HANDOUT FOR SESSION 43—Multi-Professional Topic

What I've Learned: 56 Years as an SLP
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I. Generic

A. "In the sufferer, let me see only the human being." (Rambam) Your client is a *person, not* a communication factory with a body attached.
B. Move slowly. Speak slowly. Only smile when you mean it.
C. During interviewing, never show surprise. Excuse yourself before writing a note.
D. When giving information, either avoid professional jargon or illustrate it. Don't say, "Do you understand?" "As I said before…" "You need to…"
E. When asked how long therapy will take, say, "I don't know, but I'll continue therapy only if continuous progress is made." Then define goals.
F. While repetition is indispensable, it is best done in a communication-based and pragmatically valid format.
G. Diagnosis is a critical prerequisite to intervention.
H. Interdisciplinary input often helps and rarely hurts.
I. Respect the notion that the referring physician is ultimately responsible for your client's progress.
J. Some key prognostic factors are: (1) the conditions under which the referral is made, (2) the client's felt need to change and grow, (3) his success in communicating with his significant others, and (4) and whether you and your client "connect."
K. Your clients express their wants; you define their needs. They often differ.

II. Substantive

A. Phonology

1. Interpersonal discrimination does not guarantee intrapersonal discrimination, but production correlates with self perception. For example, a client with an "R problem" perceives his production of "wing" and "ring" as different, even though they sound like the same word to you. The key initial objective is to teach the client to produce a sound that clearly represents a different phoneme to both of you.
2. Vowel perception is non-categorical, while consonant production is categorical.
3. There are many dialect- and context-based allophones of R, L, and stop sounds. The major ones are best taught separately.
4. Vowel duration is sufficient to identify word-final voiced and voiceless cognates.

5. The term "functional" or "non-organic" articulation defect is a "cop-out."
6. Consider the notion that teaching a new sound in L1 is like teaching a non-English sound. What might work is having your client imitate your phone with an exaggerated distinctive feature that differentiates the target from teaching a non-English sound. What might work is having your client imitate your phone with an exaggerated distinctive feature that differentiates the target from the client's error sound.

B. Fluency

1. If time permits, the Liddicomb approach seems to be the most valid.
2. Teach the client to verbalize a feeling to the listener after the first stuttering.
3. Charles Van Riper said it: "Don't coddle the stutterer."

C. Phonation and Resonance

1. Once a physician has determined that the patient has a functional deficit, you become the therapist of choice.
2. Give practical suggestions to clients who seek a non-recurrence of a hyperfunctionally based vocal fold lesion.
3. A written order from a physician which includes a diagnosis is pre-requisite to your intervention. The order should be based on a prior fiberoptic laryngoscopic, stroboscopic, or videofluoroscopic exam as appropriate.

D. Dysarthria

1. Use all available communication channels in treatment.
2. Insure that the client is being followed by an appropriate physician, not necessarily a neurologist. (Consider dysarthric symptoms associated with type II diabetes and UTI.)
3. A highly motivated client will accept the notion that he must exert more physical energy than a non-impaired person.

E. Aphasia

1. Most clients with aphasia have both receptive and expressive components as well as permeating deficits, e.g., memory.
2. Encourage clients to be "up front," e.g., saying "wait" or "I know it but can't say it."

3. Be sensitive to the "on-effect" and "off-effect."
4. Genuine praise is necessary for correct or improved responses.
5. Communication efficiency may vary significantly across sessions as a result of almost anything you can think of.

Very Selective References

1. Cook, Frances, et al. Basic Clinical Skills. 2007. Memphis, TN: Stuttering Foundation of America. (DVD)

2. Holland, Audrey. Communication Activities of Daily Living (Test), and any articles you can find by her!

3. Luterman, David. Counseling in Stuttering Therapy. Memphis, TN: St nbmuttering Foundation of America. (DVD)

4. Tannen, Deborah (2007). You Just Don't Understand. New York: Harper.

5. Taylor, Jill Bolte (2009). My Stroke of Insight. New York:Plume/Penguin.