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2 From alienation to therapeutic dialogue

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INTRODUCTION

If you listen to People are strange, a song by The Doors, you may hear in the lyrics allusion to the experience of being alienated. The Doors do this by creating in their song, images of a stranger in the rain, perhaps rejected, and certainly alone. The singer of this popular song is far away from home, where nobody knows his name. Perhaps the singer is a person with a communication disorder, experiencing the namelessness of aphasia, or the strangeness of stammering. Perhaps this stranger has acquired the communication disorder or maybe he has lived with it for a long time. Either way, this person seems demoralized, alienated, lost, and depressed; and is experiencing a loss of identity: perhaps not knowing who he is anymore. Perhaps his next song will be a song leading him to voice his demoralization and to seek help from one of us. Perhaps one of us will not be a strange face in the rain; and we will be able to help this strange singer to find his way home. The home of who he thought he was; who he had hoped he would become – but for the loss of his connection through communication.

Such experiences are probably most obvious, but not limited to the communication disorders following strokes, where damage can obliterate large portions of the individual’s self (Brumfitt & Clarke, 1982); and could therefore evoke strong and negative emotions (Parr, Byng, Gilpin, & Ireland, 1997). According to Parr and her colleagues, thoughts of suicide are not uncommon in people who have had strokes that have interfered with their communication (Parr et al., 1997). Brumfitt and Clarke’s description of the loss of communication resulting in a crisis of self-identity are illustrated as follows: “If I am no longer what I was, what on earth am I now? Perhaps I am now utterly different; just the opposite to what I was. If I was strong, am I now weak? If I felt constrained, am I now free? If I was always pushed to one side, can I now be a burden?” (Brumfitt & Clarke, 1982, p. 3). The individual asking these questions is asking questions that try to answer the universal question: Who am I? Who am I becoming? These questions seem fundamental to the life issues each of us must face in our existence (Yalom, 1980). The following poem by Walt Whitman (1860, p. 425) comes to mind:

http://www.psypress.com/therapeutic-processes-for-communication-disorders-9781848720411
I thought I was not alone, walking here by the shore,
But the one I thought was with me, as now I walk by the shore,
As I lean and look through the glimmering light – that one has utterly disappeared,
And those appear that perplex me.

Walt Whitman (1819–1892) *Leaves of Grass*

Is this one of whom Walt Whitman speaks, in fact, a lost aspect of his own self? Alienation is something few of us wish to contemplate because it is so negative, dark, and unappealing. Why focus on something we all hope to escape? However, as speech and hearing clinicians, we inevitably look into the shadows of other people’s lives and are tasked with the job of trying to make possible something meaningful out of what we see. We are tasked with listening to our clients’ stories (see Chapter 3), relating to them in an ongoing way (see Chapter 5) and accompanying our clients on a journey (Spillers, 2007; see also Chapter 17).

**BEING AT HOME IN TOGETHERNESS AND THE LOSS OF CONNECTION**

Being together, cooperating, and looking after each other are the love stories humans have been telling each other for millennia; and it is the plots of these stories that have guaranteed our survival in a harsh evolutionary environment. Perhaps we emulated wolves, and realized that to work together with others was more successful than being on our own (Schleidt, 1999). To be in relationship with others – to connect and to be part of something, is fundamental to human life and survival: We can be and do very little if we are not part of the lives of others.

