Ep 163 Klaire SSD Approaches

Sarah: Hello and welcome to the SLP Happy Hour Podcast, and Sarah and SLP and your host for today. And we are talking about speech sound disorders, specifically the overwhelm of choosing approaches for treating them minimal pairs, the complexity approach cycles, maximal oppositions, the core word approach, motor speech approaches, the stimuli ability approach, and that's just scratching the surface. There are so many ways that we can work with our students. And you, like me, may sometimes feel frozen trying to choose the best approach for the children we work with. We will go through some common myths about treating speech, sound disorders, and some more balanced thoughts to keep you going on today's episode. So to the rescue! Today is Klaire, a current SLP doctoral student in education focused on speech sound disorders. We're so glad you're here. Can you tell us a bit about yourself?

Klaire: Thank you, Sarah. Like Sarah said, my name is Klaire Brumbaugh and I have been practicing since 2011. I have been primarily in early intervention. I have been an assistant professor, a director of clinical education, and currently a graduate program director at the university level, all while teaching and supervising in the area of speech on disorders.

Sarah: And since we talk a lot about mental health on this show, and also since I don't believe that burnout is something that happens once but is common in helping professions. It's this balance between looking outward and wanting to help others and looking inward to find what we need, and that the balance often gets on off and then we have to course adjust and get back on. So can you tell me about a time that you've experienced some burnout, like symptoms, what that was like for you, what you noticed at the time and how you dealt with it?

Klaire: That's a really good question. I have experienced burnout, pretty intermittent but consistent throughout my whole career, and I'm currently at a place where I could look back and reflect and see as even just look at my CV or my resume each time I change a job, it was often related to a burnout experience. At the time, I was trying to externalize all that to productivity requirements or drive time or whatever the symptom the current symptom may be, but a lot of it was the internal burnout that I didn't know how to identify at the time. Now, I would say I have put up a lot of protective barriers around myself. I find myself going through periods of time of enforcing those a little bit better than others. But as soon as I start letting down those guards or overcommitting, I go back to the same place of burnout and trying to figure out how to dig myself out of the hole that I created. So I think I have a lot of symptoms that I can tell one of them is related to my anxiety. Just general anxiety, not even work related anxiety. But if I'm

starting to feel anxious in other areas of my life. And when you reevaluate. And by the way, I relate so much to so much of what you just said, I feel like my SLP career is this constant cycle of getting close to burnout and then implementing strategies to make my work life more pleasant and kind of going back and forth like that. What are some things that have helped you when you start to feel some of those burnout symptoms? I think I've been able to really identify currently in my career what I need to do to be successful. And I think that's a little bit easier in higher ed. I'm not saying that the job is easier or the time commitment is easier, but I can really put my day into three buckets. I need to have excellent teaching, a service record and scholarship. And so if I can prioritize based on the current institution and their priorities, that's how I'm going to achieve career success within that setting. So I can look at all the things that my to do list and see if those are serving me in one of those three categories. But I really try to take all of my work assignments and put them into those three buckets for which I'm measured. My success is measured at work. If it's work related and it doesn't fit into one of those three buckets, then I really have to consider the value and the time and the commitment that I'm going to put forth to do that, I don't.

Sarah: So what I'm hearing is it's a lot of letting things go. And that's what I've found in my own life. I have to give myself permission, for example, to get bad at email and bad at consultation, because when I start to feel those feelings of overwhelm and I can't do this, I have to let parts of this job go and figure out what is essential. And for me, that's time spent with students and billing for that time, because otherwise they don't get paid. So what are some things that you've had to let go? Or some examples? Maybe when you're in a time of anxiety or overwhelm?

Klaire: One example is for the past couple of years, I've been asked to co-chair our state association conference. I would love to do that. I love nothing more than networking, reaching out to SLPs, bringing the best continuing education to local SLPs. But I just knew that the time commitment, I couldn’t do it. Yes, it service, it matches one of those buckets, but my service buckets are already full. I don't have the capacity. One thing that just happened this week is I'm working on a research project, and research again is one of my buckets. But my research bucket is very full right now as I'm trying to finish my dissertation by name. We were talking about roles for the paper that we are getting ready to submit, and I called the last author. I said in the email, I know this is an uncommon request, but I am calling last author because order of authorship in our field goes by the amount of time and commitment to the paper. I just don’t have the capacity at this time. So in my past life, I never would have called last author. I mean, somebody has to be last author, but I never would have been like, I'll do it, I'll do it, I'll do it. But at this point, that's the capacity that I have. And I think it's only fair to myself and fair to my colleagues to know what to expect from me.

