

GRADUATE STUDENTS' PERSPECTIVES ON MODERATE TO SEVERE
COMMUNICATION DISABILITIES AND ITS IMPACT

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A thesis submitted to the faculty of
San Francisco State University
In partial fulfillment of
The Requirements for
The Degree

Master of Science
In
Communicative Disorders

by

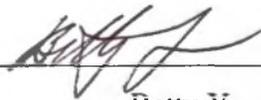
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San Francisco, California

May 2019

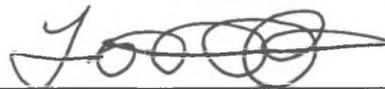
CERTIFICATION OF APPROVAL

I certify that I have read *Graduate Students' Perspectives on Moderate to Severe Communication Disabilities and its Impact* by Andalusia Najla Masad, and that in my opinion this work meets the criteria for approving a thesis submitted in partial fulfillment of the requirements for the degree: Master of Science in Communicative Disorders at San Francisco State University.



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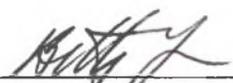
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Andalusia Najla Masad
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It has been argued that when applied to practice for health professionals, the medical and social models sit at either end of a spectrum but neither fully captures the life experience of people with disabilities (Roush & Sharby, 2011). In response, academics have proposed a perspective to view the experience of individuals with disabilities from a more holistic standpoint, the embodied perspective, or biopsychosocial model. The American Speech-Language-Hearing Association supports this model through listing the use of the ICF as part of the role of being a speech-language pathologist. However, SLP education and terminology is still largely rooted in the medical model (Gravel, 2003). Primary research has demonstrated that when students are exposed to the social model of disability their perspectives shift to draw on aspects of both medical and social models. However, there is limited research exploring student perceptions of disability and its impact on their experiences with individuals with disabilities. The current study seeks to expand on previous research and explore whether familiarity with the social model influences students' perceptions of their role as future SLPs and experiences with the population. 47 first and third semester graduate SLP students at San Francisco State University participated in focus groups to discuss four questions about their experience with and perceptions of individuals who have "moderate to severe communication disorders." The students also completed a follow-up survey about their knowledge of the medical and social models. Results demonstrated that students aligned their role as SLPs most with the biopsychosocial model of disability. In addition, students more familiar with the social model were more likely to share positive experiences with individuals with moderate to severe communication disorders. Students shared negative experiences regardless of their familiarity with the medical and social models of disability. Further results and implications for graduate education and clinical practice are discussed.

I certify that the Abstract is a correct representation of the content of this thesis.



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Chair, Thesis Committee

5/20/19.

Date

PREFACE AND/OR ACKNOWLEDGEMENT

I would like to thank all of the individuals who supported me while completing this research project. This project would not have been possible without the volunteer graduate Speech, Language, and Hearing Sciences students from San Francisco State University who took the time to participate in the focus groups and complete the follow-up survey.

I would like to thank my friends and family who workshopped ideas with me, served as extra sets of eyes, and cheered me on throughout this process.

Thank you to my advisor and mentor, Dr. Betty Yu, for her kindness, shared excitement for this topic, and guidance every step of the way.

Finally, I would like to thank all the families and organizations that I have had the opportunity to work with and that have helped broaden my understanding of disability and deepen my commitment to being an ally.

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Introduction

Author's Note

Language and labelling are controversial topics for individuals with disabilities and those who love, support, and work with them. In this paper, the author has chosen to utilize person-first language. Rather than using identity-first language (e.g., disabled person), this paper will state the individual before the disability (e.g., person with a disability). The author would also like to acknowledge that she is aware that this is a matter of personal preference and fully respects that others prefer identity-first language.

Models of Disability

A well-documented and critical paradox exists for health professionals: the celebration of individual differences while simultaneously working to reduce or eliminate the characteristics that set these individuals apart from the norm (Ferguson, 2009; Hersh, 2001; Garden, 2010). Since the advancement of Disability Studies (DS) in academia in the 1990's, DS scholars have highlighted this paradox and discussed its roots in the medical model (Capuzzi, 2013). Historically the practices of health professionals who work with people with disabilities have embodied the medical model philosophy (Ferguson, 2009). The medical model encourages diagnosing and treating conditions with the goal of significantly reducing or removing impairment. In this model, impairments include disorders (i.e., functional deficits) and diseases (i.e., structural abnormalities) (Brisenden, 1986). Although the medical model has demonstrated measurable gains for individuals who can be treated effectively, it has been a topic of debate among disability activists for a number of years. The social model, a response to the medical model, was popularized during the disabilities rights movement of the 1970s. The social model

removes the focus of disability from the individual (i.e., disorders and impairments) and examines the environmental and social barriers that impact individuals with disabilities. In other words, the social model emphasizes how external factors disable individuals with differences. This philosophy advocates for universal design and legislature and regulations, such as the Americans with Disabilities Act (ADA), that make experiences more accessible for all regardless of disability type (e.g., mental; physical; visual; hearing).

It has been argued that when applied to practice for health professionals, the medical and social models sit at either end of a spectrum but neither fully captures the life experience of people with disabilities (Roush & Sharby, 2011). While the medical model focuses too strongly on eliminating disabilities and fixing people, the social model disregards valid experiences unique to people with disabilities that cannot be solved by external adjustments (e.g., chronic pain) (Shakespeare & Watson, 2002). Furthermore, the social model may remove opportunities for people with disabilities to lessen the impact of a disease and augment their life participation (Shakespeare & Watson, 2002). In response, academics have proposed a perspective which accounts for a number of factors that build life experience for people with disabilities in addition to those physical and social (e.g., psychological; socio-political). This perspective, the embodied perspective, or biopsychosocial model, allows for outsiders, such as health professionals, to view the experience of individuals with disabilities from a more holistic standpoint.

