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On the Style of Communication of Children with Cleft Lip and Cleft Palate

“To speak – is to speak to someone”
(H. G. Gadamer 2003:156)

SUMMARY

When commenting on the differences in language custom observed in patients with cleft lip and palate usually disorders in the realization of phonemes are described. However, the literature also points to the risk of delays in speech development, reduced intensity of verbal expression, as well as other communication characteristics of children with cleft. The following study presents the results of a research concerning the speech of children with cleft lip and palate aged 6–7 and 9–10, which allow for a general description of the style of communication among this group of people. These results indicate that children with cleft lips are passive interlocutors, i.e. they rarely initiate conversation, but respond to encouragement.

Keywords: speech disorders in children with cleft, communication style of children with cleft, participation in a dialogue of children with cleft.

INTRODUCTION

The cleft lip and palate, create in particular different conditions for the development of articulatory skills, and therefore various disorders of phoneme realization become one of the characteristics of the speech of children with a defect within the central part of the facial skeleton. Logopedic and phoniatic literature in different ways describes the above mentioned disorders, profiling non-normative realizations of phonemes, including the impairment of resonance,

or – using the phoniatic approach – nasalization and articulatory disorders (Pluta-Wojciechowska, 2002, 2010). Segmental substance disorders are a relatively common theme as regards people with cleft, which results from the structure of the defect. The literature also mentions other differences in the language custom, indicating on the one hand a delay in speech development, on the other, smaller intensity of verbal expression, as well as other communication characteristics of children with cleft (e.g. Chapman 1993; ester, Broen 1989; Golding- Kushner 2001; Hortis-Dzierzbicka 1999; Hortis-Dzierzbicka, Komorowska 1996; Matthews-Brzozowska, Zalesska-Kręcicka, Moravian-Kochman 2007; McWilliams, Morris, Shelton 1990; Pluta-Wojciechowska, 2011). The latter correspond to the popular opinions of some people involved in the treatment of children with cleft or having contact with them. They suggest that younger and older patients with cleft rarely take the initiative in conversation, are more withdrawn, less active. Such observations require a study of a communication style, that is some characteristic features observed during a contact with another person with the use of language.

The issue is so important because insufficient interactive skills may contribute to difficulties or disturbances in communication with the use of language. Assuming that dialogue is associated with a mutual exchange of ideas by language utterances we can say that it is an important skill, on the one hand, to take the initiative in conversation, on the other hand, to participate actively in it, which involves asking questions, answering questions, paraphrasing the interlocutor's utterances, responding to encouragement. An important feature of a dialogue is turn taking – first I speak to you, then you speak to me. The exploration of such skills is not easy during a logopedic test, which assumes the form of tasks given to the child. Some insight into the person's communication style is possible through observation and recording of naturally and spontaneously occurring linguistic behaviors of children during a logopedic examination. I had the opportunity to experience such a situation many times during the first stage of the logopedic procedure, when a child addressed me, telling me about different issues important to him, asking various questions, commenting on my statements, etc.

This study is an account of research on the style of communication of 6–7 and 9–10 years old children with cleft lip and palate, compared with children of the same age, but without facial skeleton defects¹.

COMMUNICATION STYLE

The Universal Dictionary of the Polish language says that style is “a way of conduct, behavior and thinking, as well as specific preferences characterizing

¹ The research presented in the present paper is based on my earlier publication (Pluta-Wojciechowska 2011).

a person or an environment” (2004). Thus, for the purposes of this study it can be assumed that a communication style means characteristic features of communication of a person, observed during their contact with other people with the use of language. The background for such an approach to the issue could be the words of Joseph Porayski-Pomsta, who wrote that “child’s intentions have a bearing on their communication strategies. These strategies are also the evidence that even small children at preschool age begin to plan their participation in a conversation with an adult “(Poraysky-Pomsta 2005: 20).

An important element of an incident of speech is intention, without which it is difficult to imagine people’s conversation. It is an engine that starts successive mechanisms of a cognitive-linguistic character, which lead, on the one hand, to the initiation of a conversation, on the other hand, to active participation, which should be understood not only as answering questions, paraphrasing statements, presenting one’s own opinion, responding to encouragements, requests, but also asking questions, initiating subsequent themes and topics during the dialogue, etc.

Betty J. McWilliams, Hughlett L. Morris, and Ralph L. Shelton (1990), commenting on the speech of children with cleft lip and palate, and specifically the ability to make use of language when dealing with a group, evoke the model proposed by Marc E. Fey (1986). This model is sometimes used to assess communication behaviors of children with cleft (McWilliams, Morris, Shelton 1990: 244). In this perspective, testing of two different types of behavior and communication is proposed, namely: the ability, willingness to speak in a conversation without any encouragement from the interlocutor (e.g. certain ability to initiate a conversation), and with the use of such encouragement. According to the authors, children with cleft are usually passive or inactive interlocutors. The authors present several possible options, which allow for a description of the communication style of people with cleft. Children may react differently to incentives and initiate a conversation. According to the authors’ commentary, generally speaking, the

Table 1. Characteristic features of different communication styles

Communication style	Ability, willingness to take part in a conversation	
	Without incentives, so with a certain ability to initiate a conversation	With incentives from the interlocutor
Active interlocutor	Initiates conversation	Reacts to incentives
Passive interlocutor	Rarely initiates conversation	Reacts to incentives
Inactive interlocutor	Rarely initiates conversation	Does not react to incentives
Uncommunicative interlocutor	Initiates conversation	Does not react to incentives

Source: author’s own study based on B.J. McWilliams, H.L. Morris, R.L. Shelton: Cleft Palate Speech ...,; 244th

following styles of communication can be distinguished : 1. active interlocutor 2. passive interlocutor 3. inactive interlocutor 4. uncommunicative interlocutor (McWilliams, Morris, Shelton 1990: 244). Characteristic features of the individual styles of communication are presented in Table 2.