Sarah: Yeah. And being an ambitious person, which you're getting your doctor, as you clearly are, I am as well. And it's the idea that calling last author and understanding that that's maybe your capacity and accepting that. And I'm also hearing that you're very clear on what's important to you. And that's something that I found in my own life. For example, when I'm asked to write a letter of recommendation or take a new student, or perhaps there's a family that's like, can you see me pro bono? My answer is no. And I feel so bad. And I have to remind myself, like, how am I getting to the SLP community? I'm doing that through SLP Happy Hour. That's where I do that. So I know who I serve and how I serve them, and I have to let the rest go.

Klaire: Our jobs and our ability to be involved span as wide as we let them span. And so we really have to prioritize, and I think that's what I've been doing in the last three years. But even since then, each year that focus for me gets narrower and narrower as I just run out of time and energy and trying to protect myself and my future goals.

Sarah: So let's transition a bit to speech sound disorders and treatment overwhelm. So this is something I felt, it's something that SLP friends that I know have felt. And it's that idea that there are so many different approaches and we have to find the right approach for the client. Also, things like the complexity approach are things that I've only heard about in the past few years. We have to learn the new approaches. It becomes very overwhelming to choose a strategy or target selection method for students. So can you speak a little bit to that place of - I have the student, it's a pretty tricky SSD client or student, and I don't know what to do. And when I see this list of all these possible ways to work with them, I want to give them the best service possible and most effective service possible. But I'm so overwhelmed. I'm frozen in this moment.

Klaire: Yeah, that is such a common feeling. Even as somebody who teaches SSDs and treats SSDs and researches SSD, I don't know all the approaches. The options are so many that we could get lost. I think you made a really important distinction about the target selection approach for the treatment versus the approach. We are doing the best that we can with the approach, but we're also adding in all of our own techniques, right. So if we are doing, let's say minimal pairs, we are also probably using a bunch of different treatment techniques like facilitative context or shaping that aren't truly associated with that approach. So I think that we just have to give ourselves some grace. We know so much about so many different things that we are very rarely operating in the silo of what that specific intervention approach was intended to be. So I think just recognizing how much we know that we are the masters of this art, and I really do think it is an art, the well-researched area within our field, and we still are having to apply quite a bit of art to the science to get it just right. So I think just thinking of it as unlimited options, but that also

means unlimited opportunities for us to grow, for our clients to experience success in different capacities.

Sarah: Let's come back to this, you know, choosing treatment approaches, because we are going to have some case studies coming up soon. But first let's talk about some myths. So when it comes to treating SSDs, we read a lot of things in the research studies that it is impossible to replicate. And that can make us feel really guilty or stressed or like we're not doing an approach right. So first of all, can you speak a little to I'm just going to give one example, cycles is one hour a week, many of us have our kids for 30 minutes a week plus illnesses we're not able to make up. We can't implement that exactly as it is. But do we need to throw the baby out with the bathwater? And can we give ourselves some grace that we don't need to exactly replicate these studies?

Klaire: Yeah, I think it's impossible to exactly replicate those studies. As somebody who does research in a university clinic, as I'm doing the research, I know if I was a practicing clinician for seven years, that I wouldn't have had 50 minutes twice a week to do this. There are proximal versus distal measurements of success. And the more proximal measures of success were things like the percentage of target words improved, or I think the next level was percentage of words to a generalized wordless versus the most distal, where things like quality of life, activity and participation limitation. And those are harder to measure. But I think that's where we get stuck as clinicians, because we are really working on those more distal. We want the child's family to notice improvements. We want the child to be speaking more in class. We want them to be able to say their name with greater clarity, but that's hard to measure. So I think that we are kind of stuck in this construct of we have to show the data, we have to show the data, which is those more proximal measures of success. Whereas as clinicians, as often we are really focused on that. But it's distal. We need to work towards capturing the things that change the child's life with the greatest emphasis.