Some of the ways in which we express this connectedness is through talking, gossiping, listening, eating together, singing together, and laughing. It is written into our genes that there is safety in numbers (Dunbar, 1996); and we all hope that if we are ever in trouble, that our friends, our family and our society will help us. We will not be alone in facing what existence has to offer. But what if, when we face the inevitabilities of suffering, loneliness, possible death, and difficult choices, we find ourselves looking at strange faces in the rain? What if the connectedness and the familiar world we knew and enjoyed when all was well, unexpectedly dissolves when troubles arrive? What if all our connectedness is gone and we are left alienated? With whom will we sing, eat, gossip, and laugh then? Who will accompany us in these harrowing moments of penetrating alienation and loneliness (Nystrom, 2006), when we can no longer communicate as we did before? Who will we be if we have changed so much?
MAKING THE SUBJECTIVE ABSTRACT AND OBJECTIVE

In the same way that Marx focussed on how captains of industry value the product of labor, rather than the qualities of the person producing that product (Marx, 1978), so in the field of medicine and health, clinicians can often focus on the illness and labels of illness, rather than on the experiences of the people producing such illnesses or ill health. Therefore, a dynamic, complex, and conscious system (a person) is reduced to static, linear, and simplistic labels; and the human experience of illness and suffering is somehow often overlooked. Because of this disregard for phenomenology, useful information could be lost, thus leading the practitioner to miss something vitally important to the client and to the client’s health. But this process of labeling the client and undervaluing their experiences of illness, could also lead clients to inhabit positions that single them out as contaminated or deserving of isolation (see Chapter 9 on stigma in the profession).

According to Ollman (1976), alienation is a problem of the individual becoming an abstraction. What Ollman meant by this is that individuals who have become alienated have apparently lost the qualities that signal their recognition as being part of the rest of the world. “Thus denuded, the alienated person has become an ‘abstraction’ ” (Ollman, 1976, p. 134). In other words, their unique and personal characteristics become invisible; instead replaced with abstract labels. It is this process of becoming an abstraction that is at the core of alienation according to Ollman. In the process of becoming depersonalized and objectified, individuals are estranged from their life activity (Ollman, 1976).

This process of depersonalization and alienation is demonstrated in the following conversational extract with Veronica, a patient who had suffered from cancer of the tongue, and who consequently needed speech therapy. She explained to me the process of receiving a diagnosis of cancer of the tongue from a private surgeon.

Veronica: Exactly, well. You sit and you wait and you’re called in. The consultant that I went into first hardly looked at me; he just looked over my head. He said, “Open your mouth.” He never called me by my name and he said, “You can pay on your way out.” . . . He didn’t want me to ask him how he was. He said, “I’m well how are you?” Now obviously the man had a lot of people waiting for him. But I don’t find that an excuse. He didn’t want to know anything more about me. I was just a number. That is awful.

In this account, Veronica was acutely aware of a sensation of not being real to the surgeon. In her experience, she was merely an abstraction to him, a number – one of many numbers that needed processing for his job to be done. It is in this moment that Veronica becomes alienated. She experiences what it is like to lose one’s intrinsic value in the eyes of another. In some perverted
way, Veronica has become a life support system for cancer—a topic of interest for the surgeon. Wallach Bologh (1981) criticizes some practitioners of medicine who “disregard the patient as anything but a possessor of the body or illness” (Wallach Bologh, 1981, p. 190). Veronica seems invisible to the clinician; but she sees the surgeon. He does not relate to her as a real person who laughs, sings songs, and who gossips with her friends. Therefore, Veronica is simply something abstract—a number to him. In Veronica’s words, “That is awful.”

Of course, many would argue they would rather have an excellent surgeon with poor bedside manners than a clumsy surgeon who was very “nice.” However, there may be a link between bedside manner and recovery in patients. Evidence in the field of neuroimmunology is emerging that indicates that there are multiple relationships between the central nervous system, the immune system, and the general health of the individual, which support this argument (Evans, 2003; Kop & Gottdiener, 2005). In short, the relationships between client and professional may have a real effect on the immune system and the healing process.

These ideas from neuroimmunology ring true to me. I recall myself going for an eye operation recently. The anesthetist, a senior houseman, came to take a history. I took an intense and immediate dislike to him, as I didn’t like his scraggly beard, his poor pragmatics, and his unintelligible accent. Moreover, he did not seem to understand the reasons for my surgery. I was ready to book myself out of the planned surgery because I believed that an incompetent person would be in charge of keeping me alive during surgery. Luckily, shortly after this, an older and wiser professor of anesthetics, who was supervising the procedure, put my mind at ease by touching my arm, using a calm and reassuring voice, and by giving me clear information. This difference in tone certainly mattered to me; and it is clear from Veronica’s comments above, that the surgeon’s tone had an alienating impact on her.

