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ABSTRACT

Presented is the syllabus of a training program to prepare therapists to work with stuttering children or adults. Intended for instructors, the information is presented in the form of five major chapters, each of which is divided into units. The unit usually consists of an introduction, suggested lecture topics (with source references), suggested discussion questions, recommended supplementary experiences such as use of films or tape recordings, and a bibliography. Four units deal with the nature and etiology of stuttering; five units with the historical background, types and results of research, theories and the basis for them; five units with diagnosis; 13 units with treatment; and four units with understandings and personal characteristics needed by the therapist. Following are examples of unit titles: "Experimental Studies of the Variability of Stuttering Behavior", Theories Which View Stuttering as a Problem of Learned Behavior", "Appraisal and Prognosis: Defining the Clinical Problem in the Child Stutterer", "Coping with Communicative Stress", and "Changes in the Therapy Relationship at Different Stages in Therapy". (DB)

Stuttering

TRAINING THE THERAPIST

SPEECH FOUNDATION OF AMERICA

Stuttering

TRAINING THE THERAPIST

A Syllabus or Course of Study

This course of study sponsored and published by the
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To the Reader

Surveys reveal that many speech therapists working in our schools feel that they are inadequately prepared to cope with the baffling problems they encounter in working with the stutterer.

For this reason the Foundation asked a group of authorities (whose names are listed on the following pages) to draw up an outline for a training program for therapists to work with stutterers.

At a preliminary session held in Chicago each member of the group was asked to write up his recommendations. After a tremendous amount of study and writings, a week's conference was held in Hawaii to review and revise these writings so as to co-ordinate them into a logical program of study.

This publication is the result of their combined efforts. Stanley Ainsworth, a former president of the American Speech and Hearing Association, served as chairman of the group and Charles Van Riper, an outstanding authority in this field, was chosen to edit the final work.

We hope that through the use of this syllabus or course of study the instructor may be better equipped to cover all phases of the subject, and that it will help the student to gain a better understanding of the problems involved and the procedures to be used in working with the stutterer.

MALCOLM FRASER

For the Speech Foundation of America
Memphis, Tennessee

DEDICATED TO

Wendell Johnson

1906-1965

A distinguished clinician and teacher in the field of speech pathology who had a masterful grasp of the problems of the stutterer and whose activities included a constant interest in improving the training of speech therapists.

√ √ √

(Dr. Johnson had taken part in some of the advance planning for this publication and had expected to be a participant in the final conference as he had been in three of our previous conferences.)

Participants

Stanley Ainsworth, Ph.D., Chairman

Associate dean for Research and Graduate Studies and distinguished professor of Speech Correction, University of Georgia. President (1960) and executive vice-president (1955-59) American Speech and Hearing Association.

Hugo H. Gregory, Ph.D.

Associate professor and director, Stuttering Programs, Department of Communicative Disorders, Northwestern University. Editor "Learning Theory and Stuttering Therapy."

Harold L. Luper, Ph.D.

Professor and head, Department of Audiology and Speech Pathology, University of Tennessee. Co-author "Stuttering: Therapy for Children." Associate editor for speech (1960-) dsh Abstracts.

Albert T. Murphy, Ph.D.

Professor and chairman, Department of Special Education, Schools of Education and Medicine, Boston University. Author "Stuttering and Personality Dynamics" and other books.

*Charles D. Parker, Ph.D.**

Professor and chairman, Department of Speech Pathology and Audiology, University of Montana, Missoula, Montana. Editorial consultant, Journal Speech and Hearing Disorders.

*Dr. Parker, primarily an audiologist, was asked to contribute representing the point of view of an audiologist and administrator of a training program.

Participants

Frank Robinson, Ph.D.

Professor speech pathology, director Speech and Hearing Clinic, Miami University, Oxford, Ohio. Author "Introduction to Stuttering." Fellow, American Speech and Hearing Association.

Joseph G. Sheehan, Ph.D.

Professor of psychology, University of California, Los Angeles. Associate editor, Journal of Speech and Hearing Disorders (1958-65), and Asha (1964-68). Editor, "Stuttering: Research and Therapy."

Charles Van Riper, Ph.D., Editor

Psychologist and speech pathologist, distinguished professor and head, Department Speech Pathology and Audiology, Western Michigan University. Councilor (1950-53). Associate editor (1939); honors of the Association, Asha Author "Speech Correction, Principles and Methods," and other books.

Dean Williams, Ph.D.

Professor speech pathology and audiology. University of Iowa. Councilor (1960-61; 64-67) and Fellow American Speech and Hearing Association. Associate editor (1962) of the Journal of Speech and Hearing Disorders and of Asha (1962).