Sarah: I love that, and that makes me truly pretty emotional when I think about a few of my clients, because it's true. We're taught in grad school, and when I read studies, I get the impression that I have to show a continuous upward graph of like a very specific thing that I'm measuring. But thinking of some of the children I work with, it's like, can he say his name? Can he say his best friend's name? Can he say how old he is? Can he talk about his favorite topic? So what I hear you say with those distal measures is it's almost like if we're in the Grand Canyon, we can take one piece of sound and look at it in the microscope. And that's what grad school teaches us to do. S an initial word position 80% accuracy with maximal cues. What you're saying is, let's zoom out and look at all the Grand Canyon, how beautiful it is, how varied it is for us. It's looking at the children we work with as whole humans, and looking at their participation in life as the ultimate goal.

Klaire: Yeah. And so I think we have to figure out a way to merge those, because some of those bigger constructs aren't easy to measure, which we need for IEPs and for insurance. So how do we measure and marry the goals, like we're working on initial s, but maybe let's not pick random /s/ initial word. Through research we can see how we I mean there are intelligibility scales, there are quality of life measures, but really trying to improve the fidelity and validity of all those different measures so we can have more options when we are writing goals, to really look at the individual is the human experience.

Sarah: What this makes me think about is that the data I take is not the most important part of the session, and that's not what I was taught in grad school. And it's not - I've had students for the past year, several different, you know, SLP students, it's not what they're taught.

Klaire: And I think what you're saying is true. We can take data knowing that that's what we need, but also not making that the number one priority of the session. Or we can take data for a short period of our session. We can probe, we can baseline at the beginning and end of every session. And then in the middle, we can really work on dynamic intervention and meeting the child where they're at and providing maximal prompts and cues and achieving success instead of focusing on that item by item analysis, really focusing on, you know, probe it intermittently, probe it throughout the session or at the beginning or just at the end and see where that progress currently is.

Can this child discuss things that are important to them? Because that's going to improve the quality of life in a way that is understandable to other people. We need to remember that while dosage is important, it's not the only measure of intensity. So we really need to think about it. The intensity of our sessions, the duration, the frequency, the dose and all those different measures. There is a large range of dosage, which we know when we're working with kids. Sometimes we're getting 12 trials per session, sometimes we can get the 100 trials per session. But I really think that we need to understand and recognize that maybe that 100 trials isn't always attainable. We need to think about the individual child in the session. So is it a group or is it individual? Is it five minute speedy speech? Is there a 30 minute pull out? Is it a push in? So we need to just also understand that while it's often recommended 70 to 100 trials, that research found that 38% of the studies reviewed provided 24 to 49 trials and 40 approximately 40% were the 50 to 100 range. There's a lot of variability, and what it doesn't really account for is when we are working on like perceptual and conceptual skills. So that's only counting for the productions. There's so much more to dosage that we haven't learned or we're just starting to explore.

Sarah: So is it fair to say it’s a myth that you need to have 100 trials per session? In my private practice, the kids that I'm seeing with SSDs are within that pretty severe range, and they're very difficult to understand. I found that's not realistic for many of the kids because it depends on their temperament, their age, their ability to, you know, keep going when things are hard. So what would you say to an SLP who's where I've been? Which is like, I need to get 100 trials per session per student, and that's the way to do it, right?

Klaire: I think higher dose and greater intensity is always a good goal, but it's not always attainable. And so looking at your sessions and we don't have metrics that I know of that measure how much of the dosage should be a production versus perceptual versus conceptual. But I think of your session when we are targeting a new pattern or targeting a new phoneme, we're spending a lot of time in that conceptual perceptual work. And that's still a value that's so valuable. So I think recognizing that we have to start in a different place for every single trial with the goal, as intervention progresses, that we will be getting high dosage. But that might be the second session for one kid in six months down the road. For another kid, based on their their tolerance and their, you know, risk, are they willing to take a break? So production is you're saying the target word. The perceptual is really working on the auditory discrimination or maybe auditory bombardment, especially if you're doing something like cycles or if you're working with a child with low attention. Maybe you're spending quite a bit of time in that perceptual auditory bombardment that's still valuable therapy. And then the other one was conceptual. And that's where we're doing the phonological awareness and maybe some of that meta phonological skills. So teaching the awareness of the features of a target. So the long snake sound or the short sound or the tail on a word, we're not having a tail. So some of those might have phonological skills. And we'd have to teach the underlying phonological representation information that the child needs to be successful in producing that sound. What we don't know, or what at least I don't know, is the weight that we need to give all of those things. And I think that is currently a big question that at least I have, maybe other practicing SLPs. It also gives SLPs permission to think about their sessions more than just production trials. We don't want our child just to come in and drill, drill drill drill drill, drill, drill unless able to do that. And it's successful for them because we have to teach. Okay, so it was about the dosage. Okay.

