (including a possible second interview), and understand that the data generated in my interview will be interpreted, analysed and used as seen fit by the researcher.

Name of participant: ______________________

Address: ______________________________

Tel: (h) ______________

(w) _________________

(cell) ______________

Signature of participant: ____________________

Date: ______________

Name of researcher: Jocelyn Warden

Address: 23 The Village, Bell Road, Kenilworth, 7708

Tel: (h) 674 6760 (w) 404 6458 (cell) 0832560484

e-mail: jocelynw@webmail.co.za

Signature of researcher: ____________________ Date: ______________

Name of study supervisor: Pat Mayers

Tel: (w) 406 6464

e-mail: pmayers@uctgsh1.uct.ac.za

Signature of supervisor: ____________________ Date: ______________

University of Cape Town

APPENDIX H

Summary of themes, categories and clusters

Themes	Categories	Clusters
1. expectations of practice and practice realities	Moving from idealism to realism	Desires to make a difference in people's lives Disappointed that SLT is not as it was portrayed during training The setting increases the challenge Reflecting on personal change The idealistic versus realistic way of looking at her work The need to accept the challenges Reactions to not being able to help/fix everybody
	Not always being able to fix what's broken	The 'unfixable' nature of SLT disorders Not understanding how it is for the patient and family Empowering patients to bring about their own change Taking less responsibility for patients' progress Attendance as a barrier to what is possible to offer clients Language as a barrier to being able to help
	Slow and steady rather than rapid and immediate	The long term nature of SLT intervention Quick results are rewarding for the SLT Therapy rewards are usually slow to see

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	The challenge to know more and do better	Needing to be competent at everything Staying ahead with the latest treatments Communication disorders are abstract Communication disorders are difficult to define Communication disorders are difficult to measure and identify Having the skills needed to bring about change Professional reflections of working in the public service for a long time Mentorship experiences
2. Being part of the "underdog" profession: role definition and status	Ignorance and misperception about SLT roles and function	The public's perceptions of SLT Feeling devalued by doctors and other health professionals Profession is misunderstood by the public Profession is misunderstood due to the abstract nature of the disorders it treats Stressful that public don't know what SLT does Tension over the profession's title
	Not reaching those who require the services	SLT services under-represented in the community The reduced effectiveness of SLT services at tertiary level Reduced access to complimentary therapies at tertiary level
	The invisibility of communication disorders	Invisible nature of communication disorders make them less of a priority

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	The misunderstood patient	People with communication disorders are teased People with communication disorders are viewed negatively by the public
	The existing ignorance and misperception about where she works	The public's perceptions of the public service setting Experiencing the public service setting as nurturing
	Feeling unimportant and trivial	Feeling devalued Feeling useless Feeling stupid
	Challenging ignorance and misperception	The challenge of professional advocacy SLTs are too apathetic to advocate Attempts to advocate are well received
3. Being connected	Collaboration with patients and families	Mobilising people for change Patient-centred therapy Using the family as a resource for change Multiple roles of working with families Family-lead intervention The family or patients' reaction to diagnoses or intervention plans
	Collaboration with the healthcare team and fellow SLTs	Lack of community-based SLT services Consequences of lack of community based SLTs services Teams mean the SLT doesn't have to struggle alone The team context as an advantage Colleagues act as a community
	Being mentored	Experiencing mentoring relationships

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	Experiencing poor collaborative partnerships	The public versus private sector tension The department of education versus health department tension
4. The holistic nature of the SLT's practice	Focussing on more than the presenting problem	The SLT as more than a therapist Consciously engaging with the patient Looking at the patient and family holistically Seeing more than what meets the eye
	Providing a tool for life	Seeing communication as valuable for life Providing more than speech and language skills
	Helping by just being there	Giving the patient space Giving emotional support Stepping back
	Making personal investments	Personally investing in clients Giving her all Experiencing emotions with her patients The effects of seeing repeated suffering Becoming hard to others' suffering The drain of her emotional investment
	Bouncing back	Staying optimistic Regaining her balance Accepting suffering as part of life Reflecting on personal thoughts Time alone to help restore her mind Talking with others Colleagues as supportive allies Not becoming overly involved with patients Helping others is a way to overcome sadness

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5. Erosion or Promotion	Working with systemic challenges	Time pressures Increased caseload Administrative duties Little time to network Lack of staff Lack of rank promotion No increase in salary Lack of appropriate budget Lack of sufficient posts Difficulty with new service establishment Stress of being a manager Difficult management structures
	Predictability and security as determiners to stay	A set and guaranteed salary and benefits The public service is highly secure Leaving the public service means losing job security and benefits Negative aspects are predictable Predictability is settling
	Diversity gives opportunities to grow as a therapist	Involvement in student training Challenging caseload Given time and opportunity to develop Validated and given freedom to develop as an independent SLT Simultaneous clinical/personal growth Academic setting offers growth opportunities Selecting areas of practice is validating Varied caseload gives opportunities Busy and diverse setting Busyness leaves little time to reflect Busyness is not chaotic

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	Experiencing support from administrative systems	Support of well-established administrative systems Support staff relieve the pressure
	The choice to work in the public service	Socially motivated Politically motivated Professionally motivated
	Feeling accomplished and enriched	General enjoyment of the experience Enjoys the public service clientele Feeling validated by hospital professionals Having good client experiences Forming friendships with colleagues Has learned life-lessons A deepened experience of the human race Looking outwards Rethinking personal priorities Feeling close to and humbled by patients Making a difference to her patients Feeling competent to help others

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