Malcolm Fraser

Director, Speech Foundation of America.

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TO THE STUDENT

Prologue

"Fifteen million of our fellows throughout the world, one million in our land, speak with words whose wings are broken." These words of Wendell Johnson about his fellow stutterers are the theme and inspiration of this booklet. It is written for all of us who have some responsibility for the training of therapists or for the clinical treatment of the stutterers we serve. Too often the therapist feels inadequately prepared, frightened, and confused about this disorder. A survey of the preparation given to prospective therapists in different training centers has revealed not only a wide variability in practicum experiences but also great discrepancies in the amount and kind of information provided. To put it bluntly, far too many of our therapists who must work with stuttering feel that their training was grossly limited. In part this reflects the complexity of the disorder, the conflicting points of view concerning its nature and origin, and perhaps the sheer overload of information available. Both instructors and students, though they find the disorder fascinating and challenging, tend to get lost in the maze. What follows is a source book designed to provide as completely as possible the information necessary to prepare a therapist to work in this area. It is styled and written primarily for the instructor who, through choice or circumstance, finds himself with the responsibility for molding a student into a clinician capable of working with stutterers. In addition it is expected that this booklet will be of real benefit to others: to the student, to the clinical supervisor and to the practicing clinician who desires to improve his competencies.

The format of this booklet is somewhat unusual. It is not a text; it is not a workbook and it is not simply an outline. Though not designed as the format for a single academic course on stuttering, it is essentially a syllabus—or course of study. There are five main chapters. Each chapter deals with a major area of study and within each chapter there are numerous "units." Each "unit" is preceded by an introduction designed to provide continuity between units and to orient the reader to the basic core of information.

The core of information is then presented in the form of "Lecture Topics" since the primary purpose of this booklet is to serve as source material for instructors. Whenever possible, references are given to supplement these topics. In some instances the topic seemed not to lend itself to this type of organization and the references at the end of the unit should then be utilized more generally. Following the "Lecture Topics" are those called "Discussion Questions," designed to be used to stimulate class participation. Often it was difficult to decide whether a

cluster of information belonged here or in the lecture section. Recognizing that each reader will use these to best suit his needs the placement is arbitrary and subject to change as the need dictates. Following these two categories we present a section entitled "Supplementary Experiences." These have been designed for the dual purpose of providing the instructor other materials for use in student projects and for stimulating active participation by the student or clinician. Following these "Supplemental Experiences" we provide a carefully selected bibliography. The references included therein are not to be viewed as exclusive or comprehensive nor are they presented in a preferential listing. It is recognized that there well may be other references just as appropriate but the intent here is to provide a sufficient listing to guide the student in the exploration of the massive literature available. We expect that often he and his instructor may wish to go beyond what has been provided. In any case the numbers of the references correspond to the numbers in parentheses following the topics in the "Lecture Topics."

As mentioned previously our intent in developing this booklet was to provide a source book to cover the content and experience deemed necessary to prepare a clinician to deal adequately with stutterers. The inherent weaknesses of preparing such resource material is obvious. What to put in, what to leave out, problems of duplication, errors; all these have plagued us. It is recognized that each instructor or student will utilize this production in light of his own background and will take from it those things most helpful to him. We expect the reader to be critical—sometimes agreeing, sometimes disagreeing—but hopefully in the end finding the material and manner of presentation useful and challenging. We also expect that there will be feelings of frustration. "How can anyone be expected to know and utilize this enormous amount of information?" is an anticipated feeling, but we hope that this will be tempered with a desire for the reader to add to his already existing knowledge and skill. It should also be very clear that this is not intended to be the final syllabus. We can only say that each of us should at least look at this map if only to know the areas we need to explore.

In the preparation of this project each of the participant authors has suffered constantly from feelings of inadequacy and a concern lest personal bias be introduced. We persisted only because we have felt an urgency for our task. We have tried hard to provide information that may be of help to you so that you can in turn help others. We have no illusions that this booklet is perfect or even complete for we know our own frailty and limitations. However, we feel we have provided aid, if not comfort, to those who desire to train or to be competent clinicians of stutterers.

CHAPTER I

The Nature and Etiology of Stuttering

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unit 1.