CHARACTERIZATION OF THE STUDY GROUP

The study, whose results will be presented below, comprised 39 children aged 6-7 and 9-10 years, with various types of clefts, which are being treated in the Institute of Orthodontics of the Department of Developmental Age, Medical University of Silesia in Katowice (The clinic is located in Zabrze) and 41 children without cleft of the same age. In the study group there were only those who had undergone basic surgical operations of closing the cleft fissure, and other corrective and supplementary surgeries. It should be noted that the surgical treatment of the children was not uniform, because children were being treated in various centers. This means that some of them have undergone a single-step operation of closing the cleft at about 6 - 7 months of age, with others the lip fissure was closed between 3 - 6-7 months of age, and the palate fissure at about 9 months of age. With still others, after the closure of the cleft lip at about 6 - 7 months old, the palate closure followed at 2 years of age.

Children who did not have malformations other than cleft were selected for the research, although the study included children with hearing loss reaching 30 - 40 dB or whose hearing loss had occurred in earlier years of life. The majority of the children showed various maxillary and occlusion defects, and some of them slight ankyloglossia (many of the children with ankyloglossia detected in the first months of life had already had the tongue frenulum cut during the operation of the cleft, which should be regarded as beneficial). It is necessary to emphasize, however, that the observed effect of surgical and orthodontic treatment (the condition of lip and palate, occlusion, patency of the nasal cavity, etc.) was different with various children. This is a result not only of the diversity of the methods of treatment, existence of iatrogenic factors, compensatory mechanisms of the body, the course of biological functions, but also other individual characteristics of the child and his environment.

Children aged 6 - 7 years and 9 - 10 years with cleft and children without cleft of the same age came mainly from urban environment, and education of their parents was comparable. The study of children without cleft was conducted in one school in Zabrze, in a kindergarten in Jankowice and Katowice. I selected children without malformations, although with some patients a slight malocclusion and ankyloglossia appeared. However, in the case of children with cleft malocclusion was more intense than with children without cleft. To provide a complete picture of the children without cleft, it is important to emphasize that they were recruited

mainly from families of average social status, and in most cases the parents were of primary or secondary education. What's more, many of these children needed specialized pedagogical and logopedic care, which was obvious from the analysis of pedagogical and logopedic tests, but most families did not make use of such assistance.

Among the children with cleft, the largest group constituted of children with complete unilateral cleft of primary and secondary palate (56.41%), followed by children with cleft secondary palate, (25.64%), children with the most severe type of cleft, which is a complete bilateral cleft of the primary and secondary palate (10.26%) and children with cleft primary palate (7.69%). The majority of parents of the children with cleft had vocational or secondary education, rarely primary or higher education. The same was true in the case of education of the parents of children without cleft. Most parents of the studied children without cleft had vocational or secondary education, the rest primary or higher education.

Table 2. The number of the children with cleft lip and palate and children without cleft

Appearance of cleft	Age group					
	6–7 years		9–10 years		Total	
	l.	%	l.	%	l.	%
PP	2	9.09	1	5.88	3	7.69
PW	7	31.82	3	17.65	10	25.64
CJ	10	45.45	12	70.59	22	56.41
CO	3	13.64	1	5.88	4	10.26
Children with cleft total	22	100.00	17	100.00	39	100.00
Children without cleft	22	100.00	19	100.00	41	100.00

Note. To denote types of clefts I use the following abbreviations:

- PP – persons with cleft primary palate
- PW – persons with cleft secondary palate (complete or partial),
- CJ – those with complete unilateral cleft of primary and secondary palate (right-or left),
- CO – a person with complete bilateral cleft of primary and secondary palate.

Source: author's own study based on research

RESEARCH METHOD

The results presented below and their analysis are part of a much more extensive research on different aspects of speech of children with cleft from 4 months to 10 years of age. Partial tests (not shown in this study) included the following elements:

- level of development of speech from 4 months to 3 years of age, including the assessment of pace, rhythm and quality of the key stages according to the prepared scale,
- level of development of primary activities (breathing, taking in food and drink) from 4 months to 3 years of age,
- level of selected language skills based on recorded speech samples of children 6-7 and 9-10 years old, such as:
 - the execution of paralingual characteristics and fluency of speech,
 - the realization of phonemes,
 - speech intelligibility,
 - knowledge of the names of parent categories,
 - knowledge of the names of elements of parent categories,
 - finding rhyming words,
 - understanding of metaphors,
 - creating metaphorical expressions,
 - creating meronymies,
 - defining expressions with a low level of concreteness,
 - creating narrative texts (description and narrative),
 - participation in a controlled dialogue,
 - initiating a dialogue by the children during a logopedic test,
 - learning and using new words in experimental situations, which was an opportunity to see how they are learning and the use of some abstract patterns in the created statements, as well as an element of language creativity².

It is worth noting that the method of testing different language skills adopted by me took into account the vision of description of interactive abilities postulated by Stanislaw Grabias, in which the author includes motor skills, pronunciation, language, conceptual structures, realization of a dialogue and narrative statements (Grabias 2008, s. 15).

In the research I assumed that the acquisition of speech is related to the influence of different factors, which in various ways can modify the development, the level and the method of constructing expressions. The aim of the undertaken study was to seek answers to the question if, and to what extent, the difference of the model of development of a child with cleft (biological, psychological and social conditions related to the defect) affects the development of different language skills in verbal expression, not only the realization of phonemes. Therefore in the present paper only those results of research are presented, the analysis of which provides some insight into the communication style of children with cleft, aged 6–7 and 9–10 years.

