The Great Communicator: Audrey Holland's Legacy and Lessons

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ABSTRACT

Audrey Holland's core beliefs of respect for people and the quality of their lives informed her life's work. This examination of the ways she managed the academic, research, and clinical parts of her illustrious career shows how Audrey leaves a rich legacy and serves as a model for navigating an impactful career path and enhancing clinical interactions. First, she mentored more than 30 doctoral students who then mentored further generations of students, ran clinics, or shaped policy. She also regularly taught classes, supervised student clinicians, and traveled the world doing lectures and workshops. Second, her scholarship spanned more than 50 years and a range of subjects, such as assessment and treatment, self-determination and self-advocacy, pragmatics, counseling, coaching, and communication strategies. Third, her collaborations with many colleagues within the field and in related fields extended her impact even further. Finally, a close analysis of her clinical communication style shows how Audrey's simple, nonverbal behaviors (e.g., eye contact, body position) brought out the best in the people with whom she worked. On all these levels—mentorship, scholarship, collaboration, and communication style—Audrey's legacy leaves a vast array of powerful lessons that can be studied, emulated, and appreciated for years to come.

KEYWORDS: functional communication, person-centered approach, AphasiaBank, Famous People Protocol

Learning Outcomes: As a result of this activity, the reader will be able to:

- Intentionally employ simple tools (e.g., body posture, eye contact, touch) to establish rapport and build authentic working relationships as seen in Audrey Holland's clinical interactions.
- Practice an attitude of "clinical respectfulness" toward clients and their families.
- Continue to collaborate with and learn from others throughout your life.

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Dr. Audrey L. Holland was a singularly powerful force who changed people's lives and the field of speech-language pathology for the better. She was also the matriarch of a large and diverse academic family, spreading her impact broadly in the field and creating a robust legacy. In this article, we first focus on how she created that broad impact and robust legacy. We show how, over the years, she evolved with the field but also forged new paths and led the field in new directions. Then, we zoom in to highlight core features of her communication style that reflected her deeply held principles about clinical interactions and brought out the best in others. It is an extraordinary career and life to honor and remember. Our goal is to reflect on Audrey's professional career and learn lessons from many of the big ways and small ways in which she made a difference.

LEGACY THROUGH MENTORSHIP, SCHOLARSHIP, AND COLLABORATION

Mentorship

Audrey's legacy is truly a gift, and many people feel blessed to have inherited pieces of it. If one compares academic families to biological families, one can trace the ways Audrey set an example, encouraged, guided, and passed on ethics and values just as a parent or grandparent might.[1] In this comparison, academic families have some interesting advantages over biological families. One advantage is the number of "children" one person can have or, in academic terms, the number of doctoral students who can be mentored by one professor. Using a strict measure of those who graduated with doctoral degrees, Audrey had over 30 "children" at the three universities where she served on the faculty (Emerson University, University of Pittsburgh, and University of Arizona). Of course, that fails to account for the thousands of students she taught in undergraduate- and graduate-level classes, students she supervised in clinical placements, and people lucky enough to have attended her many lectures, presentations, and workshops all over the world. In fact, Audrey was still traveling and teaching abroad (even in China!) well into her 80s. Many former students and colleagues have their "Audrey encounter" stories, and many of those include the phrase "she changed my life." In some cases, her influence caused them to change their course of study (e.g., from art history to communication sciences and disorders). Others say she supported them and instilled in them the confidence to take risks and achieve more than they ever imagined for themselves.

Another advantageous difference between academic and biological families is that in academia a new generation happens in much less time. As some of those 30+ doctoral students became junior faculty members and mentored students of their own, the legacy continued. Though Audrey's legacy in aphasia is extensive, we choose two other examples to illustrate the breadth of her legacy. In the late 1990s, Audrey mentored Michelle Bourgeois (University of Pittsburgh) who developed innovative, person-centered treatments such as memory books and communication aids for persons with dementia (Bourgeois, 1992). In the 2010s, Michelle mentored Alyssa Lanzi (University of South Florida), who developed the Functional External Memory Aid Tool (FEMAT) to quantify and describe external aid use in adults with cognitive–communication disorders (Lanzi et al., 2023). Alyssa now mentors Anna Saylor (University of Delaware) who is deeply influenced by all of her forebearers and carries their work forward in her doctoral program. Anna helped develop the new DementiaBank standard discourse protocol and collects data for the Delaware corpus of participants with and without mild cognitive impairment (Saylor et al., 2022). That is the equivalent of Audrey becoming a mother, grandmother, and great-grandmother in the span of slightly more than 30 years. It illustrates how one person can be an inspiration and role model, passing on "traits" to many academic generations during her lifetime. In this case, Michelle, Alyssa, and Anna learned from