A CLINICAL OVERVIEW OF THE PROBLEM

introduction

The purpose of this section is to provide a broad picture of the multifaceted problem called stuttering. Stuttering is more than a disorder of speech. In addition to the overt features of the problem, there are many covert aspects such as fear, and feelings of being different, which characterize stuttering. Many features of the stuttering problem are common to all stutterers yet there are distinct differences among individuals and even within the same individual at different times. One of the significant characteristics of stuttering is that the problem changes as the individual lives with it. Students should be aware of the major terms and concepts used to describe the growth and change of stuttering. Emphasis in this introductory section is more on the clinical problem than on the research findings since these are covered in later sections.

lecture topics

Descriptions and definitions of stuttering (22, 18, 24, 3, 25); stuttering as disfluent speech; similarities of stuttering to non-stuttering speech; stuttering as an abnormal degree of tension in the speech musculature. Visible and audible characteristics of stuttering (11, 2). Covert features of stuttering such as feelings of embarrassment, frustration, helplessness, fear (5, 6, 7, 8). Differences in stuttering among individuals presenting the problem. Variations in frequency and severity of stuttering within the same speaker at different times (8). Variations in the problem between children and adults (2, 11). Common features among stutterers (18, 22). Growth and change of the stuttering problem: phases or stages of stuttering development; primary stuttering, transitional forms of stuttering, secondary stuttering (18, 19, 20, 21).

discussion topics

What is stuttering? What do you notice that makes you think a person is a stutterer? What are some useful continua for describing the problem called stuttering? What behaviors, if any, appear to be

present in all stutterers? In what ways does the problem in children differ from that in adults? Why is it difficult to describe stuttering at its inception? What does the use of avoidance and concealment devices tell us about the nature of the problem? What factors lead to the development of feelings of guilt, embarrassment, anticipation of difficulty, disturbed self-image, etc?

supplemental experiences

1. After listening to tape recordings or sound-movies of both describe how the speech of stutterers differs from the speech of children not so labeled.

2. Describe signs of tension in the speech of a group of children in nursery school.

3. Observe the speech examination of a young child referred for stuttering and summarize the parents' complaint and the problem in the child as you see it.

4. Summarize the stuttering problem described in the film CBS Film "The Search" (26).

5. Note the changes that have occurred after listening to recordings of the same stutterer made over a period of time.

6. Plot the development of the stuttering problem in the "Story of Mike" (8).

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CBS. "You are There—The Search" film. (Univ. of Iowa film.)

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unit 2.

THE INCIDENCE OF STUTTERING.

introduction

Study of the incidence of stuttering is important for more than statistical purposes. The fact that stuttering appears to be highly variable among different groups has influenced certain theoretical positions concerning the etiology and nature of stuttering. Some theorists have utilized the data on sex-ratio differences to support an organic etiology; others have leaned on the data concerning variable incidence among cultural groups to support a position of stuttering as learned behavior. The age-related incidence information appears to offer some clues to the nature of the problem.

lecture topics

Incidence vs. prevalence. Prevalence of stuttering in U.S. (12). Comparison of incidence of stuttering with incidence of other speech problems (12). Male-female ratio (8, 12). Relative incidence at different age levels (8), among different ethnic and cultural groups (3, 4, 5, 6, 7, 10, 11), and at different socio-economic levels (8, 9). Incidence of stuttering among certain exceptional groups, e.g., mentally retarded, deaf, blind, diabetic, etc. (8, 1, 13).

discussion topics

What are the weaknesses in the incidence/prevalence data? What implications are there for the theoretical explanations of stuttering from the incidence findings? Is there any way to avoid an increase in the incidence of stuttering for groups who are about to experience a change in socio-economic status (such as among recently desegregated negroes)? What cultural pressures in our society could most likely cause stuttering?

supplemental experiences

1. Interview three public school therapists and record their experiences with stutterers as follows:
   a. How many stutterers have you known?
   b. What percentage of your case load have problems of stuttering?

c. What proportion of these were in (a) the primary grades, (b) the upper elementary grades, (c) high school?
d. How many of the stutterers were boys? Girls?
e. How many had other noticeable problems?

2. Read an anthropological description of some primitive culture and list factors in that culture that would appear to increase or decrease the likelihood of a child's becoming "speech conscious."

3. Conduct a survey of the prevalence of stuttering in a beginning speech class by: (1) listening to each class member talk and make a decision as to whether or not he stutters (without letting the group know what you are doing), (2) asking all people who consider themselves to be stutterers to raise their hands, and (3) asking the teacher of the class to tell you which members of the class stutter.

On the basis of these findings, decide what the advantages and disadvantages of each type of survey method are. What interpretations can you make concerning the methods used in the various studies of incidence listed in the references below?

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unit 3.