**LOSS OF IDENTITY, SOCIAL RECEDING, AND EMBARRASSMENT**

Seeman (1959) hinted at the universality of the concept of alienation when he noted that themes of alienation permeated common sociological topics such as “powerlessness,” “meaninglessness,” “normlessness,” “isolation,” and “self-estrangement.” These associations with alienation are similar to those described by Van Riper and Erickson’s (1996) explanations of the multifactorial impact of the loss of speech and communication. These authors highlighted how communication disorders are associated with penalties, guilt, frustration, hostility, and anxiety; and it is not difficult to see how these labels are related to Seeman’s themes of alienation.

If we no longer seem to be who we were, then perhaps we are no longer ourselves. Instead, we are strangers who our friends may not recognize: once
our identities are no longer sure, then neither we nor others know how to relate to this new me. Maureen, a woman who had aphasia following a stroke, described to me the embarrassment of friends who when meeting her on the street would not stay and chat for a while: “They wouldn’t want to talk to you. But I know – I can understand. Well I’d say, ‘Look, it’s OK, if you don’t stop,’ because I understand that I am a different person.” Maureen told me that they would say “they were flying” or “going someplace else.” She reported understanding that these individuals did not want to talk to her; and while she did not blame her friends for this avoidant behavior, she noted that “they couldn’t do it for themselves”; and that she understood this behavior because she was “a different person.” While these comments are stoic, they nevertheless hint at a loss of identity and a sense of disconnectedness from others and from herself after the onset of aphasia. Maureen said to me about this experience of losing her previous communication abilities: “When our speech is gone really and truly a lot is gone of your person, of your whole being, is gone.”

This is not an insignificant statement – it is one that I have encountered with other research participants who have told me the stories of their loss of communication. It suggests that the work of speech and hearing clinicians is more than simply promoting a return to communication; and that it may involve “dis-estranging” the client and those relating to the client. This implies that clinicians need to think of ways of helping the client find continuity between their present and their past identities.

Many therapists do this. For example, some participants in my study said that their speech clinicians recognized this loss of self-identity and responded to it in a meaningful way. Veronica told me that her clinician was able to respond to this perceived loss of identity and inspired her to remember her intrinsic value.

Veronica: She pointed out to me that I haven’t changed. The only thing that has changed about me is the way I’m speaking, and that’s part of me now and I have to face up to it and that’s the kind of the attitude she adopted which I felt was only wonderful you know. [My therapist] soon pointed out to me that I had no disability. I spoke differently and face up to that and that’s it. She helped me that way.

According to Charmaz (1983), ill individuals may cause discomfort in those who relate to them, because illness strips away the social/public face of the individual. Similarly, Emerson and Enderby, in their study examining attitudes to communication disorders, reported that most of the participants in their study who had aphasia associated interactions with the general public as negative (Emerson & Enderby, 2000). This discomfort in others may then result in re-evaluations of the self and a corresponding withdrawal from those with whom the individual previously associated (Younger, 1995). It also
has negative implications for employability following the onset of communication disorders.

It is this withdrawal that is caused by unfavorable evaluations by others in relation to their own comfort that may result in alienation. Younger (1995, p. 54) explains that “people who were previously friendly become embarrassed and strained in their [the sick person’s] presence.” Loss of communication particularly involves the loss of a socially salient activity that forms a major point of articulation between the individual and others in the individual’s environment. Breakdown in this ability therefore represents an obvious discontinuity of contact between individuals.

