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Indicators for a family guidance proposal for families of children in Speech Therapy

Indicadores para uma proposta de orientação a familiares de crianças com alterações de linguagem em atendimento fonoaudiológico

Indicadores para una propuesta de orientación a las familias de los niños con trastornos del lenguaje en la terapia fonoaudiológica

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Abstract

Objective: *To develop a chart with indicators to help elaborate a family guidance proposal for families of children suffering from language disorders and undergoing speech therapy. That will be done by understanding the families' needs.* ***Method:*** *In 3 different moments of the treatment process, 22 family members of children between 2 and 11 years old who were in treatment, participated in semi-structured interviews for a qualitative enquiry. The analysis of the interviews resulted in 18 indicators, each of them specifying a goal and a guideline for the speech therapist.* ***Results:*** *Based on these indicators, a guidance proposal was constructed to help the professional to attend to the families' needs, as understood from their perspective.* ***Conclusion:*** *The literature offers few studies about family guidance in speech therapy. Therefore, the present study is based on the needs of the families, emphasizing the importance of taking the family in and guaranteeing respect for the singularities of both patients and their relatives..*

Keywords: *Family Relations; Child Guidance; Language Disorders; Speech, Language and Hearing Sciences; Family.*

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Authors' contributions: LOP participated in the concept, collection and analysis of the data and writing of the manuscript. LV co-coordinated a data analysis, a method and a manuscript essay. LVVT guided all stages of the project.

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Resumo

Objetivo: *Desenvolver um levantamento de indicadores para elaboração de uma proposta de orientação a familiares das crianças com alterações de linguagem em atendimento fonoaudiológico, baseado na compreensão das suas necessidades.* ***Método:*** *Em três diferentes momentos do processo terapêutico, 22 familiares de crianças atendidas, entre 2 a 11 anos, participaram de entrevistas semiestruturadas, baseadas na metodologia qualitativa. A análise das entrevistas resultou em 18 indicadores, especificando, para cada um deles, objetivos e sugestões de condutas.* ***Resultados:*** *A partir desses indicadores, uma proposta de intervenção foi construída para ajudar o profissional a atender as necessidades dos familiares, baseado nas suas perspectivas.* ***Conclusão:*** *A literatura conta com poucos estudos sobre intervenções fonoaudiológicas com famílias, logo, este estudo considerou as necessidades dos familiares, para enfatizar a importância de acolher a família e assegurar o respeito às singularidades do paciente e de seus familiares.*

Palavras-chave: *Relações Familiares; Orientação Infantil; Transtornos da Linguagem; Fonoaudiologia; Família.*

Resumen

Objetivo: *Desarrollar una investigación de indicadores para preparar una propuesta de orientación a las familias de los niños con trastornos del lenguaje en la terapia fonoaudiológica, basado en la comprensión de sus necesidades.* ***Método:*** *En tres distintos momentos del proceso terapéutico fonoaudiológico, 22 familiares de niños en tratamiento, entre 2 y 11 años participaron de entrevistas semiestructuradas basadas en la metodología cualitativa. Del analisis de las entrevistas, resultaron 18 indicadores y se especifico, para cada una de ellos, metas y sugerencias de conductas.* ***Resultados:*** *A partir de estes indicadores, una propuesta de intervención fue construida para ayudar al Fonoaudiólogo para atender las necesidades de las familias, en fución de sus perspectivas.* ***Conclusión:*** *La literatura tiene pocos estudios sobre las intervenciones fonoaudiológica con las familias, por lo que este estudio tuvo en cuenta las necesidades de las familias para destacar la importancia de acojerlas y garantizar el respeto a las singularidades del paciente y de sus familias.*

Palabras clave: *Relaciones Familiares; Orientación Infantil; Trastornos del Lenguaje; Fonoaudiología; Familia.*

Introduction

The process of working with parents in speech therapy is extremely complex, since it is not only a matter of simply including them, but it also requires true reciprocity, assistance and involvement. Thus, parental involvement should not be limited to initial interviews, but must be part of the therapeutic process[1].