The biopsychosocial model can be thought of in conjunction with the World Health Organization's (WHO) International Classification of Function, Disability and Health (ICF). The ICF framework values external characteristics such as environmental

and personal factors equally with body functions and structures and health conditions (World Health Organization, 2001). The ICF framework supports health professionals in developing functional and person-centered goals while working with their clients. In their Scope of Practice document (2016), the American Speech-Language-Hearing Association (ASHA) lists the use of the ICF as part of the role of being a speech-language pathologist (SLP). Per ASHA (2016), “SLPs play critical roles in health literacy; screening, diagnosis, and treatment of autism spectrum disorder; and use of the ICF”. While the biopsychosocial model is the current preferred construct for many health professionals, the discourse and education surrounding people with disabilities in these fields is still grounded in the medical model (Garden, 2010; Roush & Sharby, 2011). This is concerning because health professionals play an integral role in the lives of many people with disabilities and are important disability activists both in and outside of clinics. In her book *Disability History: Why We Need Another “Other”* (2003) Dr. Catherine Kudlick, a prominent DS scholar wrote, “By approaching disability as a social category rather than an individualistic characteristic, the field challenges long-held perceptions that relegate it to the unglamorous backwaters primarily of interest to people in rehabilitation, special education, and other applied professional fields.” Health professionals’ perceptions of disabilities impact more than the quality of their interactions with patients; health professionals, through their language, literature, and interactions, are in part responsible for re-balancing the power dynamic and de-stigmatizing disability in society.

Health Professionals’ Perceptions of Disability

There is little research that directly examines health professionals’ perceptions of people with disabilities outside of the scope of the clinical setting. Furthermore, research

in this field largely focuses on attitudes of medical professionals while working with people with intellectual disabilities. This research supports that increased quality and amount of interaction with people with intellectual disabilities leads to improved attitudes towards those individuals (McManus, Feyes, & Saucier, 2001; Cater, Hughes, Copeland, & Breen, 2001; Barr & Bracchitta, 2015). Further, research indicates that medical students' attitudes, not knowledge or education, is the strongest predictor of their self-efficacy while working with people with disabilities (Culp, Rojas-Guyler, Vidourek, & King, 2017). While these studies are primarily limited to intellectual disability and do not account for the experience of individuals with disabilities, they do reveal the power of attitudes, experience, and perceptions in society with regard to people with disabilities.

Attitudes alone are one of the largest barriers from life participation for people with disabilities (Roush & Sharby, 2011). This indicates that a shift in societal intent and a reduced stigmatization of disability would help facilitate maximum life participation. However, perceptions cannot change without exposure and education. While national organizations of health professionals may tout implementation of the biopsychosocial model, few programs have adjusted their discourse to reflect this or comprehensively integrate DS into their education programs (Roush & Sharby, 2011). Garden (2010) encourages clinical education programs to include "critical engagement with narratives" written by people with disabilities to better understand a larger framework outside of disease or disability. The disability rights slogan is: 'Nothing about us without us'; engaging with narratives allows the perspectives of people with disabilities to be part of the conversation, rather than focusing on their disability. Roush & Sharby (2011) describe the biopsychosocial model in the classroom as a shift in education and

socialization of students. They call for disability experience to “be included under the cultural competence umbrella.” The development of cultural competence first requires an intentional re-evaluation of personal biases followed by a deliberate effort to alter those biases through interactions and building relationships with the population (Leavitt, 2010). While this teaching is not currently the norm, some progressive programs in special education, occupational therapy, physical therapy, and nursing have begun to implement DS into their curricular requirements (Phelan, 2011; Yu & Epstein, 2011).

Speech Language Pathologists’ Perceptions of Disability

Speech-language pathology (SLP) education and terminology is largely rooted in the medical model. After review of SLP textbooks, Gravel (2003) found that most books only discuss disabilities in the context of clinical intervention. In addition, the word “pathology” itself distinctly refers to the cause and effect of diseases. Utilizing the word pathology in the name of the role instantaneously aligns SLPs with the medical model. In accordance with the medical model, when examining ASHA’s description of who SLPs work with, all conditions are referred to as “disorders” (e.g., speech disorder; language disorder; social-communication disorder) (“Speech-language pathologists”, n.d.). Other commonly used terms among SLPs include “deficit” and “dysfunction”. Because this vocabulary is so normalized in the field, few take time to reflect on the impact or potential harm this terminology holds in and outside of clinic (Yu & Epstein, 2011). Furthermore, it is impossible to talk about the field without implicitly aligning oneself with a medical orientation or having to explicitly reject it. Ferguson (2009) elaborated on the issues in a broader context by highlighting the obvious medical aspect of SLP’s work in contrast to the advocacy role SLPs play. Ferguson writes that “advocacy for the rights

of people with communication and swallowing disorders...calls for the recognition of the rights of clients to be fully accepted in the community regardless of the presence or extent of disability". In order for this paradox to be more understood, SLPs need to be aware it exists.

There are few studies that examine SLP perceptions of individuals with disabilities. Further, there is limited information on how education of SLPs impacts their engagement with disability advocacy. In 2011, Yu & Epstein pioneered exploration of this topic by examining how teaching approaches along the medical, social, and experiential continuum impacted undergraduate and graduate students' perceptions about the nature of developmental communication disorders. Through analysis of students' reflective essays, findings demonstrated that students baseline attitudes were largely aligned with the medical model. Following the introduction of material about the social model, most students' perspectives shifted to draw on aspects of both medical and social models.

