



Binary and Ternary Relation between Participants of the Diagnostic and Therapeutic Process in Speech-language Pathology

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The article discusses the problem of the main binary relation in speech-language therapist (therapist-patient) and the interrelated ternary relationship (speech-language therapist-patient-family/carer), which should be addressed with respect to dialogue personalization, respecting the autonomy of each participant in speech-language therapy as well as the specificity of the primary group (family) and secondary (organizational, contractual). The sequence of appropriate interactions, that is the interactions of the main actors of the diagnostic and therapeutic process, can transform into a lasting relationship and thereby influence the progress in speech-language therapy and the quality of the patient's life, if personal contacts and utterances are characterised by mutual kindness, respect and willingness to work together in partnership.

KEY WORDS: speech-language therapist, patient, family, carer, binary relation, ternary relation

Introduction

Civilisational changes and the changing model of social and cultural life motivate the transformations of objectives and role of speech therapy in the contemporary world. It is a science which deals with the linguistic image of the world and, in a specific manner, the biological conditions of language and linguistic behaviour¹. Different approaches to speech therapy, treated as a multi-, inter- or transdisciplinary science², results from its subject matter and from the necessity to involve specialists from other fields in the care of patients with speech disorders, among others: psychologists, educators, SI therapists, doctors (audiologists, orthodontists, neurologists, neurosurgeons, phonists, psychiatrists), physiotherapists, preschool educators and teachers of early school education. They are an important link in identifying patients in need of speech therapy and can provide the necessary expertise and additional support in the treatment of speech disorders. The most significant influence on the speech therapy procedure is also exerted by persons who are constantly taking care of the patient and accompanying him/her in everyday activities: family members (e. g. parents, spouses, children, grandchildren) or specialist carers of dependent patients.

The assistance that takes into account the multifaceted needs of the patient refers to the sphere of linguistic behaviours viewed from the individual's perspective and forming a personal individuality, as well as linguistic interactions, which pertain to behaviours that build up each – even the smallest – community³, i.e. a group of peo-

¹ S. Grabias, *Teoria zaburzeń mowy. Perspektywy badań, typologie zaburzeń, procedury postępowania logopedycznego*, [in:] *Logopedia. Teoria zaburzeń mowy*, red. S. Grabias, M. Kurkowski, Wyd. UMCS, Lublin 2014, p. 32.

² Cf. S. Michalik, *Transdyscyplinarność logopedii – między metodologiczną koniecznością a teoretyczną utopią*, [in:] *Metodologia badań logopedycznych z perspektywy teorii i praktyki*, eds. S. Milewski, E. Czaplewska, Harmonia Universalis, Gdańsk 2015, pp. 32–46.

³ S. Grabias, *Teoria zaburzeń mowy. Perspektywy badań, typologie zaburzeń, procedury postępowania logopedycznego*, [in:] *Logopedia. Teoria zaburzeń mowy*, eds. S. Grabias, M. Kurkowski, Wyd. UMCS, Lublin 2014, p. 17.

ple connected by various types of relations. In the course of diagnostic and therapeutic procedures, the interaction should mainly be carried out through a binary relation between the patient (individuality) and speech therapist (a specialist in the subject, a therapist of speech disorders). From the very first meeting, building the bond should be based on a dialogue⁴, mutual respect, recognition of the autonomy of the other, and mutual authenticity. This is facilitated by a friendly atmosphere and proper organisation of meetings, taking into account the individual needs and limitations of both parties. However, a significant percentage of speech therapy patients are children and adults in need of care, which is why one often observes the patient-therapist binary relation to be transformed into a ternary system, namely: patient-therapist-family/carer relation. In every case, maintaining proper relations, i.e. activities that the subject initiates or undertakes, which s/he undergoes and whose effects s/he receives⁵, requires the application of an appropriate motivation strategy and involvement in ongoing activities. The sequence of proper interactions, i.e. the interaction between the main actors in the diagnostic and therapeutic process, may be transformed into a lasting relationship, and thus influence the progress of speech disorder treatment and individual's functioning on a daily basis.