Speech-language therapists' efforts to verify the family's understanding of the pathology and the treatment has been based on a demand from professionals who understood that "behind a speech symptom there is always a family context giving this symptom form and meaning"[1]. Even though the object of the speech therapist is not the family, it is often necessary to be aware of this aspect, as family influence can reveal itself in the form of symptoms.

There is specialized literature that addresses the contributions of family guidance while the child is waiting for treatment to start, noting that changes in family behavior can be important support until the child can receive appropriate care[2,3,4].. Other studies consider family guidance as an issue associated with the actual speech therapy and confirm its importance to provide a child-friendly communicative environment by improving family understanding of the development of their children[5,6]

Systematic and specific guidelines can contribute, on the short-term, to the improvement of the communicative environment of children with language disorders. However, to measure the efficacy of the guidelines offered in conjunction with speech therapy, it is necessary to submit it to appropriate methodological procedures[6]. In this sense, the change in the behavior of the parents may reduce the

language alterations or even signalizes a solution, when the family becomes an active agent in the intervention process of the child's development[3].

It is worth noting that none of the studies mentioned excludes the need for individual therapeutic intervention with the child, which may occur after or simultaneously with family guidance.

Working with a group of family members allows to better following the therapeutic process of the children. In addition, it establishes social support favorable to dialogue, reflection and discussion about the speech or language disorders and about their needs. Therefore, the participation of the family brings significant contributions to the speech therapy[7].

A family counseling program naturally benefits the community by reducing the length of time spent in therapy and consequently decreasing the queues in public services. It is a low-cost procedure that contributes to the therapeutic process of the children and reduces the anxieties and frustrations of relatives related to the symptoms of their children[5].

Awareness of the therapeutic process and guidance concerning language development ensures parents are empowered and able to give meaning to their children's language development. In addition, while listening to the family members, the speech therapist collaborates to the respect of differences, singularities and subjectivities present in the language clinic.

In this way, a chart of indicators was developed to support a guidance proposal for family members of children with language disorders undergoing speech therapy. Giorgi's phenomenological method was used as a resource to obtain an understanding of the needs of family members. These needs were afterwards organized into thematic categories that indicate, for each of them, objectives and suggestions for guidance conduct.

Method

This study, undertaken at the Speech and Hearing Therapy Clinic-School at the Pontifical Catholic University of Goiás (PUC-GO), was approved by PUC-GO Research Ethics Committee, protocol 041984/2014, in compliance with Resolution 466/12 of the National Health Council.

This cross-sectional, qualitative and prospective study was conducted through interviews. Twenty-two relatives of children aged between 2 and 11 years attended the Speech Therapy Clinic-School. Participants were: parents or guardians of children with language disorders who were treated in supervised curricular and extracurricular internships (their ages ranging from 2 to 11, corresponds to the developmental stage of oral language and obeys the limit of early adolescence). All participants signed the Free and Informed Consent Term, authorizing the research. Confidentiality of identity and volunteering were guaranteed.

Three meetings for data collection were organized with each family member through semi-structured interviews using Giorgi's phenomenology as a methodological resource aiming at entering into the living experience of the families. The interviews were recorded by voice recorder (OLYMPUS - digital voice recorder - VN-8600PC), and later transcribed. Moments of emotion or silence were registered.

In the first interview, we involved the participants in order to understand their needs, i.e.: to obtain a family portrait, to identify special facts about the child's pathology, as well as to describe his/her way of dealing with difficulties and with the speech therapy intervention. In the second meeting, we detailed conflicts and/or relationship difficulties between patient and family. In the third and last one, we asked for analysis and suggestions from family members about their communication with the therapist, and their vision regarding the treatment plan.

The phenomenological interview is a methodological resource that mediates the meeting of the participant and the researcher, forming an interrelationship so that the interviewees can share their experiences. The main source of data is the dialogue, which reveals how the person lives his/her reality and deals with the challenges embedded in it. The data are descriptions of statements, accounts or interviews about experiences lived in relation to a certain phenomenon, which must be followed from discussions[8,9].