[1] *Readers can see several video tributes to Audrey Holland from former students and colleagues at this AphasiaBank webpage: AphasiaBank (n.d.). Tributes to Dr. Audrey L. Holland. Retrieved June 28, 2024, from https://aphasia.talkbank.org/tributes/.*

Audrey's mentorship the importance of focusing on how people use language in their real lives and developing new tools for researchers and clinicians to use to measure those behaviors. The accomplishments of these women are filling critical, unmet needs in the field of dementia that are benefitting patients, their families, and the scientific community.

The second example comes from the work of Mark Ylvisaker, an earlier doctoral student also from the University of Pittsburgh who went on to have a profound influence in the area of traumatic brain injury clinical practice. Mark's focus on everyday routines spread to other areas of practice with persons with neurological communication disorders (Ylvisaker, 1998). His "descendants" (e.g., Jim Feeney, Melissa Capo, and Ellen Hickey) have passed these lessons on to their students and carried on his lessons in clinical practice and scholarly work. Audrey, too, wrote about how Mark influenced her future work in coaching and scripting as well as general principles of good clinical treatment (Holland, 2010).

Those two examples help highlight one of the ways in which academic families are not necessarily different from biological families. For example, siblings are often very different from each other. In Audrey's case, her academic children were interested in a broad range of areas such as dementia, aphasia, child language, and head injury. Furthermore, within those diverse areas, some were more clinically oriented and started private practices or ran clinics, whereas others were drawn to policy and administration. Many pursued academic research careers. Each one took off in his or her unique direction. However, despite the individual differences, a common genetic thread binds Audrey's academic offspring and helps transmit her legacy more broadly than she could on her own. Our focus here is on that thread, the dominant gene or force that Audrey imparted through her life's work: authentic and unbiased respect for people and the quality of their lives.

Scholarship

The irony is that Audrey started out as a strict Skinnerian, which implies more of a focus on a stimulus, a response, and conditioning or controlling behaviors. Her involvement in aphasia research and treatment dates back to the mid-1960s, when her first published article in the *Journal of Speech and Hearing Disorders* reviewed basic behaviorist principles and related them to clinical management (Holland, 1967). Other articles early in her career promoted operant procedures in speech and language remediation (Holland & Harris, 1968), detailed a programmed task for auditory comprehension training based on the token test (Holland & Sonderman, 1974), and even advocated for the application of "teaching machine" [2] concepts to speech pathology and audiology (Holland & Matthews, 1970). Many years later, in her own words, she described her evolution away from Skinnerian principles and her concerns about the relevance of the behavior analysis approach to communication disorders (Holland, 2005). In that article, she wrote about becoming disillusioned about operant training and the failure of its treatment effects to generalize to meaningful environments. She felt that the language of operant training was missing the "richness of human communicative interaction" (Holland, 2005, p. 2).

Audrey's evolution happened over several decades and led her to spearhead many initiatives for the assessment and treatment that considered individuals in their natural environments. For instance, in 1980 she developed Communication Activities of Daily Living (CADL), the first formal, standardized assessment for functional communication in aphasia, which she updated twice thereafter (Holland, 1980; Holland et al., 1999; Holland et al., 2018). The research that went into the original CADL started 5 years before the test was published. The first phase of developing the instrument involved hours of observing people with aphasia and coding the frequency, appropriateness, and type of their communicative behavior; the second phase involved developing psychometric properties for the instrument to establish its validity and reliability (Holland, 1982a, 1982b). This is just one example of a huge and innovative undertaking by Audrey that resulted in a unique and

[2] *Teaching machines were mechanical devices designed to automate and individualize instruction so that students could learn at their own pace.*

valuable tool that clinicians and researchers have been using for over 40 years.