Current Study: Adaptations to Yu & Epstein (2011)

While the Yu & Epstein (2011) study explored whether teaching approaches along the spectrum of disability models impacted students' perspectives, it did not examine how these perspectives impacted students' experiences with the population. The current study seeks to build on Yu & Epstein's 2011 study by (a) employing focus groups rather than written responses to the study of graduate students' perceptions of individuals with disabilities, (b) focusing on perceptions of moderate to severe communication, and (c) capturing a snapshot of two cohorts moving through the same program at different

stages (i.e., a cohort in their first semester and a cohort in their third semester), rather than employing an intervention or teaching model.

The author chose to include only graduate students in this study because she is particularly interested in future SLPs perceptions. Undergraduate students are not as likely as graduate students to pursue a career as an SLP and consequently the focus group discussions may have been less successful. Successful focus groups require a somewhat homogenous group of participants who are likely to be interested in the topic discussed (Acocella, 2012).

The current study utilized focus group discussions rather than reflective essays. Focus groups are the preferred method for exploring peoples' attitudes, may produce more robust responses than a one-on-one interview or written response, and are a fitting methodology for open-ended questions that encourage self-reflection (Kitzenger, 1995). In 2014, Ryan & Scior completed a review of 24 studies that examined the attitudes of medical students towards people with intellectual disabilities. While overall the researchers emphasized a lack of quality among methodology across studies (e.g., self-selection bias; poor measurement), they preferred one study which included qualitatively examining medical students written responses (i.e., Karl, et al., 2013). In their future recommendations they stated that "interviews or focus groups can produce richer data than written surveys." Therefore, through the use of focus groups, this study aims to explore more deeply the dynamic ways SLP students' talk about disability and reveal their perceptions.

While Yu & Epstein (2011) asked participants their thoughts on "developmental communication disorders", the current study modified the topic to "moderate to severe

communication disorders.” The author chose to remove the word “developmental” to broaden the scope of the topic. The author decided to include the terms “disorder” and “moderate to severe” to encourage discussion about labelling in the field. Previous research has demonstrated that while populations with both mild and moderate to severe disabilities are at risk in inclusion settings, professionals feel least prepared to talk about children with severe or more apparent disabilities (Cook, 2001; Cook & Cameron, 2010). The overall term “moderate to severe communication disorders” is intentionally broad and open-ended because the nature of these focus groups is probing. The author was also interested gathering information about how participants tackle broad questions about their field and reconcile differences in opinions. The current study seeks to explore whether students with exposure to the social model of disability, either in the classroom or in practical settings, will express perceptions of persons with moderate to severe communication disabilities that are more aligned with the social model. The aim of the study is exploratory; it seeks to discover possible patterns and trends in participants’ responses.

Methods

Data Collection

Recruitment. In the Summer 2018 and Fall 2018 semesters, first and second-year SLP graduate students at SFSU were recruited during classes which their entire cohorts attended. At the beginning of the classes the researcher announced she would be holding a study that would take about 30 minutes and require the students to record themselves discussing four open-ended questions with 2-4 peers. Students were informed that the

questions would center on perspectives about disability and that all data would be de-identified.

Focus groups. Data was collected separately from 19 first-year graduate students and 28 second-year graduate students. After participants filled out consent forms, they were broken up into groups of 3-5 people. The investigator provided each participant with a flip book of four questions adapted from Yu & Epstein's 2011 study (see appendix for a copy of the flip book). The participants could see the first question but needed to flip the pages to see the next ones. The questions in the flip book included:

1. What do you think of when you hear the term moderate to severe communication disorders?
2. How would you define the term moderate to severe communication disorders?
3. What do you think is the SLP's role in working with individuals with moderate to severe communication disorders?
4. What experiences, if any, have you had with individuals with moderate to severe communication disorders?

Next, the investigator instructed the participants to find a quiet place to discuss the questions and begin a voice recorder immediately before starting discussion.

Participants were asked not to flip ahead and look at the next question until the group was ready to move on. The participants were told to speak freely and as much or as little about the questions within the time limit of 30 minutes. If they finished before the 30 minutes, they could stop and let the investigator know. Participants then shared the voice note file with the researcher via e-mail.

Follow-up survey. Following the focus groups, all participants were e-mailed a Google Form follow-up survey which they were asked complete as soon as possible (see appendix for a copy of the survey). Participants completed the survey following focus group discussions because the survey contained language (i.e., mention of the models) that may have impacted the conversations. The survey asked participants to rank their familiarity with the difference between the social model and the medical model of disability on a scale of 1-5. If they answered above a 1, they were then asked to briefly explain the difference between the models and where they learned about the models. Upon completed, the participants' definitions were ranked on a scale of 0-2. Definitions were considered correct (score of 2), if they identified the social model as perceiving disability as a societal construct and the medical model as focused on the individual with the disability. Participants received a score of 1 if they correctly described one of the models and a score of 0 if they did not describe either model correctly. Participants were also asked to disclose if their follow-up survey answers may have been influenced by any experiences (e.g., class) that occurred between recording the focus group and completing the survey.