During the research, some relatives did not participate in all stages of the interviews since they left the Clinic-School. In the first interviews, 22 family members participated. In the last two stages, there were only 15 relatives. It was decided to include only the interviews of family members who participated in the first interview because of the significance of the information obtained, which was relevant to the research. Participants represent

the various families structures (nuclear, single--parent or remarried), with varying age, occupation and schooling. The interviews were done with 20 mothers and two fathers. However, there was only one event with a father and a mother together, which was grouped in the name F13.

Table I shows the age and corresponding pathology of the participating children, according to the information obtained in the Clinic-School's patient records.

Table 1. Characteristics of the children participating of the study

Name	Age	Child's Pathology
F1	5 years old	Congenital Sensorineural Deafness
F2	7 years old	Congenital Sensorineural Deafness
F3	10 years old	Congenital Sensorineural Deafness
F4	8 years old	Congenital Sensorineural Deafness
F5	4 and 9 years old	Congenital Sensorineural Deafness
F6	6 years old	Cleft palate and lip
F7	5 years old	Language Delay
F8	4 years old	Language Delay
F9	2 years old	Language Delay
F10	4 years old	Language Delay
F11	4 years old	Down Syndrome
F12	6 years old	Down Syndrome
F13	4 years old	Down Syndrome
F14	4 years old	Autism Spectrum Disorder
F15	11 years old	Learning Difficulty
F16	5 years old	Developmental expressive language disorder
F17	5 years old	Developmental expressive language disorder
F18	11 years old	Cleft palate and lip
F19	4 years old	Language Delay
F20	5 years old	Developmental expressive language disorder
F21	6 years old	Developmental expressive language disorder

Subsequently, a thematic analysis of the data was carried out, organizing the family members' needs into thematic indicators. For each indicator, objectives and suggestions of professional conduct were developed to meet the detected needs of the family members. During readings following the transcriptions, we extracted experiences that evidenced the needs of orientation and reception of the participants, revealing guidelines in two criteria: recurrent statements in the discourse and unique statements, but that were significant for the research questions. The units of meaning extracted were grouped thematically.

During the re-reading of the material, the units were regrouped systematically. First, we grouped the units with similar contents; after this selection, we compiled them according to similar behaviors and objectives for the construction of the guidance proposal, resulting in 18 indicators described in Table 1. Some indicators were induced by the interview questions, while others emerged unexpectedly during the reading of the reports.

The indicators induced by the interview questions are: reason for seeking speech therapy, the function of the speech-language therapist, understanding of the therapeutic process, dealing with the child's problem, expectancy of rehabilitation, impulsivity of the child, educational strategies, the parents' major difficulty, feedback and missing information. Other indicators emerged unexpectedly: difficulties in dealing with stigma and access to sources of information. Furthermore, we grouped mixed indicators, essentially emergent but also partially induced, that appeared in response to a

question with a related theme: theories about the cause of language disorders, needs, school issues, difficulties in family relationships, changes noticed by parents and understanding of the language acquisition process. In order to organize the explanation of the results that follow, we illustrate them with examples of family statements, and use the abbreviations F1 to F21 to identify the relatives.

Results

Recurrent aspects of family members' impressions of what happens in therapy and their needs to deal with children's language changes were observed. These impressions considered the difficulties in family relationships, confirmed by F3: "When I was married to his father, we fought a lot, he drank, then he used to fall out in front of G. [...] and he seems to have got stuck in the middle of it all, when we split up, that I took G. out of that environment that everything improved and much! [...] Because G opened up, you know? He developed".

Theories about the cause of language change have arisen at various times in the discourse of parents. Many do not know what the child presents as reported by F16: "Now what made "A" to be like this I don't know [.. .] If she had a kind of an accident, if she had fallen and hit her mouth, then I would say so, but no, I do not know where her problem came from"; or characterize the change in an organic form as F6: "This change in her was caused by the problem she had at birth, of the cleft lip and cleft palate, that is why she has this alteration of speech". The presence of delayed motor and language development was a recurring response, as F8: "I understand that his difficulty was enormous, questions of speech [...] it took him a long time for everything, too, it took him a year and ten months on to start to walk " There were still reports on characteristics linked to the pathology itself, heredity, sequelae of infectious diseases, prematurity or a "problem" that would be resolved over time.