² A comprehensive report from the conducted research was presented in the paper D. Pluta-Wojciechowska, 2011

The basic method of research was collecting children's statements connected with specific tasks prepared by me, which include a variety of language skills. The test consisting of tasks developed by me, was conducted by me personally. The necessary additional information on types of cleft and surgical and orthodontic procedures used I obtained from the analysis of orthodontic cards, and – in the context of speech therapy – speech therapy cards.

The entire logopedic test was recorded on a digital recorder. Then the individual recordings were played by me and saved. The next phase of work consisted of preparing summary tables showing the quantitative data on the skills tested in each group of children with cleft and with no cleft, in relation to age. The last stage of work included statistical analysis, which allowed me to determine statistically significant dependencies and, therefore, of particular interest to science. Reaching into history, it is worth pointing out that the necessity of taking into account the quantitative analysis of linguistic studies was already pointed out by J. Baudouin de Courtenay. The author in fact included an appropriate comment concerning this postulate in his book about the Polish language, "O języku polskim" and specifically in the chapter entitled "Quantitativity in linguistic thinking" (Baudouin de Courtenay, 1984, pp. 423–443).

In the study I used the following statistical tests:

- chi-square test with Yates's amendment
- test of the difference of structure indicators.

The results which I regarded as statistically significant were those for which the probability was $p < 0.05$. The results, for which the probability was as follows: $p \geq 0.05$, but $p < 0.10$, I acknowledged as being on the border of significance. The results of research, including statistical tests, will be presented below, along with tables containing summary data on the basis of which indicators showing statistically relevant data were calculated. In the tables showing the results of the statistical test statistically significant values are indicated in red, and in blue color those being on the border of significance. For greater clarity of results before the number showing the result of the statistical test I put an arrow that indicates whether the analyzed feature occurs in children with cleft more frequently or less frequently, compared with children without cleft. If the arrow is pointing up, this means that the analyzed trait occurs in children with cleft often, and if it points down, it means that the test feature is less frequent in children with a craniofacial defect.

Making use of the method of analysis of the communication style of children with cleft cited by B.J. McWilliams, H.L. Morris and R.L. Shelton (1990) involves selecting such indicators that can determine whether and to what extent children initiate conversation and how they respond to incentives. This is not an easy task. However, a test can be organized in such a way that it is possible to develop an opinion on the issue, using, on the one hand, spontaneous verbal activity of the

child, on the other, to provoke a situation in which we see a child responding to the offer of taking the initiative in conversation during special tasks. The use of verbal incentives during a logopedic test is often used as a method of motivating the child to work, particularly in the absence of the child's response to the task posed to him, as well as in the case of new tasks and tasks unknown to the child. Let us note, however, that the number of incentives used may affect the child's performance during the test. So it seems important to indicate the number of incentives used during the test, because it allows for some insight into the way children respond to a task proposed to them.

Coming up to referring the method of testing, it is worth remembering that the most important textual forms of expression, in the approach of Stanisław Grabias, Mark Kurkowski and Tomasz Wozniak, is a dialogue and two forms of narrative expression - a narrative and a description. The authors recognize that "interference in the realization of any of those forms hinders efficient and effective interaction, crucial for personal success in the society" (Grabias, Kurkowski, Wozniak 2002: 9). This dimension of the communication of children with cleft has not been as yet the subject of detailed research in Poland, although some observations on the intensity of verbal expression are present in the study of Tadeusz Galkowski and Jerzy Grossman (1987). Extensive account of the studies concerning the ability to relate and describe in children with cleft has been presented in another study (Pluta-Wojciechowska, 2011). In the present paper only some features observed while testing those narrative forms will be presented, features which enable the use of the presented model concerning the communication style of children with cleft.

Given the scope of the conducted studies and the structure of the model presented above, the conclusions about a general style of communication of children with cleft will be made on the basis of the following results of partial research and related indicators:

- participation in a controlled dialogue, namely, taking the initiative by a child during a telephone conversation,
- spontaneous initiation of a conversation with a therapist by a child during the test,
- necessity of using verbal incentives while testing the ability to relate and describe.

RESEARCH RESULTS

Participation in a controlled dialogue

S. Grabias indicates that the language interaction can be described with regard to the speaker, the person at whom the statement is addressed, the situation and the aim of the utterance (Grabias 2007: 367). Studying participation in a dialogue

Table 2. The results of the study of participation in a controlled dialogue

Aspect studied	Group studied					
	Children with cleft			Children without cleft		
	6-7 years	9-10 years	Total	6-7 years	9-10 years	Total
	number	number	number	number	number	number
Initiative taking						
Takes the initiative	22	19	41	22	17	39
Does not take the initiative	0	0	0	0	0	0
Using polite expressions						
Uses a polite expression when indicated	22	18	40	18	16	34
Does not use the expression when indicated	0	1	1	4	1	5
Uses the expression after finishing the conversation	22	18	40	17	17	34
Does not use the expression after finishing the conversation	0	1	1	5	0	5
Answering questions						
Answers questions	22	19	41	22	17	39
Answers adequately to a real situation	11	11	22	12	10	22
Answers making up a real situation	11	8	19	10	7	17
Taking the initiative of asking questions						
Takes the initiative	18	17	35	11	10	21
Does not take the initiative	4	2	6	11	7	18
Takes the initiative by asking questions	15	17	32	10	9	19
Takes the initiative by creating indicative sentences	3	0	3	1	1	2
Number of questions asked after taking the initiative	58	62	120	37	24	61
Number of indicative sentences uttered (instead of questions) while taking the initiative	9	0	9	1	2	3