Knowledge about the cooperation between the speech therapist and the patient along with his/her immediate environment is still insufficient⁶ and requires more in-depth studies. The relations of the participants in the diagnostic and therapeutic process are primarily related to the overriding practical goal of speech therapy, i.e. eliminating speech disorders and improving the process of linguistic

⁴ Cf. M. Kaźmierczak, *Dialogiczna relacja logopedy i pacjenta*, [in:] *Problemy badawcze i diagnostyczne w logopedii*, eds. I. Jaros, R. Gliwa, Wydawnictwo UE, Łódź 2016, pp. 9-17.

⁵ M. Gogacz, *Człowiek i jego relacje (materiały do filozofii człowieka)*, ATK, Warszawa 1985, p. 33.

⁶ A. Banaszekwicz, A. Walencik-Topiłko, *Model współpracy logopedy z otoczeniem pacjenta – założenia teoretyczne i rozwiązania praktyczne*, [in:] *Terapia logopedyczna*, ed. D. Baczała, J. Bleszyński, Wyd. Nauk. UMK, Toruń 2014, p. 86.

interaction, and achieving it depends on the patient's abilities, his/her cognitive activity, and professionalism of the speech therapist⁷. Less often and to a lesser extent is attention paid to the value of the meeting itself between people who thus fulfil their need to be in company and contact with others, and thanks to mutual personal relations, they can crystallize their individual identities and pursue their own fulfilment in dialogue and through dialogue.

Initiation of the speech therapist-patient relationship

According to the dialogical principle, human constitutes him/herself through the encounter with *Thou* (symmetrical relation – M. Buber), in relation to *Other* (asymmetrical relation – E. Levinas), but also to the surrounding reality⁸. Such a relationship is connected with a communion of actions and attitudes (including co-existence, co-feeling, co-cognition), in which the dignity of each participant in the dialogical situation is respected⁹. Personal relation excludes reification of a human being, domination or subordination of any of the parties to the dialogue¹⁰, therefore it constitutes something more than just the transmission of information (transmission and information model of communication), verbal transmission or exercise the remembered content.

During the meeting, even before verbal contact is initiated, the patient and speech therapist get used to the presence of the newly

⁷ M. Sochoń, E. Krajewska-Kulak, J. Śmigielska-Kuzia, *Oczekiwania rodziców dzieci w wieku przedszkolnym wobec logopedy*, „Pielęgniarstwo i Zdrowie Publiczne” 2016, No. 2, p. 110.

⁸ Cf. T. Gadacz, *Historia filozofii XX wieku*. Nurty, vol. 2 *Neokantyzm, filozofia egzystencji, filozofia dialogu*, Wyd. Znak, Kraków 2009, p. 506 and others.

⁹ B. Kiereś, *Współczesna pedagogika a problem godności człowieka*, [in:] *Personalistyczny wymiar filozofii wychowania*, eds. A. Szudra, K. Uzar, Wyd. KUL Lublin 2009, p. 188.

¹⁰ W. Chudy, *Pedagogia godności. Elementy etyki pedagogicznej*, Wyd. KUL, Lublin 2009, pp. 209–213.

met person, get used to each other, and the concern about the newly-established relationship becomes an important task for both parties. This can happen if none of the participants perceives the other as a threat, if they trust each other and feel each other's good intentions: the patient sees the speech therapist's kindness and willingness to help, and the speech therapist – the patient's readiness to (co-)work on the speech disorders. Different non-verbal and verbal behaviours are considered manifestations of the addresser's intentions; they serve to negotiate and build meanings in interaction, including the expression of emotions or mental and communicative needs of the dialogue participants. In speech therapy, different elements of the code used by the patients may be disturbed and their interpretation by the therapist may be hindered.