The titles of many of the treatment articles Audrey went on to author or co-author over the next several decades tell a clear story of her focus on functional communication and quality of life. Some examples include the following: Pragmatic Aspects of Intervention in Aphasia (Holland, 1991); Why Can't Clinicians Talk to Aphasic Adults? Comments on Supported Conversation for Adults with Aphasia: Methods and Resources for Training Conversational Partners (Holland, 1998); Conversational Coaching: Treatment Outcomes and Future Directions (Hopper et al., 2002); Self-determination and Self-advocacy: New Concepts for Aphasic Individuals and Their Partners (Holland, 2002); Assessment and Treatment of Pragmatic Aspects of Communication in Aphasia (Holland & Hinckley, 2002); Living Successfully with Aphasia: Three Variations on the Theme (Holland, 2006); Concentrating on the Consequences (Holland, 2008); Tell Me Your Story: Analysis of Script Topics Selected by Persons with Aphasia (Holland et al., 2010); and the Value of "Communication Strategies" in the Treatment of Aphasia (Holland, 2021). These and other articles reported on both individual therapy and group therapy and were based on case studies, group studies, and single-subject design studies. What they all had in common was a concerted effort to develop and share meaningful and effective rehabilitation approaches in aphasia for patients and their families.

Audrey's lifelong professional evolution reflected her infinite curiosity and her openness to learning new things at any stage of her life. For instance, well into Audrey's career she studied life coaching and positive psychology. This led her to write several seminal books and articles on counseling families and adults with speech and language disorders (Holland, 2007; Holland, 2012; Holland & Elman, 2020; Holland & Nelson, 2018). Counseling was a topic that had not received the attention it deserved in our field. Audrey saw another need that demanded attention. She did her due diligence and again, as with her efforts to create a measure of functional communication, she shared essential new resources to bring the rest of the field along with her to address counseling. As iPads and similar devices became ubiquitous, Audrey published an article on the clinical use of apps for aphasia (Holland et al., 2012) and then edited a special issue of *Seminars in Speech and Language* on the use of such devices in aphasia treatment (Holland, 2014). The focus on the assessment and treatment of functional communication, the speech-language pathologist's (SLP's) role in counseling, and the use of computer technology in aphasia are just a few examples of the changes Audrey made in her career not only to stay current but also to challenge the status quo and create new ways to target quality of life and real-world interventions for people with communication impairments.

Collaboration

In addition to the mentorship and scholarship, a final factor in appreciating the breadth and depth of Audrey's legacy is her ability to attract collaborators from within the field as well as from other disciplines. Early in her career, she co-authored a seminal paper detailing step-by-step instructions for using melodic intonation therapy for aphasia treatment (Sparks & Holland, 1976). In later years, after writing plenty of other papers about aphasia treatment (some co-authored titles listed in the previous section), Audrey and colleagues were instrumental in establishing the Life Participation Approach to Aphasia (LPAA) as a model for enhancing life participation for people with aphasia and their families (Chapey et al., 2000; Holland & Elman, 2020). She was a force in the creation of aphasia centers and support communities such as Aphasia Access and the Adler Aphasia Center, where she served as the Director of Research and Clinical Advisor. One of Audrey's edited books that truly exemplifies her commitment to outreach and collaboration describes world perspectives on aphasia treatment (Holland & Forbes, 2013). For this work, she sought out fellow aphasiologists to share approaches from at least a dozen different countries.

From disciplines outside the field of speech-language pathology, Audrey worked with neurologists, neuropsychologists, neurosurgeons, neuroradiologists, neuropathologists, pediatric neurologists, neuroscientists, psycholinguists, psychiatrists, psychologists, geriatricians, and

more. She published a gem of a paper with colleagues from psychology, neuropathology, and neurology detailing the dissolution of language in a patient who was ultimately diagnosed (upon autopsy) with Pick's disease (Holland et al., 1985). Other research collaborations outside the realm of aphasia include language and cognitive consequences of pediatric head injury (Feldman et al., 1992; Tompkins et al., 1990) and predictors of decline in Alzheimer's disease (Boller et al., 1991).

One of her later collaborations was as a coinvestigator with Brian MacWhinney on the AphasiaBank project (Macwhinney et al., 2011). The idea behind AphasiaBank began at a meeting of the Academy of Aphasia at the Hilton Hotel in Pittsburgh where Audrey was giving a keynote address. During a poster session, she proposed to Brian the idea of extending his work on a child language database to the field of aphasia. Having planted the seed of this idea, they then worked together to sketch out the AphasiaBank project which began officially in 2005 with a planning meeting of 20 senior aphasia experts. The bank now has approximately 1,500 members from around the world and a vast set of multimedia discourse data and resources that are being used for research, teaching, and clinical purposes. One of the popular teaching resources, AphasiaBank Grand Rounds, is essentially Audrey's guided tutorial through aphasia diagnosis and treatment with curated examples from the database. These various examples of groundbreaking, collaborative work are a further testament to the giant legacy Audrey created. Importantly, they make a strong case for the value of seeking out communities of like-minded professionals and organizers who can work together to achieve common goals.

