ORAL COMMUNICATIONS OF SPEECH LANGUAGE PATHOLOGISTS IN A CLINICAL SETTING

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Abstract

This paper reports on a study that attempts to describe the oral communication of Speech-Language Pathologists (SLP) in a clinical setting within a multicultural society and addresses, to some extent, the problem of lack of research on SLP practice in Malaysia.

Introduction

In striving to attain the status of a developed nation, Malaysia has made much improvement in the living standards of the people. Following this trend, services for individuals with special needs, too have been upgraded over the past few years. Despite these developments, the profession of Speech-language Pathologists (SLPs, henceforth) that caters for the communicatively impaired can be said to be only in its infancy in this country. In fact, the professional body representing the SLPs and audiologists in the country, Malaysian Association of Speech-Language and Hearing (MASH), was formed in the year 1995 with only eleven SLPs as registered members. These SLPs had all been trained abroad and only in 1999, did the first batch of locally trained students

from the Faculty of Allied Health in Universiti Kebangsaan Malaysia graduate. Yet, the number of SLPs practising locally has not increased significantly while the number of people seeking their services is on the increase. It is clear that efforts to train more SLPs locally needs to be intensified and therefore, research into the practical issues in this discipline, such as the communication skills needed for delivery of services to communicatively impaired individuals in multicultural societies, is essential.

SLPs as Professionals

Before discussing the issues in the practice of SLPs, it is necessary to understand what the profession entails. However, with the situation being such in this country, one needs to look at other countries where the profession has already been established. Commenting on speech therapy services in Great Britain, Crystal (1980) citing from the Quirk Report (1972) gives the following account of the range of skills expected in the profession of SLPs:

> The majority of our witnesses concurred in distinguishing, in the services offered by speech therapists, four elements: assessment, treatment, advice to patients and their families and an additional role, containing advice, teaching and the provision of information, in relation to teachers and members of other professions concerned with communication disorders.
>
> (Crystal,D. 1980:2)

American Speech-Language-HearingAssociation (ASHA) stipulation of scope of work , on the other hand, expects the clinicians to have "an in-depth knowledge of normal communicative processes, development and disorders thereof, evaluation procedures to assess the bases of such disorders, and clinical techniques that have been shown to improve or eradicate them" (1975 formulation).

Drawing from these two sources, it can be concluded that assessing communication disorders and carrying out intervention, that is, the two tasks that requires them to communicate with communicatively impaired individuals and their families, are central to the profession of SLPs. As such communication comunication skills, specifically oral skills would be an essential tool in SLP practice.

Issues in SLP Practice

Management of communicative disorders, in SLP practice requires integration of various disciplines namely that of Human Communication Sciences and Disorders, Psychology, Rehabilitation, Medicine, Education and Dentistry

among others, so collaboration is important. Many researchers including Dyer, Williams, and Luce, 1994, Waddle 1991, Christensen and Luckett, 1990 cited in Klein et.al. 1994, and Wright, 1994 have conducted studies on collaborations between SLPs and teachers. Gibbard (1994), on the other hand, reports on collaboration between SLPs with families of communicatively impaired persons. The common findings in these researches is that collaboration is of great importance in the work of SLPs, and this would also make communicatives skills an asset to SLPs.

The issue of practicing in multicultural populations is another equally important matter for the SLPs. As early as in 1968, at the annual ASHA convention the need for serious study about communication disorders in multicultural populations had been recognised. Cole (1986), in ASHA article No. 16, also advocates multicultural research in communication disorders studies. In fact, she emphasises that:

> If there indeed is a concern about under-served populations, the communicative disorders profession must become involved in topics that affect developing nations Also in need of study are the effects of colonization and government policies such as apartheid, on health status, service delivery, and communicative disorders.
>
> (Op cit.:97)

Given the multicultural character of Malaysia, one would expect many researches to have been conducted in this area but, to date no such study has been carried out locally.

The tasks of the SLPs in dealing with patients form multicultural and multilingual societies has become that much more difficult with the move in the SLP discipline from the medical model to linguistic model and current emphasis on linguistic profiling. In addition to the problem of making accurate assessments of linguistic abilities of multilinguals these SLPs are faced with the challenge of finding the most appropriate manner in which to communicate with people from diverse backgrounds.

This paper reports on a study that attempts to describe the oral communication of SLPs in a clinical setting within a multicultural society and in doing so, addresses to some extent, the problem of lack of research on SLP practice in Malaysia.