This loss of social contact may also manifest as a perception of being invisible to others. For example, Alfred, a professor who had dysarthria, explained his sense of invisibility to others and his perception of not being taken seriously anymore. He explained how he had become aware of his dwindling social impact following the onset of Parkinson’s disease, and that people paid him less attention and took him less seriously. Moreover, he found that his wife was doing all of the talking for him.

Alfred: People with diseases like mine are not inclined to be taken seriously and speech is part of this . . . If you’re in a group of say five people and you’re chatting, they center the attention on anybody but me. That’s what I feel sometimes. It doesn’t bother me because I can just stand and listen . . . My wife notices it too. She says she finds she has to do a lot of the talking if we’re talking in a group, she’ll do nine-tenths of the talking. I know that people don’t take me as seriously as they did 10 years ago.

According to Bunning (2004), changing role allocations are an important influential factor to be considered by speech-language therapists. In the case of Alfred, it seemed that he was painfully aware of this loss of identity and his changing role. This sense of being invisible was evident in others I interviewed. For example, Jack, a client with aphasia who had suffered from stammering prior to his stroke, said the following to me: “I cannot say things fast enough. If there is a group speaking, I feel that I cannot speak very well in that group to attract their attention. I’m too slow. I was always sidelined, but I’m more so now.” In this situation, Jack was unable to find a meaningful self in an unequal interaction and then lost his “identity as [a] meaningful contributor to the interaction process” (Twining, 1980, p. 426).

Taken to an extreme, alienation may involve not only estrangement and withdrawal from others, but may also involve an estrangement from the self. One dimension of self-estrangement may involve an estrangement from one’s physical body. Clarkson (2003, p. 213) referred to this type of alienation as being “alienated from your own physiology.” This sense of estrangement from your own physiology was evident in Priscilla, a singing teacher I interviewed, who herself had suffered from vocal cord nodules. Her difficulties
producing a singing voice had led to embarrassment and disappointment in her abilities as a singing teacher. She told me: “And it’s embarrassing. There are days that I’m their singing teacher and I can’t sing what my students are doing, you know, and that’s really a horrible situation to be in you know. I know how they should do it. I know how they should approach it, yet I can’t do it myself.”

Seeman (1959) related self-estrangement to the idea that the individual might only understand their value in relation to their usefulness to others, and not in terms of their own intrinsic value. In this situation, Priscilla understood her own significance contingent upon the presence of a good voice – and her embarrassment and disappointment revealed an attenuated self-valuing associated with the problem of vocal cord nodules. To me, Priscilla seemed really demoralized by her persistent vocal cord nodules.

**DEMORALIZATION**

Most of the participants in my research on the therapeutic relationship (Fourie, 2009), were demoralized. This demoralization can also be seen as a type of alienation similar to Seeman’s (1959) themes of “powerlessness,” “meaninglessness,” “normlessness,” “isolation,” and “self-estrangement.” While most individuals must face such existential issues in their lives (Spillers, 2007), the onset of a communication disorder is likely to accentuate such processes. For example, Ian, who had suffered from dysphagia following cancer, explained his sense of demoralization: “I first came here very sick not feeling good at all. I feel a lot better than I did when I first came. I was very pretty, I won’t say depressed, but I mean down in the dumps.” Ian was not alone in this regard. Veronica, the participant who had suffered from tongue cancer, and had subsequently received a partial glossectomy, told me that when she first came to therapy, she believed: “[she] would never ever be able to pick up the pieces that [she had] left over and [teary voice] were gone.”

Writing from the perspective of psychotherapists, Frank and Frank (1991) explained their theory that most individuals seeking help in therapy seemed to do so, not because of their symptoms *per se*, but for the resultant sense of demoralization they experienced because of their symptoms. These authors referred to this as their “demoralization hypothesis.” More specifically, they defined demoralization as an individual’s inability to “live up to their own or others’ expectations for mastering a situation or controlling their own responses to the world around them” (Frank & Frank, 1991, p. 53). This is similar to Seeman’s (1959) description of meaninglessness in alienation, as the valuing of productive efficiency over autonomy and insight.

