

In the field of communication disorders, the domains of research and clinical practice are frequently regarded as distinctly separate entities. Mr. Max Asquith, a 52-year-old computer programmer, demonstrates the following speech and language characteristics on pretreatment baseline procedures:

- Omission of final consonants such as /s/, /k/, and /t/
- Distortion of vowels in all word positions
- Misarticulation of consonant blends, such as /br/, /pl/, /fl/, /ks/, and /skw/
- Omission of the copula forms (is and are) as in "He sad" for "He is sad"
- Difficulty with the accurate use of spatial, temporal, and numerical vocabulary
- Difficulty with subject-verb agreement, especially third-person singular constructions, as in "He drink milk" for "He drinks milk"

From the client-specific perspective, initial speech intervention targets could consist of /ks/ and /skw/, because these blends occur in the client's name and therefore constitute a high priority for him. An appropriate initial language target for this client would be vocabulary words that convey number concepts, because his position as a computer programmer relies heavily on the use of this terminology.

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A 6-year-old child with an articulation disorder exhibits the following speech sound errors on baseline procedures:

- /t/ for /s/ as in thun for sun
- /g/ for /d/ as in guck for duck
- /w/ for /l/ as in wight for light
- /t/ for /t/ as in shew for chew

Using the client-specific strategy, the initial therapy target would be /s/, regardless of developmental considerations. The results of stimulability testing conducted during the diagnostic test indicated that this child's ability to imitate /s/ was superior to performance on the other error sounds. In addition, /s/ occurs far more frequently in English than /l/, /w/, and /t/. Unlike the developmental approach, a client-specific strategy can be implemented across a wide range of communication disorders with both pediatric and adult populations. In addition, a combination of the two strategies is often an effective way to approach therapy target selection for children with speech and language impairments.

Sequencing of Therapy Targets

Following therapy target selection and prioritization, programming involves the development of a logical sequence of steps that will be implemented to accomplish each objective. Three major factors determine the progression of the therapy sequence: stimulus type, task mode, and response level. The following outline presents a hierarchy of complexity for each of these factors.

Stimulus Type (Nature of Input Used to Elicit Target Responses)

- Direct physical manipulation
- Concrete symbols
- Objects
- Photographs/color pictures
- Black-and-white line drawings
- Abstract symbols
- Oral language
- Written language

Task Mode (Type of Clinician Support/Scaffolding Provided to Obtain Desired Responses)

- Imitation
- Cue/prompt
- Spontaneous

Response Level (Degree of Difficulty of Target Responses)

1. Increase length and complexity of desired response
2. Isolation
3. Syllable
4. Word
5. Carrier phrase (e.g., "I see a _____.")

(In education settings, student progress is measured through benchmarks, which are sets of skills required to achieve specific learning standards.) These objectives must be clearly delineated to ensure appropriate and effective intervention programming. A widely used approach to task design is the formulation of behavioral objectives. A behavioral objective is a statement that describes a specific target behavior in observable and measurable terms. There are three main components of a behavioral objective:

1. Condition
2. Number of repetitions can be easily counted, whereas "learning" is a behavior that cannot be directly observed.
3. The condition portion of a behavioral objective identifies the situation in which the target behavior is to be performed. It

specifies one or more of the following: when the behavior will occur, where it will be performed, in whose presence, or what materials and cues will be used to elicit the target. Following are common examples of condition statements: ?Given the clinician's model ? In response to a question from the teacher ? In the presence of three classmates ?During book report presentation ?Given a list of written words ? In the home environment ?During a job interview ?Using pictures ?During free play ? In the presence of other group therapy members ?During storybook reading time

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Condition statements are critical parts of behavioral objectives, because clients may demonstrate adequate mastery of a communicative behavior in one situation and yet be completely unable to perform the same behavior under different conditions. For example, a client's ability to perform a "do" statement, such as "Produce 1 min of connected speech without disfluency," is likely to be quite different if the condition statement specifies "while talking to a familiar clinician" versus "while talking to a potential date." The criterion specifies how well the target behavior must be performed for the objective to be achieved. It can be expressed in several ways, including percent correct, within a given time period, minimum number of correct responses, or maximum number of error responses. Criterion measures typically used in speech–language therapy are as follows: ?90% accuracy ?Eight correct out of 10 trials ?Less than four errors over three consecutive sessions ?80% accuracy over two consecutive sessions ?90% agreement between clinician and client judgments ?Continuously over a 2–min period

A well–formulated behavioral objective allows the client, as well as the clinician, to know exactly what the therapy target is, how it is to be accomplished, and what constitutes successful performance. It also is helpful to consider that unexpected changes can occur in caseloads. Clear behavioral objectives help ease the transition of care by clearly defining the focus of therapy for the next clinician. The following examples illustrate how to formulate behavioral objectives.