Communication in Clinical Settings

Since this study ventures into an area where there is paucity of research, one available option is to draw upon studies on communication in clinical settings. One such study is Tannen and Wallat's (1993) sociolinguistic analysis of multiple demands on paediatrician in doctor/mother/ patient interaction involving a

child with cerebral palsy. In addition to this, Shuy's (1993) detailed discussion on structure of discourse as areas of interference of communication between physician and patient and Cicourel's (1993) exploration on the effects of conflicts in belief on doctor patient communication and the eventual treatment are also of relevance. On the local front, research on communicative strategies and history taking in primary care medical context by Damodran, Norazit and Teoh (1995) sheds some light on communication in a clinical setting.

Methodology

While the status of SLP practice in the country motivates this study, it also dictates the methodology adopted here. The ethnographic approach was chosen for data collection in order to arrive at a wide angled description of the SLPs' oral communication. The setting chosen for this study is the Speech Therapy Unit in the Otolaryngology Department of a local public hospital but restrictions normally associated with data collection in clinical settings were alleviated because this is a teaching hospital where research is almost a routine.

The oral communication of the two SLPs employed in the Hospital at the time study, was studied following the ethnographic principles put forth by proponents such as Hymes (1962,1972,1974,1986) and Saville-Troike (1989). Preliminary non-participant observation was carried out for a period of six months. This served to develop researcher sensitivity as well as enable a more trusting relationship to develop between the participants and the researcher. Field notes taken during this time was used to identify the different types of communicative situations the SLPs participate in and to zero in on the most common type of these situations. This period was followed by participant observations of Speech Therapy Sessions for children with Speech- language delay (SLD). Ten such sessions involving seven different children and consecutive sessions for three of them were observed.

A coding system was developed to preserve the children's anonymity. The label CPn was used for the child patients with 'n' referring to the chronological order of the therapy sessions in which they were first observed by the researcher. Thus, CP3 would refer to the third child patient who was observed and the respective session was labelled TS3. An asterisk was used to indicate the consecutive session for the same patient (e.g. TS3*).

In addition to the taking of field notes that were continued for all the seven children, the sessions were also audiotaped. Transcriptions of the recordings were then made for the purpose of analysis. Parents who accompanied the seven children were interviewed to find out their perceptions of the services provided in the Speech Therapy Unit. The SLPs were also interviewed informally about the cases immediately after the sessions ended. The

Head of the Otolaryngology Department's views on the Speech Therapy Unit and more specifically on the work of the SLPs were also recorded. The information gathered from the observations and the interviews with the other participants were verified in a formal interview with the SLPs and this was an effort at triangulation in the data collection procedures.

In this manner, data was collected from therapy sessions for the seven children of whom four were SLD due to autism while the other three were SLD due to mental retardation. The major ethnic groups in Malaysia were represented in this sample. Information about the children and their families and the two SLPs observed in this study is presented in tables 1 and 2 below.

PATIENT	AGE	SEX	SPEECH Dx	FAMILY	ETHNICITY
CP1	4;3	F	SLD ~ MR	F1,M1	INDIAN
CP2	7;5	M	SLD ~ AUT	M2	CHINESE
CP3	9;2	F	SLD ~ AUT	F3,M3	CHINESE
CP4	4;6	M	SLD ~ AUT	F4,M4	MALAY
CP5	6;2	M	SLD ~ AUT	F5	CHINESE
CP6	3;10	M	SLD ~ AUT	F6,M6	MALAY
CP7	6;4	M	SLD ~ MR	M7,S7	INDIAN

Table 1: Information about Child Patients and Family attending the Speech Therapy sessions

Abbreviations	**Explanation**
CP(n)	Child patient with the numerals (n) for the chronological order in which the children were observed.
F(n), M(n), S(n)	Father, Mother and Sister of the child referred to with the number (n)
Age (x;y)	Age of the child in years and months
Speech Dx	Speech-language disorder experienced by the individual children
SLD ~ MR	Speech-language delayed due to mental retardation
SLD ~ AUT	Speech-language delayed due to autism

SLP	AGE(yr)	QUALIFICATION	LANGUAGES SPOKEN (L1/L2/L3)
SLP1	25	B.A (Communication Disorders)	Tamil/English/ Malay
SLP2	31	B.Sc. (Audiology and Speech Therapy)	Punjabi/English/Malay

Table 2: Information about the SLPs in the Speech Therapy Unit of the hospital.