Data Analysis

The researcher transcribed all focus group audio files in Microsoft Word. To de-identify each participant, the speakers were matched to their corresponding Google Form follow-up survey and then assigned to a participant number (i.e., 1-47) that was used to reference them during analysis. After transcribing all focus groups, the researcher used the online software Dedoose to code each conversation at the individual level based on the research question. The researcher used grounded theory to analyze data during this

process. Grounded theory is a method of data collection and analysis that involves continually examining data to better understand the interest area or research question. When using grounded theory, initial data analysis informs future data collections (Chesnay, 2014). For this study, the researcher read the focus group transcripts multiple times looking for themes or patterns in conversations relevant to students' perspectives of disabilities. Transcripts were read based on a single participant (i.e., researcher focused on finding themes for a single participant while reading their comments in context of the focus group discussion). Once familiar with the themes across participants, the researcher narrowed the themes to specific codes (i.e., focused themes) for each question (Hennink, 2007). During analysis, the researcher looked for meaningful patterns that connected these codes to characteristics of individual participants. These descriptors included cohort (i.e., first or third semester in graduate school), size of the focus group (i.e., 3-5 people), self-rated knowledge of social and medical model (i.e., on a scale of 1-5), score on definition of social and medical model (i.e., score 0-2), and how the knowledge of the models was acquired (e.g., in school; through independent research).

Results

Participants' Knowledge of the Models

Self-ranking and definition score. Results from the follow-up survey provided information about students familiarly with the medical and social model. About 80% of 3rd semester students claimed to have some familiarity with the models (i.e., a score of 2 or above), while 40% of 1st semester students claimed some familiarity with the models. When students were scored by the researcher based on their definition of the difference between the medical and social model, 50% of 1st semester and 65% of 3rd semester

students received a score of 1 (i.e., partially correct explanations). All participants with scores of 1 provided correct definitions of the medical model, but incorrect definitions of the social model. The majority of social model definitions that received a score of 1 were more aligned with the biopsychosocial model. See Table 2 for examples of definitions and the scores they received. While 21% of 3rd semester students provided correct definitions of the medical and social model, no 1st semester students did.

Table 1		
<i>Participants' Knowledge of the Models</i>		
	1st Semester Students	3rd Semester Students
Number of participants	19	28
Self-ranked familiarity with medical and social models	1: 32% 2: 26% 3: 32% 4: 10% 5: 0%	1: 14% 2: 7% 3: 36% 4: 25% 5: 18%
Model description score	0: 50% 1: 50% 2: 0%	0: 14% 1: 65% 2: 21%
<i>Note:</i> Self-ranking was completed on a 1-5 scale, 1: not at all familiar; 5: extremely familiar. Model description scores were given on a scale of 0-2, 0: completely incorrect; 1: partially correct; 2: fully correct.		

Table 1

Table 2	
<i>Examples of Scored Student Definitions</i>	
Score	Student Quotes
0	“Social model may be based on social norms/communication expectations of clients age while medical is based on medical norms and expectations (more hard science)”.

1	<p>“The medical model focuses on the person's disorder. The social model focuses on the impact the disorder has on the person's life (work, relationships, activities, attitude of oneself, etc.)”.</p> <p>“The medical model refers mostly to the ways in which we classify and interact with clients based on a westernized medical concepts. The social model considers classifications of disability based on a more holistic approach. I.e considering the entire person and the dynamics of their disability influencing every aspect of their life”.</p>
2	<p>“The Social Model identifies disability as a consequence of external factors rather than by the person's impairment/differences...the medical model identifies disability as the result of a physical condition/impairment/ differences that a person has and that the disability is a "problem" that belongs to the disabled person”.</p> <p>“People are defined and categorized by their impairments and are only offered medical solutions for their challenges when operating in everyday life. Social model: people are defined by our external environment and are offered physical/societal solutions for their impairments when operating in everyday life”.</p>
<p><i>Note:</i> Definitions were intended to explain the difference between the medical and the social model.</p>	

Table 2

Where students learned about the models. The follow-up survey revealed that most students (38% of 1st semester, 67% of 3rd semester) with some self-ranked familiarity with the models learned about the models in Speech, Language, and Hearing Sciences graduate classes. No students from the 3rd semesters cohort reported uncertainty about where they learned about the models, while 23% of 1st semester students were unsure where they learned about them. The majority of students, 67%, who received a

definition score of 2 gained familiarity with the models from Special Education coursework.

Table 3				
<i>Where Students Learned About the Models</i>				
	Students who self-ranked 2 or above		Descriptor score of 2	
	1 st Semester Students	3 rd Semester Students	1 st Semester Students	3 rd Semester Students
SLHS graduate classes	38%	67%	0%	33%
SLHS undergraduate classes	31%	41%	0%	33%
SPED classes	23%	13%	0%	67%
Independent research	0%	17%	0%	0%
Personal experience	15%	4%	0%	0%
Unsure	23%	0%	0%	0%
<i>Note:</i> Students were allowed to enter multiple settings therefore percentages in columns may exceed 100%. No 1 st semester students received a score of 2 therefore the column has no responses.				

Table 3

Responses to Question 1 and 2: What do you think of when you hear and how would you define the term moderate to severe communication disorders?

There was a 90% overlap in coded responses to these questions, so the questions results were combined to avoid redundancy. Across cohorts, 80% of participants expressed discomfort while discussing individuals with moderate to severe communication disorders. Discomfort was coded when individuals admitted confusion,

abandoned thoughts, or commented in a tone that suggested self-doubt. See Table 4 for examples of these comment types.

Table 4	
<i>Examples of Discomfort Quotes</i>	
Type of Discomfort Quote	Discomfort Quote
Admitted confusion	<ul style="list-style-type: none"> • “Moderate to severe is obviously on the very high end of the spectrum. Whatever that is.” • “I don’t know there really isn’t a clear-cut definition.” • “I feel like I have never thought of it...in such deep terms.”
Abandoned thoughts	<ul style="list-style-type: none"> • “Um...well it’s very....” • “I’m trying to think...uh.”
Self-doubting tone	<ul style="list-style-type: none"> • “Do we even refer to them as that?” • “So children with autism?” • “How <i>would</i> I define it?”