Conceivably, this may also be the case with clients who have communication disorders; or the parents or children of clients. In my own research on the therapeutic relationship (Fourie, 2009), alienation was cited as the starting point for narratives regarding participants’ experiences of therapy; and the
enactment by speech-language therapists of various therapeutic qualities and actions resulted in the alleviation of alienation (Fourie, 2009).

Perhaps this highlights that the ultimate goal of speech-language therapy is linked to helping clients live through and maybe resolve existential issues such as alienation and loneliness, which are often the inevitable resultants of the loss of communication (Nystrom, 2006). Therefore as clinicians concerned with communication, we need to be looking between the lines. Ostensible reasons for receiving therapy or (re)habilitation may be obvious: stuttering; loss of voice; aphasia. But the real reason for seeking or accepting help may not be so much the disorder itself, but because of the demoralization associated with the loss of social interconnectedness, cohesion, and the security inherent in group life. Our connection with others provides every individual with a sense of shelter, well-being and protection from the harshness of life. Perhaps our job then is also to “re-moralize” and help restore connections and the well-being that is associated with gossiping, listening, laughing, and singing.

**DISCONNECTION AND THE LOSS OF DIALOGUE**

Younger notes that alienation may not be so much about the suffering created by adversity *per se*; but about the secondary loss of connectedness and community the adversity elicits in the individual. It is therefore a second level of suffering that compounds the first (Younger, 1995). This is in harmony with the ideas of Twining (1980), who suggested that alienation should be viewed as a relational concept that involves a consideration of how the individual relates to family and social situations (see also Chapter 16 on stress and burnout to understand how this may also apply to the therapist). Ollman (1976) conceives of alienation, stripped down to its essential components as a disintegration or decomposition of elements that belong naturally together – a sort of dis-synergy. Therefore, those who are alienated do not feel that they belong, or are in harmony with a collective unit. The “other” is therefore a “face in the rain.” Similarly, Twining states that alienation can be defined as: “. . . an interactional, or relational, consequence of a negative encounter of some duration which involves the degree of felt separateness from fundamental social situations in which self is being defined” (Twining, 1980, p. 422). Twining suggests that alienation is essentially relational in character and that unless the individual can interpret interactions with others positively or with an alternate focus, alienation follows. This is particularly the case when the individual interprets an interaction as resulting in a loss of control/power and/or a negative evaluation of the self (Twining, 1980).

According to Younger (1995, p. 56), suffering undermines an individual’s ability to communicate what they are experiencing to others: “The tendency of pain and suffering is not simply to resist expression but to destroy the capacity for speech by breaking off the autonomous voice, making it cry out
when agony wants it to cry and be silent when agony wants its silence, turning it on and off without the autonomous will of the person.” This is the double-edged sword of the communication disorder: both autonomy and dialogue are damaged. First, in terms of the physical loss of speech (“loss of the outer voice”); and second, by the loss associated with the internal or psychological (“loss of inner voice”) which may accompany any eating or communication disorder.

Younger cites Erik Erikson’s belief that it is the professional’s work to care for the client in this position by “‘cherishing’ and ‘caressing’ that which in its helplessness emits signals of despair” (Erikson, 1982, pp. 59–60, cited in Younger, 1995); and thereby give expression to the inner voice, which is made silent in its experience of loss. Loss of speech, language, and hearing, therefore impairs mutual dialogue and common purpose. Perhaps then, at least some of the work of the clinician should be aimed at dealing with this “inner aphonia.”