MEASURES OF FLUENCY AND OF STUTTERING.

introduction

Disfluency as well as fluency is an integral part of the speech behavior both of persons who speak normally and of persons who stutter. Efforts to describe and to measure the ways of talking that are considered to be stuttering are facilitated by placing them in perspective with the ways of talking that are considered to be normal. The purpose of this section is to familiarize the student with different aspects of speech fluency of both normal speakers and stutterers and with the methods used to assess them.

lecture topics

Fluency norms of both children and adults (1, 2, 3). Comparison of the frequency, types and duration in the speech of normal speakers and of stutterers (3, 4). Types of disfluencies more often considered to be "stuttering" than normal, more often considered to be "normal" than stuttering; and the overlap between them (8, 11). Differences in listener evaluation of what constitutes "stuttering" and "normal disfluencies" (7, 8, 9, 10, 11). Comparison of the rate of talking between stutterers and nonstutterers (3). Methods for judging severity of stuttering (5). The relationship of frequency and duration of stuttering to judged severity (6).

discussion

In what ways can an understanding of the disfluencies present in normal speakers help us in our understanding of stuttering? How can one tell when a child is beginning to stutter if disfluencies are common in the speech of all children? Is there any given amount of disfluencies necessary for a child to be considered as a stutterer? How do you know a stutterer when you hear one? Why are the types of disfluencies that occur "on a word" (example, repetition and prolongation) more often considered to be "stuttering" than those that occur "between words" (example, interjections, phrase repetitions, etc.)?

supplemental experiences

1. Obtain tape recorded samples of young children who are

considered to be stutterers by at least one person. Also, obtain samples of speech from children who are considered to be normal speakers. These can then be played to students so that they can describe the difference in the speech patterns of the children. It is meaningful also for them to judge from listening to the speech samples which children they think are considered to be "stutterers" and which ones are considered to be "normal."

2. Observe three normal speakers in social situations and tabulate the frequency of disfluencies occurring in their speech in a five-minute period.

3. Take to class a person who stutters and one who does not stutter (the nonstutterer should not be known by any member in the class). Ask the stutterer to stand up and talk and have each member of the class tabulate each time they hear the person "stutter." Then have the normal speaker stand and introduce him to the class as a stutterer who is working on his speech in the clinic and have him talk. Ask the members of the class to tabulate each time they hear him stutter. Then, tabulate the frequency of stutterings that are heard by different members of the class. One will usually find that (a) the students in the class will vary in terms of the number of stutterings they hear from the stutterer, and (b) they will most often hear "stutterings" in the speech of the normal speaker.

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unit 4.

EXPERIMENTAL STUDIES OF THE VARIABILITY OF STUTTERING BEHAVIOR

introduction

Any scientific study of a problem involves an effort to describe it in as much detail as possible and to investigate the conditions under which it varies. Observation of a number of persons who stutter makes it evident that there are certain similarities and differences both in their speech behavior and in the situations in which they stutter. Studying the predictableness of these variables helps us in our theoretical formulations about the nature of the problem.

The purpose of this section is to introduce the reader to the experimental studies that have dealt with the systematic variation of stuttering behavior under specific conditions. It is obvious that new research findings are appearing continuously in professional journals.

lecture topics

The phenomena of adaptation (1, 2, 3, 4), consistency (1, 3) and spontaneous recovery (3, 4, 8). The use of the phenomenon of adaptation to study the ways stuttering varies in relation to the complexity and length of the reading passage, nature and size of audience, etc. (2, 3, 5, 6, 7, 8).

The tendency for a person to stutter on the same words upon repeated readings of the passage and to stutter more frequently under certain experimental conditions than in others (3, 6, 7). Spontaneous recovery following adaptation. Its theoretical and practical implications (3, 15). The importance of the concept of "expectancy" in understanding the nature of the problem of stuttering (9, 10, 11, 12, 13, 14). The clinical implications of the findings on stuttering variability (15). The theoretical importance of these findings in understanding the maintaining factors in stuttering (5, 8).

discussion topics

What are the problems of generalizing from group data to the individual? Are there needs, and if so what are they, for doing additional research on adaptation, consistency, and expectancy?

What are the dangers involved in or the benefits derived from ignoring the kinds of research findings outlined above because of a philosophy that "they don't tell me what to do in the clinical situation"? What are the similarities and the differences in the *methods* used in doing research and the methods used in clinical work?

supplemental experiences

1. Have a stutterer read a passage five times and compute adaptation and consistency scores. Also observe the nature of the loci of the stuttering. (Follow the procedures for doing this as described in Diagnostic Methods in Speech Pathology by Johnson, Darley, and Spriestersbach, Chapter 8).

2. Present a stutterer with a word list. Ask him to signal before he says each word as to whether he expects to stutter or not. Keep track of his accuracy.

3. Review the findings on adaptation, consistency, spontaneous recovery, and anticipation and prepare a report on how these findings can be accounted for on the basis of an organic, neurotic, learning or multicausation theory of stuttering.