Discussion and Analysis

The Analysis of data on communication of the SLPs begins with identification of the various communicative situations that the SLPs participate in and moves on to the communicative events within the most common of situations before looking at features in the SLPs' communication in that one type of situation.

A. The Communicative Situations

Observations of the SLPs carrying out their duties in the Speech Therapy Unit of the hospital revealed that they participate in many communicative situations. These situations are listed out below by adopting the labels used to refer to them in this setting based on Hymes' (1962) concept of labels defined as "words that name them and in so far as the participants in the society conceive their verbal interaction in terms of such categories, the critical attributes and distribution are worth discovering":

i) Speech Therapy Sessions
ii) Combined -Cleft-Clinics
iii) Lectures
iv) Case Discussions
v) Department meetings and Others.

The discovery of the "critical attributes and distribution" of the identified categories is the aim of the following sections.

i) Speech Therapy Sessions

The speech therapy sessions can be divided further into two categories namely, sessions for adults and sessions for children. At present, each adult patient comes for therapy once a fortnight while the children come once in three weeks in this Speech Therapy Unit. According to the SLPs, they are able to have the sessions for adults more often because there are simply too many children on their caseloads. However, the frequency of therapy sessions for individual patients actually varies according to case types and the patient's rate of progress.

The general flow of communication in this type of communicative setuations is from the SLP to the patient and/or the family with the SLPs initiating the moves and the other participants merely responding. The following diagram represents the flow of oral communication between participants in the Speech Therapy Sessions.

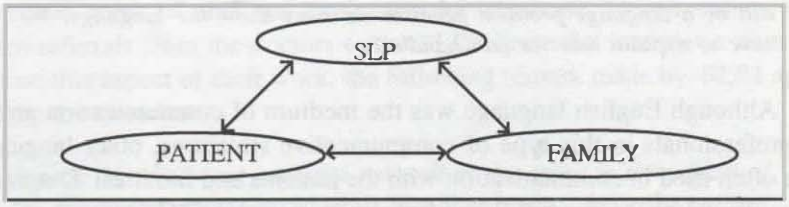

Diagram 1 Oral communication among participants in the Speech Therapy Sessions

In addition to these regular participants, from time to time, postgraduate students from the Otolaryngology Department of the hospital too attend the Speech Therapy Sessions as part of their clinical placement in the hospital. They observe most cases but interact with the participants only in cases related to their area of specialisation. All the cases seen at this Unit are referrals from doctors from the different departments in the hospital However, during the period of this study the doctors had not been present for any one of the therapy sessions.

The SLPs interact with many different patients and their families daily as the speech therapy sessions are held on every working day The first session starts at 8.15 a.m and each session lasts about 45 minutes to an hour. Therefore rendering of services for the communicatively impaired individuals makes up the largest portion of the SLPs' work in this setting. This type of communicative situations will be discussed in greater detail later in this paper.

ii) Combined-Cleft-Clinic (C-C-C)

In the C-C-C, various professionals from the hospital, namely the plastic surgeon, orthodontists, otorhinolaryngologists (ENT doctors), audiologists and SLPs, come together to discuss the cases. Patients with cleft palate and craniofacial abnormalities are the focus of this type of communicative situations and the plastic surgeon usually acts as the chairperson directing questions to get inputs from the other participants. SLP2 confirms the observation with the following account:

> *The team meets the patients and the parents to discuss what we want to do with the patient. The plastic surgeon decides when he wants to do the surgery. We have to tell them when we can give the speech appointment. The doctor won't know when to send the patient for speech therapy. We have to tell them to send as soon as possible, before the operation so that we can see the progress. In some cases like Chinese patients, the Doctors don't want to refer them because they think there*

will be a language problem because we don't know the language. We have to explain how we can handle it.

Although English language was the medium of communication among the professionals in this type of communicative situations, other languages were often used in communication with the patients and families. Diagram 2 below illustrates the general flow of communication in C-C-C.

