The Trouble With Speech Pathology

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When the new Editor of The Cleft Palate Journal asked the worn-out Editor to write about the strengths and weaknesses of speech-language-pathologists (hereinafter referred to simply as “speech pathologists”), I felt obligated to say “yes,” since I had asked for and received similar favors and kindnesses from many people over the previous six years. Now, I rather wish I had been a little less cooperative! It is not easy to look objectively at one’s own profession and one’s own colleagues. It is difficult to write honestly and candidly and almost impossible to recognize bias when it occurs. However, in a moment of nostalgia for my old job and of compassion for the new Editor, I committed myself to this task.

Even though I belong to the speech pathology fraternity and love what we do, I have forced myself to look at our weaknesses along with our strengths. Not all speech pathologists will see the situation in quite the same way I do. However, this diversity of position is not unique to our professional group within A.C.P.A. Thus, I am reasonably comfortable with this assignment because I believe that A.C.P.A. has helped us all to communicate well enough so that we can appreciate each others’ strengths and work together to overcome the weaknesses.

Background

History. The historical roots of speech pathology in Europe are older than they are in this country, and they have their origins in otolaryngology. That model was not followed in the United States, where the needs of the communicatively handicapped were largely unmet or were handled by “elocutionists” until 50 to 60 years ago when a handful of people with general training in speech recognized the necessity for learning about the nature and natural history of speech problems and how to treat them. Beginning with nothing, they built a new profession. They laid a firm foundation, mandated educational requirements, did research, developed a sizable body of literature, established journals, and organized what is now the American Speech-Language-Hearing Association, which we know as A.S.H.A. and which has in the neighborhood of 30,000 members. It took committed giants to accomplish all of that in little more than half a century. Thus, this young profession emerged out of need and dedication, and these remain as driving forces today.

Educational Requirements. The rapid growth of speech pathology has been associated with information explosions, especially in linguistics, and has necessitated parallel changes in the education required to be a speech pathologist. At the present time, the best evidence of adequate training is the Certificate of Clinical Competency issued by the American Speech-Language-Hearing Association to candidates who have completed the Master’s degree or its equivalent, served a Clinical Fellowship year, and successfully passed a national examination. Beyond these basic credentials, many speech pathologists elect to complete the doctoral degree and to specialize in one or another aspect of communicative disorders.

While the field has gradually changed from its early days and continues to expand in a variety of ways, training programs have tended to react to the various pressures in somewhat unique ways even as they have continued to meet the spirit of A.S.H.A.’s Certificate of Clinical Competency (C.C.C.). This has resulted in some institutions placing major stress on the speech sciences, while others have emphasized clinical skills, instrumentation, behavior modification, normal language, stuttering, aphasia, voice, or cleft palate, among others. Thus, students taking a degree at Institution A may have had few learning experiences comparable to a student coming from Institution B even though both would probably qualify for the C.C.C. This means that individual speech pathologists

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may be outstanding in some areas but only average or even below in others. In short, speech pathologists may be created equal in the legalistic sense of certification, but they are certainly not alike and cannot all qualify for the same types of clinical placements. The same statement may be made about our colleagues in medical and dental specialties as well.

Fortunately, training programs usually prepare students to continue studying and learning after formal instruction has ceased. Many speech pathologists, recognizing their special limitations, have responded well to job demands by remaining open to new educational opportunities, keeping up with the literature, and attending professional meetings. There are still inadequacies, however, which remain to be managed.

Development of New Information. In spite of the newness of the field, speech pathologists have made marked contributions to the understanding of the communicative process. Major examples of this are the information that has already emerged about communicative disorders in patients with various types of clefts and other disturbances of the craniofacial complex. Many of the early studies devoted to velopharyngeal valving and its necessity for normal speech undoubtedly emerged out of the frustrations of speech pathologists who had no therapeutic magic for getting normal speech from an individual with defective anatomy and physiology. Years of failure with such patients and feelings of being somehow "to blame," motivated appropriate questions about the nature of velopharyngeal valving, how the integrity of that mechanism could be measured, what could be done to improve speech when speech therapy did not and could not accomplish the goal, and what other factors contributed to defective speech patterns in these patients.

