

PREFACE

The Tools of Our Trade: Ethics, Outcomes, and Effects of Therapeutic Discourse

A traditional interaction between a speech-language pathologist and a client is most frequently characterized by a request for some sort of speech and language performance, followed by the client's response, and evaluated—usually for accuracy relative to some objective—by the clinician. This interactional sequence is so pervasive that it is usually described as a request-response-evaluation exchange. It been described and observed in all different types of speech-language therapy sessions, across diagnoses and treatments.¹

When clinicians' responses to their clients' communicative acts are primarily on the accuracy of the production, rather than the content, the clinician is communicating, possibly unintentionally, that the form of the production is more important than the content. Although in some cases, it may be advantageous for clients to practice drills that are separated from meaning making, communication in real contexts is always focused on communicating meaning, whether or not the production itself was completely accurate.

A primary focus on evaluating the accuracy of the form of the production creates at least an implied separation between the person who is the client, the production, and the person who is the therapist. It is as though the production, which is the target of the clinician's attention, is separable from the client. It is a thing that can be placed on the table, examined, poked, dissected, sewn together, repaired, and—perhaps—replaced. But the words that flow out of any of our mouths are intimately integrated with our image of ourselves and our beings.

Another consequence of the separation that comes from traditional therapeutic interactions is that the therapist is separated from who he or she is as a person. Clinicians spend relatively little time interacting with their clients in a truly human interaction; most often, this is limited to the first and last few minutes of any therapeutic session. During the “work” portion of a typical therapy session,² the clinician may stop paying attention to interactive meaning making. Doing so, the clinician may unwittingly take away the client's selfhood and his or her autonomy of communication. “If I say to you, speaking of the wedding I attended last week, ‘And then there was the most amazing coincidence!’ I expect you to reply ‘Really? What happened?’ I will be surprised and not especially pleased if instead you say, ‘Isn't it interesting how you make ordinary events so dramatic?’ To pay attention to speakers' rhetoric seems to rob them of authority. It suggests that narrators do not know what they mean to say or cannot find the way to say it and that someone else—the interpreter—can do a better job.”³

Why would a clinician “rob” their client of “authority” over their own message? Most likely, clinicians believe that they are conducting exercises that are in the best interest of their client, or they would not choose to do such a thing. But are these traditional therapeutic interactions in the best interest of our clients? Does focusing on production for the majority of any therapeutic session produce the ultimate outcomes that we desire for our clients?

A focus on production and content, with a deemphasis on affective/emotional communication, has thus far been shown to be much less

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satisfactory in most circumstances than an approach that combines equal parts emotion and content—a more balanced human interaction. In one model, cognitive-behavioral changes in the client are most likely to result in cognitive outcomes—understanding of information or ability to change a behavior. Cognitive-behavioral changes alone may not be sufficient to produce affective outcomes: changes in the client's belief in their ability to perform tasks, self-perception, self-confidence, or persistence.^{4,5} The affective aspects of any interaction, including all therapeutic interactions, require the same attention as that given to the cognitive behavioral performance aspects of a communication interaction.⁶

In this issue, the contributors attack different aspects of the problem of a balanced therapeutic interaction—one that pays attention to the meaning making inherent in all human communication—and the goal of improving the production abilities of clients. Clinicians operate with the best intentions to aid their clients and are impelled by their professional ethics. O'Halloran and colleagues use two stories of clinicians' experiences to explore the importance of ethics in a person-centered approach. A person-centered approach is one in which the clinician takes a holistic view of the client as an autonomous person, and at the same time acknowledges that the clinician him- or herself is a complete human, not just a responder or evaluator. In this approach, both parties come together for a therapeutic interaction that can be mutually meaningful and satisfactory. O'Halloran and colleagues explore the risks that a clinician faces when opening up to the possibilities of these more holistic interactions.

Although not all of the articles in this issue use the phrase *person-centeredness*, all of them address the notion of person-centeredness in therapeutic interaction. DiLollo and Favreau wonder whether student clinicians improve behaviors that embody person-centeredness over the course of their 2-year graduate training. The risks that students experience as they grapple with grading schemes and clinical values are discussed.

Leahy, Litt, and Walsh uncover the implicit roles that are reinforced by the structure of our discourse during therapeutic interac-

tions. We may engage in some of these discourse behaviors as a way to distance ourselves personally or decrease personal risk.

Diehl and Vaughn show how certain kinds of discourse features substantially change client responses during therapeutic sessions. They demonstrate that following the specific procedures of a particular treatment protocol alone may not be sufficient for some children with language impairment to be engaged in the therapeutic activities. Diehl and Vaughn conclude that clinicians who pay attention themselves to the meaning in the interaction facilitate engagement in some children.

Brinton, Fujiki, and Baldrige show the disheartening long-term outcomes of young women with language impairment who have been enrolled in speech-language pathology services for some years. Although one of the students followed by Brinton and colleagues ended up with average language scores in the junior high years, the remaining four continued with language scores parallel to their initial scores in elementary school and demonstrated concerning social and behavioral patterns that could likely impede them from functional productive adult lives.

Beginning with ethics, through training, to our therapeutic work, and the ultimate outcomes our interactions may have on the lives of our clients, the articles in this issue show us how important it is to interact with our clients as one person to another. Speech-language pathologists use talk as our primary tool to improve people's lives. Our talk with our clients must map on to our values and our goals and lead to happier lives for our clients.

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