LEGACY THROUGH COMMUNICATION STYLE

Along with the big, high-level accomplishments that impacted the field (e.g., research grants, aphasia centers, articles, books, new assessment tools, and treatment models), Audrey's impact was felt in her one-on-one interactions with individuals with aphasia and their family members, which continued throughout her 50+ year career. She conducted assessments and treatments with the goal of maximizing the individual's ability to communicate meaningfully. Surely that goal is shared by most clinicians. Yet, it is the unique way in which she presented herself and engaged with people who always made a difference. In fact, Roberta Elman's Internet sleuthing uncovered Audrey's high school yearbook, where this quote was written on the page with Audrey's graduation photo: "*an attractive girl whose conversation ability makes her popular with both sexes*." Clearly Audrey's communication style was an innate gift apparent to her classmates well before she had acquired any professional training or experience.

We chose to study Audrey's unique style by focusing on basic nonverbal social communication skills that she employed as powerful tools in her clinical interactions. We chose to focus on the nonverbals for several reasons: (1) they may be overlooked or underappreciated in clinical training and practice; (2) they can make a big difference in any social interaction; (3) Audrey provides excellent examples of how to use nonverbal communication both naturally and on purpose to create a feeling of solidarity and support; and (4) they are not specific to a particular treatment or type and severity of impairment. These behaviors reflect the core principles of her functional and humane approach to clinical interactions. Importantly, they can be an effective way for Audrey's legacy to inspire current and future generations of SLPs to be more intentional about remembering to employ these simple tools. Plenty of articles about the nature of clinical interactions stress the importance of establishing rapport and building authentic working relationships (e.g., Ferguson & Elliot, 2001; Hersh et al., 2018; Walsh, 2007). Simmons-Mackie and Damico (2011) explain that rapport building should be a treatment goal, not just something that happens along the way. Audrey's clinical interactions demonstrated a host of nonverbal behaviors that can be considered fundamental elements for successful rapport and, ultimately, for engaging patients, motivating them, and positively impacting clinical outcomes.

The relevant behaviors that are pervasive in Audrey's interactions with individuals with aphasia include eye contact, smiling, laughing, touching, leaning in, relaxed posture, proximity, and a full range of natural facial expressions.

In other words, Audrey interacted with individuals with aphasia in the same way she would interact with a friend—with warmth, sincerity, interest, honesty, and a great sense of humor. She managed to do this while still maintaining her role as the professional SLP running the session. It was clear she was in charge, but it was equally clear she related to her patients as people. As many can attest, she communicated genuine compassion and interest in the people she met and, importantly, she communicated respect. Audrey often reminded us that the "disorder exists in the person," and to be successful in treatment "the person with the disorder" must be considered (Holland, 2012, p. 345). In that regard, she reminded us to "try TALKING to your patients occasionally, instead of working on their language problems" (Holland, 1982b, p. 3). Audrey's approach to speech and language therapy was a relationship-centered experience.

We describe the rich, nonverbal subtext that infused Audrey's clinical approach and augment these descriptions with illustrative examples from the AphasiaBank[3] database. Also, we provide references to the many helpful books, chapters, and articles where Audrey explained the importance of these essential aspects of her work. Lastly, we cite published studies that attest to the psychological, emotional, and physiological impacts of these behaviors. Clearly, our approach here is descriptive and anecdotal rather than data-driven and statistically tested. Evidence is provided in screenshots with the goal of encouraging people to see the effect of these behaviors and emulate them. Readers are strongly urged to view the screenshots by going to the links provided for each one. The beauty of these nonverbal behaviors is that they can be incorporated into any clinical interaction. The importance of these behaviors is that they communicate respect for the full person and for the essence of communicative interactions. Individuals sense this and respond in a way that creates a meaningful connection and rapport that positively impacts the working relationship.

