Psychotherapy Guidebook

Communication Therapy

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e-Book 2016 International Psychotherapy Institute

From *The Psychotherapy Guidebook* edited by Richie Herink and Paul R. Herink

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DEFINITION

Communication Therapy in childhood psychosis involves treatment of speech, language, and interactional behavior as well as attention to the cognitive substrate that underlies communication performance. As such, Communication Therapy with the psychotic child is concerned with the child's difficulties with the structure, the meaning, and the function of a speech act.

The particular approach to be described here is based on the hypothesis that self-awareness and other awareness deficits that characterize childhood psychosis have consequences for speech, language, and concept acquisition and maintenance. A child who is psychotic is not adequately aware of his own internal states and action, and not adequately open to receiving information from the environment. The development of language and concepts seems to be dependent on: 1) the ability to adequately monitor one's own actions and thoughts, 2) the ability to monitor actions and events outside the self (including language), and 3) the ability to assess and make comparisons between the two. It is the continual ability to make such comparisons and, consequently, to make any necessary adjustments in language and thought (concepts) that characterize a developing and active child in Piaget's

developmental psychology (equilibration theory) and in the auditory feedback model of language acquisition and maintenance. From the viewpoint of communication, then, psychotic children exhibit deficits in auditory monitoring, both as it relates to attending to salient and relevant language and associated nonlanguage experiences outside themselves (external monitoring), and as it relates to attending to information about language and the world that they have already taken in and stored in their memories (internal monitoring). This auditory monitoring disturbance, crucial to their communication failure, exists as part of their total disturbance in self-awareness and self-regulation.

HISTORY

From the earliest reports of childhood psychosis, deficits in language expression and comprehension have been seen as a prominent symptom (see Baltaxe and Simmons, 1975). In recent years, the communication deficits have been focused on even more specifically, often with the underlying assumption that the disorders of childhood psychosis encompass a central language and/ or central cognitive deficit (see Rutter, et al., 1971; Cohen, et al., 1976).

Much of the reported work in specific language therapy with psychotic children has focused on those children who are nonverbal or who have very

limited verbal behavior, with training occurring primarily through operant techniques (see Lovaas, 1966) and, more recently, through the use of signed speech, gestures, and manipulation of visual symbols (see Fulwiler and Fouts, 1976). Some other reported treatments of communication include Rutusnik and Rutusnik's (1976) use of Lee's Interactive Teaching Approach and Shopler and Reichler's (1971) use of teachers and parents. Yudkovitz, Lewison, and Rottersman (1975, 1977); Yudkovitz and Rottersman (1973) developed a rationale and treatment approach based upon auditory monitoring and feedback principles and Piaget's equilibration theory for use with psychotic children. Their pilot study (1975) indicated changes in the selective attention abilities of four speaking psychotic children, as well as modification of such specific communication errors as tangentiality, run-on language, interruption behavior, and grammatical errors. An ongoing two-year experimental study has thus far indicated similar results for selective attentional behavior and communication failures, such as lack of referential clarity, overuse of specific statements when a more abstract one would be expected, and a lack of attention to contextual shifts in deriving meanings.

TECHNIQUE

The program consists of three therapy stages: 1) creation of a listening attitude, 2) general error sensitivity, and 3) modification of a particular language, speech, or interactional communication behavior.

Creation of a listening attitude. Through tasks of auditory focusing and sensitivity, the child learns to scan for, and focus on, auditory stimuli for features the clinician defines as salient and relevant, and to make comparisons between various aspects of auditory inputs. In this phase of therapy, the clinician pays no attention to specific communication deficits, beyond that of paying attention, and during the therapy tasks of this stage there is only limited verbalization demanded of the child. For example, in one type of task, a nonverbal child might be asked to indicate when a sound occurs that matches the drum sound he has just heard; a verbal child might be asked to indicate if a particular word occurred in a sentence. Many kinds of selective attending and comparing activities are used at this stage.

Sounds and language are slightly amplified, or highlighted, by the child's wearing earphones during all stages of the program. Because we believe it is important the child be aware of errors, the child's discovery of any errors he makes while carrying out a task is rewarded. Thus, a self-validation procedure is incorporated into all parts of the program, with the child being asked to respond a second time to task materials and to judge whether his first response was adequate.