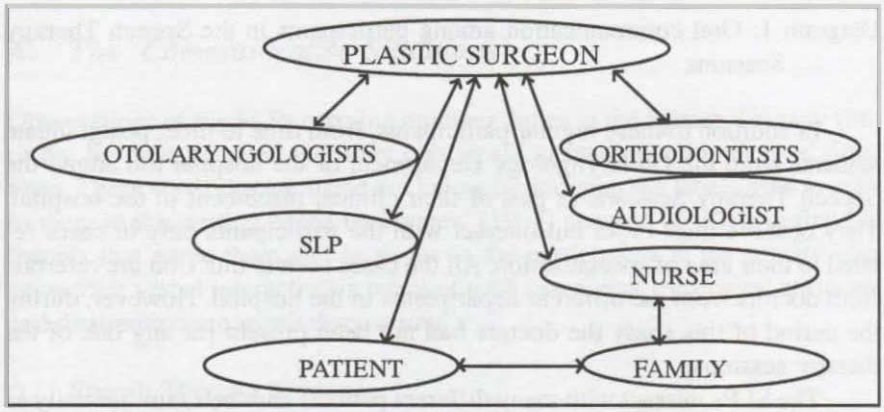

Diagram 2: Oral communication among participant in the combined-Cleft-Clinic

C-C-C is about the only occasion where there is actual collaboration among the professionals involved in handling patients with communication disorders.

iii) Lectures

This type of communicative situations involves students, either medical students or nursing students with the purpose of creating awareness among the students about the types of communicative disorders that are managed by SLPs and the services that the Speech Therapy Unit provides. The language used in these sessions which are held twice a month, is the English language.

iv) Case discussions

Case discussions initiated by the doctors who refer their patients for speech therapy is another type of communicative situations that the SLPs in this setting participate in. The doctor concerned discusses his or her diagnosis with the SLP and inquires about the services that she can provide or about the progress that a particular patient is making in therapy. However, due to time

constraints, most of this was done over the telephone. More common was written referrals from the doctors to the SLPs. From the interviews with the SLPs on this aspect of their work, the following remark made by SLP1 aptly sums up the situation.

> *Speech therapy is not accepted too well at this point in time. Most of the doctors or nurses or whoever you have, emm... have the opinion that they can perform themselves or the parents can carry it out themselves because it is usually a non-invasive procedure that needs to be followed up. As such, it is just for the portfolio or for the sake of formality that the SLP is asked to be there. Unless of course it is a case of purely ENT related case. Then, sure our input is valued. To a certain extent in the neuro rehab unit and the pediatric unit. It is obviously a problem of recognition.*

The following quote from the Head of Otolaryngology or ENT Department gives another perspective on this situation.

> *At the moment we do interact in terms of discussing our own patients. For example, if I send her a patient, I want to know how the patient is improving with her therapy. We discuss problems with the patient. We try to have face to-face discussions. If not I call her. It is a time constraint right now. That's why it is best for the Speech Therapists to sit together with the doctors who run the Voice clinic.*

The Head of the Otolaryngology Department also provided information about the Voice Clinic, which used to provide opportunity for collaboration between the ENT doctors and the SLPs. According to him, this type of communicative situations came to an end sometime ago when one important equipment used for diagnostic purposes broke down. However, he is quite enthusiastic about attempts to revive this practice.

v) Department meetings and Others

Department meetings are held once a month to discuss administrative matters pertaining to the department and the SLPs, being part of this department, attend it. The other situations include ward rounds, where the SLPs visit the patients who are admitted to the various wards in the hospital, a rather infrequent communicative situation.Also requiring the SLPs' participation are the meetings of the Laryngectomee Club and the Stroke Support Group. These meetings serve as a get-together for patients who have similar disorders for the purpose of exchanging information and providing emotional support for each other and SLPs play the role of chairpersons. Unfortunately, these have been terminated due to unavoidable circumstances.

In the course of their duties in this clinical setting, the two SLPs in this study do participate in many communicative situations. Table 3 in the next page summarizes the different types of communicative situations and the frequency of their occurrence.

COMMUNICATIVE SITUATIONS	FREQUENCY OF OCCURRENCE
SPEECH THERAPY SESSIONS	EVERY WORKING DAY
C-C-C	ONCE A MONTH
LECTURES	TWICE A MONTH
CASE DISCUSSIONS	OCCASIONALLY
DEPARTMENT MEETINGS	ONCE A MONTH

Table 3 Communicative Situations and Frequency of Occurrence

B. Communicative Events in the Therapy Sessions for Children with Speech-language Delay (SLD)

Since speech therapy sessions is the most common communicative situation and both the SLPs concurred that SLD is the most prevalent disorder that they deal with for cases involving children, the analysis of communicative situations is limited to this type of cases. Observations of therapy sessions and information from interviews confirm that each speech therapy session is made up of three phases that can be identified as three separate communicative events based on Saville Troike's (1989) definition. Although there was no change in the location and the participants during any one communicative situation of the therapy sessions, there were obvious shifts in focus of the SLPs' attention to different participants and the purpose of communication. These shifts can be used to mark the communicative events within the communicative situations.

