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THE COUNSELLOR AND THE CLIENT'S SPEECH PROBLEM

Perhaps each person remembers somewhat vividly the first time he hears a recording of his voice. The way we sound is important to us. And through that first encounter with ourselves by tape or record, each individual finds he does not hear himself as others hear him. He discovers that he must learn to hear himself as he learned to make sounds, discriminate between them, and as he then learned to formulate those sounds into meaningful noise.

But if an individual does not know that his speech behavior can be changed *because* it is learned, he can become very unhappy — especially if he is "John Thmith from Thathkatoon," or if he cannot get through a sentence without a dozen stumbling bb-b-b-bbblocks. Speech is learned: one can usually change the way one sounds. And it is the contention of this writer that, when there is not professional help available for their clients, counsellors can learn to be effective speech therapists with some types of problems. Moreover, even when the counsellor only refers a client for speech help, the referral itself can be useful if one learns to describe speech behavior specifically.

When talking about speech problems, it is important to approach language as individual sounds, not spelling. In the word "John," for example, there are three sounds; in the word "though," there are two. Spelling in English has little to do with sounds, as grade schoolers are painfully aware. When a client says "Thmith" for "Smith," one sound is wrong, not two letters — Mr. Smith is actually substituting another perfectly legitimate sound for the appropriate one.

Approaching language phonetically, as individual sounds, is important if an accurate description is to be made of the client's speech behavior. Counsellors elicit a larger sample of speech from their clients than most diagnostic speech therapists. Rather than concluding that Mr. Smith "sounds funny" or "has a speech defect," perhaps it is more useful to state that the client substitutes the voiceless /th/ sound as in "thick" for the /s/ sound in initial or beginning word position. Contrast the preceding description with the one following, written by a teacher to a speech clinic:

> In my room there is a little boy in the third grade with a kind of funny voice. I mean he doesn't talk like the other children . . . Is this stammering or baby talk and how can I cure him? Please send me some tongue exercises or something. He is a sweet little child and needs some help (Van Riper, 1963, p. 14).

The phonetic system of language is tidy and fairly simple to learn, especially with the aid of a good self-instructional text such as the one by Wise and Morgan (1967). Briefly, speech problems usually involve consonants and consonants usually occur in phonetic pairs — voiced (with vocal bands vibrating) and unvoiced (without vocal band vibration). For

example, in the short table below, if the first sounds in the opposing pairs of words are pronounced and compared, the differences between the two /th/ sounds, between /p/ and /b/, /t/ and /d/, /k/ and /g/, become apparent.

Voiceless	*Voiced*
thick	this
pick	bicker
tick	Dick
kick	give

As indicated earlier, the only difference between the production of the sound pairs is whether the vocal bands are vibrating. Voiced sounds involve vibrating; voiceless ones do not. You can feel the vibration, or lack of it, by placing your fingers on your "Adam's apple" while you utter the sounds.

Now pronounce the words in the first column aloud. Note what your tongue does for the first sound of each word as you move down the list. Do the same thing for the second column, again comparing first sounds. The characteristic you observe has to do with phonetic placement. Speech sounds are also classified by the position of the articulators (tongue, lips, jaw) when the sound is produced. The tongue is between the teeth for the /th/ sounds; thus they are called interdentals. The lips meet for /p/ and /b/; they are bilabials. The /t/ and /d/ sounds are alveolar because the tongue touches the alveolar ridge as they are uttered; and /k/ and /g/ are palatal sounds because of the contact point of the tongue. As the words in each column are uttered, the tongue moves further back in the mouth for the first sound of each word.

The counsellor-turned-speech-worker must first describe the client's problem as specifically as he can. When, then, is speech behavior problematic? Many people speak with accents; do they all need speech therapy? Van Riper's (1963) definition of a speech problem is helpful:

> Speech is defective when it deviates so far from the speech of other people that it calls attention to itself, interferes with communication, or causes its possessor to be maladjusted . . . when it is conspicuous, unintelligible, or unpleasant (p. 16).

