A FATHER-INCLUSIVE MODEL OF PAEDIATRIC DYSPHAGIA INTERVENTION

Erin Palmowski and Bernice Mathisen

Dysphagia in infants and children is commonly the result of delayed global development (Joanna Briggs Institute, 2000) or associated with chronic diseases, neuro-developmental disorders and frequently, oral-motor dysfunction (Puntis, 2008). Interest in the management of dysphagia in children has rapidly increased over the past decade (Bell & Sheckman Alper, 2007) and it is known that for optimal outcomes for the child and the family, an interdisciplinary approach is required (Arvedson & Brodsky, 2002; Bell & Sheckman Alper, 2007; Joanna Briggs Institute, 2000; Lefton-Greif & Loughlin, 1996; Mathisen, 2003, 2008; Morgan & Reilly, 2006; Newman, 2000; Puntis, 2008). The type of intervention(s) for the child with dysphagia in the context of family-centred practice (Mathisen, 2008) is dependent on the individual cause(s) of the dysphagia and the results of clinical and instrumental assessments (Puntis, 2008). At present, there are some epidemiological data on dysphagia in typically developing children; however, the incidence of dysphagia is higher in children who have a lifelong disability, such as cerebral palsy (Mathisen, 2008).

The literature frequently mentions the experiences and feelings of mothers (Joanna Briggs Institute, 2000; Mathisen, Worrall, O’Callaghan, Wall & Shepherd, 2000; Selley et al., 2001) and family-focused experiences (Joanna Briggs Institute, 2000; Mason, Harris & Blissett, 2005; Puntis, 2008). However, the experiences of the father of the child with dysphagia are frequently missing. In coping with the demands of a child with complex health problems including swallowing disorders, mothers are at risk of mental health problems such as anxiety and depression (Joanna Briggs Institute, 2000), especially where they are unsupported. With the majority of the literature focused on the maternal role in dysphagia intervention, are speech pathologists missing the crucial role of fathers?

Family-centred intervention

Family-centred intervention has emerged as a successful form of service delivery for speech pathologists working in paediatric dysphagia and across a diverse number of educational and health professions (Mathisen, 2008). The Joanna Briggs Institute (2000) reported level 3.2 and level 4 evidence to support the inclusion of parents of children with dysphagia in the intervention program to reduce the stress to the child, siblings and to the parents. Puntis (2008) recently reported that dysphagia in early childhood causes huge psychosocial stress for families and emphasised the need for increased support for families by professionals in the form of education, reassurance and/or counselling. Mathisen et al. (2000) emphasised the demand for increased parental education in dysphagia. The literature urges education and health professionals not to assume that parents understand the nature of their child’s difficulties or the implications for intervention (Feeley, Gottlieb & Zelkowitz, 2007).

Implementing a family-centred service delivery model in paediatric dysphagia is multidimensional, as health professionals must engage each member of the family differently, dependent upon their age, gender, culture and belief system. Gender differences present as the prominent issue when dealing with families. Therefore, speech pathologists need to tailor their communication skills for the different sexes and alter the support they offer to family members to ensure that it is gender-appropriate (Broadhurst, 2003).

Family-centred intervention aims to include the family in the decision-making process in terms of assessment and intervention, encouraging the child and parents to be actively involved with the professionals. The family is provided with the appropriate information they need to manage the child’s condition and reassurance is provided regarding the care they provide for the child (Joanna Briggs Institute, 2000). It is easy for educational and health professionals to collectively class “parents” as one entity with agreed emotions and views (Auslander, Netzer & Arad, 2003). However, the feelings of mothers and fathers about their child’s health care are different. Literature that addresses the role of speech pathologists in the management of paediatric dysphagia consistently focuses on the centrality of family engagement in the whole process (Mathisen, 2008).

Current father-inclusive research

Fagerskiöld (2006) examined the support provided to Swedish fathers by health care nurses and found that fathers wanted increased personal contact with nurses in order to gain more information. Nurses offered little attention to the father and many nurses gave fathers an information sheet instead of demonstrating the intervention to them. Interestingly, Fagerskiöld found that most of the inadequate education given to fathers was about breast-feeding, bottle-feeding and dysphagia, hence strengthening the need for specific father-directed intervention practice. Fagerskiöld concluded that the majority of fathers wanted to be involved with the health care of their child and were happy to seek support via a fathers’ support group, chaired by a male professional.

Supporting fathers requires speech pathologists to tailor the skills they have acquired from undergraduate coursework and professional development to develop a support network appropriate for fathers. Stereotyping the emotional status of fathers will only decrease the efficacy of support that health professionals offer to fathers (Heesacker et al., 1999) and ultimately reduces the inclusion of fathers in resolving family disputes (Fletcher, 2008).

Supporting fathers in fatherhood has a strong evidence base. It is well known that specific father-directed intervention practices will benefit the whole family (Fagerskiöld, 2006; Fegran, Helseth and Fageremo, 2008), so why does the father’s role in the child’s health care continue to be dismissed? Hallberg et al. (2007) conducted a phone interview with 227 fathers to explore this issue. The interview asked specific questions regarding the father’s role and participation in family life to gain information about how much involvement fathers actually wanted in their child’s health care. Fathers viewed their role in their child’s health as important and 55% of participants demonstrated an active role in their child’s health care. Hallberg et al. agreed that more research into father-inclusive health care and intervention practices needs to be conducted. The researchers acknowledged that new service delivery models for health care that include fathers “could be designed and researched” (p. 1086). Currently, there is no up-to-date literature that examines the efficacy of a father-inclusive service delivery model for dysphagia intervention in children.