Source: based on author's own research

Table 3. The results of the study of a child's participation in a controlled dialogue (statistical test indicators)

Aspect studied	Age group		
	6 - 7 years	9 - 10 years	Total
Taking the initiative	1.0000	1.0000	1.0000
Use of the polite expression:			
- when indicated	↓0.0210	0.4679	↓0.0410
- after finishing the conversation	↓0.0111	0.1722	↓0.0410
Answering questions:			
- adequately to the real situation	0.3820	0.4776	0.4661
- by making up the real situation	0.0038	0.4776	0.4660
Taking the initiative of asking questions			
- takes the initiative	↓0.0157	↓0.0207	↓0.0014
- does not take the initiative	↑0.0157	↑0.0207	↑0.0014
Way of taking the initiative			
- asks questions	↓0.0678	↓0.0100	↓0.0039
- creates indicative sentences (instead of questions)	0.1502	0.1769	0.2622
Number of questions asked after taking the initiative in conversation	0.1573	↓0.0118	↓0.0163
Number of sentences uttered (instead of questions) after taking the initiative in conversation	↓0.0546	0.1462	0.1487

Source: based on author's own research

is difficult because it requires creating identical test conditions for each child. It is a prerequisite to compare the obtained results. Trying to cope with this task I prepared a script of a telephone conversation, which made it possible to create reasonably identical test conditions for each child.

Method of testing. The ability to participate in a telephone conversation was tested according to the following scenario:

- speech therapist gives the child a toy telephone,
- speech therapist says: *I will call you,*
- speech therapist "makes the phone call", saying: *Drrrr,*
- child "answers" the phone, the expected reaction of the child: *Hello* or *Yes?*,
- speech therapist says *I am a speech therapist. I would like to talk to you. Can I?*,
- speech therapist asks the child a few questions: *What is your name?, How old are you?, What is your family like?, What do you like doing?*

– speech therapist encourages the child to take the initiative of asking questions, saying: *Maybe you want / would like to ask me something?*; expected response: the child asks the speech therapist questions,

– speech therapist ends the conversation by saying: *Thank you for your time. Goodbye* (expected child responds: *See you* or *goodbye* or *thank you*) or the child ends the conversation, using an appropriate salutation.

Research results. Summary statement containing the data on which the indicators of the statistical test were calculated are presented in Table 2. Data presented in Table 3 presenting the results of the statistical test show that:

– children with cleft, like children without cleft, willingly participated in the task,- there were statistically significant differences concerning the less frequent use of the polite phrases at both the beginning and the end of the conversation, but in a group of children aged 9 - 10 such differences have not been reported,

– when answering the speech therapist's questions, both children with cleft and with no cleft equally often responded to questions, formulating true sentences (e.g. to the question: *Where are you?* they responded: *At the speech therapist's*), as well as inventing the situation (e.g. a reply to the same question: *I am at a pizza place*),

– children with cleft significantly less frequently took the initiative to ask questions when compared with children without cleft and formulated fewer questions; no differences were recorded in the frequency of uttering indicative sentences that children constructed instead of questions, wanting to take the initiative in the conversation after all,

– children with cleft asked fewer questions during the conversation, which is statistically significant for the whole group of children with cleft, but is not important for children aged 6 - 7 years.

INITIATING A CONVERSATION BY A CHILD DURING THE TEST

A logopedic test is an extraordinary contact between a speech therapist and a child, because, on the one hand it is a way of testing different language skills through special tasks, on the other hand, it is an opportunity in itself for various spontaneous verbal contacts of a child with a speech therapist and a speech therapist with a child. Thus, a child can treat the logopedic test like any other relation with an adult, which whom they may (but also want or not want, not know how) come into contact by initiating a conversation. I constantly observe such situations during different contacts with children, also during a logopedic test. I watched them during the tests. I had the impression that children treated me differently, which manifested itself in taking the initiative to establish contact with me, which sometimes extended beyond the limits of the tasks proposed to the child. Children addressed me with various comments on the proposed tasks,

Table 4. The results of the study of spontaneous utterances of children recorded during a logopedic test

Feature studied	Group studied											
	Children without cleft						Children with cleft					
	6-7 years		9-10 years		Total		6-7 years		9-10 years		Total	
	number	%	number	%	number	%	number	%	number	%	number	%
Number of spontaneous utterances	102		77		179		73		15		88	
Number of children with whom spontaneous utterances appeared	3	13.64	4	21.05	7	17.07	9	40.91	8	47.06	17	43.59
Number of children with whom spontaneous utterances appeared	19	86.36	15	78.95	34	82.93	13	59.09	9	52.94	22	56.41
Average number of spontaneous utterances per a child in the whole group	4.64	-	4.05	-	4.37	-	3.32	-	0.88	-	2.26	-
Number of children with whom 1-5 spontaneous utterances appeared	14	63.64	10	52.63	24	58.54	7	31.82	9	52.94	16	41.03
Number of children with whom 6-11 spontaneous utterances appeared	3	13.64	4	21.05	7	17.07	4	18.18	0	0.00	4	10.26
Number of children with whom more than 11 spontaneous utterances appeared	2	9.09	1	5.26	3	7.32	2	9.09	0	0.00	2	5.13

Source: based on author's own research

shared their own experiences, which they thought of when talking about the task, they confided their own experiences, etc. During the test they told me about a new dog, informed that dad went abroad to earn money, that they do not believe that the animals shown in the picture actually exist, etc. Let us notice that such a spontaneous utterance directed at the investigator requires, beside the appearance of the intention, also a proper level of linguistic and communicative competence and relevant skills, and also certain characteristics associated with personality. It can therefore be stated after J. Porayski - Pomsta that children use certain strategies during a contact with an adult and that in some ways they plan their participation in a conversation with an adult (Porayski-Pomsta 2005: 20).