Sarah: So we've talked some about speech sound disorder overwhelm and approaches to take. We're going to continue to talk about that. We've talked about how replicating studies and making limits and making our treatment as practicing SLPs, exactly like the ones in the studies, is not a realistic expectation of ourselves. We shouldn't expect it of ourselves. The people who are creating this research probably don't expect it of us if they've had a clinical experience. We've also talked about the fact that this idea of 100 trials is, to a certain extent, a myth. Is that fair

enough to say that we need to get 100 trials to have a productive and effective speech session is a myth?

Klaire: Yeah, because that number is going to vary based on so many different factors. So I don't think we can ever say that a certain number of trials will do it for each kid, because maybe you're working on four different phonemes or two different patterns.

Sarah: And so just giving yourself the ability to do the best that you can with the time that you have with the child in front of you, is there flexibility in choosing approaches? Is that okay to have maybe three approaches that you use for most kids? And then when you have a kid that it's not working for you, try something else. It reminds me a bit of with AAC, we can have a universal implementation where, for example, everyone gets one system and if it doesn't work for them, we adjust. Can we do that with speech sound disorders where we have a couple approaches that we use, and if those don't work, we adjust?

Klaire: I think that's already what's happening. So the research shows that no matter the diagnosis of the child or the speech on disorder that they're presenting with, most SLPs are using a traditional motor based approach. So I think that's already happening. But I do think it's important that we look at the evidence base triangle. And one of the pillars of the triangle is our own competence as a clinician. And so I challenge SLPs to have competency in a motor-based articulation approach - an apraxia approach and a phonological approach, and be able to use those as it fits the child they need. Another important thing is to consider how many different phonological approaches that we have. But lots of them are relatively related. So if a clinician can learn minimal pairs, there could be a person do multiple oppositions? If you're probably doing a lot more different types of intervention, then you think so are you already doing naturalistic recasts? Are you already doing naturalistic recasts that you already recasting and expanding the child's utterance while you're also doing cycles intervention? So I think we're also not giving ourselves enough credit that we're doing more than we think we're doing.

Sarah: And that maybe there isn't a, you know, soulmate approach that's going to be perfect for this child. Maybe it's just going to be hard, and we need to pick one that fits the profile that we're working with. So again, if we're doing motor, we might be doing prompt or DTTC. If we're doing a phonological approach, we might be doing multiple oppositions or minimal pairs. So as long as we are doing an approach that matches the need of the student, we're golden and were probably going to need a combination of approaches. So that's my next question is do we have to just stick with one approach?

Klaire: So I think that's where our knowledge and skills with the clinician come in. And we see that the child needs more visual prompting, then do that intervention, even if the intervention doesn't call for visual prompting, we should be using that level of prompting. So I think as long as we're holding true to the treatment approach that we are following the guidelines as recommended, we have the ability to add and delete based on the individual. For example if you are working with a child with low attention and doing the auditory bombardment of cycles, and you're losing them, and it's taking seven minutes of your session to do something that should take 2 or 3. Then I think that's a good time to pause and question, why are you doing this to yourself and to them? We have to also get away from expecting a brand new two year old to do drill therapy with us, right? If that. If we can incorporate that in some capacity. Great. That's great. But we also need to understand the linguistic, cognitive, phonological attention skills that these activities have and set different expectations for ourselves and for the parent.