Obviously there are cases where speech is conspicuous but does not interfere with the speaker's ability to communicate — his listeners still pay more attention to what he says than to how he says it. This is not defective speech. We do not usually proceed to correct the speech of an Alberta resident with a French accent in English. We might encourage such a client to change his accent if his job or job goal demand accentless English. Radio announcers or grade one teachers of phonics and spelling might be more effective and/or less ambiguous accentless, perhaps not. Decisions to change a client's speech behavior must be made in the context of his environment. Probably the most healthy idea we can give to a client or to school children is the notion that people speak differently, dependent largely on where they come from, that there is not a best or right way to sound, and that learning more than one dialect can be useful.

One group with whom it may be difficult to make decisions about speech therapy is small children. Children learn the sounds of their language in a fairly organized sequence, beginning with sounds such as /p/ and /b/,

whose mechanisms of production are easily seen at about five months, and progressing to the most difficult sounds such as /r/, /l/, /s/, /z/, /sh/, /ch/ by about the sixth year. Battin and Haug (1964) and Jones (1960) provide outstanding references in the area of speech development and delay, for counsellors and for parents. Any kind of trauma can delay the development of speech. We can almost expect the speech development of premature babies, for example, to be slow. The point is, there may well be cases of first and second graders with articulation problems for whom maturation without therapy will be quite enough. Data in this area is conflicting, but in an older study, Roe and Milisen (1942) indicate that, while maturation may take care of most articulation problems in grades one through three, it seems that maturation does not affect any noticeable improvement in the speech sounds of children in higher grades. Kleffner (1952) has also shown that it is at grade four when children begin to react negatively to peers with faulty speech. These findings would suggest that speech therapy programs begin with grade four, yet we know that some first through third graders need speech help. Carter and Buck (1958) provide a helpful yardstick by suggesting that any child who cannot correct his articulation error on a nonsense syllable test be given speech therapy, on the basis that children who can make such corrections tend to lose their speech errors without therapy.

Once the counsellor determines that his client needs speech help, he can begin a more detailed process of labelling the troublesome areas. Speech problems generally fall into four groups; symbolization, rhythm, voice, and articulation problems.

Symbolization or language problems often involve an individual's total communication behavior — his reading, writing, speaking, and comprehension may be impaired, as with some kinds of aphasia. Illness, injury, emotional difficulty, cultural deprivation, or congenital brain damage may produce language problems. Neurological diagnosis is important, and a speech and/or reading specialist is usually required.

If a client's speech is too fast or slow, jumbled into unintelligible clumps, peppered with "um" and "er" to the point of listener distraction, or if he stutters, he has a rhythm problem. Though stuttering is something of a causal mystery, some things are known. We know that almost every child between two and five years old has periods of disfluency (Johnson and associates, 1959). During this period, the child may say "Da-da-daddy!" or "B-b-b-bbbetty fffall d-d-down!" and he may behave similarly for a time with the rest of his speech. This disfluency is not stuttering, according to Johnson (1967) and Van Riper (1963), but may *become* stuttering if parents, for example, cause the child to believe that he is doing something wrong — through asking him to "slow down and start over" or interrupting him, or finishing sentences for him.

In fact, Johnson's theory of stuttering involves the concept of labelling. If, during his non-fluent period, the child's behaviour is reinforced negatively, then referred to as stuttering by such statements as "Johnny stutters," then Johnny may indeed stutter, for most of his life.

It is known, also, that stuttering is intermittent (Templin & Darley, 1960). One of the student teachers through the writer's clinic this year

stuttered severely until he was 18, went into therapy, had three years of absolute fluency, then began to stutter badly again. Finally, it is known that the stutterer without help often has a tremendously high anxiety level and that he may retreat from contact with other people, from school, from a job where he has to talk.