Example A

1. "Do" statement: Verbally segment words into syllables
2. Condition: Given a written list of 100 multisyllabic words
3. Criterion: With no more than four errors

Behavioral objective: The client will verbally segment 100 written multisyllabic words into their component syllables with no more than four errors.

Example B

1. Condition: Read single sentences
3. Criterion: With 85% accuracy or better over two consecutive sessions

Behavioral objective: The client will use a slow rate of speech (four syllables per second) with 85% accuracy or higher while reading single sentences over two consecutive sessions.

Criterion

Part One

The "do" statement identifies the specific action the client is expected to perform. Thus, behavioral objectives should contain verbs that denote observable activity; nonaction verbs should be avoided. List 1 contains examples of verbs that are appropriate for inclusion in behavioral objectives; list 2 is made up of verbs that are unacceptable because they refer to behaviors that cannot be observed.

List 1

point label repeat match name tell

List 2

say write count vocalize ask elevate understand think learn believe improve discover know appreciate remember apply comprehend feel

An easy way to check the appropriateness of a verb is to ask yourself, "Will I be able to count (tally) how many times this behavior occurs?"

The following categories of clinical skills are the building blocks of therapy and serve as the foundation for all disorder–specific treatment approaches:

- ?Programming: Selection, sequencing, and generalization of therapy targets
- ?Behavior modification: Systematic use of specific stimulus–response–consequence procedures
- ?Key teaching strategies: Use of basic training techniques to facilitate learning

?Session design: Organization and implementation of therapy sessions, including interpersonal dynamics ?Data collection: Systematic measurement of client performance and treatment efficacy

Successful intervention requires the ability to effectively integrate these five parameters into a treatment program. A 4-year-old child with a language disorder exhibits the following grammatical errors on baseline procedures:

- ?Omission of present progressive tense, as in "The boy play" for "The boy is playing"
- ?Omission of the plural marker on regular nouns, as in "I see two bike" for "I see two bikes"
- ?Overgeneralization of regular past tense, as in "He runned down the street" for "He ran down the street"

Use of the developmental strategy dictates that the first target for therapy is the present progressive form (is + verb + -ing), because it is the earliest of the three structures to emerge. As applied to educational and clinical settings, it is meant to be a theoretical framework for providing the most appropriate supports for children and adults and includes the following:

- ?Multiple means of representation: There must be multiple methods available by which individuals can access and learn important information and skills (e.g., traditional textbook augmented by supplemental internet resources, speech-to-text media).

For clinicians who choose to approach therapy from a social model of intervention, potential goals might include training peers to initiate communication with an autistic child, encouraging teachers to provide written as well as oral instructions in the classroom, or educating coworkers on best practices for conversational interactions with a colleague who stutters. General discharge guidelines used by many clinicians include (a) attainment of communication skills that are commensurate with a client's chronological/developmental age or premorbid status, (b) attainment of functional communication skills that permit a client to operate in the daily environment without significant handicap, and (c) lack of discernible progress persisting beyond a predetermined time period.

Table 1–1 Comparison of Behavioral Objective Hierarchies

Objective Hierarchy Focused on Clinician Input ("condition" aspect)

Given a model, Jeremiah will produce the regular past tense forms of single verbs with 80% accuracy. Given maximal verbal and visual cues, Jeremiah will produce the regular past tense forms of single verbs with 80% accuracy. Given visual cues, Jeremiah will produce the regular past tense forms of single verbs with 80% accuracy.

Objective Hierarchy Focused on Client Skill Level ("do statement" aspect)

Given a model, Jeremiah will produce the regular past tense forms of single verbs with 80% accuracy.

Relevant factors in the selection of treatment objectives include (a) the frequency with which a specific communicative behavior occurs in a client's daily activities; (b) the relative importance of a specific communicative behavior to the client, regardless of how often it occurs; and (c) the client's potential for mastery of a given communication skill.

