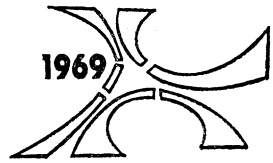
Clinical Speech Therapy in Collaboration with the Westdeutsche Kieferklinik Duesseldorf



DIETER HERRMANN, Dipl. Sprachheillehrer
Bonn, West Germany

The Rheinisches Landeskurheim fuer Sprachgeschaedigte at Oberkassel just outside Bonn is a public institution. There are children and young people who stutter, children with disturbed speech development, and those with operated cleft palate. The home can serve 100 children at a single time; of that 100, a special division of 14 beds is provided for children with cleft palate.

Treatment includes objective speech therapy, psychological, individual and group, treatment, rhythm and physical therapy, breath and voice therapy, constructive hobbies, and, in addition, sports and games. Examinations by specialists in nearby clinics are provided if necessary. The duration of the treatment is usually regulated individually and this may mean a period from three weeks up to one year. The staff includes several speech pathologists and psychologists, a breath and voice therapist, a doctor, a nurse, a teacher for physical exercise, group educators and kindergarten teachers.

According to an agreement, the cleft palate children are assigned to the home by the Westdeutsche Kieferklinik Duesseldorf, which is under the direction of Professor Dr. Dr. Rehrmann. The speech therapy represents an integrated component in their rehabilitation. Through the children's examination at Oberkassel and my participation at the consulting days for children in the Westdeutsche Kieferklinik, we try to arrange the most favorable time for the speech treatment and to develop a therapeutic plan. We have come to the conclusion that a special exercise treatment should best be terminated before starting school.

In the time before the clinical treatment, the parents receive suggestions and instructions for preparatory exercises to be done at home.

However, because of successful surgical treatment and the early operation age nowadays, speech therapy has become less important in many cases. For quite a few children, the treatment is no longer necessary; for others, however, intensive treatment is indispensable.

Mr. Herrmann is affiliated with the Rheinisches Landeskurheim fuer Sprachgeschaedigte, Bonn-Oberkassel.

This paper was presented at the 1969 International Congress on Cleft Palate, Houston.

The period of treatment, which normally lasts six weeks, can be shortened or increased. The biggest part of the cost is provided for by the health insurance.

During speech therapy, regular control examinations by surgeons of the Westdeutsche Kieferklinik take place. Should more measures be necessary, this will be decided in collaboration with the speech pathologist.

During the visiting days and the day of dismissal, the parents are informed and advised of the necessary measures which have been taken and those which are recommended. In certain cases, an ambulant treatment follows a clinical one. The treatment may even be interrupted and continued later on, in instances of further operations, physical weakness, or a lack of maturity.

Therapy for children with speech defects has to be regarded as a whole and includes more than only that sphere which is necessary for the right formation of sounds. In the case of clinical speech therapy, the following points must be considered in addition to the special methods to be discussed later. a) Psychological, pedagogical, and sociological emphases. Every success is stimulating and encouraging. Therefore all measures have to be taken which will produce good linguistic results for the child. Naturally, the necessary readiness to achieve something must be established. Those children who in the course of their development and contact with their environment are aware of their mishap, often live with a feeling of isolation, which again can result in other personality disturbances. Also we have the problem of school-age maturity. All this has to be taken into consideration during the treatment. b) Motor behavior. The motor development is important for the mental-emotional development. Changing motor behavior must be considered and delayed motor development made up for. The importance of systematic rhythmical-musical education has to be recognized and to be fitted into a day's program. c) Breath and voice therapy. The change in regularity and activity of the breathing function is an important condition for a perfect phonation. The breathing methods must be adapted to the surgically changed pharynx. Voice damage must be eliminated.

Since the special methods of treatment are generally accepted and well known, I will discuss them only briefly. a) Exercise is needed to activate muscles of the lips, mandible, tongue and palate. b) The air conduction passage has to be regulated. The still existing nasal escape of air must be removed by appropriate measures. c) Auditory exercises lead to good speech results. By increased exploitation of the hearing it will become easier to take measures which improve speaking and to exercise the hearing for the recording of sounds. With a better ability to recognize acoustical differences, the children should have the possibility of acquiring a better self control. d) Defects of articulation have to be

overcome and perfect speech must be developed. e) Through a general language education the language ability is enlarged and the assimilation into the world of thought is promoted and encouraged.

The plan for clinical treatment outlined above has several advantages. a) The disturbances of the cleft palate children present a lot of problems. The clinical treatment must therefore be complex and total. Besides the mental, emotional, and physical spheres, it includes the linguistic one. b) The day's program revolves around therapy, offering the therapist the opportunity to watch over the children, to control the day's activity, and thereupon to take individual measures. c) Clinical treatment signifies intensification. By specially selected measures it is possible to reach a depth of therapy which permits the duration of the treatment to be limited to six weeks in most cases. d) Speech therapy for cleft palate children should be in the hands of specialists who have adequate experience and are in close connection with a Cleft Center. Speech therapists working in ambulant instutitions and seeing cleft palate children only occasionally have neither the vast experience nor the possibility of complex treatment which again is important for them to carry out the follow-up treatment. e) Therapy is not transferable. Parents can help only very little and they are overburdened, particularly in serious cases. f) Centralization means greater variety of working possibilities especially for the areas with many small communities. Big families and those whose social conditions do not allow them to send their children to remote outpatient clinics must be offered the opportunity to give their children the best possible help for acquiring the right speech.

Results

The case histories of 600 children covering the period from 1960 to 1968 were considered for this report. I particularly want to thank Dr. Dr. W. Koberg from the Westdeutsche Kieferklinik Duesseldorf for letting me use his collection of data. The results are: 236 patients (40%) could do without speech therapy; for 90 patients (15%) treatment of less than six weeks was necessary; for 157 patients (26%) treatment of six weeks was necessary; and for 117 patients (19%) treatment of more than six weeks was necessary. In summary, for 364 children, or 60% of the 600 children, a treatment was necessary. A total of 68% of these needed a treatment of only six weeks or less.

Of these 364 children needing clinical speech therapy, 67% suffered from considerable articulation defects. 72% of the 364 showed a strong nasal escape of air. Of the 364, treatment for 292 (80%) was a complete success; for 60 (16%) the success was only partial; and for only 12 (3%) no success was obtained. After treatment, then, of the 600, 521 (87%) could speak perfectly, after surgery and speech therapy; 60 (10%) had a partially good result only; and 19 (3%) had poor results.

Summary

A description of the organization of the Rheinish Home for Disorders of Speech is provided. Specific attention is given to the discussion of treatment in the home for children with cleft palate. The records for 600 cleft palate children were reviewed. After surgery and/or speech therapy, 87% had good results, 10% had fair results, and 3% had poor results.

reprints: *Dieter Herrmann*
Bonn-Oberkassel
Friedrichstrasse 10
West Germany