If a client's speech pattern is too high or low, raspy or breathy, shrill or nasal, he has a voice problem. Medical diagnosis by an otolaryngologist is important before voice therapy begins, as adenoids, vocal nodules, an inflamed larynx, a cleft palate or hearing problem can cause voice problems. Voice troubles are often too easy to dismiss. The teacher, who screams daily at Freddy with the foghorn voice to be quiet, may forget that perhaps he cannot hear himself well enough to monitor his volume. Even where there is not an organic cause, it may be simpler for the counsellor to excuse the soprano voice of the thirty year old male client than it is for the client to excuse the reactions of his listeners. But problems of this nature, once perceived and recognized, are easily amenable to treatment: given good reason, such as illustrated in the above examples, voices can and should be changed.

The fouth type of speech problems are problems of articulation, they account for about three-fourths of all speech problems (Eisenson & Mardel, 1963). Articulation problems fall into three groups: omission, distortion, and substitution. Saying abbit for rabbit involves omitting a sound; using wabbit for rabbit is substitution — of /w/ for /r/. When a person has a slushy or hissing way of producing his /s/ sound, as in something close to sham for Sam, he is distorting a sound. The four most commonly defective consonants are /r/, /s/, /l/, and /th/ (Eisenson & Mardel, 1963) which are, interestingly, among the last the child learns. Articulation problems are often not consistent — the child may substitute /th/ for /s/ at the beginning of a word (in initial position), but may not make the error when the sound is medial (messy) or final (lace). Following is a typical descriptive report for a client with articulation problems:

> Our analysis of the conditions under which articulation errors occurred is as follows: Jackson substituted /th/ for /s/ and /th/ for /z/ in initial, medial, and final word position consistently in swift, emotional speech, swift nonemotional speech, when carefully trying to speak correctly in oral reading, and when repeating single words after the examiner. One exception occurred: he said "six" correctly when repeating it carefully. He made the same errors on nonsense syllables when they were spoken at fast speeds but had good final /s/ sounds when prolonged with teeth closed. The /s/ was only occasionally good in isolation, even with strong stimulation by the examiner. He is always able to hear the error in another's speech but does not seem to be able to hear his own except on isolated words. (Templin & Darley, 1960, p. 227).

A descriptive summary report is necessary if the counsellor chooses to refer this client and if he is to design a series of helpful therapies for him. But how does the counsellor decide whether to refer or to conduct the therapy himself? It is the writer's contention that organically caused problems should be referred to a specialist for treatment and therapy whenever possible. If such clients continue to see the counsellor about emotional troubles, then the counsellor should certainly be in touch with the speech

therapist or medical team, but organic troubles demand specialized help. Actually, where there is adequate speech and hearing help available, the counsellor's job should probably end with the summary report of speech behaviour. But when there is no professional to provide therapy for a speech defective client, then it seems that the counsellor can train himself to work with many rhythm, voice, and articulation problems, and with language problems that are not organically based.

If a counsellor suspects hearing loss, the most useful approach is to encourage the client to have a professional assessment from a speech and hearing unit, such as the ones in most university medical centres.

It is stated earlier that barring organic cause, counsellors can learn to work effectively with some kinds of speech problems — particularly with stuttering, voice, and articulation problems.

Since stuttering is the problem with the highest level of mystique, how does a counsellor help a stutterer? About 1% of school children may be expected to stutter with a male-female ratio of 4:1 (Eisenson & Mandel, 1963). Though there are many approaches to stuttering therapy, success seems to depend largely upon the particular client-clinician relationship. Van Riper (1963) and Johnson and associates (1959) and Johnson et al. (1964) have framed approaches many therapists have found effective.

Van Riper (1963) presents a number of general statements about stuttering therapy before he outlines his extremely specific treatments. A typical Van Riper first step is to approach the client with, "So you stutter; so what?" then to teach him that there are many ways to stutter and that he can learn to do so more easily. Van Riper believes that the frequency and severity of stuttering is dependent upon a number of factors that can be manipulated and controlled through selective reinforcement and extinction. He suggests the therapist move from penalty reduction to frustration reduction, to increasing the client's tolerance for frustration. Often parents must be counselled into lowering their standards of fluency for the child who stutters.

Johnson et al. (1967), as stated earlier, believes that causing a child to believe he stutters can cause him to stutter: "If a person is convinced that he stutters, he definitely has a problem even though he may speak quite fluently . . . (p. 233)."