Why should we involve fathers?

A study by Bronte-Tinkew, Carrano, Horowitz and Kinukawa (2008) examined the effects of early father involvement in the
child's life and found that early positive interactions between the father and his child reduce later cognitive delay in the child. Interestingly, the study found that the reduction in cognitive delay was greater in male children and was also greater in children who had a disability in contrast to those who did not. Positive outcomes for the child also included increased social competence, general well-being and school performance (Oliver, Schmied & Gailey, 2001).

Increased father involvement in the care of their child has shown to increase the mental and emotional state of the mother. Misri, Kostaras, Fox and Kostaras (2000) conducted a study on the impact of partner support for a mother who had postnatal depression. The results revealed that mothers who had supportive partners who were actively involved in the infant's care showed a significant decrease in their depressive symptoms.

Just as postnatal depression in mothers has a disastrous effect on a child’s overall developmental status, so does postnatal depression in fathers (Fletcher, Matthey & Marley, 2006; Ramchandani, Stein, Evans, O’Connor & the ALSPAC Study Team, 2005). Depression among new fathers is high, due to societal expectations of the father and the unexpected changes to their former lifestyle after having a child (Fletcher et al., 2006). Depression in fathers has many negative effects on the child, the child’s mother, other siblings and on the family as a whole. Therefore, speech pathologists can potentially reduce the risk of ongoing mental health issues in fathers by significantly increasing support to them. It is argued that promoting and using a father-inclusive model for dysphagia intervention in children is one powerful way this issue could be addressed.

How can we adopt a father-inclusive model in intervention?

Fletcher (2008) asserts that adopting a father-inclusive service delivery model is not easy, and that even extensively-trained health and educational practitioners still find it difficult to adequately interact with fathers. All aspects of the service need to be reviewed so that it appeals to both the mother and the father. This will include areas such as the service’s opening hours, signage and the nature of any staff postgraduate education (see table 1).

Establishing a father support group, chaired by a male leader, has been found to be an effective method of support for fathers (Fågerskiöld, 2006). This type of group enables fathers to speak openly about their experiences and to discuss any issues with other fathers who can relate to (Fågerskiöld, 2006; Porter & Mabbutt, 2005). A fathers’ group could be organised for other services (e.g., a hospital ward or a community health clinic) that is not specific to paediatric dysphagia or within a paediatric dysphagia service.

Information on the development and growth of infants is well utilised by new parents to gain advice on effective parenting (Fletcher, Vimpani, Russell & Keatinge, 2008). Information for fathers, however, needs to be tailored, in order for them to actively seek and use the parenting information available. Providing information for fathers via the Internet may increase and encourage fathers’ access to information (Fletcher et al., 2008) about issues they may not be comfortable discussing in person. Parenting and support network websites for fathers need to be user-friendly and fathers need to be consulted regarding their appropriateness. This will increase the efficiency of use and therefore decrease the frustration of users.

How can speech pathologists further develop a father-inclusive service delivery model?

In order for speech pathologists to effectively engage fathers, they must be trained to do so (O’Brien & Rich, 2002). Male speech pathologists still require specific father-inclusive

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<tr>
<th>Table 1. Suggested guidelines for a father-inclusive model of paediatric dysphagia intervention</th>
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<td><strong>Be flexible</strong></td>
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<td><strong>Encourage attendance appointments</strong></td>
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<td><strong>Appreciate and acknowledge</strong></td>
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<td><strong>Engage</strong></td>
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<td><strong>Ask</strong></td>
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<td><strong>Value the opinions of both parents</strong></td>
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<td><strong>Professional development</strong></td>
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Note: Adapted from Coleman, Garfield & the Committee on Psychosocial Aspects of Child and Family Health, 2004.
education – simply being a father or male does not exclude the need for this education (Fletcher, 2008). As the demand for father-inclusive practice increases, competencies for speech pathologists working with fathers will develop. To date, the need for these competencies has been neglected (Fletcher, 2008). The introduction of specific father-inclusive practice during tertiary education would provide future speech pathologists with the academic knowledge and clinical skills to adequately include fathers in speech pathology intervention.

**Conclusion**

It is clear from the literature that an interdisciplinary team (Arvedson & Brodsky, 2002; Bell & Sheckman Alper, 2007; Joanna Briggs Institute, 2000; Lefton-Greif & Loughlin, 1996; Mathisen, 2008, 2003; Morgan & Reilly, 2006; Newman, 2000; Punits, 2008), working in a family-centred model is best practice in managing the dysphagia of a child (see also Mathisen, 2008). An increase in community attitudes about the inclusion of fathers has been recommended across many education and health care professions (Fletcher, 2008). Currently, there are no documented or specific father-inclusive models of intervention in paediatric dysphagia practice. Therefore speech pathologists are encouraged to establish such models to engage fathers. Doing so will have significant benefits not only for the child but also for the mother, the siblings, the extended family and of course, the father (Bronte-Tinkew et al., 2008; Misri et al., 2000; Oliver, Schmied & Gailey 2001).

**References**


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