Research method. Table 4 presents a quantitative summary of spontaneous children's utterances during the test, along with the number of children who have exhibited such behavior. The indicators of statistical test are shown in Table 5. It should be emphasized, however, that children's questions, which were asked to understand the task instruction better, were not regarded as such spontaneous statements. Determining the number of children's utterances which I called spontaneous required listening to each recording made during a logopedic test and its analysis.

Table 5. Children's spontaneous speech recorded during a logopedic test (statistical test indicators)

Feature studied	Age group		
	6 - 7 years	9 - 10 years	Total
Number of children, with whom spontaneous utterances did not appear	↑0.0243	↑0.0538	↑0.0058
Number of children, with whom spontaneous utterances appeared	↓0.0243	↓0.0538	↓0.0058
Average number of spontaneous utterances per a child in the whole group	0.2160	↓0.0063	↓0.0259
Number of children, with whom 1-5 spontaneous utterances appeared	↓0.0203	0.4926	↓0.0607
Number of children, with whom 6-11 spontaneous utterances appeared	0.3413	↓0.0264	0.1897
Number of children, with whom more than 11 spontaneous utterances appeared	1.0000	0.1722	0.3435

Source: based on author's own research

Research results. The statistical test results presented in Table 5 allow for the formulation of the following conclusions:

– in the case of children with cleft spontaneous speech appeared significantly less frequently during the test, although in the case of children aged 9 - 10 years there were no statistically significant differences (differences at the border level of significance),

– statistically smaller number of spontaneous utterances, occurring in children with cleft, was recorded, but in children aged 6 - 7 years no such statistical differences were observed,

– given the number of children who produced 1 - 5 utterances, 6 - 11 or more than 11 spontaneous utterances during the test, there were no statistically significant differences between the two groups of children, although such differences were recorded in different age groups.

Verbal incentives used during the test of descriptive and narrative skills

Narrative statements are an important form of language use, because there integration of different skills – linguistic and cognitive ones - occurs. They are activated in order to express one's own interpretation of the world. Issues related to the narrative are extensively discussed by T. Wozniak, who treats the narrative as a mental process and states that it is ‘a procedure of unifying knowledge with the use of language’, and in another place he writes that “a narrative is a procedure of interpreting the world through language” (Wozniak, 2005: 96.:101). The author stresses that a story is a universal form of expression in all cultures, and the way the story is told is similar for people living in different parts of the world.

Commenting on the essential features of a story, usually dynamics, a sequence of events related to the cause and effect relationships and plot are mentioned. What is more, those features are contrasted with a description, which is more static, and has a simultaneous character. For some children storytelling is a relatively difficult skill, especially taking into account a description, which is a less frequently used form of testing language skills. During the test of description (for the research I used two pictures: a picture of a girl and a picture of a boy) and narrative (for the research I used a picture story of 3 elements), some children were encouraged by me to speak, especially when I was not sure whether the child had completed his speech, or is thinking about the next part of the speech.

Due to the subject of this study some selected results of the research related to testing the skills of storytelling and description are presented below. Both the storytelling and description were provoked, which means that the texts constructed by children were based on individual pictures in the case of description or on a picture story for the narrative. Although description skills do not appear until the tenth year of life, as indicated by Grabias S. (2008: 20), but different forms

of such linguistic activity are observed during kindergarten classes. Testing the description of the human form was carried out in two variants - the description of a girl and a boy.

Research method. As indicated above, while testing the narrative skills listed above the situations in which I encouraged children to speak occurred. Verbal encouragement consisted of my statements such as: *What else will you say?, Is this all?, Can you say something more?, Can you add anything?* Such encouragement is a change of the test conditions and should be taken into account when considering the results of the tests. So it happened in the case of the analysis of narrative and descriptive skills. It should be emphasized that I continued encouraging storytelling or description until the child communicated, in an unequivocal manner – by a gesture or a word - that it was everything he wanted to say.

Table 6. Summary of verbal incentives applied during the test of narrative skills and description of a human form

Number of verbal incentives used while testing the skill of	Studied group					
	Children without cleft			Children with cleft		
	6-7 years	9-10 years	Total	6-7 years	9-10 years	Total
Describing a girl	6	16	22	19	5	24
Describing a boy	10	10	20	15	6	21
Telling a picture story	1	1	7	8	2	10

Source: based on author's own research

In Table 6 I presented a summary on the basis of which the statistical tests were prepared. Table 7 presents the results of a statistical analysis, which concerns the frequency of the use of verbal incentives during the description of a girl and a boy, and also while telling the story.

Research results. Statistical test results contained in Table 7 allow us to state that children with cleft, like children without cleft, considering the group as a whole, did not need more verbal incentives during the test, which is statistically significant. Let us notice, however, that significant differences occurred in the case of children 6 - 7 years old in relation to the description of a girl (children with cleft needed significantly more verbal incentives) and among children 9 - 10 years old (children with cleft needed significantly less verbal incentives than children without cleft). The interpretation of this phenomenon may be as follows:

Table 7. The results of a statistical test concerning the number of verbal incentives used during the test of narrative skills and description of a human form (statistical test indicators)

Type of task	Age group		
	6-7 years	9-10 years	Total
Description of a girl	↑0.0246	↓0.0108	0.3440
Description of a boy	0.1877	0.1709	0.3806
Telling a picture story	↑0.0987	0.2308	↑0.0651

Source: based on author's own research

in the first case greater number of incentives may be a reaction to a new type of task - the description of a girl. In the case of the description of a boy (which was proposed to the children usually after the description of a girl³) children with cleft no longer needed to be encouraged to work, because the task was already known to them. Thus, differences in the group of children aged 9-10 years (significantly smaller number of necessary verbal incentives) may indicate that the 9-10 years-old children with cleft are used to pursuing new tasks, which may be related to their experiences with speech therapy. Let us also note that in the cases of both children with cleft and without cleft significant difference was noted between the number of incentives used in the case of a narrative and a description. The narrative did not require the use of large numbers of verbal incentives, because - I think - it is better known to children and more interesting than the description of a human figure.

