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Video - a reflective tool

Continual self-analysis ensures we all practise what we preach. Keena Cummins and Sarah Hulme focus on the strengths of video playback as a reflective tool in the therapy process and for ongoing professional development

Children who have no language difficulties make interaction accessible; however children with difficulties immediately have the potential to throw even the most experienced of clinicians into a mode of poor timing. All professionals need continually to assess and reassess their skills in relation to each child's abilities as, as with 'parents,' 'students' may perceive their skills as very different from the reality.

'Student' applies in this article to all those hoping to develop their skills further; be they client, carer, student therapist, therapist, supervisor or manager. The use of video is not intended to be promoted in isolation, but rather as a sensitive additional resource which augments the skills of the clients and professionals involved.

Partnership with parents

'Parent child interaction' as a therapy tool has been used within Camden and Islington for many years. Its main principle is partnership with parents, enhancing their knowledge and understanding of their child with the therapist's theoretical and clinical experience. Its most unique feature is the use of video to analyse in minute detail the transitory nature of communication. It is this fine detail which distinguishes it from the Hanen model, although the basic philosophy of both programmes is complementary.

Both authors feel, having specialised in working with parent child interaction in its true form for a number of years, that the benefits to working practice and the subsequent development of the service have been dramatic. This is particularly in relation to child language acquisition, the role of the parent and primary carers such as nursery workers, and perhaps even more importantly – the role of the therapist and the real development of clinical skills.

Health Centre Service

Camden and Islington NHS Trust's Health Centre Service consists of 13 staff members - eight employed in community clinics, two working in pre-school language units, ourselves (community clinic based) and a speech and language therapy assistant. The service addresses the needs of children under five who present with a variety of language difficulties, classically language delay through to language disorder. Through the parent child model, it has been possible to offer across the Trust an equitable service, which prioritises children with language disorder and maintains waiting lists at an almost manageable level despite the increased referral rate of 146 per cent over the last five years. (Children whose needs include learning difficulties or pervasive developmental language disorders are managed by the child development team.)

Our team consists largely of newly qualified staff, that is, up to three years post-qualification. Our team structure is however unique in having four members of staff over grade 28, all of whom have specialised in working within health centres in addition to their varied experience in other clinical settings.

One of the major tasks in managing the team has been affording support and supervision to posts which make potentially excessive demands on team members with little experience of working in challenging situations. The parent child model has offered appealing strategies for addressing the needs of these clinicians whilst continuing to provide a high level quality service to children and their carers.

Video philosophy

As this article does not seek to describe the parent child interaction model per se, a brief summary of the course of video sessions is in Appendix I. (The authors consider Kelman & Schneider; 1994, essential reading for full details.)

Interaction is a transient experience which can never be repeated. In therapy we aim to identify the type and timing of communicative events within an interaction, to recognise where a child is in their communication development process, and how their timing moulds with the adult's. In using video a visual record of most aspects of interaction can be achieved from which detailed analysis can be made. Of primary importance is that observation can be made by those involved in the interaction rather than merely by those who have looked on. Communication events can be captured without their immediacy being lost, and the communicative partners are in a position to provide a perspective inaccessible to the observer. The student is in an active position of identifying their own behaviour and its effect on the child. The student can then modify their behaviour accordingly, either with the support of another or in isolation.

Observation not perception

With video playback, therapists are able not only to assess themselves along the same parameters as parents, but to extend self-observation and appraisal into all areas of work, developing a personal critique based on observation rather than perception of their own behaviour, in as fine detail as is required. The importance of 'Reflection time' is described by Marson et al (1990); we believe video maximizes its use. Therapists are also placing themselves in a similar situation to the client and acknowledging their own skills are similarly dependent on the unique situation.

We therefore suggest that, in self-analysis of an interaction with a child, therapists utilise an observation sheet similar to the parent's self rating scale (Appendix 2). Initially they may wish to do so in isolation then, when more confident, with a colleague or in a group context with their peer facilitator (Appendix 3). It is important for the manager to allow self-assessment time in their timetables.

A valuable tool

Supervision is a controversial concept which means different things to different people. Within our service it has proven to be a valuable tool for generating new ideas and projects whilst providing support, discussion and advice around complex issues. We have adapted many of the principles outlined in Stengelhofen's book 'Teaching students in Clinical Settings' to provide ongoing support for both newly qualified staff and those wishing to continue sharing their learning experiences and to benefit from the experience of their colleagues. Her principles of supervision have also been complemented by the Camden & Islington video interaction technique.

Supervision without the use of video playback is dependent on the therapist's self perception and awareness of a situation which occurred in the past, in combination with subjective observations by the supervisor. In recounting situations, the immediacy of the moment is lost, as is the behaviour in relation to the emotion/feeling. A purely objective perspective in fine detail is difficult.