Most family members refer to the child being able to speak well as a primary expectation and a motivation for searching for services, others refer to the child's pathology and also a need for inclusion in a group with the same characteristics as mentioned by F4: "Insert C in a group so she does not think she's alone". Family members expressed concern about the therapeutic process and stressed their willingness to contribute to the child's development.

A questioning that drew the researchers' attention refers to the parents' understanding of the speech-language therapist's function; some family members could not answer this question, such as F2: "*I'll be honest; I'm not sure what she does*." They failed to distinguish treatment goals from therapeutic strategies and emphasized helping the child speak. For F7, the role of the speech therapist is associated with providing a favorable communicative environment. "*What we have been following is perfect, a matter of socialization, making the child increase self-esteem in order to develop."*

While trying to understand the needs of the family members, the parent's request became evident for interdisciplinary action between Speech Therapy and Psychology, as exposed by F16: *"From the psychologist, because I'm not a patient person as a result of my emotional problems, then I end up overstressing her*"; and F13:" *I think that this psychological aspect in his treatment is missing [...] I think it has to be an integrated treatment.* "Other families consider there is a lack of information even when they do not ask for it. Or they even miss participating more effectively in the therapies in order to learn about their child's difficulty.

Dealing with the stigma imposed by society is an important point, as F6 reports: "*well, do you think the boys look at my girl because they think she is attractive? my daughter?*", "*no, because they think her mouth is hideous*", she adds. In addition to social behaviors that may interfere with the development of the child, mentioned by F2*:" Many and many times I decided not to go out, because I did not want him to cause me a problem and make me feel embarrassed*".

Another problem raised by parents is the behavior of their children and how they deal with the situation, "*He learned that when he wants something, he knows how to convince me and that makes me feel angry*" says F3. The most quoted parental strategies in dealing with the children's behavior were: punishing, beating, speaking "louder" and threatening. But F19 says that "*I'd rather talk than fight, I try to explain instead of arguing*."

Some results express the behavioral changes of family members due to the speech-language therapist's interference, including the caregiver's appreciation of the child's effort to communicate, beneficial identification with other members of the

group, and the caregiver's perception of the child's vocabulary improvement, and understanding. F14 mentions: "*before, I did not use to do that ... I thought it was no use talking to him, because he did not understand. Now I know it's good*."

Chart I summarizes the recurrent and unique sentences spoken by the family members, divided into indicators. Each of the units generated a point for the construction of the intervention plan.