A typical session begins with the attending SLP asking questions about the patient. The aim of this communicative event is to assess the nature and degree of communicative disorder present in the patient as well as the progress that the patient is making. Therefore the label ASSESSMENT is used for this type of events. Having assessed the type and severity or the progress of the patient, the SLP moves on to carrying out the actual intervention. Thus INTERVENTION is the next communicative event. Finally there is the stage where the attending SLP discusses her observations and gives advice to the parents or counsels them about ways to help the children. This communicative event is labelled COUNSELLING. The interviews with SLPs and parents confirmed that the communicative situations are made up of these three stages.

Information regarding the communicative events is summarised in the table below:

COMMUNICATIVE EVENTS	PARTICIPANTS FOCUSSED ON
ASSESMENT	CHILD PATIENT, PARENT
INTERVENTION	CHILD PATIENT
COUNSELLING	PARENT

Table 4: Communicative Events in Therapy Sessions for Children with SLD

C. *Features in SLP's Communication during the Therapy Sessions*

It was observed that in spite of the differences in participants' ethnicity and their linguistic background, the language used most in speech therapy session was the English language. The SLPs chose the language to be used with the parents, while the parents were given the opportunity to decide on the language to be used with the child patients. However, the SLPs were seen making accommodations in their speech addressed to both the child patients and their parents. Linguistic features of code-switching, use of terms of address and jargon as well as variations of tone and motherese, were noted in their communication.

Code-switching

Even though the SLPs stressed on consistent use of one language for communication with these children, it was evident that they resorted to code-switching as exemplified in the excerpt below.

Excerpt from TS6
(SLP1 sits infront of the mirror and puts TS6 on her lap)

SLP1:	[TS6], *tunjuk eyes.*
	Tunjuk nose.
	Mana nose ...*mana* eyes?
	Show me your eyes please.
	You show me only two.
	I won't ask again.
	Kakak tak akan tanya lagi.

(CP6 does not respond. He avoids making eye contact and looks down)

SLP1:	*Satu jari ...macam ini ... tunjuk* eyes.
	*(song)*This is your eyes and your nose and your mouth.
	(wispher) Eyes ... nose.
CP6.	XXX

(CP6 covers his mouth with hand)

SLP1.	Oh!

[CP6] *punya mulut dah hilang*
(CP6 does not repsond.)

According to both the SLPs, they do this only when they find that the child does not understand the language that the parents want them to use with their children.

The SLPs also admitted that they do code-switch or use another language that the interlocutor is more comfortable with in the same conversation with the parents.Code-switching between English and Malay is prevalent here consistent with Asmah's (1992) observation that code-switching is common among the Malay–English bilinguals in the multilingual society in Malaysia. (Refer to Table 1 and 2 for languages spoken by the participants.)

As Ozog (1993) has pointed out, a major feature in mixed discourse in the Peninsular Malaysia is the almost total use of English first person and second person pronouns, the following excerpt bears evidence of this:

Excerpt from TS3*

SLP2:	You *mau tukar sekolah dia*, you *ingat dia ...dia boleh biasakan dirikah*?
M3 ·	Yeah *lah, itu satu* problem *lagi.*
SLP2:	*Mesti ingat itu ah... sebab dia ini* autistic *ah.*

In this extract, the neutral pronouns and the terminology used are kept in English even when the entire sentence is in Malay. Based on the explantation provided by Noor Azlina (1979) cited in Ozog (1993) that since English pronouns represent neutral reference, bears no connotations of respect, seniority and power, the deliberate use of code switching can be construed as the SLPs attempts at reducing social distance.