Table 4

Responses to Question 3: What do you think is the SLP’s role in working with individuals with moderate to severe communication disorders?

Across cohorts, responses primarily highlighted the importance of utilizing the biopsychosocial model, with a tilt towards the medical versus the social model. Responses that restricted SLPs’ interactions with the population to a clinical setting and focused on disability as an internal impairment that needed to be fixed, altered, or minimized were considered most aligned with the medical model. These codes included “provide means to communicate basic needs”, “increase overall communication”, and “seek alternative means of communication.” Responses that mentioned the population outside of the speech therapy setting, but still within the realm of treatment were

considered biopsychosocial. These codes included “collaborate with other professionals”, “create individualized and functional goals”, and “collaborate with family.” Responses that highlighted the importance external and structural changes were considered most aligned with the social model. These codes included “presume competence” and “public awareness and advocacy.” Only individuals who self-ranked their familiarity with the models as 3 or higher mentioned presuming competence, and only individuals who self-ranked 2 or higher mentioned public advocacy. The only students who mentioned the SLP’s role outside of therapy included were those who mentioned public advocacy. See Table 5 for examples of student responses and how they were coded.

Spectrum of medical to social	Codes and number of times mentioned	Student quote
Medical	Provide means to communicate basic needs (3)	“To have them communicate their needs and their wants and what they need.”
	Increase overall communication (21)	“Help them communicate to the best of their ability, like communicate the most and with the best quality.”
	Seek alternative means of communication (14)	“Figure out what modality would work for the child or adult we are working with like whether it be AAC or um I don’t know or different communication system.”
	Collaborate with other professionals (2)	“I think that it’s the SLPs job to work interdisciplinary with other professionals who are working with the client so that be a teacher or the family or adaptive PE teacher or the OT.”
	Create individualized and functional goals (28)	“The biggest goal of an SLP is um catering like goals and things that you wanna work on like specifically to them specially things that are going to be very functional in their life.”

Social	Collaborate with family (17)	“The slp has to support the family and the people around the individual to educate them and teach them how to support this individual and their communication, especially functional communication”
	Presume competence (7)	“I feel like it’s the SLP’s role to definitely facilitate any development that can occur and always push for clients most potential and never to underachieve just because of a diagnosis or an impression.”
	Public awareness and advocacy (4)	“I think like advocacy is a big thing to so many people don’t know about people that have problems communicating...I feel like when people haven’t heard about the types of people we work with they don’t know.”

Table 5

Responses to Question 4: What experiences, if any, have you had with individuals with moderate to severe communication disorders?

The majority of experiences expressed while responding to this question were negative (40.4%). Positive experiences (29.8%) and neutral experiences (19.1%) were the next most shared type of experience. In addition to being coded based on their quality of experience, 22% of students also mentioned that they felt they had limited experience.

See Figure 1 for a breakdown of all experiences discussed.

Perceived Quality of Experience with Population

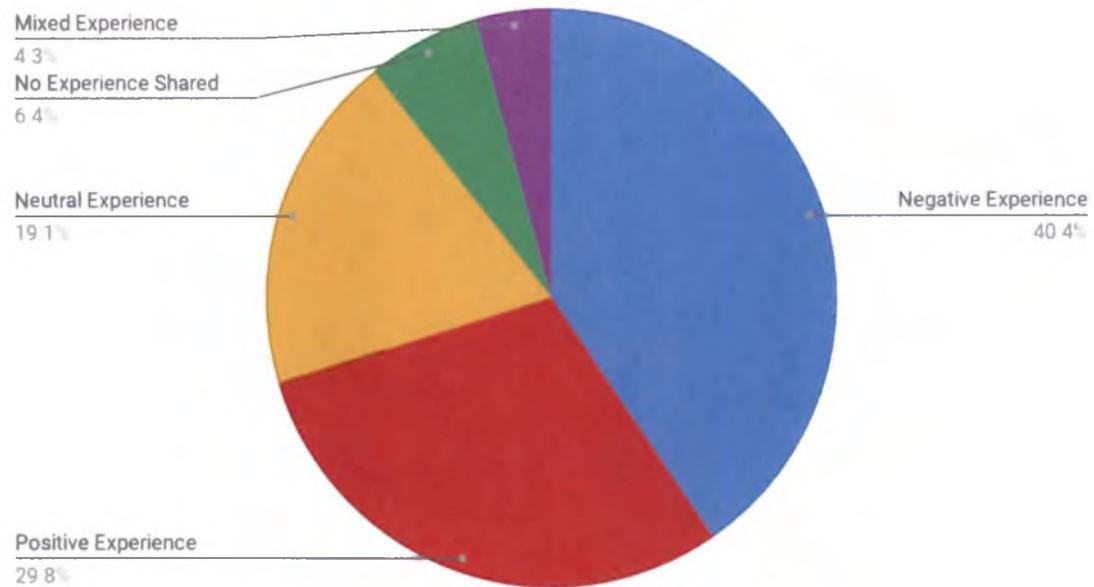


Figure 1

Note: Each participant only received one code.

Closer examination of students' negative experiences revealed that the majority of negative experiences were due to systemic challenges (31.4% of negative experiences), versus direct interactions with the individual with the moderate to severe communication disorder (20% of negative experiences). See Figure 2 for a detailed breakdown of individuals' negative experiences. See Table 6 for examples of quotes that were coded to represent the student's overall experience.