This federal legislation (Public Law 101–336) and its amendments (Public Law 110–325) prohibit discrimination and ensure equal opportunity in public accommodations, employment, transportation, government services, and telecommunications (see <https://www.ada.gov> for more specific information). This framework focuses on enhancing communicative daily function in society by providing supports, accommodations, and modifications that address physical, environmental, and sensory barriers experienced by the client. As the client's performance improves and initial training objectives are mastered, the stimulus type, task mode, and response level should be manipulated systematically to gradually increase the difficulty of therapy tasks until the final criterion is met for a given target.

Generalization/Carryover

A crucial consideration in programming involves a client's ability to

transfer newly mastered communicative behaviors from the clinical setting to the everyday environment.

Formulation of Behavioral Objectives

Once long-term goals and initial treatment levels have been identified, the clinician develops short term objectives designed to culminate in the achievement of the selected long-term goals.

Universal Design Principles for Learning: An Overarching Framework

In 2000, Rose and Meyer put forth a framework based on the premise that every individual – regardless of physical, cognitive, sensory, learning, or other type of disability – is entitled to universal access to information and to learning. In other words, the hierarchy of objectives should be built to move the client to higher levels of skill mastery rather than focusing on the incremental differences in teaching input strategies used by the clinician.

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Additional examples of behavioral objectives and worksheets are provided in Appendix 1-B and Appendix 1-C on the companion website for this book. Appendix 1-A, listed on the companion website, provides a checklist of clinician behaviors that correspond to each of the parameters. Rather than targeting specific skill deficits demonstrated by the client, a social model focuses on reducing barriers to successful communication found within the individual's environment or interpersonal relationships.

/d/ for /b/ as in doat for boat

Use of the developmental strategy guides the clinician to select /b/ as the initial therapy target, because typically developing children demonstrate mastery of this sound earlier than the others. This modification is known as branching and is achieved by increasing or decreasing the difficulty level by one step according to the therapy sequence hierarchies listed previously. The following sample behavioral objectives illustrate the manipulation of each of the three factors:

Behavioral objective: The client will imitatively produce /s/ in the initial position of single words with 90% accuracy while naming 20 photographs. Appendix 1-D on the companion website contains a sample Daily Therapy Plan that illustrates the following components of a single session: behavioral objectives, client data, and clinician comments.

SLPs are responsible for fully understanding the areas of communication and swallowing that they are qualified to address (e.g., voice, language, fluency) as well as the range of services that they are eligible to deliver (e.g., screening, consultation, treatment). Accommodations are changes that help clients overcome or compensate for their disability, such as preferential seating or allowing written rather than spoken communication. Intervention is a dynamic rather than static process in which the clinician continuously assesses a client's progress toward established goals and modifies them as necessary. The ratio of correct versus incorrect responses is calculated; the resulting percentage is used to determine whether the behavior should be selected as a therapy target. For individuals who demonstrate a large number of errors, clinicians may choose a broad programming

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strategy that attacks as many targets as possible in a given time frame.

The Developmental/Normative Strategy

This strategy is based on known normative sequences of communicative behaviors in typically achieving individuals. When two or more potential targets are identified from baseline procedures, the earliest emerging behaviors are selected as the first therapy objectives. Moreover, the characteristics of the standardization sample (e.g., ethnicity, gender, socioeconomic status) may differ significantly from those of an individual client.

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Modified task mode: The client will spontaneously produce /s/ in the initial position of single words with 90% accuracy while naming 20 photographs.