Sarah: So let's get to some case studies and I will start with one. The child is four and a half, suspected CAS, if not certainly a significant phonological disorder. I'm going to be honest that from treatment and being able to see him try new things, I am leaning towards the side of a significant phonological disorder. I think that when we have severe to profound SSDs, they can look like a Apraxia. But if there's not also those hallmarks of Apraxia, like groping or different prosody, things like that, it's not my first thought. So this child has a very short attention span, poor short term memory and a low frustration tolerance. So things that I've tried is getting 100 trials, he cried. So I'm not doing that. He just felt totally like he wasn't doing it right. I have also tried multiple oppositions, so that's essentially where you're doing think about minimal pairs, but with more than just two words - so he has a phoneme collapse where d is also f, but not the s, z, k, and g. So we would do like di kai and sigh and fai and guy. Something like that. And it was too many words for him to remember, that did not work. We tried cycles which because every few sessions I'm changing the targets and he has a low frustration tolerance, that didn't work. We have tried maximal oppositions where I'm contrasting m with s because they are so different, and I saw some success with that. You can tell I've seen this kid for a while. Many years I have tried the complexity approach, but to be completely honest, I just don't love doing it. There are a lot of reasons why the complexity approach is not my favorite one is that it's really hard and he has a low frustration tolerance. But what I like is I can focus on 1 to 2 words or just one word per session. And because of his poor short term memory and low frustration tolerance, I have seen some success. So things that I've learned not from research, but just from practical experiences, I want smaller sets. And if I'm going to use an approach that contrasts one word with another word, they need to be super duper different, not minimal pairs like maximal oppositions. Like when I was doing cycles and said, I also have to acknowledge that 25 trials is a good day and that makes me feel bad, but it's the truth for him. Do you mind sharing in a few sentences what the complexity approach is?

Klaire: The complexity approach is the target selection technique. The theory behind it is if we target the more complex phonemes, we get other ones for free. So we are working on three elements. We will create each of those elements as a singleton contract for free. So we are working on more complex targets, we'll get stops and fricatives for free. And this is just from personal experience, when we have a child with low threshold, low risk takers working on 2 or 3 element clusters or phonemes that are really, really hard can be defeating and cause the child to shut down. Not saying this happens all the time. Not saying this is, you know, a reason not to give complexity a shot, but I do think you have to think about the resilience of the child and match. Consider that as one of your intervention matching techniques. Have you done any language testing on this child?

Sarah: Yes. Language is within normal limits.

Klaire: Yeah. Something's gotta be looking at is an integrated approach of phonological awareness to see if we can improve the phonological knowledge of the different syllable shapes and individual phonemes. I think I'd also maybe be looking at a stimulability approach. So taking some of that pressure off for a while and building our rapport through stimulability. If we suspect CAS, we really need to be doing like DTTC or something with simultaneous prompting and simultaneous production. But if we're just not there yet, then we can't force it.

Sarah: And the nice thing about DTTC is you can do it like you can use that queuing hierarchy of simultaneous production, and then you're just whispering, but they're saying it and then you're just mouthing it and they're saying it. You can do that with phonological awareness approaches, which is nice.

Klaire: Yeah. So when you mention his weak short term memory, I just think about retaining all that phonological knowledge and that motor base knowledge and how we can work on that simultaneously, because what we also know about speech sound disorders is a risk for later language and literacy disorders. So how can we already start building that foundation, a solid foundation of phonological knowledge for future success? Doing nursery rhymes. Talking about rhyming. Talking about how different songs feel in their mouth. Bringing out some letter sounds.

Klaire: Segmenting and blending and syllables and rhyming and all this. I think that's where we get back to that conceptual piece. Phonological awareness is the conceptual piece, and it's not all about the production.

Sarah: Let's define the stimulability approach for a moment. So what I know of it is it's there's a picture and a sound, um, with each of those materials are available for free. You usually do it for about 12 sessions. And it's really focused on auditorium bombardment for each sound, each session. And it's okay if the child isn't, if there's not a lot of production, uh, what would you add to this?

Klaire: Yeah. So the simultaneous approach, it's a short term for non syllable sound. So there's the picture cards like you mentioned. And you go through each picture um and associated with the phoneme. And and you give each phoneme this identity through these, these names. And so you're working on the phonological production knowledge. But it's a pretty low stakes. So you go through there's 21 of them I believe, and you go through each one. And then you use a couple of them. I think it's recommended to do seven at a time where you're doing auditory bombardment, maybe some production practice and manipulation targets.