Chart 1

Indicators for the development of the intervention proposal	
Families' Needs and Difficulties	**Professional Task**
Reason for seeking speech-language assistance: The child does not speak; parents do not understand what the child is saying; The child presents difficulty interacting; The child has a diagnosis (Hearing disorder, Down syndrome); The child was referred by other professionals or institutions; The child needs to be included in a group with the same difficulty as the child. **Rehabilitation Expectation:** The child will learn to say the names of siblings and parents; s/he will "develop appropriate speech"; Parents will be able to understand the child; The work will contribute to the development of the child; It will be considered effective if it occurs in conjunction with the family.	Apprehend the families' understanding of the child's need, and about the care, always considering their perspectives.
The role of the Speech Therapist: Four parents were unaware of the role of the Speech therapist. Others said that "s/he helps them to speak" or mention strategies: "putting his/her hand on her throat", "ask her to repeat", asks him/her to exercise a lot, and suggests massaging. The objective is to provide a space for children's integration; Stimulate the use of voice in games; organize child's play; "Show small letters"; Influence child's communication; Increase vocabulary; Work with the vocabulary and writing; The speech therapist "establishes exercises to improve speech and assumes the role of psychologist"; Teach the right way to speak "small words".	Clarify the function of the speech therapist and how he/she works. Differentiate the goals of therapy from the strategies used.
Theories about the cause of language alteration: Some parents do not know and never tried to find out the causes; They attribute it to organic cause (otitis, Autism, Down syndrome, cleft lip and palate, alcoholism/drug use in pregnancy, complications in childbirth, seizure, prematurity, and genetics). Caused by developmental delay; Muscle hypotonic disorder; Difficulty in understanding; because the parents are divorced; It is caused by the parents not speaking appropriately; As a result of the difficulty in understanding abstractions and socializing; A problem that will be solved as time passes.	Explain the cause and symptoms of language alteration, informing the child's real needs.
Difficulty dealing with stigma: Parents do not go out with the child to avoid embarrassment; The parent is ashamed of the aesthetics of the cochlear implant; It is caused by the bullying that the child suffers at school; Low self-esteem of the child by the scar of the labial surgery; Anguish because the others may see the child as incapable and/or with pity; The parent does not think the language alteration is normal, but is learning to cope with it; S/he says that the child is a normal child and does not see difficulty as a consequence of a speech problem; Parents entertain the child not to draw attention in public places.	Concepts of normality and disease can be crystallized and complex, however, they can be deconstructed throughout the intervention, through informal conversations in the therapeutic setting, in dialogic sessions, as well as specific orientations directed to each family member.
Sources of information: Health professionals; search in the internet; Institutions.	Provide information; Indicate sites and available professionals; Prepare a manual.
Living with the language alteration: the patient lives well with the language alteration or learned to deal "with it"; parents guess what the child wants; At first they despaired, in time they settled down; s/he learned "the language" of the child; Uses psychologist´s tips to understand the child; Stimulates every day; Point the finger to show what the patient meant; Corrects the child with every mistake; s/he insists on talking and understanding his\her son.	Validate the accounts and good attitudes of parents. The professional must be attentive to statements by family members.
Needs: Psychological counseling for parents to deal with children's behaviors ("tantrum"); Understanding the child's teachers; Pedagogy program to help with literacy; Get to talk to the child about bullying and about low self-esteem; Psychological care for the child; Understand why the child does not speak; Time to help the child at home; Psychological care to solve emotional problems and not punishing the child; Obtain an explanation from the speech therapist about what the child presents; Clarify the doubts of the mothers and guide them even when they do not ask; Spend a few minutes of therapy to talk with parents about speech therapy; Participate in therapy to learn more about the difficulty presented by the child.	Referrals for Psychology and Social Work, if possible, for professionals of the same team. Suggestion of joint work. Sessions with parents to clarify doubts and provide guidance during the therapeutic process.