Innateness

Theory/Biological Model (Chomsky, 1965; Fodor, 1975; Piaget, 1973) The hypothesis is that human beings have an innate predisposition to acquire knowledge. formulation of conclusions about the validity of the original hypotheses Based on the authors' experiences, an essential ingredient to successful intervention is critical thinking. ?Multiple means of engagement: Individuals must be provided with enough successful learning opportunities and meaningful interactions to maintain adequate motivation for learning. Also inherent in UDLs is the use of assistive technology (AT) as support for students and adults with disabilities (Dalton et al., 2002; Hall et al., 2012; Ralabate, 2011; Strangman, 2003). Whereas skills are required to achieve specific outcomes in given situations, strategies enable the individual to know when and how to use these skills in new and varied learning contexts. To the extent possible, therapy should occur in realistic situations and provide a client with opportunities to engage in meaningful communicative interactions. New behaviors are introduced and taught in highly structured situations with multiple prompts and maximal support provided by the clinician. Speech and language differences arising from dialect usage or a non-English native language do not constitute a communicative disorder. Other clinicians argue strongly that behaviors with much lower baseline rates of accuracy may be the most appropriate choices based on individual client characteristics (e.g., intelligibility level, age). Alternatively, clinicians may select a deep programming strategy for clients who demonstrate either relatively few or highly atypical errors. In addition, clinicians typically employ one of two basic approaches for choosing among potential targets: developmental/normative or client specific. The sample population from which the norms were derived may have been too small to permit valid generalization of the findings to other populations. This last factor addresses the notion of stimulability, which is typically defined as the degree to which a client can approximate the correct production of an error pattern on imitation. Therefore, it is important to vary the audience (familiar adult, sibling, unfamiliar adult) with whom therapy targets are practiced, to maximize the likelihood of successful generalization. The authors strongly believe that the establishment of reliable treatment outcome measures is critical in the current climate of professional accountability in both the public and private sectors. In this paradigm, the following characteristics are the essential components of therapy objectives: Specific -- establish a clear goal behavior. The most fundamental similarity is that both research and clinical practice are scientific processes based on the highest quality of evidence available (often referred to as evidence-based practice). Periodic follow-up is performed to monitor retention and stability of the newly acquired behaviors. The scope of practice in 3.4 Preparing for Effective Intervention Part One speech-language pathology is delineated by the American Speech-Language-Hearing Association, or ASHA (ASHA, 2007b). A related document of major importance to all SLPs is the 2023 ASHA Code of Ethics (see Appendix A on the companion website). This document outlines standards for professional behavior with regard to several areas (e.g., client welfare, SLP competence level, public understanding of the profession). ?Multiple means of expression: Various methods and modalities must be available for individuals to demonstrate their mastery of information and skills. AT may include speech-to-text software that converts speech into text documents, translation software for English-language learners, and internet access as a means of information gathering. Intervention programs should be designed with careful consideration of a client's verbal and nonverbal cognitive abilities. ?The

ultimate goal of intervention is to teach strategies for facilitating the communication process rather than teaching isolated skills or behaviors (to the extent possible). Speech and language abilities are acquired and used primarily for the purpose of communication and therefore should be taught in a communicative context. To provide effective intervention for any type of communication disorder, SLPs must acquire certain essential clinical skills.

5.6 Preparing for Effective Intervention Programming Part One

Programming involves the selection and sequencing of specific communicative behaviors. Subsequent activities progress through a hierarchy of difficulty and complexity, with decreasing support from the clinician. In recent literature (e.g., DeThorne & Gerlach-Houck, 2023), there is a growing call for intervention that is based on a social model of intervention. Initial information about potential therapy targets should be obtained by reviewing the results of previous diagnostic findings. It indicates only a potential area of weakness, which then must be sampled more extensively to determine whether a genuine deficit exists. Baselines are clinician-designed measures that provide multiple opportunities for a client to demonstrate a given communicative behavior. Many clinicians view a performance level of 75% accuracy or higher as an indication that the communication skill in question is not in need of remediation.

Sentence Text (conversation, narration)
Decrease latency (actual time) between stimulus presentation and client response

Part One

The sequencing process starts with a decision regarding the most appropriate level to begin training on each target behavior. Adherence to these procedures generally will result in a progression of targets at the appropriate levels of difficulty. Generalization is enhanced when intervention is provided in the most authentic, realistic contexts possible. A variety of stimuli (objects, pictures, questions) should be used during therapy activities to avoid tying learning to only a small set of specific stimulus items. Finally, clinicians should bear in mind that target behaviors frequently become attached to the individual who consistently reinforces them (i.e., the clinician). At the current time, there are no valid empirical data that can be used to determine appropriate dismissal criteria for any particular communicative disorder. Within the past few years, the availability of efficacy data has increased significantly for a variety of communication disorders.

