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PREPARING FUTURE CLINICIANS: STUDENT EVALUATION OF PROGRESS IN THE SMITH ACCENT TECHNIQUE

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SHORT INTRODUCTION

Breath support is a foundational concept in voice therapy, yet it remains variably defined across disciplines — encompassing airflow, subglottic pressure, muscular coordination, and perceptual effort. In voice therapy, breath support provides the essential air pressure (subglottic pressure) required to vibrate the vocal folds and produce sound. In clinical training, teaching speech-language therapy (SLT) students to not only apply breath support techniques but also to evaluate patient progress in breath support is a distinct and underexplored challenge.

The Smith Accent Technique (SAT) offers a structured approach to breath support training, targeting diaphragmatic breathing, expiratory control, abdomino-phonatory tuning, and overall voice quality. Effective SAT training aims to achieve quick, silent inspiration and efficient, controlled expiratory airflow for functional speech. While research has documented SAT outcomes in patients, little attention has been given to the learning experience of novice clinicians acquiring the skills needed to observe and rate breath support progress — a competency critical for evidence-based voice therapy practice.

OBJECTIVE(S) AND METHODS

This study aimed to describe and explore the subjective experience of undergraduate SLT students learning to evaluate breath support progress using the SAT. Specifically, it sought to:
(1) document the challenges trainees encountered when learning to rate SAT breath support performance;
(2) track their perceived progress and confidence across training sessions; and
(3) gather their recommendations for integrating rating skill development into SLT curricula.

Two undergraduate SLT students at Riga Technical University, Liepaja Academy participated in a structured SAT rating training program. Training consisted of eight on-site SAT voice therapy sessions followed by seven online breath support rating sessions. Rating materials included video recordings of two subjects captured at four time points throughout SAT training (before, during, and after), using respiratory plethysmography for concurrent objective measurement. Videos were focused on the face, chest wall, and abdominal wall in both seated and standing conditions. Trainees used an edited version of Khidr's (2010) SAT Subjective Progress Form to rate performance across five domains on a 0–90% scale. Training progressed from group sessions with expert guidance to independent rating. After each session, trainees provided written subjective reflections on their challenges, progress, and insights.

Khidr's 2025 Short Subjective rating of SAT Breath Support (% of time)

Breathing	% of time observed
1. No visible chest wall movement during inspiration	0% 25% 50% 75% 90%
2. Visible outward displacement of abdominal wall during inspiration	0% 25% 50% 75% 90%
3. No visible chest wall movement during expiration	0% 25% 50% 75% 90%
4. Slow gradual inward displacement of abdominal wall during resting expiration	0% 25% 50% 75% 90%

Largo / Andante / Allegro / Reading	% of time observed
1. No visible chest wall movement during inspiration	0% 25% 50% 75% 90%
2. Visible outward displacement of abdominal wall during inspiration	0% 25% 50% 75% 90%
3. No visible chest wall movement during expiration	0% 25% 50% 75% 90%
4. Controlled number and speed of accents with inward displacement of the abdominal wall during expiration with voicing	0% 25% 50% 75% 90%
5. No running out of air (adequate inspiratory reserve)	0% 25% 50% 75% 90%

RESULTS

Both trainees began the training feeling nervous and uncertain, reporting that they did not know what to expect or whether they would be able to judge breath support control correctly. This initial anxiety was a shared experience, though it manifested differently for each trainee. Trainee #1's primary difficulty was uncertainty about whether she had correctly understood and applied the rating rules. This doubt persisted across early sessions even as her performance improved. Trainee #2 faced additional practical challenges, including viewing videos on a small phone screen, which compounded her initial difficulty in assigning scores confidently.

Despite these early struggles, both trainees reported steady progress over the course of the training. Trainee #1 described each rating session as building incrementally on the last, gradually increasing her comfort with the rating process and her understanding of SAT therapy steps. Trainee #2 credited group rating sessions and peer discussions as pivotal to her development, noting that comparing observations with others helped clarify the rating criteria and sharpen her observational skills. She identified sessions 4–5 as the point at which she began to feel genuinely confident, though she acknowledged that uncertainty returned during independent rating, highlighting the continued need for practice.

Both trainees identified collaboration and mentored feedback as the most effective elements of their learning. Trainee #1 noted that confidence grew most noticeably when rating in pairs, while Trainee #2 emphasised that persistence and repeated exposure were transformative. A shared personal insight was the recognition that mastering the SAT method and mastering the ability to rate it are deeply interconnected and that neither can be rushed.

CONCLUSIONS

The reflective accounts of both trainees point to a consistent learning trajectory: initial anxiety giving way to gradual confidence through practice, peer collaboration, and guided feedback. Their experiences underscore that learning to evaluate breath support progress is a distinct clinical skill that requires dedicated training alongside hands-on SAT experience. Neither trainee felt ready to rate accurately from the outset, and both emphasised that confidence developed slowly and should not be expected early in the process.

Several pedagogical themes emerge from their reflections. First, group rating sessions and mentor-guided discussions were identified as essential, providing the calibration and shared reference points that independent study alone could not offer. Second, both trainees noted that their growing familiarity with SAT therapy steps directly improved their rating accuracy, reinforcing the view that understanding the technique is a prerequisite for evaluating it reliably. Third, the return of uncertainty during independent rating for Trainee #2 suggests that supervised practice should be sustained longer than might be assumed, and that the transition to independent rating warrants careful scaffolding.

Both trainees recommended that future SLT students learn rating skills after accumulating sufficient SAT training experience, and ideally before taking on any teaching role. Their collective advice to future learners to approach the process with patience, persistence, and realistic expectations reflects a mature understanding of clinical skill acquisition and offers valuable guidance for the design of voice therapy training programs.

REFERENCES

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