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CHAPTER II

Historical Background, Types And Results Of Research, Theories And The Basis For Them

Unit 5: *Historical Review of Theories and Research Procedures*

Unit 6: *Organic Theories*

Unit 7: *Theories of Stuttering Which Consider the Problem to be Based on a Neurosis or a Definable "Stuttering Personality"*

Unit 8: *Theories Which View Stuttering as a Problem of Learned Behavior*

Unit 9: *Stuttering as Having Multiple Origins*

Unit 10: *Puzzlers and Unanswered Questions—Nature, Etiology and Research*

It appears to be generally true that a clinician's therapy is influenced significantly by his theoretical conception of stuttering. Therefore, to comprehend and evaluate a therapeutic approach it is important to understand the theoretical system or systems underlying the therapeutic methods and procedures. Also, in the formulation of new research, it is necessary to have knowledge of the design, methodology, and results of previous research.

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unit 5.

HISTORICAL REVIEW OF THEORIES AND RESEARCH PROCEDURES.

introduction

The purpose of this section is to describe the shift from the anti-stuttering, suppression of stuttering era through the development of the experimental approach in stuttering research and the anxiety, avoidance reduction era in therapy.

lecture topics

Faulty size, shape, or functioning of some part of speech mechanism as the etiology (2, 6, 9). Asynchrony of breathing, phonation, and articulation as casual factors (6, 9). Theories of impaired visualization and auditorization of word (5, 6). Overview of organic, psychological, psychoanalytic, learning, and multiple etiology theories (2, 4, 7, 10). Contradictory nature of research findings (2, 4). Improved research methodology and design in recent years (3, 11). Importance of critical assessment of theories (1). The single versus multicausality concept (8, 10). Ideas of "different types of stutterers," "contributing factors which combine in various ways to produce stuttering," and "different avenues to becoming a stutterer" (8, 10).

discussion topics

(a) What procedures are used in the clinic to examine a stutterer? How do these reflect a concept pertaining to the etiology and development of stuttering?

(b) How do therapeutic procedures vary with findings of the clinical examinations and how do both of these reflect a point of view about the etiology and development of stuttering?

(c) If there are different causes of stuttering for different individuals, what type of research design is needed to verify these?

supplemental experiences

1. Obtain pictures of appliances or devices which were used at time in the treatment of stuttering.

2. Prepare a chart listing and comparing the ideas about the etiology of stuttering which were held before 1925.

3. Make a report on the development of the scientific approach to the study of human behavior in psychology and speech pathology.

4. Trace the development of the American Speech and Hearing Association and show how this development coincides with the increased scientific study of speech pathologies.

5. Write a paper on the historical development in stuttering research in the U. S. as compared to Europe during the last 35 years.

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unit 6.

ORGANIC THEORIES

introduction

During the period, 1925 to 1945, as speech pathology became more scientific and research oriented in its search for the etiology of stuttering, many investigations were carried out in an attempt to find an organic etiology. Much of the data which accumulated during this period was contradictory. Studies directed toward evaluating organic factors in stuttering have continued, with a decrease in frequency during recent years, as new hypotheses have developed, new methodology has been revealed, and new research tools became available. Reviewers of the literature have commented that more recent studies in this area, which in many cases contradicted earlier ones, have been characterized by increased accuracy in technique of experimentation. At present, the point of view is held by many investigators and clinicians that organic factors may be contributing causes in the development of stuttering, or as it is often stated, organic factors may function as a predisposition to stuttering. Therefore, the purpose of this section is to describe the major organic theories of stuttering and to assess the validity of these concepts in terms of continuing research and clinical practice.

lecture topics

(a) Concept of Predisposition (3, 22). Definition of predisposition. Possible types of predisposition. Varying degrees of predisposition and interaction with precipitating factors. Examples of theories which have utilized this concept (primarily organic theories such as dysphemia, but in some cases neurotic conflicts, etc.).

(b) Theory of Cerebral Dominance (13, 18). Speech as a midline function. Language function related to cerebral dominance. Handedness and cerebral dominance. Handedness shift and ambidexterity as related to cerebral dominance and the development of stuttering.

(c) Physiological Laboratory Research Related to Cerebral Dominance Concept (14, 21). Contradictory research findings. Opinions that differences in findings reflected differing conditions of ing.

(d) Clinical Studies of Sidedness and Cerebral Dominance (5, 16). Handedness or sidedness as related to cerebral dominance and stuttering. Use of questionnaire and performance tests. Contradictory research results. Recent research studies of more technically satisfactory design indicates no differences between groups of stutterers and groups of non-stutterers.

(e) Electromyographic Investigations and the Concept of Cerebral Dominance (19, 25). Neural impulses to paired speech musculature and cerebral dominance. EMG viewed as a technique for investigating the synchrony of neural impulses to speech mechanism. Research findings contradictory. Approach reveals difference in tension and movement, not functional capacity of the central nervous system.