Experiences from the previous speech therapy treatment always have an impact on establishing new relations – when they were disturbed or took a form that ignored the patient's subjectivity (e. g. the need for the conscious patient to passively submit him- or herself to mechanical actions or authoritative decisions of the speech therapist)¹¹, they cause his/her mistrust and create a distance that needs to be gradually eliminated. When a speech therapist interacts with a patient and opens up to the same influence, a relationship of kindness occurs between them, which excludes absolute domination, aggression or destructive actions. A reference as a basis for human relations, resulting from the existence of each entity, is expressed in mutual respect and trust. Participants of a real dialogue in speech therapy are focused on counteracting uniformity and maximizing individual development. It is connected with perceiving the patient as an individual, an autonomous being, which allows to avoid relativism and authoritarianism.

¹¹ T. Szasz, M. H. Hollender called these types of patient-doctor interaction: management-collaboration and activity-passivity, whereas E. and L. Emanuel described them as informative and paternalistic; J. Barański, *Interakcja lekarz-pacjent*, [in:] *Zdrowie i choroba. Wybrane problemy socjologii medycyny*, red. J. Barański, W. Piątkowski, Wyd. Atut, Wrocław 2002, p. 159; A. Kowalska i in., *Etyczne aspekty komunikacji pacjent – lekarz*, „Medycyna Ogólna” 2010, No. 16, p. 428.

Moreover, the therapist is not just a passive listener or instructor, but also a committed partner who assumes an accepting attitude in interaction. To do this, s/he must first have a well-established individual identity, be open to new challenges and be open to others. Because of the epistemic authority (based on competences) and deontic solidarity (taking a leading role in achieving a common goal)¹², speech therapists are considered to be the cause of an asymmetrical relationship, through which and thanks to which the quality of linguistic behaviour, among other things, can be improved. In the patient, what is mainly sought for are the effects of the measures taken, but reciprocity implies that the interaction can also be initiated by the patient if s/he is not subject to passive therapy. Co-participation (T. Szasz, M. H. Hollender), or in other words joint consultation (E. and L. Emanuel)¹³, is characterized by the fact that the specialist clearly presents possible strategies of conduct, actively listens to the patient's comments, advises him/her and discusses each stage of work before developing the therapy programme. Thanks to partnership and mutual, two-way communication, the patient is more motivated to achieve the set goals, of which s/he is aware; s/he is more clearly engaged in individualised therapy, more often initiating dialogue and action, because s/he knows what to expect during the next meetings. S/he also accepts co-responsibility for the final effects of the therapeutic process.

The very diagnostic and therapeutic procedure is organized by the speech therapist him- or herself who, when making decisions about its form, takes into account the type of speech disorder diagnosed, the age of the patient, his or her family and legal situation, psychophysical condition, etc. Due to the patient's negative experiences or fears, the first meetings may require the presence of a par-

¹² J. M. Bocheński, *Co to jest autorytet?*, [in:] J. M. Bocheński, *Logika i filozofia. Wybór pism*, translated and collected by J. Parys, Warszawa 1993, pp. 242, 293.

¹³ J. Barański, *Interakcja lekarz-pacjent*, [in:] *Zdrowie i choroba. Wybrane problemy socjologii medycyny*, eds. J. Barański, W. Piątkowski, Wyd. Atut, Wrocław 2002, p. 161; A. Kowalska and others, *Etyczne aspekty komunikacji pacjent – lekarz*, „*Medycyna Ogólna*” 2010, No. 16, p. 428.

ent/carer (in a preschool institution – a group mate or a teacher) or even the active participation of a third person in the exercises. When it is necessary to have a third participant (parent, grandfather, spouse, nurse, guardian, etc.), it is necessary to define his/her tasks and role, to make him or her aware of his/her co-responsibility for the course of therapy and the patient's communication. The basis of the new relation is not a simple synthesis of the individual and the social. It is necessary to maintain the subjectivity of each person, as well as the specificity of primary (family) and secondary groups (of an organisational or contractual nature). In the case of independent patients, with time the parent/carer gradually reduces his or her activity during therapy, becomes an observer or, in consultation with the speech therapist and the child/charge, partially or completely resigns from his or her attendance in the office.

