

# Speech and the Laryngectomized

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Since speech is the most characteristic human act and the first means by which social relationships are established and kept intact, its loss seriously threatens the laryngectomized patient's feeling of security and balance, both in the family and in the community.

To complete a satisfactory rehabilitation or adjustment involves several steps, none of which should be neglected.

I shall discuss these factors as I see them, in order of their importance to the patient, as I attempt to evaluate the teaching program.

## 1. The Mental and Emotional Preparation of the Pupil Prior to Surgery

There can be no set rules established in this pre-operative preparation since each person's reaction to any crisis or strain is determined or measured by one's own personality structure, and one's own way in previously dealing with crises. Many times the surgeon will provide the necessary psychological help. Again, a well-trained speech therapist can be of great value to the prospective patient. In any case, the preparation should be based upon a critical evaluation of the personality of the patient through a personal interview. It is advisable at this time to include a member of the family. During the interview the pupil should be encouraged to discuss the many problems he will have to face. Naturally, the loss of his voice and the resulting social and economic problems are the most serious. If possible, it is advantageous at this point to have the pupil meet someone about his own age and social status who has developed a good voice and returned to work. The new patient must constantly be reassured that loss of speech is only temporary.

## 2. Patient's Approach to his Convalescence

How much the patient appreciates his post-operative condition depends upon his age, education, experience, and general personality make-up.

## 3. Speech Re-education

I am not in sympathy with beginning instruction prior to surgery, but I do recommend that the pupil be given the basic facts of how esophageal speech will be produced. This should be confined to a consideration of the general characteristics of esophageal speech - quality of tone and control of air - without, at this time, burdening the pupil with the mechanics and problems associated with its production. He must be advised that, for a time, he should communicate by writing and in no case resort to whispering. Also, it should be stressed that much of his success in acquiring his new voice depends almost entirely on his determination to practise regularly.

I have found that the earlier instruction is begun following surgery the more satisfactory the results. I have followed four rather simple steps in developing this voice and always refrain from discussing surgery with the patient. These four steps are:

- 1) Open mouth
- 2) Close mouth
- 3) Swallow air (same as one swallows food or drink)
- 4) Open mouth at once and with lips try to say "ba."

You will note that, in the very first approach to this program, I call attention to the use of

the lips in forming sound. Over the years I have used phonetic sounds. This I believe has several advantages - the pupil is not confronted with trying to say words when at that time, his mental reaction is that he cannot speak, and speech is made of words either singly or in sequence. Many of these phonetic sounds are words in themselves, such as be, bi, me, mi, ti, to mention a few. My entire approach is geared to what the patient himself can accomplish and do well. Single syllables having been articulated and enunciated well, I then proceed to doubling, tripling, and the use of more advanced rhythms, thus enabling the pupil not only to learn to control this air, but at the same time giving him much variety in pitch. These rhythms are more fully explained in my manual "Esophageal Speech" and the recording which I have made for home practice.

#### 4. Solving the Practical Problems of Living Without a Larynx

To many pupils the days immediately following surgery are the most frustrating. Many questions arise in his mind such as the control of mucous, ability to breathe, problems of eating, dressing and matters of personal hygiene. Some of these could have been explained prior to surgery, but they become more realistic once surgery has been performed. Those closely associated with the pupil should approach these problems with a very positive attitude, not one of sympathy but rather, one of complete understanding. The pupil should be assured that he will be able to eat and dress as he did prior to surgery, that he can shower, making sure that the stoma is covered at all times. Here the importance of team work with the doctor, nurse, family, social workers, and speech therapist is of utmost assistance to the pupil.

Many years ago the patient could anticipate only years of silence, but today, with new surgical techniques and the advancement in better teaching methods of esophageal speech, there is much encouragement for the patient to look forward to a normal and very satisfactory life in the future.

#### SUMMARY

The sudden loss of speech in the larynx-

gectomee is a traumatic and frightening experience. He must be prepared before the operation for what is to follow and be reassured that the loss of speech is only temporary.

Prior to surgery the patient should be given the basic facts of how esophageal speech will be produced. He must be advised that immediately after the operation he should communicate in writing, but on no account resort to whispered speech.

Therapy follows four rather simple steps: (i) open mouth; (ii) close mouth; (iii) swallow air (same as one swallows food or drink); (iv) open mouth at once and with lips try to say "ba". Phonetic sounds are used in preference to words, which may, in the early stages, have acquired negative aspects for the patient. As therapy progresses, more advanced syllables and rhythms are used.

Personal problems with regard to adjustment should be dealt with as they arise.

#### OPSOMMING

Die skielike verlies van spraak is vir die laringektomie 'n traumatiese en vreesaanjaende ondervinding. Die pasient moet dus voor die operasie voorberei word vir wat gaan volg en hy moet gerusgestel word dat die spraakverlies net tydelik sal wees. Voor sjiurgiese behandeling moet aan die pasient al die basiese feite in verband met esofageale spraak en die produksie daarvan gegee word.

Hy behoort aangeraai te word om direk na die operasie deur middel van skrif te kommunikeer en nooit gefluisterde spraak te gebruik nie. Terapie word in 4 eenvoudige stappe verdeel: (i) maak mond oop; (ii) maak mond toe; (iii) sluk lug (soos kos en vloeistowwe gesluk word); (iv) maak mond oop en probeer dadelik met die lippe „ba" sê.

Fonetiese klanke word verkieslik gebruik bo woorde, omdat woorde aan die begin 'n negatiewe reaksie by die pasient kan ontlok. Namate die pasient met terapie vorder, word meer gevorderde lettergrepe gebruik. Persoonlikheidsprobleme ten opsigte van aanpassings moet hanteer word wanneer hulle te voorskyn kom.