When supported by video, both can be active participants in the observation process, providing a reflective learning experience benefiting student and supervisor. Marson et al (1990) specify that adult learning is achieved through providing the opportunity to talk through the experience, using positive feelings and removing obstructive ones. In this way the adult can be motivated to learn by internal rewards, such as increased self-esteem and a sense of accomplishment (Stengelhofen, 1993). Video offers the opportunity to complement discussion, observe issues already discussed and to try out alternative strategies and record their effects. Students are in a position to think through their feelings and define an area requiring further work, then given the opportunity to work on that area and have video feedback on their development. This also highlights their strengths, which often they find so easy to ignore.

Where therapists choose to use video playback for their supervision sessions, it is important they take responsibility for the choice of video, and for obtaining support and gaining confidence in this style of analysis. It is the supervisor's role to provide a systematic framework for feedback. As with parent child interaction, the aim the session is to 'deepen understanding of what has taken place through enabling enhancement and modification of skills being used' (Stengelhofen 1993). The supervisor

should also identify with the therapist their exact stage of 'learning', and adapt accordingly, adjusting their timing in teaching to gel with the student's needs.

Evolution

Our service continues to have a long way to go. Supervisory therapists need to address their own perceptions and beliefs about the supervisory process and require a regular discussion venue to share what they have learnt from their 'students'. Munroe describes supervision as being 'the opportunity to share experiences, to acquire fresh insights and new ideas which naturally lead to an assessment of the individual supervisor's own skills and performance in relation to patient management'. It is this analytical, ongoing assessment of the whole therapeutic process that hopefully will continue to assist in the evolution of the service, so that all therapists are in a position to provide ideas, knowledge, intuition and feedback on further desired developments.

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References

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Questions

- How does video facilitate parent child interaction therapy?
- What are the benefits to individuals of self-assessment using video compared with other methods?
- How can a service gain from therapists' self-evaluation through video?

Answers

- A parent is videoed playing with their child and, within a framework provided by the therapist, identifies from the footage adaptations in their own behaviour which would help their child's communication.
- Observing yourself on video gives a more objective than perceptual view of events, your actions and their effects, both positive and negative.
- The ongoing, analytical assessment in minute detail of the therapeutic process increases understanding and stimulates ideas for further developments.

APPENDIX 1 – VIDEO INTERACTION SESSIONS FOR PARENTS

The video interaction aspect of the parent child course provides a pre-assessment session, six interaction sessions once weekly, and a six week consolidation period followed by a review appointment. Video feedback is a sensitive tool, primarily used for self-assessment and discussion. It is not for providing judgements – particularly by therapists who have not already analysed themselves in a similar fashion. The main purposes should be for parents to leave the session feeling better about

themselves. Feedback should therefore be supportive and realistic, highlighting the strengths of the parent.

Session 1

A brief rationale is given to the parents advising them that, because they are the primary caregivers, they are best placed to help their child. They are reassured that they and the therapist will be working together to develop the child's skills. It is important to stress the parent has not done anything wrong - as Fey points out, 'there is no evidence that children's language impairments are caused by parents' behaviour' - but that the child's behaviour does affect the adult's interaction style. The video sessions are for the therapist and parent to work out where the communication is breaking down and to use certain strategies to facilitate a quicker rate of development.

The parent is instructed to spend time with the child, talking and playing in the way they would usually do at home. Care is taken that the parent understands not to 'make' the child talk.

The therapy room is arranged with a variety of toys covering the developmental play stages, from exploratory through to symbolic. The therapist leaves the room and the session is videotaped for five to ten minutes.

When the therapist returns to the room, the parent is invited to comment upon whether the session was typical of how they usually play together at home and, if it was different, how so. Any issues arising at this stage should be discussed immediately. A commonly arising point may be that the parent felt unnatural because of the camera. In such a circumstance the parent may be reassured that, because the child is unaware initially that they are being videotaped and later is not self-conscious in the presence of the video camera, parental behaviour generally remains natural because the parent responds to the child's interaction, which is as it would be at home.

On finishing the video recording and returning to the therapy room, the therapist should first make a positive statement about the interaction such as 'I like the way you play on the floor with him'. The therapist and parent watch the video together. Parents are asked to observe their own behaviour in general, having previously scanned the self-rating (appendix 2) scale, so they have an idea of the sort of things the therapist is looking for. A detailed Interaction Profile (Kelman & Schneider, Appendix 4) is used by the therapist to analyse the parent's verbal and non-verbal interaction with the child, non-verbal behaviours being of equal significance. The analysis is not shown to the parent, but is kept for reference and comparison at the end of therapy

Having watched the video, the parent is invited to identify what they are doing that is helping their child, and the therapist then highlights in general terms many of the parent's strengths. The parent and therapist discuss the parameters of the Self-Rating Scale in turn. This has been adapted from the Interaction Profile and is merely used as a conversational tool to

- a. focus the parent
- b. provide a starting point and
- c. obtain the parent's understanding of such terms as 'following his lead'.