Respecting the autonomy of individuals and the distinctiveness of the primary group requires the speech therapist to respect different standards, patterns of conduct and behaviour of the patient and his or her family. However, when building a ternary relationship, one should also take into account the subjectivity of the speech therapist or specialist tutor, their values and principles. Only if cultural pluralism is taken into account and the accepted norms of linguistic and cultural interaction are respected can support and recognition strategies be transformed into sincere, genuine relations, providing a solid basis for cooperation, which is one of the teleological assumptions of the diagnostic and therapeutic process in speech therapy.

Thus, mutual kindness, acceptance of the subjects in the diagnostic and therapeutic process in speech therapy, results from the very presence of other people, the sense of co-responsibility for the other person. The willingness to know requires mutual openness to each other and faith in the success of the actions taken, which can be achieved thanks to the trust that people have in each other. Personal relations in the social dimension, i.e. focusing on oneself and mutual interactions between community members, are characterized by social support, both in the emotional and evaluative dimension (the

significance of an individual within a group), in the instrumental one (providing assistance, rendering services), and also in the informative one (advice, data and message transfer)¹⁴. Adequate support, resulting from signals and messages enabling people to believe that they are surrounded by friendly people and care in terms of speech disorders, contributes to the normalisation of family life, psychosocial development of the patient, and improvement of the quality of his/her daily linguistic behaviours.

Relations in linguistic interaction

According to philosophers of dialogue, building a personal relationship between I-Thou/Other during a meeting relates to the category of good. However, it was Hans-Georg Gadamer who took upon himself to rehabilitate the cognitive sphere in dialogue and stressed the unity of truth and goodness, logos and ethos¹⁵. Dialogue, understood as a conversation, can be considered as a kind of bridge between unrecognizable entities. The verbal message is important because it connects interlocutors who use the same language and function in a common tradition, but refrain from striving for uniformity and assimilation of their interlocutor. The verbalization and exchange of thoughts and feelings, as well as the confrontation of opinions in dialogue takes place in a dynamic way; it constitutes a result of the manifestation of interlocutors' personalities, abilities and their psychophysical condition, and also depends on external circumstances. Seeing *Thou/Other* as an unrecognisable being excludes objectification and reducing the individual to merely his or her representation. The principles of co-functioning concern both the emerging relation and its impact on speech therapy, the

¹⁴ K. Kmieciak-Baran, *Skala wsparcia społecznego. Teoria i właściwości psychometryczne*, „Przegląd Psychologiczny” 1995, vol. 38, No. 1, p. 202.

¹⁵ P. Sznajder, *Logos wyłaniający się z rozmowy. Inny a prawda w dialogu w filozofii Hansa-Georga Gadamera*, „Estetyka i Krytyka” 2012, No. 2, p. 197.

reference of each of the actors to themselves and to the interlocutor, but also to the linguistic interaction.

Reciprocity requires authenticity of utterance, consistency of verbal messages with body language and facial expressions. Choosing a communicate that is adequate to the therapeutic situation allows to take responsibility for one's words as well as a lack of any utterance, which gives time to decide whether or not to answer a question or respond to a contact initiated by another person. Left to the patient, the choice concerning the moment of undertaking the conversation with the therapist is an expression of respect for the interlocutor and for oneself, understanding the communication difficulties not only in the physical, but also psychological and emotional sphere. The responsible exercise of freedom, emphasised in dialogue personalism, requires empathy, understanding and acceptance of the interlocutor's personality, thanks to which a bond can be formed between the therapist and the patient, a certain alliance, which facilitates achieving subsequent goals related to the improvement of the quality of linguistic interaction. Mutual trust is also fostered by establishing clear rules accepted by both parties which form the basis for organizing the meetings. Such transparency is important in order to ensure informed and active participation in therapy¹⁶.

