Efficacy of phonological intervention is rooted in the assessment of the speech disorder—its nature, characteristics, severity, and prognosis for improvement. From the assessment that a clinician completes on a child, appropriate phonologic goals are targeted that will maximize treatment outcomes. Our treatment goal is to achieve the greatest amount of change in the least amount of time. According to Gierut (1986), our treatments are only as effective as our assessment is accurate and complete.

In a typical 60 to 90 minute evaluation session with a child, what do you assess? This is a simple question, and one that clinicians and researchers face daily. It has become so routine to many of us that we no longer question what we will do in an evaluation session. Yet the procedures we choose are a reflection of what we believe speech disorders are, whether speech is viewed as part of a linguistic structure, and how we can utilize treatment to restructure a child’s sound system.

The questions embedded in the assessment decision include the following: What data do you collect? What aspects of the child’s communication abilities do you include in your assessment? What analyses do you complete? How do you differentially diagnose articulation impairment (AI) from phonological impairment (PI)? Further, how do you determine whether there is an organic motor speech disorder or a nonorganic basis of the speech disorder? If you accept the possibility of a diagnosis of childhood apraxia of speech (CAS), how would you differentially diagnose CAS from AI and PI? Finally, what are your recommendations for intervention?

The goal of this clinical forum is to provide five different perspectives on this essential question of what to assess when the clock is ticking. The contributors discuss their assessment procedures within a time frame and provide a rationale for their procedures. The contributors to this forum were invited to present their evaluation perspective because of their clinical and scholarly competence and their qualifications in working with children who have speech disorders. They also represent a wide variety of perspectives, which provides a range of viewpoints in the assessment of speech disorders in children. In addition to the articles by contributors who practice primarily in university settings, there is also a clinician’s perspective from a community viewpoint.

Finally, two brief commentaries from leading experts in child phonology appear at the end of the forum to address assessment issues that are open for debate.

It has been about a decade since a forum has been devoted to clinical assessment of child speech. Shelton and others discussed assessment procedures in the 1993 forum in *Seminars in Speech and Language* for a child, Matthew, who exhibited a persistent sound disorder. Fey (1992) coordinated a clinical forum in *Language, Speech, and Hearing Services in Schools (LSHSS)* that addressed critical issues in clinical phonology and helped to clarify and expand our thinking with regard to the range and extent of phonological principles in the assessment and treatment of children with speech disorders. As this forum’s articles demonstrate, our field has moved beyond the articulation/phonology debate discussed in those earlier forums. The present collection of articles does not focus on whether to incorporate phonological principles into the assessment of children’s speech, but rather on the rationale for incorporating specific aspects of phonological principles. The current forum moves previous discussions forward in a way that will allow the reader to compare and contrast the different assessment methodologies, particularly with regard to how each demonstrates the theory-practice coherence and assessment-intervention congruence that Schwartz (1992) and Kamhi (1992) discussed in the *LSHSS* forum.

The Role of Theory

What role does theory play in our assessment frameworks? Kamhi (1999) and Apel (1999) addressed this question as they discussed the lack of application of research into clinical work and the scientist-practitioner dichotomy that exists in our field. Their articles raise the question that many clinicians ask and academicians struggle to demonstrate through research and coursework: Are theories relevant to the clinician?

Johnston (1983) addressed this question several years ago, arguing that theory must have the attention and commitment of clinicians. Without theory, assessment becomes a set of activities lacking an explicit reference to their underlying assumptions about how children learn the ambient sound system, how errors are characterized, or how
sound systems are organized. As a consequence, the assessment activities are not regulated or guided in a focused or principled approach, and intervention strategies become equally haphazard. The selection of treatment targets based on phonological assessment has the potential to maximize treatment outcome, and therefore, plays a major role in treatment efficacy. Criteria used to select treatment targets form the intermediate component in the link between assessment and intervention. This link has recently been investigated in its role in treatment efficacy (Dinnisen & O’Connor, 2001; Gierut, Morrisette, Hughes, & Rowland, 1996; Miccio, Elbert, & Forrest, 1999; Rvachew & Nowak, 2001; Williams, 2000). Finally, the selection of treatment targets provides another example of “theory coherence” and “assessment-intervention congruence” (Kamhi, 1992; Schwartz, 1992). In summary, actively choosing a theory forces us to examine the assumptions that underlie our assessment procedures and to focus on the rationale behind the use of those procedures.

In the articles that follow, the reader will recognize assessment procedures that fall under the theory of Natural Phonology (Tyler & Tolbert, 2002; Hodson, Scherz, & Strattman, 2002; Khan, 2002). Hoffman & Norris used a whole-language perspective whereas Bleile incorporated a “phonomotor” perspective. Miccio incorporated an integrated perspective, which accommodates a rule-based system with speech production processes.

The different perspectives could also be seen as appearing on a speech-language continuum. Most assessment frameworks (Miccio, 2002; Tyler & Tolbert, 2002; Hodson, Scherz, & Strattman, 2002; Khan, 2002) fell in the center with phonology viewed as a component of language—but with unique aspects that integrate both speech and language components in the assessment. Their assessment protocols reflected the rule-based perspective of speech disorders as well as the relationship of speech disorders to other aspects of language (e.g., morphosyntax or phonological awareness). Views from the ends of the continuum represent a greater degree of focus on speech (Bleile, 2002) or language (Hoffman & Norris, 2002). Bleile’s assessment focused almost entirely on speech—with emphasis on individual sounds, better abilities, facilitating contexts, and key words. In contrast, Hoffman & Norris emphasized narrative samples that examined Situation, Semantic, and Discourse levels with a minimal focus on phonology.

These theoretical perspectives of the assessments then form the basis for selection of treatment targets. Specifically, criteria are specified for target selection on the basis of phonetic factors, such as stimulability (Bleile, 2002) and/or developmental norms (Tyler & Tolbert, 2002; Hodson, Scherz, & Strattman, 2002; Hoffman & Norris, 2002); or a combination of phonetic and phonemic factors, such as stimulability, markedness, and phonetic complexity (Miccio, 2002).

Summary

The pragmatic challenge posed by the forum of completing an assessment within a 60 to 90 minute time limit challenges us to think about the theoretical perspectives that underlie our evaluation procedures. Hopefully, it will lead us to question some of our procedures in light of new theories and clinical advances and to develop stronger rationales for and greater understanding of “tried and true” procedures.

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