> So far as the type (and amount) of disfluency is concerned, one can hardly be sure from the known data that there is *at the moment of original judgment or diagnosis* any considerable difference — and there may be little or no difference — between the . . . disfluency in the speech of children judged by their parents to be stutters and those who are judged by their parents to be normal speakers . . . (Johnson et al., 1967, p. 237).
>
> What appears to have been crucial was the fact that the parents were motivated to evaluate the disfluencies as unacceptable, or distressing, to classify them as 'stuttering' and to react, nonverbally as a rule but verbally in some cases, to them and to the child accordingly (Johnson and associates, 1959, p. 261).

Johnson et al. (1967) explains that the stutter: 1) expects to stutter, 2) dreads doing it, and then 3) reacts negatively, usually by tensing — both in anticipation and in an effort to avoid stuttering. Voluntary stuttering, sometimes in teams before an audience is used by Johnson. All stutter-

ing therapists emphasize the importance of helping the client to be realistic about his stuttering.

Robin Andrews, a member of the Counselling Centre staff at the University of Alberta this year, was very effective with one stutterer using the Wolpe-based approach evplained in his *Reciprocal Inhibition Operant Reinforcement Treatment Manual* (1), designed to reduce the anxiety level of the client.

Finally, some major complaints of stutterers include listeners who look away during conversation, people who try to help by finishing sentences for them, or by manipulating conversations so the stutterer does not have a chance to talk.

Next we come to voice problems, which are often perplexing. Though many of them can have organic causes — adenoids, cleft palate, hearing loss — a high number seem to stem from emotional cause and are quite difficult to treat. Medical diagnosis is imperative in case the trouble is organic. It is easy to make an emotionally-based argument for the girl who comes into the clinic with an extremely whiny nasal voice, especially if she is having troubles in school at the same time. But when one such client was sent to the hospital for a medical check this winter, the otolaryngologist discovered that her palate was simply too short to close her nasal passage off from her oral cavity. Both client and therapist would have been frustrated had voice therapy been begun before the medical examination.

Of the 1,200 student teachers screened in 1969 by the University of Alberta Education Speech Centre, 18% were referred for some degree of remedial speech help. Of this 18%, about 1/3 were women with voices that became high and shrill under classroom pressures, then usually resulted in laryngitis. After much trial and error, a technique was found that is fairly successful most of the time, and does not require more than several weeks of visits to the Speech Centre.

First, using a tape recorder, the client is asked to read a five minute passage at a normal rate, varying his voice from very high to very low in a gradual manner. He might begin reading with his voice very high, then gradually lower it as he was reading, then repeat the process. He is asked to concentrate on the degree of tenseness in his front neck muscles next, while repeating the same exercise, contrasting the way they feel when his voice is high to when it is low. With guidance, he will usually become aware that there is a correlation between the tenseness of his "throat" muscles and the highness of his voice. By tightening, then gradually relaxing these muscles as he reads, he is asked to make another recording. It may be necessary for him to physically massage the front of his throat to begin the relaxation process. By repeating the reading exercise, first with tight, then gradually relaxed neck muscles, he learns to associate a physical condition with his undesirable voice (tightness) and a relaxed condition with the voice that is less painful and more pleasant.

Though the percentage of clients with voice problems is likely to be very small — two tenths of one percent of school children — an undesirable voice can be terribly disturbing to a client. There is no good reason for the 30 year old male client to keep his soprano voice if it bothers him and if there is not an organic reason for it.

The last area of concern for counsellors interested in remedial speech is the largest — problems of articulation. Again, it is important to check for organic cause, particularly for hearing loss. The next step is probably to study several good chapters on articulation therapy. It is possible to learn to make articulation diagnoses very quickly; Siegel (1962) has indicated that, with very few hours of training, inexperienced examiners can screen as reliably as experts.