A genuine dialogue requires accepting the need to exchange the roles of the addresser-recipient of a message. In a conversation, it is the addresser who decides what truth he conveys about him- or herself and the world, to what extent s/he can afford to engage in a relation with another person. Thanks to the conversation, there occurs a manifestation of one's own desires, but also an exchange of thoughts with respect to the different opinion and attitude of the other person. In an interpersonal relation, language mediates in building the representation of another person, it becomes a tool of

¹⁶ G. Jastrzębowska, O. Pęc-Pękała, *Metodyka ogólna diagnozy i terapii logopedycznej*, [in:] *Logopedia. Pytania i odpowiedzi*, eds. G. Jastrzębowska i T. Gałkowski, Wyd. UO, Opole 2003, p. 327.

understanding and rapport, which requires exceeding one's own horizon of cognition, opening to another point of view, getting rid of prejudices without resigning from one's own position or wanting to dominate the interlocutor, which would mean introducing a subjective relationship. The assumption of linguistic interaction is not to fully recognize the other person and eliminate differences between the participants of the conversation. Although in the speech therapy dialogue the relation of cognition results from affirming the other person, it refers to the system of *I-It* and *phronesis*¹⁷, practical wisdom of the subject, i.e. the form and content of the linguistic and extra-linguistic message.

Nevertheless, the dialogue is not a simple conversation where participants focus on technical skills. The art of dialogue is a search for original ways of establishing interpersonal contacts, leading to the transformation of interactions, including the increase in internal motivation to work on speech disorders and the willingness to talk. Thanks to trust laid in the authority and support for the patient's natural potential, even in an asymmetrical dialogue, the work in the speech therapy room is focused mainly on the development of the person, and not just on the therapy programme, which often requires critical reflection, verification, and adaptation to the needs in the particular moment. In a therapeutic situation, it is difficult to describe in detail and predict the course of the dialogue. The reflective (self-)consciousness of the speech therapist and the patient accounts for the unpredictability of the answers given, and allows for the problematic nature of the occurring or provoked communication situations, in which what may emerge are ambiguous or residual statements as well as understatements, characteristic of living speech.

Mutual respect and partnership are also required in the relations between the speech therapist and the participants of speech therapies and diagnoses who play a supporting, additional role. The

¹⁷ Arystoteles, *Etyka nikomachejska*, transl. D. Gromska, PWN, Warszawa 1982, 1140 a 24-1142 b 31.

support provided to the patient by his or her family results from the attitude of the closest environment to the individual and constitutes an expression of ongoing relations, not occasional actions, taken in random situations. Especially after the therapy comes to an end, the parent becomes the main partner in the dialogue with the speech therapist, with whom s/he discusses the course of exercises, the patient's progress or tasks to work on at home, and often shares his or her observations on the everyday life of the child. If the young patient is present but does not actively participate in the conversation, he or she must not be objectified in any way.

In the course of speech therapy, it is important to satisfy the emotional needs of the patient and for the family to perform emotional and social functions. This can be done by spontaneously demonstrating an interest in communication interaction on a daily basis, as well as by providing a protective and supportive function through remedial action or intervention in an exceptional situation¹⁸, such as the diagnosis of a speech disorder and the need for speech therapy. Satisfying the needs for closeness, bonds or interest gives the patient a sense of security and support. Therefore, the quality of the ternary family-speech therapist-patient relation depends to a large extent on the attitudes not only of the therapist, but also of the relatives, who themselves need support in the new situation.

Parents adopt different attitudes towards their child: positive (acceptance, autonomy) or negative (rejection, excessive demands, excessive protection, inconsistency)¹⁹. Because of their own experiences and world views, they exhibit various approaches to the therapy of speech disorders offered to children: they either perceive it from the perspective of their own childhood experiences, or they are sceptical and only want to have the sense of undertaking a remedial

¹⁸ G. Filipiak, *Funkcja wsparcia społecznego w rodzinie*, „Roczniki Socjologii Rodziny” 1999, Annals XI, p. 135.