Types of Negative Experiences Described

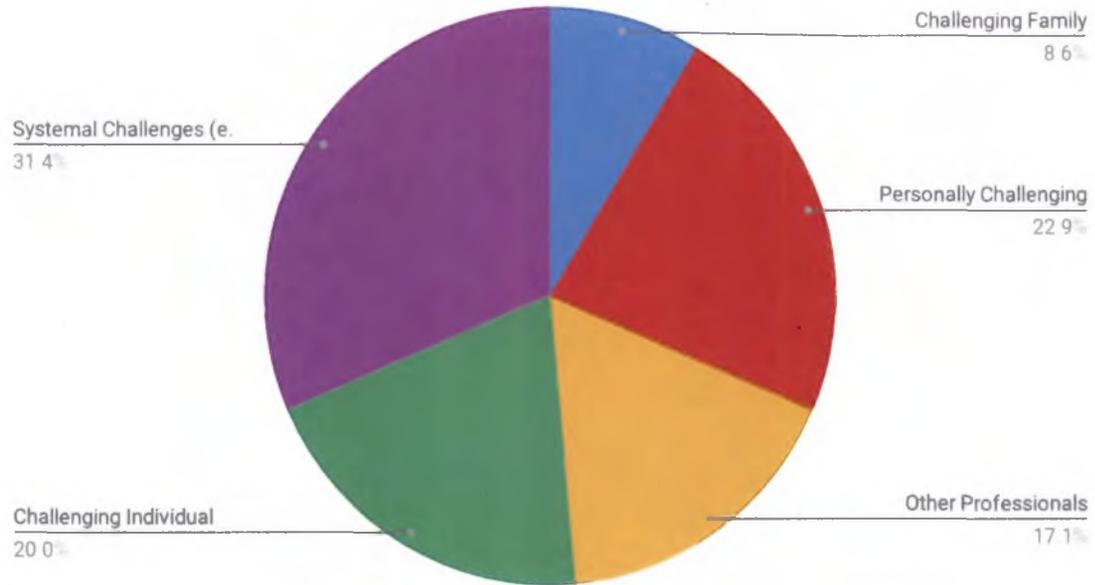


Figure 2

Table 6	
<i>Examples of Neutral, Positive, and Negative Experiences</i>	
Experience Code	Student Quote
Neutral Experience	“I had the opportunity to work with older individual who can’t communicate at all...speech therapists come and they would have communication boards set up.”
Positive Experience	“The days I do work with X I feel super positive about the day like coming back to my house I feel very good and uplifted.”
Negative Experience: Challenging family	“It was hard because her dad was so keen on Her using this 10,000 dollar machine that he bought for her but it was clear after several months that she’s not seeking it out, she’s not benefitting from it.”
Negative Experience: Systemic challenges (e.g., health care; school system)	“Some kids could do long division and some kids were needed hand over hand help for coloring but yet they’re placed in the same classroom and so many of their communication needs aren’t being met because they’re in this moderate to severe

	disability classroom.”
Negative Experience: Personally challenging	“I feel like it’s just really sad for me I feel like after they’re done with me they’re not going to continue the goal.”
Negative Experience: Challenging individual	“This little girl, her daughter, was testing everybody and they didn’t know what to do with her.”
Negative Experience: Other professionals	“They didn’t even implement her iPad. Nobody really even touched it...kids are given AAC devices nobody uses them.”

Table 6

As demonstrated in Figure 3, students shared negative experiences regardless of their self-ranked familiarity with the models. Students who self-ranked as more familiar with the models were more likely to share positive experiences as their familiarity increased. Figure 4, which compares the disability model definition score the students received to the type of experience shared showed similar results. Students who demonstrated a deeper knowledge of the social and medical model in their definitions were more likely to share positive experiences. Negative experiences were shared regardless of familiarity.