One of the most important principles to remember when dealing with articulation problems is that, since one must learn to tell the difference between sounds, (and the boy who says "wabbit" at age 12 has learned a sound wrong) we have to teach the client to be aware of his own error. If this were not so, it should be enough for us to say, "Don't say wabbit, say rabbit!" and expect him to make the change. But if this should be said to him, he probably would reply in fury, "I DID! I said WABBIT!" The first step in treating articulation problems is ear training; we teach the client to recognize the error in another individual's speech, then in his own. When he can hear his error, he can be taught the new sound, by one of several methods. The new sound is then reinforced until it is automatic, and the client is then trained to transfer what he has learned to all his speech behaviour. Following is basic procedure for treating a frontal lisp, which involves substituting /th/ for /s/:

1. Take a developmental history of the client.
2. Check for organic cause.
3. Determine the client's attitude toward his speech problem.
4. Make a thorough descriptive diagnosis.
5. Begin a program designed to improve his ear.
6. Teach him the desired sound, if he cannot make it; in this case, perhaps, by having him produce a prolonged /th/ and then gradually pull in his tongue until he is making an /s/.
7. When he can make the desired sound in isolation, move to nonsense syllables and words beginning with the sound, then to words with the sound in final and medial position, then to sentences.
8. When the client can work successfully with the sound in sentences, concentrate on helping him transfer the new sound to his total speech behaviour. The transfer process is often the most difficult for the client.

Many speech therapists have been elated with a client's progress with a lisp in the clinic, only to find that it returns as soon as he steps into the hall. Sometimes there is an emotional cause which prevents the client from changing the way he sounds:

> For over two years we worked with a co-operative girl who had what seemed like a fairly simple frontal lisp. She seemed to do her utmost; she obviously disliked the penalties which it evoked in her college classes, but she consistently failed to master the correct /s/ and /z/ sounds . . . Then her father visited us and said: 'Dorothy always gets what she wants from me. If I say no, she just crawls up on my lap and puts her arms around me and talks baby talk. I'm a sucker, but she hooks me every time. That lisp of hers cost me $800 last year. Put it into a car she wanted.' (Van Riper, 1963, p. 203).

In cases of this nature, it is essential that the emotional basis for the speech defect be recognized and treated prior to, or in conjunction with, speech therapy; either treatment, alone, will be of little aid to the client.

Finally, it is best to keep speech therapy sessions very short — under a half hour for adults and around 10-15 minutes for children. And, although the statement below is written about children, it applies both universally and appropriately as an overriding principle to remember when dealing with speech defective clients:

> Listen to the child well, to what he is saying, and almost saying, and not saying at all. He has something he wants to tell you, something that has meaning for him, that is important to him. He is not just being verbally frisky.
>
> Respect him as a speaker. Listen to him enough to hear him out. It is wonderful for him as a growing person to feel that he is being heard. that others care about what he is saying. Assume he's doing the best he can and that it is more important for him to want to talk to you than to sound correct (Johnson et al., 1967, p. v).

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LE CONSEILLER ET LES DEFAUTS DE LANGUAGE DU CLIENT

EMILY GOETZ

Les conseillers devraient connaître les problèmes des personnes ayant un language défectueux pour au moins deux raisons: Premièrement, dans la plupart des régions du Canada, il est difficile de s'assurer l' assistance de personnes compétentes pour aider les gens avec un problème de language. Deuxièmement, avec un minimum d'instruction, les conseillers peuvent devenir des aides efficaces dans le domaine de la parole, d'autant plus que beaucoup de problèmes de language sont d'ordre émotif.

Parmi les quatre sortes de défauts affectant la parole: articulation, rythme, voix et symbolisation, environ trois-quarts portent sur l'articulation, problème que le conseiller peut facilement apprendre à corriger. De même, les conseillers peuvent apprendre à traiter avec efficacité le bégaiement, qui est un problème de rythme. De nombreux problèmes de la voix sont de nature émotive, et le conseiller peut recevoir l'éducation nécéssaire pour travailler dans ce domaine. Finalement, les défauts ayant une cause organique, comprenant normalement la symbolisation, devraient faire l'objet d'une recommendation à un specialiste.