¹⁹ M. Plopa, *Więzi w małżeństwie i rodzinie. Metody badań*, Oficyna Wydawnicza „Impuls”, Kraków 2005, pp. 235–238.

action, because they have never met a speech and voice therapist, or are open and willing to cooperate, as in the case of any other specialist child consultation, or they ignore the recommendations and fail to refer to the speech therapist. Already during the first contact, the therapist shall remember that each member of the primary group comes with set goals, expectations and beliefs, which are based on the available knowledge about speech disorders and speech therapy, with the attitude towards the therapist resulting from the belief about the role and tasks of the patient. Divergent expectations and assumptions on the part of the speech therapist on the one hand, and the patient and parent on the other, in relation to therapy may make it particularly difficult to establish a true ternary relation at the beginning; however, it is worth taking this effort. Parents of young patients play an extremely important supporting role, but they are also a valuable source of information, decide which intimate details of the patient's life and health condition to reveal, become the main recipients of information and diagnostic function messages, often also persuasive, whose aim is to introduce desirable changes in the child's approach. They are responsible for performing exercises at home, eliminating habits that have a negative impact on speech, which sometimes requires modification of the behaviour and attitudes of all members of the household. Partnership, as the basis of the relationship between the speech therapist and the parent, becomes one of the most important factors determining the effects of speech therapies on young patients²⁰.

In the family, there are first and foremost real relationships, such as friendship, kindness, trust, faith in others and acceptance. They can also appear in the speech therapy practice, as they do not depend on decision or knowledge. However, in a group of organisational character, it happens that real relations are dominated by

²⁰ M. Sochoń, E. Krajewska-Kułak, J. Śmigielska-Kuzia, *Oczekiwania rodziców dzieci w wieku przedszkolnym wobec logopedy*, „Pielęgniarstwo i Zdrowie Publiczne” 2016, No. 2, p. 114; K. Węsierska, *Profilaktyka logopedyczna w praktyce edukacyjnej*, vol. 1, ed. K. Węsierska, Wyd. UŚ, Katowice 2012, p. 41.

mental ones, i.e. taking place between people and their creations, among others, conversations and ideologies²¹. The activities undertaken by the speech therapist are a part of the system activity of the network of aid institutions employing specialists, including speech and voice therapists. Reducing a person solely to the role of a patient, customer or supplicant only focuses the speech therapy on a speech disorder (*It*), and not on a patient as a person with a speech disorder (*Thou/Other*).

No less important is the relationship of the speech therapist with the caregiver who professionally deals with a patient who is not fully independent. Specialized caregivers represent institutions providing temporary assistance, in specific cases and within the specified scope²²; therefore, they are generally less emotionally involved, expecting primarily instruction and professional advice on the work at hand to eliminate or limit the disorder. However, this professional group is not only expected to provide professional help and reliable information on the course of treatment, the effectiveness of the measures and treatments applied, and on the progress in (re)education of speech. Although their perception of the disease and the related speech disorders is different than the family's, specialised staff should also be characterised by empathy, understanding and provide the patient with safety and comfort of everyday life. The very presence of another person generates the need to manifest emotions connected with the therapy – at the beginning often negative, but over time in many cases a desire arises in the patient to initiate positive contacts, also verbal.

The problem of cooperation between a speech therapist on the one hand and a patient, their family or carer on the other shall be resolved in dialogue and through dialogue. However, due to their knowledge and authority, the family/carer and the speech therapist

²¹ M. Gogacz, *Człowiek i jego relacje (materiały do filozofii człowieka)*, Akademia Teologii Katolickiej, Warszawa 1985, p. 133.

²² G. Filipiak, *Funkcja wsparcia społecznego w rodzinie*, „Roczniki Socjologii Rodziny” 1999, Annals XI, p. 133.

often discuss the problematic issues among themselves and make key decisions aimed at the patient's well-being. If in the ternary system the authority is used to exert pressure and the patient is only expected to obey and submit to the imposed strategy, it is difficult to assume good interpersonal relations; similarly, in a situation where the therapist expects absolute adaptation and humble implementation of the imposed action plan. The change from the adaptation paradigm to the subjective therapy paradigm enables to define the role and place of each person in the organized community, a reasonable and consistent division of tasks, as well as the emergence of a real dialogue.