Indicators for the development of the intervention proposal	
Families' Needs and Difficulties	**Professional Task**
Impulsivity of the child: The parent's main difficulty is the impatience of the child who does not wait to be cared for; child mugs school mates; Grandparents contribute to maintaining certain behaviors; Child disobedience; Time to put him/her to sleep; Insistence to make him perform the task and feed himself properly; When the child has a "tantrum," s/he pretends s/he does not listen and/or does not understand; Personal problems interfere in the relationship with the daughter, who does not understand the discomfort of the mother. **Educational Strategies:** Punish; "beat"; s/he cannot explain to his/her child the reason for what cannot be done; s/he yields to the whims and is aware that contributes to the behavior of the son; To threaten; Talk in "private"; To speak "angrily"; S/he positions him/herself, physically, at the height of the child to talk; Let the child realize that "no one cares about tantrums"; Speaks louder"; "Old style physical punishment"; "I try to talk more than fight, I try to explain more than argue"; Shout out; Use conditionals, for example: "if you scream, you will not do this or that".	Teach strategies to positively influence child behavior, examples: set limits, implement consequences contracts (cause / consequence).
School Issues: Parents are dissatisfied with school; Difficulty for the school to understand the limitations of the child; The child does not want to go to school; Parents' anguish with low school performance; School omission in relation to bullying; Lack of inclusion programs in schools; Child refuses to wear hearing aid at school; The school teaches respect for differences; The school works with the child and the family; The teacher has specialization in inclusion and always has a meeting to give information and guidance; "The teacher does not give feedback."	Characterize the child's language changes and to guide the teacher regarding his / her behavior towards the child who has difficulty and/or limitation in the teaching-learning relationship, as a result of oral and/or written language changes. Propose lectures to teachers on how to deal with bullying and "stigma". Inform teachers about inclusion programs in order to re-signify the school's view of the student with language changes.
Understanding the process of language acquisition: "The child has his time to learn"; Encourage talking instead of pointing; Speak and show daily life situations; Parents does not require more correct speech pattern; Parents do not speak in the diminutive; Pay more attention; Be patient.	Explain to parents the order of language acquisition and development. Encourage parents to use language correctly, without correcting misuse, to avoid stigma and / or inhibition.
Increased difficulty of parents: Dealing in public situations when the child demands attention; Explain what is right or wrong; Dealing with difficulty in literacy; "You see ,she cannot do it even if she tries"; Difficulty in seeing that the child is unable to speak and not understand; Anxiety at seeing people treat the child as vulnerable because they have the syndrome; Afraid that others will mistreat the child; Do not understand the daughter's speech. **Changes perceived by parents:** "Before, I did not talk to him, because I did not think it would work"; Although I do not see evolution, outsiders notice improvement; "Every day that passes a new word"; No longer criticizes the child; Talk "calmly".	Teach parents how to expose the child to communicative contexts, to induce speech situations, where there is a need for interlocutions.
Understanding of the therapeutic process: "It would be the last treatment to be suspended"; You have the help and attention you need; The child's understanding improved greatly; You think it has improved because of the partnership between therapy, family and school.	Insert the parents in some sessions of the child's therapy, to demonstrate how to reinforce at home the activities that were proposed in the office.
Feedback: Feedback sessions are offered by the supervisor; Trainees do not have time; They did not receive feedback; they just talk about performance in therapy; they just assign exercises to be done at home; They talk about the importance of working together.	Active involvement of the professional who performed the service on the feedback.
Missing information: Refers to being well informed to "stimulate"; Information is not missing; s/he did not think about it; s/he is feeling "a bit lost", s/he think s/he needed to know the process of therapy a bit more; s/he does not know if s/he has anything to know, if s/he has, s/he thinks s/he will be informed; s/he thought s/he knew everything until s/he had a meeting on how to deal with the child; s/he needs information on how to "deal with the situation at home"; Missing guidelines and exercises to do at home; S/he wants to know how many years will be necessary the daughter will be "perfect".	Provide missing therapeutic process information.
Difficulties in family relations: Non-understanding of the family impairs the child's development; Overprotection of family members promotes negative behavior ("s/he is spoiled" because hearing loss); Parents' troubled relationship hinders the development of the child; Failure to face repeated or continuous difficulties; The child only obeys the people of the masculine gender; The father has no active participation in the child's life.	Evaluate the understanding of information received by family members. Ask them to explain in their own words, helping to elaborate the discourse that will be passed on to the other members of the family.

Chart I was elaborated, with the 18 thematic indicators that describe the difficulties and needs of the families and the projected actions of the professional to attend them. Based on this scenario, the intervention plan was organized (Diagram I) according to these contents. Four moments were identified for effective orientation, according to the needs of families. The first moment corresponds to the **establishing contact with the family member**, to comprehend their understanding of the need for speech therapy for the child. Then, it is necessary to **manage their expectations**, by way of an introduction to Speech-Language therapy, explaining its function and clarifying the strategies that will be used during the treatment process.

Thus, the next step is to **clarify** two important aspects: the causes and symptoms of language alterations, informing about the real needs of the child, and the deconstruction of concepts of normality and disease that may be crystallized and complex. This effort may be extended throughout the intervention, through informal conversations in the therapeutic setting, in dialogic sessions, along with specific explanations directed at each family member.