Terms of Address

Another way of reducing social distance is by adopting terms of address from the culture of the participants. Kinship terms like "ummi", "ayah" and "kakak" are used in the spoken discourse with the Malay patients in this setting are comparable to the observations of Damotharan et.al.(1993) in the local medical context. With the Indian and Chinese patients, terms such as "auntie" is used. The SLPs referred to themselves and also to the researcher as "auntie" However, the "more equal relationship developed between the patient and her "doctor" observed in the period of their study was not evident in either TS3*, TS4* TS6*, the consecutive sessions for the three children in this study

The SLPs opt for more formal terms to address the parents. Most of the time the SLPs call the parents by their name, for example Mr[F5]. Only one parent, M3 referred to SLP1 as "doctor", possibly because the SLPs work in the clinical setting. This kind of formal term of reference could be a reflection of the perceived asymmetrical relationship between the parent and the SLPs which could also explain why the parents hardly ask the SLPs any questions. However, it could just be a reflection of culture of respecting authority where asking questions can be seen as challenging the authority Whatever the explanation is, perception of distribution of power can hamper the smooth flow of communication and indirectly the success of the speech therapy sessions.

Jargon

In addition to these features, jargon or specialised terms which have been accounted for increasing social distance in doctor patient communication by Shuy (1993) were also heard in the SLPs' speech. The SLPs used terms like "high functioning" or "stimulation" as well as abbreviations like "SLD" and "MR" In fact terms like "autistic" or "autism" used as diagnostic labels are in themselves jargon because in the parents seldom come across these terms in their daily life. This could have become a habit for the SLPs because in the clinical setting that they work these terms are common. However, the SLPs do explain the terms to the parents when they sense the need to do so as seen in the following discussion in TS6:

Excerpt from TS6

SLP1: Emm... he does have traces of certain behaviours that are quite noticeable in children with autism.
Okay, but I feel that his is a point where he is a high functioning child.
That means he can be trained to do a lot of things.
But you have to work very very hard with him.
This is just one session.
I mean let's assess him further *lah*.

Variation in Tone and Motherese

Another feature was variations noted in the manner and spirit in which the SLPs produced utterances. In their dealings with the children, the SLPs adopted a cheerful tone of voice most of the time. When the children did not follow instructions then they used a more serious tone of voice. Use of single word utterances, falling and rising intonation, topics that are here and now as well as simplification of language rules typical of "motherese" (Gleitman, 1987) were evident in the SLPs' communication directed to the children.

Although the SLPs displayed sensitivity when dealing with the parents, they did not do so overtly One instance when the SLP was seen practising this kind of restraint occurred with M4 who while discussing her son's performance in the intervention stage became visibly upset. The SLP remained calm in responding to M4's outburst and paused long enough for M4 to regain composure before continuing the discussion.

The SLPs actually had to juggle between the different tones that they used because most of the time they were interacting with the parents and the patients in the presence of one another. At other times, like in the presence of other professionals or observers during therapy, an even more varied tone is used as shown in the following example:

Excerpt from TS5*
(CP5 looks at the pictures pasted on the mirror)

CP5	XXX...key.
SLP1.	Where's the monkey?
	That's the donkey not monkey.
	Can you say "donkey"?
CP5	XXX *(pointing to other pictures)*
SLP1.	Where's the horse?
	Is that the horse?
	[CP5], is that the horse?
	[CP5], where's the horse?
CP5	XXX *(shaking his head and flapping his hands)*
SLP1.	Okay
	Sit down.

(CP5 points to the mirror and bangs the mirror with his hands)

SLP1.	No!
	[CP5], no bang mirror
	That's the horse.
	Where's the rabbit?

(SLP1 holding down CP5 turns to the ENT post graduate student.)

SLP1.	See how hyperactive he is.
	He has no attention span at all.

This observation is in line with the findings of Tannen et. al. (1993) where the paediatrician balanced multiple and sometimes conflicting demands, addressing three audiences.

Besides the conflicting demands, in their communication with the parents, the SLPs sometimes have to face conflicts in beliefs which could lead to misinterpretation of SLPs' communicative intentions. The following excerpt illustrates one such conflict and how the SLP resolved it.