Conclusions

The activities undertaken in the diagnostic and therapeutic process are a response to irregularities in linguistic communication, the aetiology of which should be sought in the biological, psychological and social conditions of speech. The overriding practical goal of speech therapy is to extinguish, reduce or eliminate problems related to the observed disorders of linguistic interaction. The activities are indicated by standards of conduct and the final form of each stage is adjusted individually to each particular patient with a speech disorder.

The emergence of relationships resulting from interpersonal contacts can be considered as a constitutive component of speech therapy, especially in the face of today's social contacts of a transient and impersonal nature. Sensitivity of both the family/carer and the speech therapist to the patient's needs, supporting him/her during therapy, taking into account his or her limitations, is not only a matter of striving for a norm, i.e. a set of features, competences and skills which should be available to him/her at a given age. The principle of individualisation²³ applied in speech therapy requires

²³ G. Jastrzębowska, O. Pęc-Pękala, *Metodyka ogólna diagnozy i terapii logopedycznej*, [in:] *Logopedia. Pytania i odpowiedzi*, eds. G. Jastrzębowska, T. Gałkowski, Wyd. UO, Opole 2003, p. 327.

empathy and greater care to adapt strategies or stages of work to the patient's abilities, which excludes thoughtless pursuit of the assumed goal of speech therapy.

In mutual contacts, the patient needs help and support, the family needs understanding, and the speech therapist needs the best possible action based on his or her competences and professional experience. In the ternary system, effective and harmonious communication facilitates the division of tasks in accordance with the capabilities and needs of each entity, allows for the clarification of the principles of cooperation to be accepted by all participants of the diagnostic and therapeutic process, and can significantly influence the subsequent coordination of procedures and verification of effects.

The methods of teacher-centred instruction, verification and control, known from lessons at school and expressed by the school's scale of assessment, should be replaced by participation, cooperation, (self)control and even (self)evaluation of a conscious patient who decides about his or her own activity and takes responsibility for the effects of their own speech therapy. In situations of internal conflict (the patient does not want to attend therapy, but knows that s/he should) or dispute with the family/carer, there may occur a denial of the patient's own feelings and submission to the stronger, i.e. the transfer of the situation of coercion (e. g. compulsory education/learning, the need to submit to the superior) to speech therapy, which in the case of conscious patients should be based on the principle of voluntary participation.

Reflection on relations in speech therapy indicates the necessity of theoretical justifications of empirical research, but due to the difference and autonomy of each of the subjects, it is impossible to determine a single paradigm according to which cooperation related to the correction of speech disorders can be designed. It should be noted, however, that humanization of speech therapy results from treating the patient as a person, which requires making attempts to counteract disturbed interpersonal relations and non-normative linguistic behaviour. Such proposals may be considered to include a shift towards the philosophical and anthropological

trends of the 20th and 21st centuries, including the existential and dialectic trend, or personalism, understood as an attitude oriented towards respect for another person who – (self)conscious and free in decisions – can fulfil him- or herself. What is more, it is important to equip future speech therapists already in the course of professional training of students with communication competences that take into account the principles of real dialogue and linguistic interaction, which are part of subjective interpersonal relations. With regard to these assumptions, the tools, technical or financial measures, which are used during the specialist training and later in the diagnosis and therapy of speech therapy, must be given a secondary, auxiliary role, although in general awareness they are assigned a greater meaning than they actually have.