The subsequent stage refers to the **orientation** process. At this stage, there is no systematized order of activities. It is important to validate productive reports and attitudes of the parents and help with strategies that positively influence the child's behavior and introduce sources of information: Sites; Books and folders. Working with an interdisciplinary team (e.g., Psychology, Educational Psychology, Occupational Therapy, Physiotherapy, Medicine, and Social Work, among others), to attend to parents' claims about their difficulties in dealing with issues involved in child rehabilitation. In this sense, working with the school also becomes essential during the process, as regards mobilizing the teacher concerning the language changes of the child, and as to ways of dealing with bullying and "stigma", in order to re-signify the school's perception of the student with language alterations. There are actions during the orientation process that can be extended throughout the course of all therapeutic work with the child, such as: helping the family understand the order of language acquisition and speech development; teaching them how to expose the child to communicative contexts; involve them in some of the child's therapy sessions, to demonstrate how to reinforce the activities that were proposed at home; fortnightly or monthly sessions to clear out doubts; providing information about the therapeutic process that was missing and actively involving the professional who provided the care in the feedback.

At the end of each stage, it is essential to evaluate the understanding of the information received by family members, requesting, if necessary, an interpretation in their own words, to identify what was learned in the orientation process. These considerations support them in the elaboration of the discourse they will pass on to the other members of the family. If the professional identifies that there are still doubts or difficulties with a topic already worked, it is necessary to reinforce the step in question, offering the information anew, or helping with their difficulty.