General error sensitivity. This is a transitional stage that is designed to highlight error detection. Again, the focus is not on the child's production but rather on his attending to and comparing two language stimuli produced by

the clinician. One is identified as “correct” and a second, which varies from the first, is identified as containing an “error” that the child must detect. For example: 1) The boy has four new toys. 2) The boy has four new feet.

In both Stage 1 and Stage 2, 95 percent accuracy is required for each activity before a new task, or the next stage, can begin.

Modification of a particular language, speech, or interactional communication behavior. One error specific to the child is chosen. Several techniques are employed: 1) interpersonal scanning (including recognition of the correct form when necessary), 2) intrapersonal scanning, 3) comparing, and 4) modeling for change. While the techniques may generally be used in any order as the needs of the child indicate, this stage always begins with interpersonal scanning.

1. **Interpersonal scanning.** The objective is to create an awareness in the child of his particular error as it is deliberately produced by the clinician. The child is required to identify the error from within a larger verbal stimulus. The error must be contrasted with the correct form. In addition, before the child can scan the clinician’s output for instances of the error, he must be able to recognize the correct linguistic form as well as understand the underlying concept.

   Once the child can consistently recognize the correct form, he is required to identify the error the clinician

produces in increasingly complex linguistic environments — for example, sentences, paragraphs, interactions. Moreover, the child may experience the clinician making the error: speaking on tape, speaking to him directly, or conversing with another speaker on tape. We find the latter mode particularly beneficial because it displays a microcosm of the consequences of the behavior, it validates his judgment of the effects of a particular communication, and it offers some limited experience in role-playing — something that is difficult for psychotic children.

2. **Intrapersonal scanning.** The focus is still on the child's active awareness of error rather than on correction of it. While this active awareness may be important for any language-impaired child, the psychotic child's deficiency in self-awarenessmakes this an even more critical procedure for him. The child begins by identifying errors of previously taped samples, thus removing the scanning task from the need to communicate. Later, a child may be asked to identify errors as he is speaking, using a kind of simultaneous feedback. While correction is not the objective here, frequently proficiency in error detection leads to anticipation of error, elimination of error, or even introduction of the new or correct communication behavior.

3. **Comparing.** The clinician may produce the content of the child's utterance but use the correct language behavior in immediate juxtaposition. Placing the correct and incorrect side by side in this way increases the possibilities of perceiving differences.

4. **Modeling for change.** The focus of modeling is on the child's production of the correct speech, language, or conceptual behavior. Within a meaningful language context, the child follows the clinician's correct behaviors with his own production, but codes a different set of stimuli, although they are of the same type as the clinician's. The child is, at some level, abstracting the rule that governs that particular communication behavior since he is not purely imitating the clinician's utterances. Comparison is always operative and leads to searching as the child attempts to produce a behavior that is like the clinician's.

In the recognition and modeling techniques, in particular, the clinician attempts to bring the model stimuli near enough to the child's present level of cognitive-linguistic functioning to allow him to assimilate the new behavior. In accomplishing this, the clinician not only considers developmental characteristics of the linguistic or conceptual form itself but also the effects of the situational context in which it occurs or the linguistic context in which it is embedded.

APPLICATIONS

Because the label "childhood psychosis" appears to encompass a multitude of subgroups, it seems necessary to state that the therapy program as presented has been designed specifically for a group of children who, although they have serious communication problems, are rather verbal

already, generally function intellectually in the borderline dull-normal to bright-normal range, and for two-thirds of whom a positive, if equivocal, diagnosis of organicity has been applied. However, it seems that the process considerations and their therapeutic implications are applicable, with some modification, to other subgroups of psychotic children as well.

In addition, while this therapy model is designed particularly for communication behavior, the issues that it builds on to effect behavioral change in childhood psychosis are more far-reaching. Other remedial approaches, for example, those in the motor sphere, might consider these issues as well. Psychotherapy with these children has frequently been concerned with the lack of, and thus the development of, self and other awareness.