Currently, we know that velopharyngeal incompetency is almost invariably associated with defective speech. We do not know, however, why some individuals seem to accept the faulty valve, allow air to escape through the nostrils as it will, and do little or nothing to prevent the resulting hypernasality. Others attempt to compensate for the loss of air through the velopharyngeal portal by adopting the troublesome pharyngeal fricatives of a variety of sorts, glottal stops, and other gross articulatory errors. This variation in response to velopharyngeal incompetency can result in highly defective speech for people with mild or moderate deficits, while others with more major sources of air loss demonstrate lesser problems. While they have reduced intraoral pressure, nasal escape, and hypernasality, they manage to maintain a relatively high level of intelligibility and do not resort to these gross attempts to compensate for the inadequacy. We need to understand the options available to people suffering from velopharyngeal incompetency and why choices are made as they are. In addition, we have some information, but not enough, about the size and sites of intranasal obstructions as they influence speech in the presence of varying degrees of velopharyngeal incompetency. Laryngeal variations which accompany valving deficits also require far greater understanding than we now have. Thus, speech pathologists deal daily with unanswered questions, are handicapped by lack of appropriate information but, fortunately, continue to seek actively for the answers.

In spite of these deficiencies in knowledge, the speech pathologist can now do a better job of assessing speech problems in these patients than was possible even ten years ago. There is increasing reliance upon instrumentation to provide detail about the nature of valving and to lend direction to treatment planning. Far less speech therapy is being undertaken today in the presence of adverse conditions than was once the case. Thus, speech pathology has succeeded in providing guidelines for management and in exerting real influence in changing attitudes toward treatment. These are accomplishments to be proud of, and they reflect a rapidly maturing profession.

Major Problems

Lag Between Knowledge and Practice. Problems still exist, however. There is a vast difference between the information that is available and that which is put to use by speech pathologists working in the field, particularly outside of accepted cleft palate and craniofacial centers. Informational lags of this type exist in all endeavors including medicine, dentistry, the arts, theology, and philosophy.
This lag is often not very great in the “inner circle” responsible for creating new information, writing about it, disseminating it, and reading it in specialized journals. It is in the process of communicating from the nucleus to the periphery that valuable time is lost. That is true in speech pathology, and it often results in the clinical perpetuation of outmoded approaches to therapy as demonstrated by attempts to modify the speech of people with major disorders of the velopharyngeal valve, thus postponing the possibility of meaningful assistance.

The problem of information lag is compounded by the differences in the backgrounds of speech pathologists discussed earlier. Some graduate training programs emphasize anatomy and physiology, other basic sciences, and instrumentation. Speech pathologists with strong backgrounds in this subject matter may be more likely to seek out literature that appears in journals other than those in speech pathology and may be better acquainted with potential sources of new information. In addition, a surprising number of speech pathologists arrange to accompany their patients to specialized clinics in order that they themselves may learn about new approaches to old problems.

In spite of these positive elements, however, there is still far too much speech therapy being undertaken without knowledge or concern about structure and the limitations it places upon function. This ill-advised therapy is expensive to administer and emotionally costly to children. Informational lag is a compelling explanation for this sad state of affairs.

Availability of Referral Sources. A genuine problem for speech pathologists, even for those who are well informed, is the lack of consultation facilities within a reasonable referral distance of where their patients live. There are speech pathologists who understand a great deal about their patients’ deficiencies but who do not have access to the resources necessary to get the complex consultation and treatment required, and they may be reluctant to make referrals that require families to travel great distances at considerable cost.

A second aspect of this issue is that available services may sometimes be inadequate, may provide inaccurate information and guidance to speech pathologists, or may insist upon speech therapy which the speech pathologist is persuaded is unwise but may find it difficult to question or refuse. The very presence of a marginal facility renders the speech pathologist almost helpless to work around it without encountering professional-ethical questions.

A third element in this fundamental issue is the commonly held notion that defective speech is equated with the need for speech therapy, even if the therapy is not likely to alter the speech. This attitude, almost pandemic among speech pathologists, grows out of a compelling need to “do something,” and results in the decision to institute or continue therapy when the odds against its succeeding are overwhelming. This philosophy can lead to a great deal of fruitless therapy that is frustrating to both the clinician and the patient. Even more serious is the loss of time in getting appropriate treatment. For children, this can mean that the optimal age for intervention may have passed before other forms of management are adequately explored.