Self-Rank and Percentage of Negative and Positive Experiences

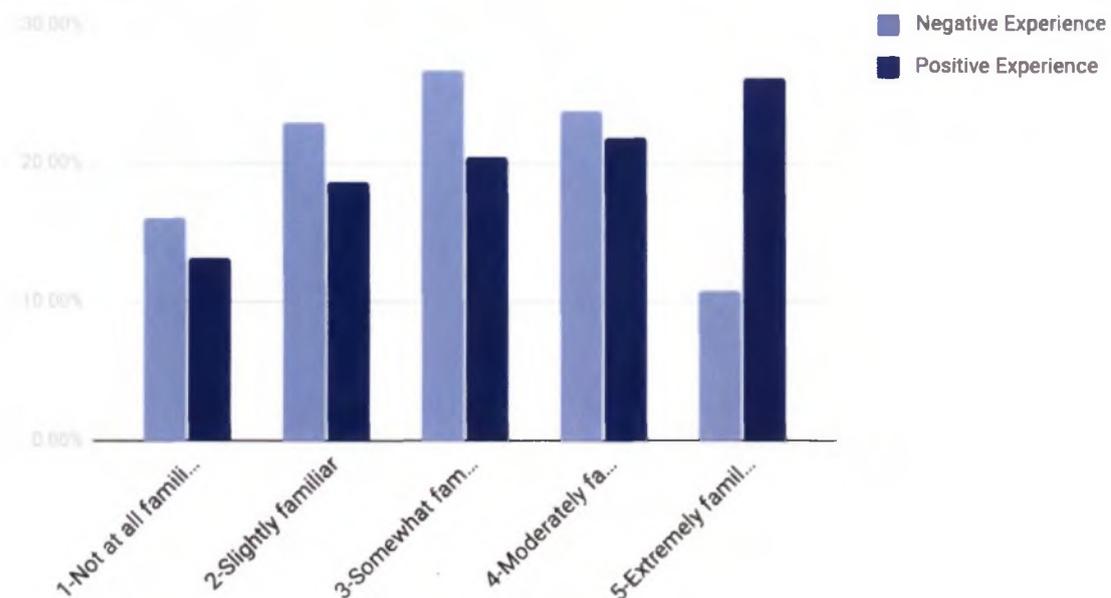


Figure 3

Model Definition Score and Percentage of Negative and Positive Experiences

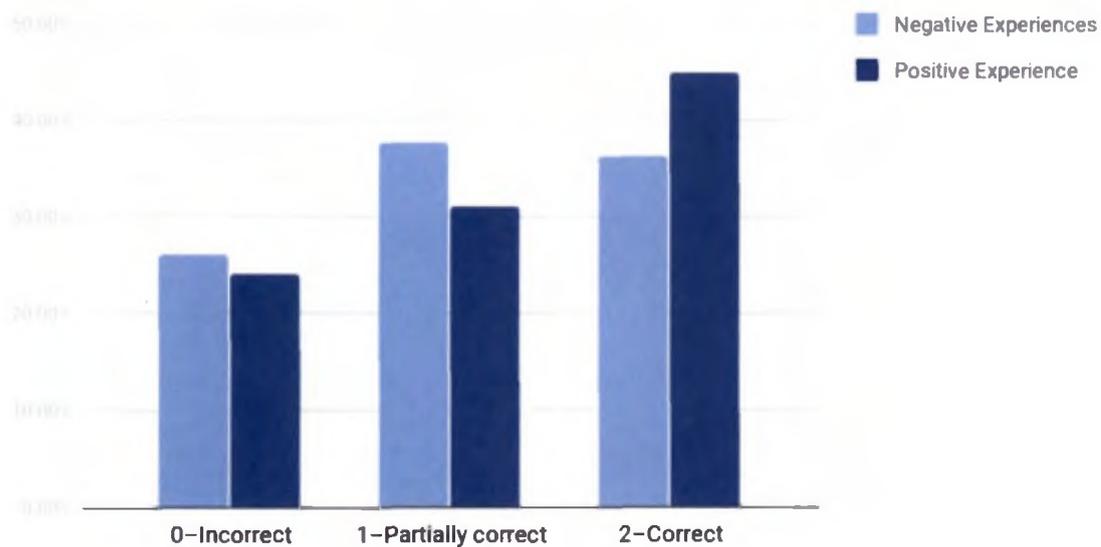


Figure 4

Discussion

Limitations

The current study has limitations that need to be considered for interpretation of the analysis section. There are a number of factors that may have impacted information shared by participants during the focus groups including, but not limited to participants' familiarity with the researcher, familiarity with each other, awareness of being recorded, and current mood or desire to participate. In addition, focus groups did not have moderators to ensure groups stayed on topic or to prevent individuals from dominating the conversation. Factors that may have impacted individuals' results on the follow-up survey included the varying amount of time taken to respond to the survey, potential failure to disclose impacting experiences that bolstered their knowledge of the models following the focus group discussion, and potential for participants to research the definitions of medical and social models of disability. Finally, all focus group discussions were coded by one researcher. Therefore, the results may be subject to her personal biases.

Analysis and Conclusion

Analysis. Results from the follow-up survey determined that the majority of students who perceived that they had some knowledge of the models learned it in graduate SLHS coursework. However, when students were judged based on their written definitions of the models, results indicated that those with the best knowledge of the models learned this information in Special Education (SPED) coursework. This indicates that while SLHS coursework introduces the concepts of the models, SPED coursework teaches the information more comprehensively. This may be because the discussion of

the dichotomy between the medical and social model is significantly more prevalent in SPED research and discussion than in SLHS.

Within SPED research there is an ongoing debate regarding the implementation of the social model in the classroom (Anastasiou & Kauffman, 2011; Reindal, 2008). For example, Anastasiou & Kauffman (2011) argued that the social model ideology hampers the benefits of SPED, while Reindal (2008) proposed a new form of the social model. While these types of discussions are plentiful in SPED research, they are extremely limited in SLHS. SLHS researchers and clinicians' professions are similarly aligned with disability as the SPED profession. Nevertheless, SLHS has failed to join the conversation, and the impact was demonstrated in this study through the discomfort expressed by SLHS graduate students while discussing disability.

Discomfort while talking about disability is not uncommon in the general population. A 2014 survey of 2,001 people commissioned by Scope, a disability equality nonprofit in the UK, found that 67% of people were uncomfortable while talking to people with disabilities. Peoples' discomfort primarily stemmed from limited interactions with population and concern that they would say the wrong thing. The majority of students in this study expressed discomfort while talking about individuals with disability, a population that they will be serving throughout their careers. This finding may have significant implications for practice. Brandes & Crowson (2009) found that discomfort with disability was one of the strongest predictors for opposition towards inclusion and negative attitudes towards students with disabilities. These links are further supported by research that has demonstrated professionals feel least prepared to talk about individuals with severe or more apparent disabilities (Cook, 2001; Cook &

Cameron, 2010). Evidence suggests that clinicians who can utilize a caring and confident communication style garners higher client satisfaction and improved health outcomes (Cousin, Mast, Roter, & Hall, 2012; Stewart, 1995). However, to achieve this level of comfort, students need experience with this population and explicit teaching about them outside of a diagnostic view (Favazza & Odom, 1997). Paterson & Hughes (2006) argues that a deep understanding of the spectrum between the medical and the social model is crucial to understanding the identity politics faced by individuals with disabilities. Without this understanding, SLPs are not serving this population with the best holistic understanding of them.