**DIALOGUE AND COMMON PURPOSE**

According to Rowan and Jacobs, in psychotherapy, particularly in the Jungian traditions “being together,” mutuality, and the equality that fosters meaningful dialogue are highlighted as an essential part of therapy. Dialogue arises when the therapist experiences the client as they truly are (Rowan & Jacobs, 2002). In other words, this meaningful dialogue is only possible when both partners do not view each other as abstractions. This is no different for clinicians working with speech, language, and hearing disorders. Many clients of speech-language therapists describe the experience of being accepted by the speech-language pathologist as they truly are, without explanation or reason as significant for regaining a sense of mutuality and common purpose (Fourie, 2009). Loss of dialogue brings up the existential position of loneliness – and the anticipation of endless aloneness. Part of the meaningfulness of therapy can be generated when the clinician consciously enables a natural connection with their client (Nystrom, 2006; Spillers, 2007, and Chapter 17) (For a contrasting example, see Robillard’s, 1999, experience of a speech-language therapist, reported in Chapter 8, this volume). Therefore, it is not difficult to see how the role of the speech and hearing clinician in therapy may involve helping the client deal with such existential positions within the context of meaningful dialogue. By understanding the context of a speech or hearing disorder, and by communicating ordinary social interest, the therapist and client engage in a process of entering a real, two-way person-to-person relationship, which may facilitate a willingness to engage and be transformed in the process of relating to one who understands (Fourie, 2009).

Perhaps also, the clinician is transformed in this dialogic interaction (see Chapter 13 on transference, counter-transference and projective identification). Rowan and Jacobs (2002, p. 50) state the following: “Dialogue is what
emerges when you and I come together in an authentically contactful manner. Dialogue is not ‘you plus I’, but rather what emerges from the interaction, which may happen when both parties make themselves present.”

This conception of dialogue as genuine interaction, is reminiscent of Rogers’ (1961) person-centered approach. Rogers cited research by Whitehorn and Betz (1954) in which the researchers found that clients preferred it when personal meaning was explored in psychotherapy, and when goals related to personality were set, rather than simplistically examining sets of symptoms (Whitehorn & Betz, 1954). While many of the goals of speech and hearing clinicians are often linguistic or medical in nature, perhaps we need to also focus on working with clients to help reinstate the meaningful dialogue that may have been lost or degraded at the onset of a communication disorder. Moreover, this work should also examine the impairment on a phenomenological level. In other words, we need to help reinstate both the autonomous inner and the outer voices of our clients. If this is true, then how we as a profession assess clients may need to change focus. Speech and hearing clinicians often start rehabilitation with tests and assessments; only paying minimal lip-service to “establishing rapport” (see Chapter 5 in this volume). Many of us are very focussed on providing explicit correction and feedback, which is not a part of natural conversation (see Chapter 4 in this book). There is therefore the risk that a focus on this type of analysis and assessment could indeed further demoralize or alienate an already alienated client. In other words, the client’s unique and personal characteristics become invisible, instead replaced with abstract labels. It is this process of becoming an abstraction, which is at the core of alienation, and one that I believe we as speech and hearing clinicians need to avoid with great diligence.

However, in the process of assessment and diagnosis, it becomes very easy to make the client “abstract” by reaching for formal tests and by attaching diagnostic labels. The client’s “usefulness in speaking” is measured and made explicit; and this could obscure the client’s inner voice and intrinsic value, thus preventing the client and therapist from entering into a meaningful dialogue with each other. Therefore, while psycholinguistic assessments may be invaluable to clinicians for determining their own agendas in therapy, these assessments will not explain to us how to enter into the demoralized client’s world, nor will they assess the client’s ability to express their demoralization or alienation. They may stipulate the linguistic impact of a communication disorder; but often they fail to reveal the personal impact of a communication disorder. In other words, quantification of a communication disorder, instead of being helpful to a client, could, when used improperly by a clinician, lead to further alienation.