Bibliography

- Aristotle, *Etyka nikomachejska*, transl. D. Gromska, PWN, Warszawa 1982.
- Banaszkiewicz A., Walencik-Topińko A., *Model współpracy logopedy z otoczeniem pacjenta – założenia teoretyczne i rozwiązania praktyczne*, [in:] *Terapia logopedyczna*, eds. D. Baczała, J. Bleszyński, Wyd. Nauk. UMK, Toruń 2014, pp. 85–96.
- Barański J., *Interakcja lekarz-pacjent*, [in:] *Zdrowie i choroba. Wybrane problemy socjologii medycyny*, eds. J. Barański, W. Piątkowski, Oficyna Wyd. Atut, Wrocław 2002, pp. 158–161.
- Bocheński J. M., *Co to jest autorytet?*, [in:] J. M. Bocheński, *Logika i filozofia. Wybór pism*, translated and collected by J. Parys, Wyd. Nauk PWN, Warszawa 1993, pp. 187–324.
- Chudy W., *Pedagogia godności. Elementy etyki pedagogicznej*, Wyd. KUL, Lublin 2009, pp. 209–213.
- Filipiak G., *Funkcja wsparcia społecznego w rodzinie*, „Roczniki Socjologii Rodziny” 1999, Annals XI, pp. 131–144.
- Gadacz T., *Historia filozofii XX wieku. Nurty*, vol. 2 *Neokantyzm, filozofia egzystencji, filozofia dialogu*, Wyd. Znak, Kraków 2009.
- Gogacz M., *Człowiek i jego relacje (materiały do filozofii człowieka)*, Akademia Teologii Katolickiej, Warszawa 1985.
- Grabias S., *Teoria zaburzeń mowy. Perspektywy badań, typologie zaburzeń, procedury postępowania logopedycznego*, [in:] *Logopedia. Teoria zaburzeń mowy*, ed. S. Grabias, M. Kurkowski, Wyd. UMCS, Lublin 20147, pp. 15–71.

- Jastrzębowska G., Pęc-Pękala O., *Metodyka ogólna diagnozy i terapii logopedycznej*, [in:] *Logopedia. Pytania i odpowiedzi*, eds. G. Jastrzębowska, T. Gałkowski, Wyd. UO, Opole 2003, pp. 309–345.
- Każmierczak M., *Dialogiczna relacja logopedy i pacjenta*, [in:] *Problemy badawcze i diagnostyczne w logopedii*, eds. I. Jaros, R. Gliwa, Wydawnictwo UŁ, Łódź 2016, pp. 9–17.
- Kiereś B., *Współczesna pedagogika a problem godności człowieka*, [in:] *Personalistyczny wymiar filozofii wychowania*, eds. A. Szudra, K. Uzar, Wyd. KUL, Lublin 2009, pp. 183–188.
- Kmieciak-Baran K., *Skala wsparcia społecznego. Teoria i właściwości psychometryczne*, „Przegląd Psychologiczny” 1995, vol. 38, No. 1, pp. 201–214.
- Kowalska and others, *Etyczne aspekty komunikacji pacjent – lekarz*, „Medycyna Ogólna” 2010, No. 16, pp. 427–435.
- Michalik S., *Transdyscyplinarność logopedii – między metodologiczną koniecznością a teoretyczną utopią*, [in:] *Metodologia badań logopedycznych z perspektywy teorii i praktyki*, eds. S. Milewski, E. Czaplewska, Harmonia Universalis, Gdańsk 2015, pp. 32–46.
- Płopa M., *Więzi w małżeństwie i rodzinie. Metody badań*, Oficyna Wydawnicza „Impuls”, Kraków 2005, pp. 235–238.
- Sznajder P., *Logos wyłaniający się z rozmowy. Inny a prawda w dialogu w filozofii Hansa-Georga Gadamera*, „Estetyka i Krytyka” 2012, No. 2, pp. 183–199.
- Sochoń M., Krajewska-Kułak E., Śmigielska-Kuzia J., *Oczekiwania rodziców dzieci w wieku przedszkolnym wobec logopedy*, „Pielęgniarstwo i Zdrowie Publiczne” 2016, No. 2, pp. 105–117.
- Węsierska K., *Profilaktyka logopedyczna w praktyce edukacyjnej*, vol. 1, ed. K. Węsierska, Wyd. UŚ, Katowice 2012.