While discussing their role with individuals on the spectrum, most responses fell into the biopsychosocial model with a lean towards the medical model. These results align with how students defined the medical and social model; the majority of students correctly defined the medical model, but then substituted the definition of the social model with the definitional biopsychosocial model. These two results, students' explanations of their roles as future SLPs and their written definitions of the models, highlight our field's lean towards the medical model. This is despite ASHA's mandate that SLPs be serving populations using the biopsychosocial model. While SLHS graduate instructors may focus on teaching the ICF, the textbooks and literature is still rooted in the medical model (Gravel, 2003). Without explicitly learning and deeply understanding what sits at the opposite end of the spectrum from the medical model, students fail to fully grasp the entire spectrum resulting in a truncated spectrum shifted towards the medical model. This was further evidenced in the limited mention of the role of an SLP outside of the clinic.

The ASHA Scope of Practice document (2016) highlights “advocacy and outreach” as a facet of its “Domains of Professional Practice” for SLPs. ASHA (2016) defines domains of professional practice as “a set of skills and knowledge that goes beyond clinical practice.” Some other areas that fall into this category include research and supervision. Examples of advocacy and outreach include community awareness and health literacy. This section of the scope of practice may force SLPs to consider philosophical questions such as where does the role of an SLP begin and end? What responsibility do SLPs have to the populations they serve outside of the clinic? In response to the question “what do you think is the SLP’s role in working with individuals with moderate to severe communication disorders,” only about 4% of the participants’ responses mentioned interactions outside of the clinic (i.e., advocacy and outreach). Whether or not individuals choose to engage in advocacy and outreach is a personal decision, however the limited mention of this aspect of the SLP’s role may indicate a failure to teach about the social model of disability.

The students who mentioned advocacy and outreach in the SLPs role were at least slightly (i.e., score of 2) familiar with the models, based on their self-ranked knowledge and definition scores. Another more socially situated response about the SLP’s role, presuming competence, was only mentioned by students who at self-ranked their knowledge as at least somewhat familiar (i.e., score of 3). In a 2006 student, Bilken & Burke determined that presuming competence was central to successful inclusion of individuals with disabilities. Students with greater familiarity of the models were more likely to mention more socially situated responses than those who were not familiar; this

further supports a shift in mindset that occurs when one has a full understanding of the spectrum (Paterson & Hughes, 2006).

This shift in mindset was demonstrated most clearly when students shared their personal experiences with individuals with moderate to severe communicative disorders. The stronger a student's understanding of the social model, the more likely they were to share positive experiences about interactions with the population. These students shared stories of rewarding personal encounters with this population. The counter to these positive experiences, which made up about 30% of experiences shared, was the negative responses, which made up 40% of all experiences shared. A range of negative experiences was expressed across students, regardless of their familiarity with the models. However, the majority of negative experiences was not focused on the individual, but external factors such as systemic barriers (e.g., school system and healthcare) and issues with other professionals. Trevo & Palmer (2004) argued that to improve health professional attitudes towards individuals with disabilities "specific educational experiences" were needed. For SLHS, these results indicate that gaining a better understanding of the models can support improved attitudes towards this population. While negative experiences seem to be inevitable due to external factors, students with a deeper understanding of the social model are able to have a more holistic view of and rewarding encounter with the individual.

Conclusion and future directions. This research project serves as preliminary evidence to support more comprehensive teaching of the models of disability in SLHS graduate courses. There may be a shift in mindset that allows students to have more rewarding and positive experiences with individuals with more significant

communicative disabilities when they have a deeper understanding of both models. This is not to say those students with a better understanding align more with the social model, because this question was not asked, but that they understand both sides of the spectrum and that may shift their lens while working with the population. Serving individuals with disabilities is a huge aspect of the SLHS field and new SLPs must be able to comfortably discuss disability to best support this population. This comfort can only come through explicit teaching and increased opportunities for interaction. These opportunities for interaction do not need to be restricted to clinical practice; programs should encourage students to consider their role as SLPs within the realm of advocacy and outreach as well. Further evidence and research are needed to fully support these claims. Future research should continue to explore student and SLPs' perspectives of disabilities and the role of the medical and social model within the SLHS field.

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Appendices

Focus Group Flip Book Template

Each flip book was created by cutting along the dotted lines. Question 1 was placed on the top of the book followed by questions 2, 3, and 4. The flip book was then stapled together on the left.

1. What do you think of when you hear the term moderate to severe communication disorders?

2. How would you define the term moderate to severe communication disorders?

3. What do you think is the SLP's role in working with individuals with moderate to severe communication disorders?

4. What experiences, if any, have you had with individuals with moderate to severe communication disorders?

Follow-up Survey

First and Last Name *

On a scale of 1 to 5, rank your familiarity with the difference between the social model and the medical model of disability.

1 = Not at all familiar

2 = Slightly familiar

3 = Somewhat familiar

4 = Moderately familiar

5 = Extremely familiar

Briefly explain the difference between the Social Model and the Medical Model of disability. Write as little or as much as you desire. Please do not supplement your answer with Google searches as it will skew the data.

Where did you learn what you know about the Social Model versus the Medical Model of disability? (Can choose multiple)

Speech, Language, and Hearing Sciences (SLHS) Graduate Classes

SLHS Undergraduate Classes

SLHS Clinic

Independent Research

Since completing the focus group with your peers, have you had any experiences (e.g., class; clinic) that may have impacted your answers in this survey? If so, please explain. How would your answers have been different prior to this experience? If not, please write N/A.

Optional: Write in any additional comments here. Thanks!

Section 1 of follow-up survey

Section 2 of follow-up survey: only completed if participant answered 2 or higher in section 1

Section 3 of follow-up survey: only completed if participant answered 2 or higher in section 1