Meeting the need for case studies

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The four central questions

What to teach next? Why? How? For how long?

We are faced with these four questions every day of our professional lives. There is no manual we can turn to which will answer these questions for us. We can spend hours wondering what to do next, in individual cases, and then more hours wondering whether we were right to do what we did.

It is essential that intervention procedures be placed on a more confident foundation. We ought to aim for an ideal, where we can say: 'This is DEFINITELY the best thing to do for this child, for the following reasons. This is DEFINITELY the best technique to use. And, if things go according to plan, we would expect the following kind of progress within *x* hours/days/weeks . . .'. There is nothing novel about such aims. This is how medicine has operated for years—and we are all grateful that such confidence exists.

The analogy with medicine takes us only so far. I am not suggesting that we will ever be able to say such things as: take 3 prepositions a day after meals! But there is one respect in which we CAN learn from the history of medical science. For where did medicine get its confident foundation from? Not out of the air. It came from a long period of development, in which practitioners carried out case studies on their patients (living and dead). Slowly, a body of data grew up, and today this information provides medical science with its empirical basis.

The same history needs to be followed in our field, and we should begin where medical science began: with case studies. There is a desperate

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shortage of case studies in the field of language handicap. In fact there has never been a reasonably complete case study published of ANY language-handicapped child. The literature is full of fragments, on aspects of pronunciation, grammar, and so on. And even here there are enormous gaps.

Types of case study

There are basically two kinds of clinical case study, relating to the demands of (*a*) assessment and (*b*) intervention. So far, almost all the fragmentary case studies which exist have related to the first of these. People 'write up' a child to show the nature of the problem, and perhaps how it relates to a diagnostic category. This is important work, but it still leaves open the question of 'what to do about it?'. It seems to me that we now need to co-ordinate our efforts and attack the second of these headings.

I propose we try to develop a policy of POLICing (a Programme Of Language Impairment Case-studies), which provides individual teachers and therapists with a reasonably standard procedure for writing-up and disseminating case-study information. As data become available, they could be catalogued and kept centrally, so that anyone wanting to check up on a point would be able to do so. Typical questions: 'I'm teaching *up* to a language-delayed 4-year-old. Has anyone done anything on this?'; 'I'd like to do a case study on how to teach the definite article to a 12-year-old deaf child. Has anyone dealt with this topic, or anything like it?' It will take a while to build up this kind of data base, but the potential value of it, once it is under way, is enormous.

This kind of thing is already being done, incidentally, in the field of foreign language teaching. The Centre for Information on Language Teaching in London provides a great deal of centralized data on all aspects of language work, and issues reports regularly. Whether we would one day be able to do anything like this in the field of language impairment I do not know. Everything depends on whether the task of writing a case study proves to be sufficiently practicable to enough people that the data base can grow. Everyone is short of time. But it does not take too much time to carry out a case study, as long as we do not set our sights too high, and remember to follow certain basic guidelines. This paper has been written to indicate the kind of thing which might be done.

An intervention case study (ICS)

An ICS selects a single, small topic and describes how it was taught over a specific period of time and what effect the teaching had. No attempt is made to cover all aspects of the child's language problems, and it is not even necessary to choose the major problem he or she faces. An ICS is no more than the writing up of what we would normally be doing in a clinic or classroom with a child—but in a rather fuller and more systematic way than we would for 'in-house' case records. It is normally essential to have recorded the session on audio or video tape, to enable an accurate description to be made—otherwise, to have someone keeping careful notes about what went on. The main time involved in case study work is in listening to the tape and making the basic transcription. However, note that only the relevant part of the tape needs to be gone through— which may be as little as just a few minutes.

Four crucial points should be noted:

(1) The choice of topic comes directly out of the demands of teaching practice. You choose a child, and a topic which you feel (on the basis of everything you know about the child) would be an appropriate one to teach. The topic should be a selection from a limited area (such as prepositions, auxiliary verbs, the definite article, plosives, nasals, words for clothes, words for furniture). The selection is quite specific—just as it would be in teaching—for example, the preposition *in*, the difference between *in* and *on*, the plosive /p/, the contrast between /p/ and /b/, the difference between the names of *n* types of fruit, or whatever. The case study would then be entitled: 'Teaching *in* and *on* to . . .', 'Teaching words for fruit to . . . ', etc.

It is not essential to base the ICS on your own work with a child. It can be just as useful to study a colleague working with a child.

(2) To whom? That could be anyone, of course. Normally, the title would give an indication of type of handicap and age of child; perhaps also some reference to the setting or the task. For example: 'Teaching /s/ to a 4-year-old child with cleft palate' or 'Teaching *in* and *on* to a 6-year-old language-delayed child: the role of pictures'. You should NOT deal with more than one child at a time—at least, not until single-subject studies have been carried out successfully. As part of the study, it is therefore necessary to give some case history information about the child—sufficient to enable other professionals to see how the child in the study relates to those they know.