Sarah: My next question is about children who are not yet imitating, and I'm going to pull up a question. This question was written in to us, and it's a case study that's really about approaches, activities and targets for a suspected motor speech disorder when imitation isn't happening or there's not a lot of imitation. So this is a four year old child. He's just started speech therapy in the past month. Expressive language is delayed, but receptive is within normal limits. He shuts down if he's asked to do production and tasks, or to finish a closed sentence like I see a ____, he will respond. And the SLPs impression is that he can imitate. But he's a very sensitive child and he feels uncomfortable. He's speaking mostly in vowels. He does have initial m and n in certain contexts, like more no and mama, but he is not stimulable for p, b. This SLP has taken a step back to build rapport and increase comfort. The SLP is using the stimulability approach and she's noticed significant groping. She highly suspects a motor speech disorder. Parents are also observing stuttering like behaviors and groping where there seems to be blocks. And she's not sure what to do in therapy after stimulus ability or even how to run the sessions. The question is how to properly affect change when she suspects a motor speech disorder, if a child isn't imitating.

Klaire: If he will engage in simultaneous productions, there’s where I would start there as a clinician. But I'd also this is a situation which I think I would use a lot of parent coaching, if the family was open. I would definitely start with simultaneous production and final actions and production and then the parent child coaching model. I think it would be tricky. I mean, I think I am just kind of pulling out my clinician hat, not necessarily from any specific evidence, but the same thing that we would do for language. I think I would prompt the parent to ask the child to say the word with them. Maybe they're, you know, planning an activity, let's say, like trains and doing choo choo or something like that. So I would teach the parent the prompt that I want them to use, or the visual cue and have the parent be the one to initiate with the child, say it with me,

or do a close procedure fill-in-the-blank type skill. So I think I would just remove myself from the direct clinician and see if the child is more receptive to the parent. And sometimes this can go complete the opposite way that you're hoping. And so without knowing the child, without damaging the parent child relationship, you would have to know when when either party was uncomfortable with it.

Sarah: So for this one, let's start with defining the core vocabulary approach, because I think it's. Really good for some of these kids we're talking about. So in this approach, you typically have, I think, 70 words, but you work on ten at a time. If I'm working with a preschooler, there's no way I'm getting ten. And those are really those power words that are determined by family, by the child. For example, I have a kid whose word is German Shepherd because it's his favorite dog. It's very specific. Also apple fritter, because on Saturdays he orders an apple fritter for his mom at the donut shop. Before I talk about the specific kid, anything you would add to the core vocabulary approach? Because that's what I use for this one.

Klaire: No, I think, though, the evidence for core vocabulary approach is rooted in children with inconsistent phonological disorder, and so that is typically the best match profile. It's not only, you know, can't you can also use it in your toolbox for other approaches, but in your mind when you're envisioning, when do I use this? I would look primarily for inconsistent, phonological inconsistent, and even within words, so intra word, so sometimes the word is consistent, sometimes some specific utterances are more consistent than others. So yeah I've seen that as well. So have you already developed with somebody's words that you're going to start using?

Sarah: Not all of them though.

Klaire: So that's where I would start is picking the target words. It's recommended to pick 100. But you know your child developed the word list with the family. It sounds like we've already looked at some power works for them. And then I would start prioritizing those words which they recommend doing ten per session. I do think that those sessions were a little bit longer in length than probably most intervention sessions, though. I want to say how clean I think that those were like 45 or 60-minute sessions. So, you know, pick as many words that you think you're going to get through. And then I would do exactly what you're doing, you know, breaking it down into syllable segmentation and blending back together. The beauty of vocabulary is really any intervention that we can use, all the different treatment techniques that we need to do. So using those placement cues and those visual cues and those verbal cues to achieve correct production.