ANALYSIS OF RESULTS

The above results allow us to some extent to formulate a general opinion about the communication style of children with cleft, compared with children without cleft aged 6-7 and 9-10 years. Using the model presented above requires determining whether and how often the children initiate the conversation and how they respond to incentives. On the basis of the research results we can say that differences in the participation of children with cleft in a controlled dialogue, compared with children without cleft concerned the following parameters:

³ I tested the difficult skill of describing showing the children two pictures: of a girl and a boy. The children could choose which picture they want to describe first. One of the features differentiating the two figures was that the girl looked-let us say-proper, but the boy was quite plump and carelessly dressed. Most children chose the girl. In the group of 6-7 years old children without cleft 19 persons chose the girl as first, in the group of 9-10 years old children - 15 persons, and in the case of children with cleft 20 and 12 persons respectively.

- less frequent use of salutations, both at the beginning of the conversation, and at the end (but in a group of children aged 9 - 10 years such differences were not been reported),
- less frequent taking the initiative of asking questions compared to children without cleft, children with cleft also formulated fewer questions;
- less frequent asking questions during the task is statistically significant for the whole group of children with cleft, but it is not important in the case of children aged 6 - 7 years.

The spontaneous verbal activity of children with cleft during the entire logopedic test manifesting itself by initiating the conversation in comparison with children without cleft can be described as follows:

- less frequent occurrence of spontaneous speech during the test, although in the case of children aged 9 - 10 years there were no statistically significant differences (differences at the border level of significance),
- fewer spontaneous utterances, occurring in children with cleft, but in the group of children aged 6–7 years such statistical differences were not reported.

Commentators of the communication analysis model by M. E. Fey emphasize that children with cleft are usually passive or inactive interlocutors. Hence – in the first case – rarely initiate a conversation, but respond to incentives, and – in the second case – rarely initiate a conversation and do not respond to incentives (McWilliams, Morris, Shelton 1990, p. 244). The presented research results in a way correspond with the opinion of the authors. This is so because children with cleft significantly less frequently initiated a conversation, which is shown by the results of the study of children's spontaneous speech, as well as rarer taking the initiative during the controlled dialogue.

Using the number of incentives employed during storytelling and describing the human form for the analysis of the communication style of children with cleft is not easy. Let us note, however, that children with cleft did not need a lot of verbal incentives during the test while creating descriptions and stories. One can cautiously state that they generally responded to the tasks proposed to them like children without cleft, but it was not so in the case of analyzing individual age groups. Let us notice that children 6–7 years old in relation to the description of a girl needed significantly more verbal incentives, and children 9–10 years old needed significantly fewer verbal incentives compared with children without cleft.

It definitely should be observed that there were differences in the number of formulated pieces of information during the description of the human figure and storytelling to the detriment of children with cleft (Pluta-Wojciechowska 2011: 312⁴). Does this result mean that children with a craniofacial defect did

⁴ In the case of testing the ability to describe a human form they were statistically important issues, and in the case of testing storytelling the differences were at the border of significance.

not respond to incentives? It is difficult to decide on the basis of the conducted studies. Studies of other language skills of children with cleft showed, in fact, that children with cleft are characterized by a generally lower verbal expression when compared with children without cleft (Pluta-Wojciechowska, 2011). Thus, keeping in mind the model of the analysis of the communication of children with cleft, cited by B.J. McWilliams, H.L. Morris and R.L. Shelton (1990), as well as the author's own research and the presented analysis, it can only be generally and cautiously stated that the tested children with cleft are passive interlocutors (rarely initiate a conversation, but respond to incentives).

DISCUSSION AND CONCLUSIONS

Commenting on the results of research I would like to point to a few issues. The first one concerns the revision of the standpoint of Aleksandra Mitrinowicz-Modrzejewska, who concluded that cleft is a multisystemic disorder (Mitrinowicz-Modrzejewska 1963: 242; Mitrinowicz-Modrzejewska, Pawlowski, Tłuchowski 1965: 33-123), meaning the respiratory, phonatory and articulatory systems, that is the executive side, responsible for the quality of the created speech sounds. The results of the study of the speech of children with cleft (also those that have not been included in this paper, see Pluta-Wojciechowska, 2011) lead to the revision of the author's position, because her approach to the issue is a too narrow perception of the problems which face a child with a cleft defect, because it limits his difficulties to articulatory disorders (although the author also mentions the possibility of delays in speech development).

In my understanding cleft is a disorder of a multi-faceted character, and not just multisystemic. This means that in addition to the deformity of the phonetic sphere, which seems a natural consequence of craniofacial disorders, there is a risk of the appearance of differences within other areas of linguistic functioning. This paper describes one of them, namely, the overall style of communication.

Interpretation of the results of research tends to indicate the complicated early speech development of the tested children, and also other differences related to the ontogeny of speech. These include factors of a biological, social and psychological nature, which can create different configurations, and their coexistence according to the cognitive thesis, that the whole is not a sum of individual factors, but it becomes a new quality, can be of vital importance. Particularly noteworthy is - I suppose - the early development of metalinguistic competence, confronted with early and, as I presume, excessive correction of adults, negative comments of other people about the child's speech, lack of automatization of the pronunciation patterns practiced with a speech therapist, fear of criticism of speech, etc. (see Pluta- Wojciechowska, 2011).