(f) Electroencephalographic Investigations (6, 7, 20). Use of this procedure and attempt to verify theory of cerebral dominance. More recent use of search for abnormal patterns. Inconsistency of research findings and differences in instrumentation, experimental design, and control procedures. Inconsistency of findings and possibility of neurologic differences in some stutterers and not in others.

(g) Stuttering as Related to a Neuromuscular Deficit (4, 24). Studies rate stutterers as being inferior and superior. More recent studies of better design indicate no group differences.

(h) Stuttering as a Perseverative Phenomenon (4, 11, 12). Constitutional and psychogenic perseveration. Studies of adults revealing differences between stutterers and non-stutterers. Anxiety-produced tension in adult stutterers as a possible explanation of perseveration.

(i) Stuttering as a Failure of the Speech Servo-System (8, 15, 17). Similarly in the speech behavior of person experiencing delayed sidetone and the person who stutters. Research to explore the neurophysiological integrity of the speech servo-system. Use of masking and delayed auditory feedback in modifying stuttering behavior.

(j) Stuttering as Related to Biochemical Factors and Epilepsy (2, 9, 23). Assumption that slight variations in blood composition of stutterers, as revealed by some research, resulted from stuttering behavior rather than being an antecedent to it. West's formulation pointing to the high incidence of stuttering in epileptics and the rareness of stuttering among diabetics.

(k) Hereditary Factors and Stuttering (1, 3, 4, 10). Factors related to the possibility—(1) predominance of stuttering in male sex, (2) familial disposition for stuttering, (3) higher incidence of stuttering in twins, and (4) essential similarity of the disorder, although variable, from person to person. Opinion that what runs in families is attitude toward dysfluent speech.

discussion topics

(a) Some authorities believe that there may be a constitutional

basis for stuttering. How does the learning theory concept of stuttering complement, supplement, or contradict these theories?

(b) What are some possible explanations for the uneven sex ratio in the incidence of stuttering?

(c) What are some possible ways to evaluate West's view of stuttering as related to an epileptic disorder?

(d) Is there a need in terms of new apparati and methodology to reinvestigate any of the organic theories of stuttering about which there are contradictory research findings?

(e) Can heredity be dismissed as a possible factor in stuttering?

supplemental experiences

1. Examine some basic textbooks in neurology, psychology, and psychiatry including ones published in each decade from 1920 to the present. How do they explain the onset and development of stuttering?

2. Outline a proposed research study to investigate or reinvestigate the possibility of some organic factor, or factors, in stuttering. State the purpose and outline the procedure.

3. Explore the literature in the field of psychosomatic medicine and prepare a paper in which there is a critical evaluation of the relationship between this concept and the way in which organic and psychological factors might be operative in stuttering.

4. Prepare a critical assessment of the concepts of "primary stuttering" and "normal dysfluency" as related to physiological variations in children and the development of stuttering.

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unit 7.

THEORIES OF STUTTERING WHICH CONSIDER THE PROBLEM TO BE BASED ON A NEUROSIS OR A DEFINABLE "STUTTERING PERSONALITY."

introduction

One of the viewpoints concerning the cause of stuttering purports that the disfluent, struggling manner of speaking is basically a manifestation of an underlying emotional disturbance. The purpose of this section is to present the theories related to this concept and to assess their validity in terms of research concerned with the onset and development of the problem.

lecture topics

Different viewpoints which consider the problem of stuttering to develop, in differing degrees, from an emotional disturbance or from stresses or breakdowns in personal relationships. Variability of viewpoints from those which consider stuttering to be strictly a symptom of neurosis (1, 3) to those which consider the problem of stuttering to be indicative of emotional disturbances such as, repressed conflict, or hostility, etc., with certain aspects being learned (2, 4). The *crucial* component in these theories as to the nature of the problem: the emotional disturbance is central with the learned components secondary to the central problem. Relating of these viewpoints with those in the next section. (Theories of Stuttering as Learned Behavior) in which the emotional components, even though existing in some instances, are secondary to the central components of learning. Review of research evidence supporting these concepts (5, 6).

discussion topics

What are the similarities and differences in these viewpoints concerning the etiology of stuttering? What experimental evidence is available which supports or refutes these viewpoints? How can one integrate the research findings concerning the variability of stuttering with these theories of etiology?

supplemental experiences

1. Write a paper discussing the ways the different theorists in this "personality disorder" area use (or ignore) the speech symptoms of stuttering. (Example: Some use them to support their theories—others ignore them.)

2. Prepare a paper discussing the similarities and differences of the specific "personality components" that appear to be crucial in the different "personality disorder" areas. (Examples—ego strength versus fixation at a developmental stage).