[3]*AphasiaBank (Macwhinney et al., 2011) is a shared database of multimedia interactions for the study of communication in aphasia. Access is password protected and restricted to members. Membership requests can be made from the main webpage: https://aphasia.talkbank.org/.*

VIDEO SCREENSHOT EXAMPLES

Most of these screenshots are from videotaped administrations of the Famous People Protocol (https://aphasia.talkbank.org/famous/), which is a scorable tool for use with people who have severe aphasia (Holland et al. 2019). All participants provided written informed consent, allowing the videos to be used for research and educational purposes. With a basic script and picture stimuli, the clinician encourages individuals to use any means (e.g., gesture, pantomime, singing, writing, circumlocution) to indicate that they know the person pictured (e.g., Elvis Presley) or the information requested (e.g., which sport five famous pictured athletes played). The goal is to discover personally relevant strategies that work for these individuals and encourage families to use them (and prompt the individuals with aphasia to use them) in conversational contexts. While following the script and scoring, Audrey makes the interaction feel natural and even enjoyable. She connects with the person on a human level while also doing the things a good clinician does such as modeling strategies, reinforcing strategies, providing cues, providing feedback, and more. After all, with the exception of stressful situations like oral exams or court testimonies, communication is a social exchange of information that should be productive and satisfying. Audrey never lost sight of that fact.

Body Posture

In 2013, an international bestselling book encouraged women to "lean in" and be more assertive in both work and non-work settings (Sandberg & Scovell, 2013). The book led to an awakening for a new generation of women. Audrey had been "leaning in" for decades, but not for purposes of assertiveness. Rather, Audrey's version of leaning in was literal; that is, her body was inclined toward the other person. She wrote, "Involve your body in the act of listening. Look, lean in, and don't assume a confrontational posture. The more you LOOK like you're listening, the more likely you are to be listening (Holland, 2012, p. 348)!" Clearly, for Audrey, listening was physical. Adopting

Audrey's version of leaning in can encourage SLPs to be more effective conversational partners in both work and non-work settings and can facilitate an awakening of the natural human instincts that drove us to this field in the first place. As she wrote, "We SLPs choose this profession because we are intrinsically helpers (Holland, 2012, p. 345)."

In one-on-one videotaped sessions, Audrey sometimes sat at the side of the table, approximately 90 degrees from the individual with whom she was interacting. In acute care hospital bedside settings, she pulled up a chair right next to the bed. She always wanted proximity for a variety of purposes such as sharing written or drawn cues as well as a friendly touch. When administering the Famous People Protocol, Audrey usually sat next to the individual so they could look at stimuli on the iPad together. She was not sitting behind a desk or in a fancy chair; she was not physically separated from the individual with aphasia. Screenshots 1, 2, and 3 show her fully engaged, lean-in body posture.[4] Her body language conveys interest, partnership, and an eagerness to work together on the task at hand (AphasiaBank, n.d.).

Screenshot 1 Body posture—fridriksson08a (https://aphasia.talkbank.org/tributes/1.png); (https://aphasia.talkbank.org/tributes/2.png); (https://aphasia.talkbank.org/tributes/3.png) show her fully engaged, lean-in body posture.

Screenshot 2 Body posture—kurland100a (https://aphasia.talkbank.org/tributes/1.png); (https://aphasia.talkbank.org/tributes/2.png); (https://aphasia.talkbank.org/tributes/3.png) show her fully engaged, lean-in body posture.

Screenshot 3 Body posture—star01a (https://aphasia.talkbank.org/tributes/1.png); (https://aphasia.talkbank.org/tributes/2.png); (https://aphasia.talkbank.org/tributes/3.png) show her fully engaged, lean-in body posture.

[4] *Screenshot titles include the participant's ID. Readers who are members of AphasiaBank can find the full videos of Audrey administering the protocol to these participants and others in the Browsable Database from this webpage: https://sla.talkbank.org/TBB/aphasia/English/Other/Famous. Readers who would like to join AphasiaBank can find instructions at the top of this webpage: https://aphasia.talkbank.org/.*

Eye Contact

Those who have chosen this profession are likely to be adept in this simple and basic pragmatic behavior. Yet, eye contact is surely not a binary thing that is either present or absent. We may have eye contact, but it may not be optimal if we are tired, distracted, or stressed. Additionally, we may have eye contact that is inadequate due to heavy reliance on scoresheets or other reference materials. Senju and Johnson (2009) wrote about the "eye contact effect" in their review of neuroimaging studies showing how eye contact modulates activity in the "social brain" network. Many other studies support the fact that eye contact can build trust, empathy, and a strong connection (e.g., Grossmann, 2017; MacDonald, 2009). As Screenshots 4, 5, and 6 show, Audrey's eye contact grabs or literally "makes contact" with the individual with aphasia (AphasiaBank, n.d.).