It should be emphasized that phonetic development (often complicated in children with craniofacial defects) does not take place in isolation but, on the one hand, in conjunction with nonverbal actions of the oro-facial complex (especially with primary activities such as breathing and intake of food and drink), on the other, with different developmental paths and levels of language, as evidenced by the comments of Maria Zarębina and Piotr Łobacz. M. Zarębina M. writes: „Simultaneous mastering of the phonological system determines the development of the remaining subsystems, such as inflection, word formation and syntax, which, at the same time, do not need to be mastered fully [...], not to mention the lexical-semantic system, which develops and enriches itself through the entire life” (Zarębina 1994: 7).

On the other hand, P. Łobacz comments by writing: “[...] the acquisition of vocabulary by a child determines his further phonetic-phonological development. [...] The more words a child possesses in an active, everyday use, the faster he is able to cope with the complexities of articulation of individual sounds, although his statements are much more strongly individualized in terms of phonetic realization than in later life “(Łobacz 2005: 241). Thus, the development and mastery of specific language skills does not happen in isolation, because many developmental paths intertwine with each other.

The start of the development of speech in many children with cleft encounters difficulties, which may take different forms and intensity, from minor disorders of the articulatory skills to the disturbances of pace, rhythm and intensity of speech development. As indicated by my research, about ¼ of the group of 112 surveyed children in the first three years of life, however, presents proper development of speech. This leads to a thorough investigation of this group of children (not just children with speech disorders), and defining the characteristics of the various factors determining normal development of speech observed in this group. Note that in this way we can see the other side of the phenomena associated with the speech development of children with cleft, namely, we can determine the variables that influence this process in a positive way.

As it follows from the reports, subsequent years of the life of a child with cleft may bring other experiences, adverse for the development, including verbal communication development. They may be related to emotional and social disorders, caused by differences in the appearance of face and quality of speech (Hortis-Dzierzbicka 1999, Kot 1995; Pluta-Wojciechowska 2004; Jakim, Szczepańska 1996; Hortis-Dzierzbicka, Dutkiewicz, Stecko 2000; Szczepańska, Łyjak 1996; Jurków 2005) and incidentally affect verbal activity. As you would expect, inadequate stimulation and speech therapy, which aims only at changing the patterns of articulation, can also influence the development of language skills. Thus, the effects of the occurrence of cleft lip and palate should be regarded in an integral way, not only in terms of disorders in the realization of phonemes. During

the ontogeny, pathways of the biological and cultural development, present in both healthy and sick children, intertwine.

In the course of the research, the greatest diversity of the linguistic custom was observed in relation to the intensity of verbal expression, as shown by, among others, a more frequent avoidance of verbal tasks when these tasks are quite unusual. Children with cleft also created poorer descriptions of the human form, when we take into account the number of formulated pieces of information. The results of the tests concerning the names of basic items of the tested categories showed that children with cleft enumerate fewer of them than children without cleft. These are, however, only selected findings from the research.

The analysis of the communication style of the studied group of children presented in this paper uncovered yet another aspect of the occurring differences. The studied children with cleft aged 6-7 and 9-10 years can be described employing the method of analysis used by B.J. McWilliams, H.L. Morris and R.L. Shelton (1990), as passive speakers (see, however, the concerns expressed above). This means that children rarely initiate conversation, but respond to incentives. Note that a passive interlocutor is someone who rarely starts a conversation, and therefore may have less contact with others or they may be less intense. As concerns contacts with adults, it can result in, for example, a more limited language experience, reduced possibility of correction, obtaining help and eliminating errors. It would, however, require undertaking a study on the communication style of children with cleft in relation to, for example, peers and other adults.

Let us also note that the use of polite phrases is an important feature of a telephone conversation (see the above research results). Children with cleft used them significantly less often than children without cleft, as shown by the statistical tests. This result encourages a closer study of the communicative competence of this group of children, and also, for example, the family communication style.

The obtained results lead to postulating, after S. Grabias, the description and analysis of the structure of intentions. This would allow some insight into the personality traits of a child and allow for a more accurate interpretation of test results (see Grabias 2007, pp. 366-367). This formulation of the arising thoughts corresponds with a commentary of T. Wozniak, who writes: "speech is a window of the mind. There is thus an insight into the mind through the study of speech. But this metaphor also implies the opposite direction. The mind perceives the world through the window of the soul" (Wozniak 2005: 7). You could then say that the speech of children with cleft shows not only (as this is mostly commented) the non-normative way of realizing phonemes. It reflects as well - even if only by the style of communication - the space of conditions, biological, psychological and social experiences that children with cleft have come to live with since their birth. A particular way of rendering it is found in speech. In one of my earlier publications I wrote commenting on the issue: "It can be (speech - note by DPW), therefore,

treated - using T. Wozniak's approach - as a sign or even a window that can be used for some insight into the mind and personality of a child, which is related with different experiences. Man is not only a user of language and its minister, but he is, by all means, embraced and immersed in it."(Pluta-Wojciechowska 2011: 367).

TOWARDS HELPING CHILDREN

Commenting on the findings of the research it is necessary to pay attention to the thesis, functioning in the everyday use of a number of people, as well as among speech therapists, according to which word bath is the best way to stimulate language development. In the light of the presented research results, is a word bath a sufficient verbal way of stimulating the speech development of a child with cleft to shape his attitude not only as a recipient, but also - and perhaps especially - a sender?