Criterion: With 90% accuracy

Part One Behavioral objective:

Given the clinician's model, the client will say /s/-initial single words with 90% accuracy while naming animal pictures. In the authors' opinions, beginning clinicians tend to put too much focus on the "condition" aspect of behavioral objectives. While this aspect is important, the "do statement" should be the primary focus. Given visual or verbal cues, Jeremiah will produce the regular past tense forms of verbs in simple sentences with 80% accuracy. Their model is characterized by three universal design for learning (UDL) principles: multiple means of representation, multiple means of expression, and multiple means of engagement. The crux of UDLs is instructional flexibility to provide the most suitable options for different learners. For individuals with disabilities, UDLs include accommodations, modifications, and assistive technology. Examples include a decreased amount of classwork/homework or reduced goals for productivity or learning.

General Principles of Intervention

The basic principles of effective intervention are consistent with a UDL framework and apply to clients of all ages and disorders. Intervention should be designed to ensure that a client experiences consistent success throughout all stages of the therapy program. This checklist can be used by students as a guide for observing therapy sessions or by supervisors for evaluating student clinician performance. Instead, it

identifies ways to modify the attitudes and structures of society to accommodate the client's communication profile.

Selection of Therapy Targets

The first step in programming is identification of the communication behaviors to be acquired over the course of the treatment program. In addition, it is essential that a clinician consider the client's cultural and linguistic background when identifying potential therapy targets. Some clinicians believe that behaviors that occur with at least 50% accuracy represent targets with the best potential for improvement. A 5-year-old child with an articulation disorder produces the following speech sound errors on baseline procedures:

Note: With clients from different cultural/linguistic backgrounds, these grammatical forms may reflect a language difference rather than a language disorder. If a client obtained a baseline score lower than 50% accuracy, training on that behavior should begin just below the level of difficulty of the baseline stimulus items. For example, a 5-year-old client scored the following on baseline measures for initial /s/: word level = 65%; carrier phrase level = 40%; and sentence level = 30%.

Modified stimulus type: The client will imitatively produce /s/ in the initial position of single words with 90% accuracy while naming 20 written words.

Modified response level: The client will imitatively produce /s/ in the initial position of words in carrier phrases with 90% accuracy in response to 20 photographs. Similarly, the clinician should vary the physical environment (location in room, location in building, real-world locations) in which therapy occurs as soon as a new target behavior has been established. Therefore, it is beyond the scope of this book to indicate realistic time frames for the duration of intervention. However, the two activities also share many common characteristics, and these similarities outweigh the differences.

Critical thinking is the objective analysis and evaluation of an issue to form a judgment, which goes beyond memorization/recall of information and is free from feelings or personal biases. Speech and language intervention is a dynamic process that follows a systematic progression. It begins with the diagnosis of a communication disorder and is followed by the selection of appropriate therapy targets. Training procedures are then implemented to facilitate the acquisition of the target behaviors. Throughout all stages of therapy, advocacy is an important role for the speech-language pathologist (SLP). Speech language pathology is a dynamic profession that is continually evolving. Modifications are changes in informational content or expectations of an individual's performance. In all cases, adequate training must be provided so that individuals can use the AT successfully and reliably. Knowledge of a client's level of cognitive functioning is critical to making decisions about eligibility for treatment and selecting appropriate therapy objectives. Intervention should be individually oriented, based on the nature of a client's specific deficits and individual learning style. Intervention should be terminated once goals are achieved or the client is no longer making demonstrable progress. The client demonstrates generalization of each newly learned behavior by using it in novel situations or contexts. Refer to Chapter 12 for common characteristics of African American English, Spanish-influenced English, and Asian-influenced English. Baseline measures that fall below the 75% accuracy level represent potential intervention targets. Ultimately, however, the selection of appropriate therapy targets relies heavily on clinical judgment.

7 8 Preparing for Effective Intervention

Part One

The developmental strategy tends to be most effective for articulation and language intervention with children. Pretreatment baseline data for a given target are analyzed to determine the entry training level. The clinician must recognize this situation when it occurs and immediately modify the