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unit 8.

THEORIES WHICH VIEW STUTTERING AS A PROBLEM OF LEARNED BEHAVIOR

introduction

The purpose of this section is to present the learning theories of stuttering and to assess the validity of these concepts in terms of available research and therapeutic practice. The reader is urged to evaluate carefully the meaning of the words "learned" and "emotional" (as used in previous section) in attempting to explain the occurrence of specified behavior. Neither is specific. Both are equally vague unless evaluated in context.

lecture topics

Consideration of the onset, development and maintenance of stuttering as a form of learned behavior (1, 2, 3). Explanation of the basic concepts involved in this viewpoint which consider the problem of stuttering to be learned with related emotional problems to come about as reactions to the disfluent speech (2, 3, 4). A detailed study of communication involving a speaker and a listener (7). The interactions of and the relationships between the listener and speaker which are hypothesized to promote hesitant cautious struggling speech with related feelings of conflict, guilt, embarrassment, etc., on the part of the speaker (1, 4, 5, 8).

Discussion of stuttering as a developing problem with consideration of the role of avoidance and escape behavior and feelings of guilt, shame, and embarrassment (2, 3, 4, 7, 9). Important here also is the concept of reinforcement in the perpetuation of specific stuttering patterns (6, 9).

discussion

What are the similarities and differences in these viewpoints concerning the etiology of stuttering? What experimental evidence is available which supports or refutes these viewpoints? How can one integrate the research findings concerning the variability of stuttering with these theories of etiology?

supplemental experiences

1. Explore a kind of behavior of your own which has exhibited some equivalences to stuttering. (Hesitancies; clumsiness; approach-avoidance feelings and behavior; guilt feeling because of avoidance; struggle; etc.). Outline the factors that have contributed to the learning and maintaining of this behavior.

2. Describe in considerable detail some "stuttering equivalents" in a child and in an adult of your acquaintance. Point out the "learned behavior" components of this pattern of behavior.

references

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unit 9.

STUTTERING AS HAVING MULTIPLE ORIGINS

introduction

Throughout the recent history of stuttering theory and therapy in the United States, Van Riper has maintained the opinion, based on his research and clinical experiences and that of others in the field, that stuttering can have multiple origins. Many other contributors have this point of view, at least to some extent. This opinion does not seem to be confined to those who believe that organic factors are of importance since some of those with a psychological, learning theory point of view often speak of different avenues in and out of stuttering. Recently, there has been considerable discussion of the need to design research studies to explore this concept, as well as emphasizing it in our diagnostic and therapeutic procedures. Consequently, this section should review and evaluate the way in which some authorities have stated the premise that stuttering may have a different origin in different stutterers and that different factors might combine in a variety of ways to produce essentially the same problem.

lecture topics

Various meanings of the concept of multiple origins (1, 2, 3, 4, 5, 6, 7). Van Riper's eclectic point of view (5, 7). Bloodstein's anticipatory struggle hypothesis as a multiple origin approach (4). The varying relationship among predisposing, precipitating and maintaining factors (4, 5, 6, 7). Relationship of multiple origin concept to research (6). The syndrome concept as related to stuttering (2, 6). The relationship between differing origins and differing symptomatology, e.g. stuttering complicated by cluttering, stuttering which begins with tonic blocks, etc. (3, 7).

discussion topics

(a) What implications does this multiple origin idea have for research?

(b) Does this theory have any implications relative to the contradictory nature of research on the etiology of stuttering?

(c) Does this theory imply a need for a team approach in research on stuttering and in the treatment of the problem?

(d) Are there other disorders of a psychological and/or physio-

logical nature that utilize this type of concept in explaining the etiology and development of the disorder (or disease).

(e) Can you find instances in the literature in which some theorists use some research to support their viewpoint and tend to ignore data which are not consistent with their theory?

supplemental experiences

1. Trace the development and modifications in diagnostic and therapeutic procedures presented by Van Riper in the three editions of the books—1947, 1954, and 1963. How do you think his methods and procedures reflect a changing concept of the problem of stuttering?

2. Prepare a chart in which you attempt to integrate stuttering theories using Ainsworth's three basic questions as presented in his chapter in the Handbook of Speech Pathology entitled, "Methods for Integrating Theories of Stuttering." The three basic questions are as follows:

(a) What are the contributions to the descriptions of the behavioral, social, and psychological concomitants of stuttering?

(b) What are the contributions to understanding the *process of development* of stuttering?

(c) What contributions toward explaining these phenomena are offered?

3. What can you find in professional journals, published during the last ten years, to support or deny this theoretical position about stuttering?