Ill-advised therapy is costly in both human and monetary terms. I know of no data showing the amount of money spent each year to provide speech therapy that is not profitable. I suspect, however, that it may run into millions of dollars in association with such problems as velopharyngeal incompetency, dental malocclusions, and orthognathic and craniofacial defects alone.

The Influence of the Times in Which We Live. The magnitude of the problems faced by the speech pathologist are probably increasing at the present time. Funding for both research and treatment in cleft palate, orthognathic anomalies, and craniofacial defects is less readily available, and families are less able to pay for diagnosis, treatment, and travel. In some instances, the actual cost of care may not even be covered by insurance. People may begin to rely more often on whatever assistance is available at home, and we could easily drift back to the rather haphazard care that was often provided for these patients 40 years ago.

Teams are possible because there is enough patient load to make them feasible. Most of them rely upon assistance from state crippled children’s programs, funding from various public agencies, and insurance when that is
applicable. However, the families have to buy the gasoline, pay for housing and food, and, often, lose work and wages. The harder times become, the more unlikely it will be for families to seek help in "centers of excellence," and the harder it will be for speech pathologists working in the field to get them to cooperate even when needed referral sources are available.

Since parents have final authority in decisions of this kind, the clinician can face an insoluble problem. Perhaps assertiveness training for speech pathologists will help them state clearly and unequivocally that they have gone as far as they can go without additional help. However, for that to work, there would have to be other supportive professional people and school systems that would understand, as they often do not now, that speech therapy is not the ultimate solution for every child who has a speech problem. Speech pathologists face both ethical and legal dilemmas in relationship to these issues, and they require the understanding and support of their colleagues in other professions.

Suggested Solutions

Financial Aid. In order to assure that individuals with problems which are intractable by behavioral modification techniques get the kind of help they need, we should all be working to make certain that more not less money is available for such treatment. At this time, it appears that the route we will have to go is by way of insurance and general improvement in health care for children. In addition, speech pathologists in small communities, perhaps hundreds of miles from the nearest center, will have to have access to financial aid for children who must travel for diagnosis, study, and basic treatment. As things now stand, the treatment available varies tremendously in this country. We all know of situations in which almost all children with clefts are communicative disasters, while we know of others in which a serious communication deficit is almost unheard of. This is certainly not an example of equal opportunity nor of equal distribution of problem cases among qualified speech pathologists.

The involvement of local groups in helping individuals in need, a national foundation willing to provide grants in aid, the development of a treatment network similar to that created by the Shriners for orthopedically impaired children might all be ways of extending the availability of services especially to children. Putting help within reach would go a long way toward providing speech pathologists with the support they require.

Direct Aid to Speech Pathologists. It sounds fairly drastic, but I suspect that speech pathologists who have had only limited training in this problem area would be more comfortable if they had easy access to consultation and supervision when needed. That supervision, which might be quite minimal, could be made available through cleft palate centers. It would be directional in nature and would help to guide inexperienced speech pathologists in their planning and execution of therapy and in their decision making relative to referrals.

This would be an outreach program designed to permit teams to relate to speech pathologists who may be working conscientiously but without the necessary background and experience. Correspondence with them, tape recordings, visits, telephone calls, reports, time for questions and answers—all could significantly upgrade the level of care that our patients receive even in large communities where services are not so difficult to come by but especially in isolated parts of the country.

Secondly, the American Cleft Palate Association and the American Cleft Palate Educational Foundation might consider very seriously the development of short courses for speech pathologists of limited background in various parts of the United States. Such short courses could provide brief overviews of the contributions which all members of the team can make to problems of speech but should emphasize the analysis of speech patterns, the reasons for their existence insofar as we know them, the questions that remain to be answered, what can be done to solve the problems, when speech therapy is and is not advisable, and where assistance can be obtained. This would require an investment of time and money and the organization of a professional volunteer network, but, with proper planning, it could be operational rather quickly.

Projected Results

If it were possible for us as a professional association to enter into a program that would
extend patient access to high-quality services, increase the possibilities of financial aid, provide educational opportunities for working speech pathologists, and develop the concept of the "extended team" to include concerned speech pathologists, the quality of patient care would be greatly improved, and costs could ultimately be reduced. In addition, many speech pathologists, coming, as they do, from a field with a remarkable but short history and from a variety of backgrounds, would be working to increase their own skills and, at the same time, to provide adequate treatment to patients who need it most. That, after all, is the mission of A.C.P.A. and of A.C.P.E.F.