task rather than persist with the original plan. This criterion level is generally set at 90% accuracy or higher in everyday conversational interactions. Relevant/realistic -- ensure that the goal is directly related to the desired outcomes. Given brief verbal cues, Jeremiah will produce the regular past tense forms of single verbs with 80% accuracy. Therefore, it is our view that intervention, like research, should be based on the principles of the scientific method. formulation of hypotheses about how to solve the problem ?manipulation of the independent variable(s) ?Teaching beginning clinicians critical-thinking skills supports their ability to manage complex issues inherent in clinical work. The intervention process is complete when mastery of these behaviors is achieved. Intervention is most effective when therapy goals are tailored to promote a client's knowledge one step beyond the current level. Intervention should be sensitive to a client's values and beliefs as well as cultural and linguistic background. The programming process culminates with a client's habitual and spontaneous use of a behavior in everyday speaking and listening situations. Frequently, assessment data are based, in part, on the administration of standardized tests. However, a single incorrect response does not constitute a sufficient basis for the inclusion of a behavior as a target in a treatment program. This sampling is accomplished through the administration of pretreatment baselines. Often, clients present with several behaviors that qualify as candidates for remediation. A developmental strategy for target selection should be implemented with careful consideration of at least two factors. The Client-Specific Strategy Using the client-specific strategy, therapy targets are chosen based on an individual's specific needs rather than according to developmental norms. If the score was between 50% and 75% accuracy, training can begin at the same difficulty level as the baseline stimuli. However, there may be occasions when a client does not perform as predicted; a chosen task turns out to be too difficult or too easy for the individual at this time. 1This response-level hierarchy pertains to oral responses only. Generalization should not be viewed as a distinct event that occurs only in the final phase of the therapy process. Termination of Therapy It is difficult to definitively state the point at which intervention services are no longer warranted. This information is presented throughout the book in pertinent chapters. A slightly modified version of behavioral design is known as SMART (Marsland & Bowman, 2010). Measurable -- ensure progress can be assessed on each established goal. Time based -- establish a projected timeline for achievement. ?Can the environment be manipulated to implement procedures that are required for this approach (e.g., hospital versus school versus clinic)? It is true that the aims of the two activities are very different. The main purpose of research is to add to the existing knowledge base in a given area, whereas the ultimate goal of clinical work is to change behavior. We must emphasize that these technologies are supportive and do not replace direct instruction. Intervention practices must be based on the best scientific evidence available. The remainder of this chapter is devoted to a detailed discussion of each basic skill area. These therapy targets are often referred to as long-term goals. These tests typically are designed to sample only one or two exemplars of a given communication behavior. A good rule of thumb is to include a minimum of 20 stimuli on each pretreatment baseline. Therapy targets are taught in the same general order as they emerge developmentally. Following are two examples that illustrate use of the developmental strategy. The plural marker is the next behavior to be targeted, followed by the regular past-tense form. Consequently, it may be difficult to draw direct comparisons between the client's

performance and the group norms. Rather, it is an integral part of programming that requires attention from the very beginning. Three main factors can influence the degree to which successful generalization occurs. Achievable -- ensure that the goal is a behavior within the skill set of a client. Jeremiah will produce the regular past tense forms of single verbs with 80% accuracy. Jeremiah will produce regular past tense forms of verbs in spontaneous speech. All clinicians should be aware of the Americans with Disabilities Act (1990).

Chapter 1 The Essential Ingredients of Good Therapy: Basic Skills ?These skills are based on fundamental principles of human behavior and learning theory. This approach does not focus on how to bring the client up to typical societal expectations. /p/ for /f/ as in pinger for f inger ?According to a developmental progression, /f/ is the next logical target, followed by /?/ and /d?/. Therefore, intervention may not be warranted. This strategy has less application for adults and disorders of voice and fluency. Following are two examples that illustrate the use of the client-specific strategy. Other response types--such as gesture, sign, and writing--may require alternative hierarchies of difficulty. This will minimize a client's natural tendency to associate target behaviors with a particular setting. For example, consider the following pair of statements: (a) "to repeat single-syllable words" and (b) "to learn single-syllable words." Only the first is an appropriate "do" statement.

13 14 Preparing for Effective Intervention Example C 1. A brief comparative example is listed in Table 1-1. Is the model appropriate for my client (e.g., cognitive issues, cultural issues)? Both research and intervention involve the following: ?identification of a problem ?review of existing knowledge regarding the problem area ?collection and analysis of data ?This important topic is discussed more extensively in Chapter 13. /d/ for /d?/ as in duice for juice ?Phrase ?Rules of thumb that can be used are as follows: ?In this example, therapy would begin at the word level of difficulty. (Mowrer, 1988). "Do" statement: Use a slow rate of speech (four syllables per second) 2. "Do" statement: Say /s/ in the initial position of single words 2. Conditions: Given the clinician's model Name pictures of animals 3. These include the following: ??????? /t/ for /?/ as in tip for ship ?? "Do" (action) statement 2.