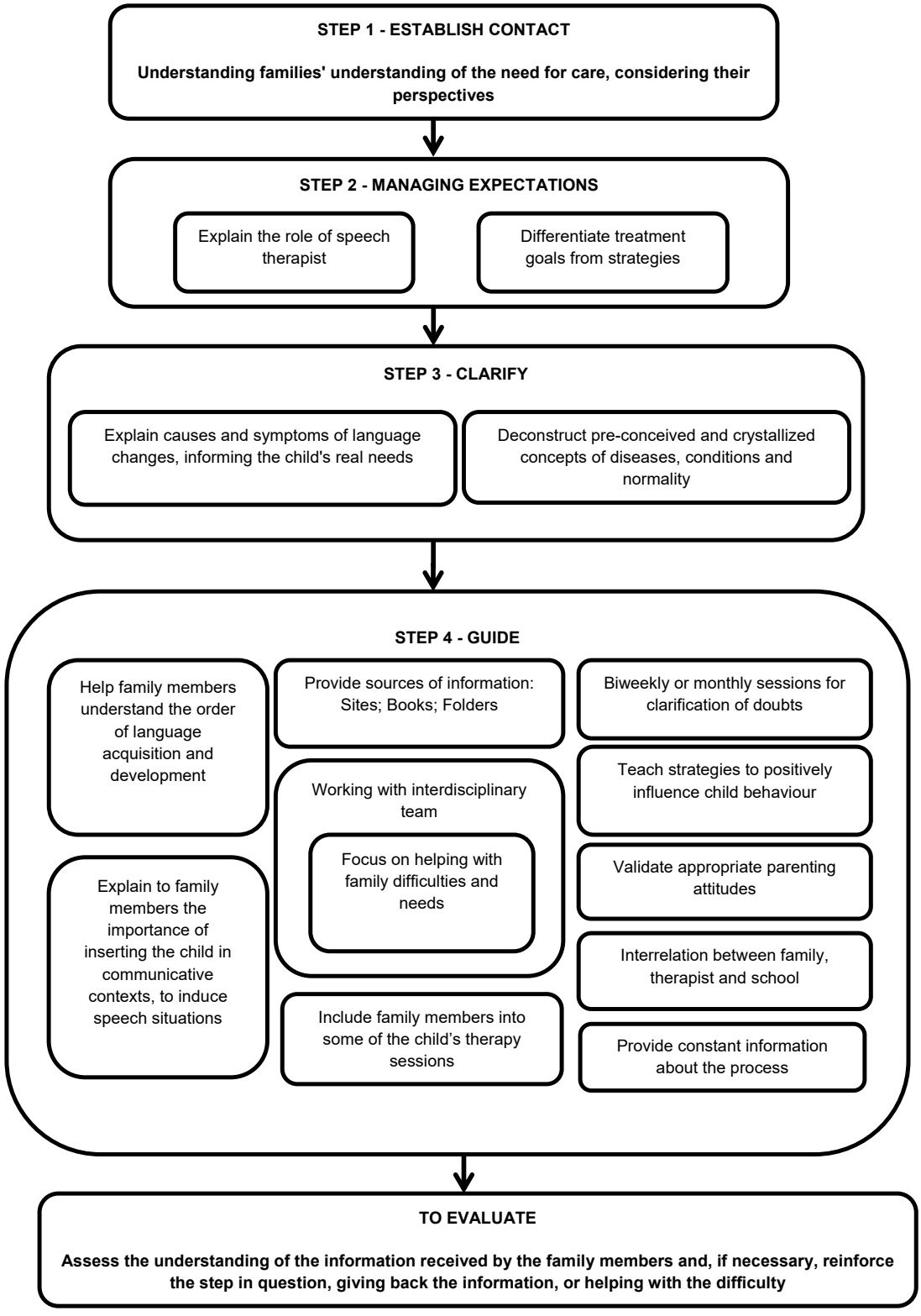

Diagram 1. Proposal for family guidance for family members of children with language disorders: specific steps

Discussion

Given the results, we see the relevance of organizing tools that help the professional work with families during the therapeutic process. The participation of the family is very important for the success of the therapeutic process, since treatment is a limited moment, not involving the entire representation of the child's world, while the family constitutes and develops communication in the exchanges between parents and children[10]. It is up to the assisting therapist to mediate the process, observing what is best for the child, paying attention to their development and their needs.

Discovering how the families understand the alterations of language of their children influence health professionals' conducts and understanding; Both in relation to the behaviors, and in the way they act before the child. In other words, knowing what the family thinks, understanding their doubts, beliefs and conceptions, make it easier to collaborate with actions that help parents cope with the situation[11].

It is fitting that family members know the true role of the professional and how the therapeutic process works so that they value their work. Because parents have difficulty dealing with the expectation of care and are concerned about the therapeutic process, but usually do not have the resources to deal with the condition[11].

Behind the expectations of parents, there are demands aimed at professionals. Creating space for listening to and understanding the family needs during the therapeutic process allows the access and recognition of the importance of intervention, as well as guarantees its effectiveness. The understanding of the complaint must allow for the emersion of subjective representations present in the discourse of parents and/or patients. So it is necessary to listen beyond what is said[12]. Even if the parents' desire does not coincide with the goal of the intervention, understanding its existence makes it possible to interpret and re-significate the symptom elaborated by them.

Many family members fear to look for information and do not express their right to be informed[11]. Therefore, the health professional must be active in building relationships with them. The speech therapist must accept the singularities of the subjects, as well as to be a mediator between the child and the family, not as one who applies formulas and recipes, but who provides a favorable environment, considering the history, space and experiences of their patients[13]. In this way, it is possible to qualify their practice and direct their attention beyond the symptoms

The literature presents few studies on speech therapy interventions with families. Thus, the authors emphasize the importance of a greater effort aiming at establishing specific orientations that consider the family demands[3 6 13], because the Brazilian speech-language sciences production still presents gaps regarding studies on the influence of family relationships on the acquisition and development of language[14].

Therefore, this research took into account the needs of family members, based on their perspectives, to elaborate a proposal for practical intervention so that the speech therapist can welcome the family and ensure respect for the singularities of the patient and their relatives. A limitation of the study is that the guideline proposal was not applied in order to verify its effectiveness. It is necessary to prove its value in everyday clinical practice. In this sense, the experience of the profession will prove its usefulness.

Conclusion

There was consensus among the parents that family orientation ought to be systematic, in addition to having an interdisciplinary interface. This partnership will help them better understand their children's language changes and contribute to their evolution. The research contemplated relatives of children with different language pathologies and, thus, it became evident that there are similar needs that will help everyone. It is up to the professional to adapt the suggested strategies to the patient in question, attending to peculiarities and characteristics of their language alteration.

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