Sarah: And as our time together comes to a close, I just want to recap some things we've talked about. So we've talked about you do not need to recreate studies item by item as a practicing SLP. Take that pressure off yourself. You do not need 100 productions each session. Really zooming out and being like, what is practical for this child? Yes, we were taught to take data on some word initial position with a certain level of cueing. But let's like zoom out and be like, what are functional words? What is our overall goal for this child? And that those are the things that are immeasurable, are sometimes the things that are the most important. We also talked about kids who don't yet have that attention, engagement, motivation, that stick to it ness, who aren't yet imitating and trying the stimulus approach and trying to implement some parent coaching because you've got to just do what you can with what you have and do the work of today. Today. Right. That's where we're at today. We also aren't about a selfie if we're struggling with speech sound disorder treatment, because there are so many approaches, there are so many ways to do this, and a lot of these kids come in with maybe not the attention, the stick to itiveness. The memory that would allow them to be as successful as the studies that we're reading about. And what are some resources for SLPs who are listening, who are like, oh, this denial ability, the core vocabulary approach that multiple oppositions, I want to learn more. And I'm going to be honest, I didn't know about many of these approaches. Like even two years ago, I came to private practice being a school SLP, so I knew about cycles, but I didn't know how to do it. I knew about motor approaches like I had heard Kaufman, that I didn't know how to do it. And if you're a generalist SLP and you're working in the schools, you're allowed to be a generalist SLP. You are already doing enough. But if you would like to learn more, one resource suggestion I have is the skip app. Scip - sound contrasts in phonology is $60. I can enter in a student name and there's tabs, so I can read about all the different contrastive approaches. So things like maximal oppositions, minimal pairs, multiple oppositions. It explains it to me. There's a little video that is about it. And then it helps me create word sets that I can then bring up on the iPad. So that is one of my favorite resources and I would not know. About half the things we've talked about today. If it wasn't for that, Scipp app. It's $60. Well worth it.

Klaire: Scip is one of my favorites that I recommend. If we're working on R and need some bio feedback, I always recommend a staRt app. Another place to go for resources is the Informed SLP. Even if you are not a member, I'm pretty sure she has a free review on speech sound disorders and there are so many resources in there. There is a resource that I just found a couple of months ago, actually sent to Sarah that will make sure to link that goes through a decision tree to help you pick the most appropriate intervention for the child. Not every intervention is in the decision tree bank, so know that there are limitations to that. Feel free to reach out to professionals. Reach out to the university in your local area, or the person who teaches speech on disorders, or just to get another perspective. I think it's always helpful. So yeah, give yourself the permission to not not know and to rely on somebody else to help you solve the problem.

Sarah: And I do that. I found a friend and I have a friend who only treats speech sound disorders, and one of the things I learned the most from her is that I often need more information. So I often need a speech sample. Or for example, if there's a phoneme collapse and they're using D for everything, what are they using d for? So often when I'm not sure where to go, she encourages me to take a pause. Take a session. You don't need to get a ton of data, or just take a day for the first few minutes and like, have a conversation with this child. Notice what you notice. Look for patterns, look for errors. Look for where the difficulties are and go from there. And that has helped me tremendously.

Sarah: Yeah, we talk about dynamic assessment in language all the time. We need to be doing the same thing in speech. We need to have all these data points. We need to be looking at intelligibility. You were talking about syllable shapes and the parent perspective and then how the child feels about their their speech. So we need so many different data points.

Sarah: Yeah. Allowing yourself the time to gather the information that you need. Okay. And if SLP is listening and they're still saying I don't know what approach to use, I'm feeling overwhelmed. I have this student. I have not had a similar student before, so this is feeling new to me. What do I do? What suggestions may you give them? Someone is listening to this episode and struggling with a client or student with speech sound disorders and not sure where to go. What is some encouragement you'd like to offer them?

Klaire: You know so much more than you are giving yourself credit for knowing you are doing the hardest job. I ask somebody who has to sit in an office all day and read the research. Your job is so, so, so important and so valuable and so, so much harder than mine. And so recognize what you are bringing to the field, the expertise that you bring to the field. You are the expert on that child. I might know more about a specific intervention, but you need to know exactly why or why not. It might not work for a child. Really. Listening to your expertise and be comfortable and confident that you have those.

Sarah: And that's this episode of the SLP Happy Hour podcast. Thank you so much to Klaire for her expertise and the pep talk at the end about working clinicians and the work that we do. If you'd like to connect with SLP Happy Hour, you can find the show notes at SLP Happy hour.com, and there will link the things that Klaire and I talked about in this episode. If you would like monthly or so lesson ideas, you can also sign up for the newsletter at SLP Happy

Hour. Com forward slash newsletter I hope that this was a helpful episode for you. You learn something along the way. And until next time.