Excerpt from TS4

M4	*Dekat rumah* depends on his mood.
F4	Especially when he wants something badly.
	Then he will follow instruction.
SLP1.	That is true of all children.
	That is when you get them... you know, to do things.
M4	You know why, because at home, we can scold him,we shouted at him.
	Here, you ... you speak softly.
SLP1.	Aah ... I didn't think it was necessary to be extremely strict with him because he was complying.
	He wasn't like running around the room, like tadi you know.
	So I give him a bit of leeway.
	If he was running around, I would have grabbed him by the hand and said " No, duduk."
	I would have been really strict.
	There are two extremes as to how you are going to deal.
	May be sometimes he's running around or sitting under the chair or whatever, then you're going to have to be really strict with him.
	Otherwise if he is, if he eventually does what he is asked to do, I would be okay with him.
M4	Even though he is very slow?
SLP1.	Yeah, it would be very very slow.

Another instance of resolution of conflict of belief is shown in the following excerpt.

Excerpt from TS6

SLP1.	How many words would you say he has?
	Less than ten, less than twenty...
M6	I think tak sampai thirty*lah*.
	Tak sampai thirty
	There are times*kan dia* surprise us *lah*.
	Macam dia kata nak sudu, everyday I tell him *"sudu, garpu, pinggan", dia diam saja.*
	Ada kala dia kata sudu.
	Eh... tahu pulak sudu.
SLP1.	You have the wrong conception that just because he is not saying it he doesn't know it.

(M6 nods her head)

In this conversation, the SLP was able to point out to M6 that she had the 'wrong conception" and M6 was able to accept this because the SLP had been tactful in resolving this conflict.

Conflicts in beliefs can become a real problem as found by Cicourel (1993) and particularly so when parents do not voice their opinions. Some of them believe that their child's condition warrants special treatments and they should "go easy on them" These parents do not realise that without being firm, they will not be able to help the child. One such parent, M7 held the opinion that speech therapy is not all that important as she herself is capable of "teaching" the child at home. Unless the SLPs are aware of these beliefs and address them appropriately, the effectiveness of the intervention will be affected.

The SLPs have been observed trying to motivate parents like M7 and in doing this too, they are tactful. They also have to monitor the message that they are sending because the interpretation is dependent on the recipient's cultural values and beliefs. An interesting finding here is that the oral communication of the SLPs did not really reflect a culture bound by their own ethnicity Linguistic features of their communication reveal that the culture of the participants is most often taken into considerations. The communicative situations and events as well as the linguistic features analysed thus far reflects clearly important aspects of the SLPs' communication in serving the multicultural society.

Conclusion

The diverse communicative situations that the SLPs in this setting participate in place different kinds of demands on their abilities and skills. In situations like the Combined-Cleft-Clinic and case discussions, collaboration among the professionals that has been proven to be important in the SLPs' work was evident but no collaborative efforts with professionals from outside the setting, for example with teachers (as reported in Klein et.al. 1994, and Wright, 1994) of the child patients had been observed. Therefore, communicative needs for such interactions cannot be ascertained from this study However, during the Speech therapy sessions for children with SLD which is the most common type of communicative situation for these SLPs, they seem to rely mostly on the co-operation of the families or parents of the patients. In fact, these sessions seem to be follow the parental-based intervention advocated by (Gibbard, 1994) especially since the SLPs are only able to see each patient only once in three weeks. The findings of this study clearly show that the ability of the SLPs to communicate with the participants, particularly parents of communicatively impaired children, is of utmost importance in their work.

Even with such reliance on the parents who come from diverse linguistic backgrounds, most of the SLPs' oral communication in this setting was carried out in the English language, but during the Speech therapy sessions, they do consider the participants' first language and the language preferred by the parents. Within this type of situations, three distinct communicative events marked by the shift in the focus on participants were evident. In the event of assessment, communication is directed to both the parent and the child patient while in the event of intervention, the child is the focus of the communicative event and in counselling, the parent is the focus.

Within each of these communicative events, linguistic features evident in their communication with the parents and patients imply that the SLPs pay particular attention to cultural factors. Code-switching and use of terms of address that the participants are familiar with are examples of features that reflect the SLPs' efforts in taking cultural differences into consideration. Variation in tone of voice is another technique constantly employed by the SLPs. In addition to these, the SLPs are also very tactful in resolving conflicts in beliefs with the parents whose beliefs may have been coloured by different cultures. Much thought seems to go into the manner in which the SLPs communicate with the participants in the Speech therapy sessions as they are aware of the consequences should they fail to communicate their intentions clearly

In spite of only having only looked at two SLPs in one clinical setting at the time of this study, these findings about oral communication of the SLPs have direct bearings on the training of SLPs especially those who will practice in multicultural societies like in Malaysia.

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