Touch

Touch is certainly another basic and essential form of human interaction. Yet, in this day and age, physical touch in a workplace setting has to be approached more cautiously and with increased awareness of the impact of gender, age, and power differentials between people. While some speech and language examinations require physical touch (e.g., oral mechanism exam), a typical aphasia therapy session probably does not. That being said, a review of touch in health

Screenshot 4 Eye contact—elman18a (https://aphasia.talkbank.org/tributes/4.png); (https://aphasia.talkbank.org/tributes/5.png); (https://aphasia.talkbank.org/tributes/6.png) show, Audrey's eye contact grabs or literally "makes contact" with the individual with aphasia.

Screenshot 5 Eye contact—elman17a (https://aphasia.talkbank.org/tributes/4.png); (https://aphasia.talkbank.org/tributes/5.png); (https://aphasia.talkbank.org/tributes/6.png) show, Audrey's eye contact grabs or literally "makes contact" with the individual with aphasia.

Screenshot 6 Eye contact—fridriksson12a (https://aphasia.talkbank.org/tributes/4.png); (https://aphasia.talkbank.org/tributes/5.png); (https://aphasia.talkbank.org/tributes/6.png) show, Audrey's eye contact grabs or literally "makes contact" with the individual with aphasia.

professional practice confirms the benefits of touch as a form of nonverbal communication that functions to orient, show interest in another, express emotion, and comfort (Davin et al., 2019). Another study concluded that expressive touch should be promoted to enhance communication which may lead to improved patient's well-being (Cocksedge et al., 2013). Specifically, all patient responders in that study reported that touch on the hand or forearm was appropriate. This is exactly the kind of touch that Audrey uses, as can be seen in Screenshots 7, 8, and 9 (AphasiaBank, n.d.).

Smiling and Laughing

A smile can be another powerful tool. An easy, natural smile indicates friendliness, warmth, a lack of threat, and perhaps even happiness and fun. Smiles make social connections with others and facilitate successful interactions (Ekman & Friesen, 1978; Ramachandran, 1998). As with eye contact, not all smiles are created equal. Screenshots 10, 11, 12, and 13 show Audrey radiating full, genuine smiles along with several of these individuals with severe aphasia (AphasiaBank, n.d.). Often, one or both of them erupt in laughter, which has been known to have therapeutic and healing benefits since ancient times. In a review of humor, laughter, and learning, Savage et al. (2017) refer to laughter as a basic, evolved function shared by humans. They encourage health care providers to improve health and enhance learning through laughter.

Screenshot 7 Touch—williamson18a [this is exactly the kind of touch that Audrey uses, as can be seen in Screenshots 7-9]: (https://aphasia.talkbank.org/tributes/7.png); (https://aphasia.talkbank.org/tributes/8.png); (https://aphasia.talkbank.org/tributes/9.png).

Screenshot 8 Touch—kurland02a [this is exactly the kind of touch that Audrey uses, as can be seen in Screenshots 7-9]: (https://aphasia.talkbank.org/tributes/7.png); (https://aphasia.talkbank.org/tributes/8.png); (https://aphasia.talkbank.org/tributes/9.png).

Screenshot 9 Touch—star01a [this is exactly the kind of touch that Audrey uses, as can be seen in Screenshots 7-9]: (https://aphasia.talkbank.org/tributes/7.png); (https://aphasia.talkbank.org/tributes/8.png); (https://aphasia.talkbank.org/tributes/9.png).

Summary

All of these nonverbal behaviors are part of our normal communication interactions to some degree or another. While individuals naturally vary in the frequency and intensity of their use of these behaviors, clinicians working on communication with impaired adults are encouraged to consider being more intentional about using them in the clinical setting. It is possible that our professional personas reduce our use of some or all of these, and that it would be beneficial to find a better balance of our professional and nonprofessional selves in this regard. The benefits from these actions range from simple comfort and kindness to improved learning and well-being.