The International Classification of Function (ICF), as described by the World Health Organization (WHO) can be used to think about this issue (WHO, 2001). Speech-language therapists may, at the outset of therapy, begin with a phenomenological assessment of the client’s world and participation restrictions; and then work backwards to activity limitations, and
finally impairment as assessed by formal testing. Then, the clinician could negotiate the necessary remedial actions required to reinstate a sense of dialogue in the client while simultaneously reducing the client’s sense of alienation. This does not mean that the therapist refrains from formal assessment, but that assessments are driven by existential and phenomenological considerations in the first instance, instead of as an afterthought. Many clinicians will attest to the power of this approach and the level of information it yields in the process of diagnosis.

THERAPEUTIC RELATIONSHIPS

Participants in my research on the therapeutic relationship in speech-language therapy were able to indicate some characteristics and actions their therapists possessed and enacted, which they believed helped them settle into therapy; and which may have facilitated their treatments (Fourie, 2009). For example, descriptions of their therapists contained shared features that surfaced as a coherent depiction of the qualities and progression of the relationships they had with their therapists. In this study, participants described therapeutic qualities (TQs) and therapeutic actions (TAs) that interacted dynamically and resulted in a therapist with “restorative poise.” It was therefore possible to describe, from the client’s viewpoint, the therapeutic relationship in speech-language therapy as an emergent and ongoing property of a complex interaction between a number of therapeutic attributes and actions.

More specifically, participants described therapeutic qualities in their speech-language therapists that referred to attitudes of being understanding, being gracious (polite, “nice,” and time generous), being erudite (knowledgeable and easily able to explain things), and being inspiring. In addition, they described therapeutic actions that referred to the things therapists did that were therapeutic such as being confident, being soothing, being practical (concrete), and being empowering (pointing out choices for the client). In general, the participants valued the patient understanding, social skills, and the calming, practical, and empowering support provided by their clinicians throughout their treatment for acquired speech-language disorders (Fourie, 2009).

To illustrate, Veronica, cited above in relation to her negative experiences of being diagnosed with cancer of the tongue, explained how her speech-language therapist was able to use the above therapeutic attributes and actions in a way that she valued as a client.

Veronica: Oh yes, she told me . . . You have a lisp and if you can improve on it, improve on it, if you can’t, she said, you’re still the same person and don’t apologize, say in your own mind, “This is me, this is how I am talking now and take it or leave it,” that kind of an effort, which I smiled at and thought “good on you” . . . I was
inclined to apologize, I’d say I’ve had surgery in my mouth you’ll have to bear with me, and all this. I’ve given up all that now and I talk as I am talking and it’s all due to Niamh, it’s just the self-confidence she instilled in me. I couldn’t explain exactly the way exactly that she got to me. But it was a beautiful way.

It is clear from this piece of narrative that Veronica’s clinician was able to reinstate the dialogue that she had lost. It was through being authentically present for her client that the clinician was able to recognize despair, and to allow the voice of suffering to speak. In making a space for this voice, the client was empowered to see beyond the suffering of cancer and the loss of speech – reminded of her true essence (“I talk as I’m talking”). It is in this reconnection that the client is brought home – out of the rain – and in which alienation is no more.

CONCLUSION

Clinicians can and must deal with the psycholinguistic and audiological aspects of communication disorders. However, we also need to consider that the core reasons for clients coming to us are not about impaired, or lost, or disordered speech and hearing. People need us because they are demoralized and alienated (Frank & Frank, 1991). They are asking themselves, “who am I now?” But if our response to this is to make our clients abstract by giving them a label; or if we cannot accompany the client through this journey of suffering (Spillers, 2007), then our efforts to reinstate communication are surely in vain.

When clinicians work to understand their clients’ worlds and the restricting, often alienated nature of these worlds, then they may provide more appropriate help. Indeed, the therapeutic relationship may provide the catalytic context for arriving together in dialogue at appropriate goals, assessments and treatments, which may in turn reconnect the client into wholeness from the position of alienation.

NOTE

1 Veronica and all other names are pseudonyms referring to participants in my research on the therapeutic relationship, for which ethical approval was sought and granted; and whose terms and conditions permit inclusion of this data in this book.