Writing on the subject of adult speech addressed to infants, Stanisław Milewski recalls the words of S. Schuman: "[...] one should speak a lot to an infant, talk to him, no matter whether the infant already understands our words or not yet" (Milewski 2004: 9). Further in the book the author, referring to Bronisław Rocławski (1991) stresses the importance of the first year of life for the formation of communication attitudes of a child, which is associated with behaviors expressing "being the recipient" and "being the sender of information" (Milewski 2004: 27). Such communication attitudes are developed spontaneously since birth, through conscious or less conscious behavior of mothers who, implementing various channels (touch, sight, hearing, movement, voice), try to shape such attitudes in children, as is observed by B. Rocławski (1991). In such alternate relationships the aim of mother's activity is eliciting specific mimic, motor, tactile, vocal reactions (Rocławski 1991, pp. 87-88). S. Milewski, points out an important aspect of such a contact and writes that "in the adult - child contact, quenching (unconscious) of the contact should be attributed to the child. The adult does everything (visual, tactile, vocal channel) to sustain the contacted as long as possible"(Milewski, 2005, pp. 27-28). Let us therefore notice, that an adult can respond to the child in different ways, to address the child in different ways. This type of contact has thus an alternating character.

In the light of what has been said, it seems reasonable to ask whether the so-called word bath is a sufficient way of stimulating the development of speech, including communicative attitudes, which consist of not only *receiving* but also *sending*.

The term *word bath* has a metaphoric nature and is associated with adult monologue, which speaks a lot to the child and the child listens. The child is immersed in words, like in a bath. The adult speaks to the child, which may be

associated with a lecture, talk, show. I think that such behavior is also required so that the child could hear the features of the language which is being assimilated. However, according to the communicative needs related to the two complementary attitudes which entice not only receiving but also sending, a word bath, understood as a monologue, cannot be the only and main way of being with a child for an adult with the use of words. You can even “see” an adult who understands the popular recommendation *You have to speak to a child a lot* literally -he really speaks a lot and quickly, according to the principle, *the more I say, the more I stimulate*. I observed such situations during my contacts with parents of young children, who - what is important - ignored the infant’s attempts to “answer”.

What then - a monologue or a dialogue, a monologue or following the child?, speaking TO the child, or talking WITH the child?, a word bath or following the child?, being NEAR the child and speaking TO the child or a dialogue, which - assuming some simplifications - in various forms is present since birth?

Acquisition of language skills causes not only the intensification, but also transformation of the communication of an adult with a child. Let us notice, however, that language does not appear out of nowhere in a child’s life, and receiving and sending verbal messages can be regarded as an extension, but also a transformation of other forms of communication, between a little child and an adult. Starting from birth we can observe protoconversations of a child, which have a clear alternating structure and can be regarded as an unusual training and introduction to attitudes – let us employ the words of S. Milewski - “being the recipient” and “being the sender of information” (Milewski 2005).

How, then, talk to a baby? Be sure to “listen to the child”, in his various forms of expression, notice different forms of addressing the adult by a child and reflect them with voice, touch, allow the child for a varied expression. On the other hand, a dialogue with an infant should include elements which sharpen verbal stimuli.

With regard to the expression of an adult speaking to a child it means modulating voice, speaking “in larger sounds” (i.e., properly loudly, clearly, distinctly), displaying the characteristics of a given language, introducing various statements into the course of being with your child everyday, especially into repetitive activities including turn taking, controlling the child’s attention, changes in the adult’s utterances on the bases of indicators of the child’s attention and behavior. Discussing this issue S. Milewski indicates that adult speech directed at infants at first is characterized by such features as melody, slowing down the pace of speaking, increasing the number of pauses, lengthening of vowels, the presence of unconscious rhymes and rhythms (Milewski, 2005, pp. 27-28).

Commenting on the importance of verbal interaction in the development of language skills, Michael Tomasello uses the term discourse. Although the author does not define the concept clearly, we can assume that he means various forms

of verbal interaction, whose essence is the exchange of ideas (Tomasello 2002: 196 and 216-266). The analysis of the model of language acquisition, presented by the author, leads us to believing that discourse is essential in this process, even because of the fact that it becomes the beginning of a process leading to the internalization of adult instruction, when the discourse has a pedagogical character. This perspective suggests that discourse is essential on the way to self-regulation, and reflection on our own mental processes. Note that a conversation is also a way of enabling the child to build a theory of another person's mind. The child's route to language runs through another person, his intentions and his mind. At the conclusion of the considerations on a word bath it can be said that a child must be immersed in culture, including developing communication attitudes "me to You" "you to Me," which means, in the light of the considerations contained in this report, much more than a monologue by an adult during the so called word bath. This is because language is alive in a conversation, which creates a new space of being with another person, taking into account the dimension of "me to You," "you to me." This new and unique way of being with another person involves emotions, intentions and mind. A baby is ready for such participation in a conversation since birth, because there are media other than speech, making it possible to be with another human being, allowing for turn taking. Then the foundations for future communication attitudes with the use of language are created.

Another reflection appearing during the analysis of results of a general style of communication of children with cleft involves revision of the general purpose of speech therapy, applicable to this group of people. It should be related with equipping the child with the skills of the effective use of language in all its dimensions, not just teaching correct articulation. The speech of a child with cleft should not and cannot be reduced solely to the pronunciation, despite the fact that the disorder in the realization of phonemes is a very important feature of this group of people (Pluta-Wojciechowska 2011, pp. 380-385).

When programming speech therapy one should therefore skillfully combine improving the realization of phonemes with the development, expansion, improvement of linguistic and communicative competence and the relevant skills. It seems important to equip the child with a kind of verbal behavior scripts, that can be applied in different situations and social roles in the realization of various needs and goals. Certainly during therapy various quasi-theatrical forms, drama, puppets, elements of socio-therapy should be used, and communication attitudes should be shaped since birth.

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