Without a doubt, for Audrey, these actions were part of her effort to make people feel seen, heard, valued, and, most of all, respected. This was part of what she called "counseling around the edges" while conducting assessments or treatments (Holland, 2012). In that 2012 essay, she coined another term, "clinical respectfulness". To

Screenshot 10 Smile—elman19a (https://aphasia.talkbank.org/tributes/10.png); (https://aphasia.talkbank.org/tributes/11.png); (https://aphasia.talkbank.org/tributes/12.png); (https://aphasia.talkbank.org/tributes/13.png) show Audrey radiating full, genuine smiles along with several of these individuals with severe aphasia.

Screenshot 11 Smile—kurland13a (https://aphasia.talkbank.org/tributes/10.png); (https://aphasia.talkbank.org/tributes/11.png); (https://aphasia.talkbank.org/tributes/12.png); (https://aphasia.talkbank.org/tributes/13.png) show Audrey radiating full, genuine smiles along with several of these individuals with severe aphasia.

Screenshot 12 Smile—elman17a (https://aphasia.talkbank.org/tributes/10.png); (https://aphasia.talkbank.org/tributes/11.png); (https://aphasia.talkbank.org/tributes/12.png); (https://aphasia.talkbank.org/tributes/13.png) show Audrey radiating full, genuine smiles along with several of these individuals with severe aphasia.

Screenshot 13 Smile—williamson18a (https://aphasia.talkbank.org/tributes/10.png); (https://aphasia.talkbank.org/tributes/11.png); (https://aphasia.talkbank.org/tributes/12.png); (https://aphasia.talkbank.org/tributes/13.png) show Audrey radiating full, genuine smiles along with several of these individuals with severe aphasia.

describe the attitude a clinician should have toward one's clients and their family members. Fundamentally, Audrey's behaviors reflected the importance of recognizing personhood, which is a primary legacy of her life and work and a most worthwhile one to embrace. A communication impairment like aphasia can dramatically alter that personhood. Her ability to recognize and honor it even in the most severely impaired people was something to behold.

FUTURE DIRECTIONS

In addition to videos from the Famous People corpus, Audrey's legacy can be tapped further by viewing the many other videos she contributed to AphasiaBank. We urge clinicians, researchers, and educators to take advantage of these other corpora from the non-protocol collection as well:

- Holland2—individual interviews with four different people with aphasia.
- SCALE—individual conversations with four people with aphasia.
- Tucson—individual conversations with two people with aphasia about their strokes, conversation with the spouse of a person who had aphasia, and individual informal conversations with 18 people with aphasia.

In all of these videos, Audrey models skills that are worth studying and emulating for enhancing our clinical interactions.

Some questions to ponder as we consider these nonverbal communication behaviors and their impact on the clinical process include the following:

1. How can we empirically test the impact of these nonverbal behaviors on treatment outcome, patient satisfaction, or some aspect of psychosocial health? How does the absence of these communication behaviors impact the encounter for the person with aphasia? Would it be ethical to conduct a controlled experiment where in one condition the clinician had poor eye contact, assumed a confrontational posture, and feigned interest in the interaction? Would it be important to measure not only the impact of these behaviors but also the subjective perception or experience of them from the client's/patient's perspective?
2. Do these behaviors need to be controlled for in aphasia treatment studies? If a study is done with multiple clinicians who are skilled in the specific treatment for aphasia, do they also need to be monitored for nonverbals such as smiling and touching?
3. Can these nonverbal behaviors be learned? Can students or even novice clinicians watch videos, identify the nonverbal behaviors being used by an experienced clinician such as Audrey, and then adopt those behaviors into their own clinical style? Or are these nonverbal behaviors too idiosyncratic?
4. Can these nonverbal tools be applied to any interactions with our patients or are there situations where they are not appropriate? Does their application depend on factors relating to the clinician, the client, and/or the goals of the session?

CONCLUSIONS

To measure the extent of Audrey's impact would be impossible, but to overstate it seems equally impossible. We believe we can continue to learn from Audrey through her writings, her videos, and the extensive branches of her academic family tree. In addition to her genuine respect for people and the quality of their lives, her life's work is a testament to so many other important lessons: continue to learn and expand your intellectual horizons, build evidence, and be willing to challenge the status quo, collaborate within and across disciplines to broaden impact, and be an authentic, exemplary human.

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CONFLICT OF INTEREST

None declared.

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