(3) The core of the case study is a step-by-step account of how you introduced the topic to the child and what exactly went on in the session(s). The best way to do this is to transcribe pieces of the dialogue between yourself and the child, describing any materials used, and if necessary providing an illustration (drawing of objects, how people were seated, etc.). Basic information is given about how many times an exercise was carried out, or how long the teaching went on. Short pieces of commentary summarize what happened and give your reactions. There is only one guideline to be followed: give enough information to enable anyone reading the ICS to be able to replicate what you did. Replicate means what it says: be able to repeat your procedure exactly.
(4) Often a single session is enough to determine the value of a procedure. The child starts to use a feature correctly, or, alternatively, makes no progress. Please note that a negative outcome is JUST AS VALUABLE as a positive one, in case studies. If a technique does not work, it is important for other people to know, so that they can modify it, or avoid it. This is the kind of thing which can save enormous amounts of time, in the long run.

Often, however, it will take more than one session for a teaching-point to be made. There is no 'magic' time-period to follow. But it is important to give some thought in advance to the length of time you propose to devote to the ICS—otherwise it will drag on indefinitely, and never get written up. This means that it is then possible to plan the demands of the project in relation to the other things you have to do—and thus to decide whether it can be done at all. You should pick a time-scale—a week, a month, or whatever—and end the project accordingly. In one recent study published in *CLTT* (Grauberg's, in Volume 2.2), the time-scale was a year. (You might, for example, decide to do a session a week for the whole of February. The project then ends on 1 March, unless something so exciting is happening that you cannot bear to stop! But even then, finish the project at the first natural stopping-point.)

Do not be distracted by other things you or others are doing with reference to the child. It is never possible to control all aspects of the environment. These can be ignored, unless there is some obvious major overlap with your topic which seems to affect the child's progress—and this can then be reported. Follow-up activities related to your topic (e.g. by parents, or by other professionals) should be avoided, unless there is a reasonable chance of your being able to report on what precisely took place.

Remember

None of this will happen unless YOU do it. This is not the kind of project which can be carried out by academic researchers alone.

Writing up

There is no standard way of writing up a case study, and you will find many models in journals. The procedure given below, which is used for *CLTT*, is to be interpreted flexibly, therefore. But it does give the main points which need to be considered. There will usually be some feedback from an editor, who will help to give your ICS its final shape—so do not be concerned if you have never done this kind of thing before.

Case studies should be organized along the following lines. Word-counts are approximations only, and should not be slavishly followed: total length should be 2–3,000 words

Title Referring to the topic to be taught and the type of patient or setting, e.g. 'Teaching auxiliary verbs to a language-delayed child'.

The child A brief case history of the child (use pseudonyms only), giving age, family background, medical and educational history, and including any relevant psychometric data. (200 words)

Diagnosis A summary of current professional opinion about the child, at the time when the intervention was carried out. Pay particular attention to any (psycho)linguistic diagnosis or assessment which may have been made, alongside any medical diagnosis. Include enough linguistic detail to ensure that the significance of choosing the teaching goal (see below) will be apparent. (500)

Teaching goal A statement of the specific structure, sounds, etc, to be taught, in the light of the preceding section. (100)

The setting A brief account of the school, clinic or other setting in which the teaching was carried out. Include here a clear indication of the time-scale of the programme—how much time per day/week, what people were involved, use of follow-up at home, etc. (200)

Methods used This is the core of the paper. Give a detailed account of the teaching methods used, SUFFICIENT TO ENABLE ANYONE ELSE TO REPLICATE IT. Give a clear account of the way you structured your input to the child, as well as details of materials used, layout of room, etc. (500)

Illustration Illustrate at least one sample of the linguistic interaction between teacher/therapist (use T as an abbreviation) and the child (use

the initial letter of his pseudonym as abbreviation). For layout, see below. (300)

Results This involves (a) an account of the child's response to the methods used, and whether these had to be altered in any way, as teaching continued; (b) an account of the child's progress, if any, as subsequently observed. Note that a negative result may be just as interesting as a positive one. (500)

Discussion Briefly evaluate the above, and indicate 'where you would go from here'. (300)

Style Use the 3rd person and the past tense as far as possible: 'T asked M to do . . .'. Give ages as follows: 3;6 (= 3 years, 6 months). If you need to refer to days, use the convention: 3;6.14 (= 3 years, 6 months, 14 days).

If you use your own dialogue conventions, you must explain them. Otherwise, follow CLTT house style, which is as follows. Dialogue should be recorded with speakers on separate lines. Use either traditional orthography and punctuation OR prosodic transcription (any recognized system). Do not mix conventions. If a phonetic transcription is used, place this after the word or at the end of a sentence (if a long utterance is to be transcribed). Contextual notes should be placed in the right-hand margin. Unintelligible or unclear speech should be placed in parentheses. An example:

Orthographic

T Is that a car? *points to car*
P Yes.
T Where are you going to put it? In the garage?
P I (got) a blue [bu:] car.
(1 syllable)

Prosodic

T is ' that a càr/ *points to car*
P yès/
T ' where are you ' going to pùt it/ – ' in the gárage/
P – I ('got) a blùe [bu:] ' car/
(1 syllable)

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