In utilising and discussing these terms, the therapist is able to understand more fully the parent's perspective of the interaction process.

For each parameter, the parent is guided to rate their use of that interaction style in terms of a 0-3 rating scale where 0 signifies they never do something and 3 indicates they always do it. The ratings are purely subjective, and it is important to remember the aim is to build parent confidence. The video can be rewound to highlight specific points, particularly where the parent and therapist do not appear to agree. This is likely to be due to lack of explanation/ understanding and the video can provide an example of the therapist's intended meaning.

Once the rating scale has been completed the parent is requested to choose the parameter they would like to work on first. If the parent has difficulty identifying the most important strategy, the therapist may suggest choosing the one with the lowest score.

It doesn't matter if the therapist doesn't agree completely with the parent's self-rating, since experience has shown that altering one of the parameters will have a knock-on effect on the other parameters, so you get there in the end. What seems to be most important is that parents choose for themselves what to change, so they are in control.

The parent is then asked to do another video using the strategy they have just identified. This is taped once more and fed back to the parent. Prior to playback the therapist asks the parent if they feel they achieved their aim, and then the tape is played with the therapist focusing on this, for example asking, "Are you following his lead there?", "and there?", using the pause button between each interaction.

The aim achieved, the parent is invited to highlight the effects on the child. The therapist then summarises, for example, "Yes, because you're following his lead he's staying with one toy for longer, doing more things with it, asking you for help either with his eyes or words (which has resulted in more eye contact), and he's starting to tell you what he wants to talk about."

The parent is requested to carry out a play session at home doing exactly what they have done within the session. The aim is also written down.

Session 2 – 6

At the start of each session the parent is asked to recap on their aim, and to feedback on how the five minute sessions have been going. A short five to ten minute video is taken and the parent and therapist watch to see if the aim has been maintained. If it has, the changes in the child are highlighted and a further aim is chosen, without the use of the self-rating scale.

The parent and child are then videoed once more and if the aim has been achieved they are requested to spend five minutes a day using the new strategy as well as the old. Their aims are written down.

On the last session, the parent is asked to carry out five minutes a day during the six week consolidation period. It is stressed progress will only continue if this is achieved.

Review session

The child is reassessed, and the parent and child videoed for the last time. Parents re-evaluate themselves using the self-rating scale with the previous scores concealed. They are then revealed so the parent can observe their own progress. The first video is shown, in contrast to the review video, to highlight the child's progress.

Appendix 2 - Self rating scale

PARENT / CARER

Please think about the following statements and rate yourself from 0 to 3 for each one.

Rating

0 - never

1 - sometimes

2 - often / frequently

3 - always appropriate

	INITIAL DATE	FINAL DATE
Letting him/her choose the toy		
Sitting where it's easy to see me		
Following what s/he wants to do		
Giving him/her extra time to talk		

Listening to what s/he says		
Talking about what s/he is doing		
Waiting for him/her to start talking		
Not asking questions		
Praising him/her		
Talking slowly		

Appendix 3 - Group self rating scale

OBSERVATION SHEET
GROUPS

SKILLS UTILISED

RATING SCALE: Name:

	Session 1 / Date	Last session / Date
Timing		
Use of silence		
Visual Cues - Sign system / Hands		
Facial Expression		
Praise / Reinforcement		
Directly relevant language		
Volume		
Rate		
Choices		
Turntaking		
Anticipation		
No Distractions		
Modelling		
Intrigue		
Positioning		
Organisation		
Other		

Appendix 4 - Interaction Profile

	Interaction profile	
NON VERBAL		VERBAL
	Directiveness	
	Following child's lead	
Listening		Turn taking
		Balance of conversation
		Interrupting
	Giving time to respond	
	Pausing	
Gaining child's attention		Rate
Observation		Intelligibility
Eye contact with child		Volume
Shared focus of attention		Fluency
Facial expression		Prosody
Animation		Complexity: semantic
Intrigue		syntactic
Touch		Semantic contingency
Gesture		Initiation:
		- questions/requests
		- imperatives
		- comments
		- other
Position		
- level		
- mobility		
- orientation		Commenting
- proximity		Responding

Manner

- warmth

- attachment

Repetition

Rephrasing

Maintaining topic

Repair

Reinforcement

Conflict management

Choice of activity