4. How many statements can you find in present day textbooks on stuttering that deny the possibility of the multiple origin belief?

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unit 10.

PUZZLERS AND UNANSWERED QUESTIONS—NATURE, ETIOLOGY AND RESEARCH

introduction

All of us who teach are aware of the tendency of many students to assume that all of the important questions about a subject have already been answered. This section is intended to dispel that notion and to encourage students to develop habits of serious original inquiry. Most of the suggested lecture topics deal with general concepts concerning research and a philosophy of science. These, however, can be tied to a look at our attempts to find our way through the stuttering maze. Frequently, we have probably asked the wrong questions. Almost continuously, we find that the set of behaviors called stuttering do not fit with ease into research designs that provide definite answers. As a result, we have many unanswered or inadequately answered questions about stuttering.

Possibly, discussion topics such as those suggested below will be the primary method for encouraging students to think more deeply about the nature and etiology of stuttering and to bring new approaches to the study of this problem.

lecture topics

The nature and impermanence of "facts" (5, 6). The processes of discovering information (3, 5). Certainty versus uncertainty in science (1). Relation of the type of question to the type of information required (2, pp. xi-xxiv). The difficulty in satisfying statistical assumptions (*e.g.*, normal distribution, random sampling, etc.) in terms of the populations of stutterers commonly available for research (1, 4).

discussion topics

What is the most important question about stuttering? How is the problem of stuttering like (and different from) the following other childhood problems: measles, habitual thumb sucking, learning to read, epilepsy, etc. How could the uneven ratio of male-female stuttering be explained by: (a) operant learning theory; drive-reduction theory, servo-mechanism theory, etc. Does the relative incidence of stuttering among males and females remain constant from culture to culture? Why? Is it possible to develop an adequate explanation of stuttering as learned behavior utilizing present-day concepts and

findings from the field of psychological learning? Can the concept of fear as an important characteristic of stuttering be included in an adequate non-neurotic explanation of stuttering? What kind of knowledge would be necessary for you to evaluate effectively such theories as: Glauber's psychoanalytic approach; Sheehan's approach-avoidance conflict theory; Johnson's diagnosgenic; West's view of stuttering as an epileptoid condition; Eisenson's perseveration theory? What type of background would you need to develop your own theory of stuttering? What value would there be in doing so? How could you evaluate your own theory? What new findings in related fields would appear to alter present-day concepts? If there are different causes of stuttering for different individuals, what type of research design and statistical analysis is needed to determine these?

supplemental experiences

1. Examine the research on stuttering reported in last year's *Journal of Speech and Hearing Disorders* and *Journal of Speech and Hearing Research* and determine how many of the studies used proper statistical sample techniques.

2. Examine the research on stuttering reported in the 1940, 1950, and 1960 *Journal of Speech Disorders* and *Journal of Speech and Hearing Disorders* and compare (1) the percentage of the total articles printed that are devoted to stuttering (2) the percentage of the articles that investigate the results of therapy versus those that investigate the nature of the problem, (3) the types of questions asked by the researcher.

3. Compare the use of research findings in the theories by Bloodstein, Sheehan, and West (5).

4. Evaluate Johnson's explanation for the lack of agreement among stuttering theoreticians in his introduction to *Stuttering: A Symposium* (2, pp. xi-xxiv).

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CHAPTER III

Diagnosis

3

unit 11.

DIAGNOSIS: EXAMINATION PROCEDURES: AN OVERVIEW

introduction

Treatment for those who come or are brought to the therapist because of concern about stuttering involves a more or less continuous effort to understand the client and his problem. Hence, in most instances, diagnosis is taking place throughout the course of treatment. And information about the tools and techniques of diagnosis will be found throughout this chapter. The purpose of this particular section is to provide an overview of the various techniques and procedures useful for gathering information from those who stutter and from the parents of children who are suspected of stuttering.

lecture topics

Principles and techniques of interviewing (1, 2, 3, 4, 5). The examination approach for young children (9, 10). Examination of the stuttering behavior in older children and adults (6, 8, 9, 10). *Gathering information about the stutterer and the ways he has been affected by the stuttering; specific devices:* case history forms (7, 9, 10), the oral interview (6, 3, 8), check lists and questionnaire-type inventories (6, 8), autobiographies (8), psychodiagnostics (7, 8, 15). Trial therapy. Preparing the professional report of the examination (11, 12, 6). Referral considerations and procedures (9, 14). The varying strategies for sequential programming of the examination for different clients (14).

discussion topics

What are the important "do's" and "don't's" to keep in mind in the initial interview? How may the initial interview serve as the first step in treatment? When are *direct* and *nondirective* techniques applicable in the information-gathering process? What are some effective opening gambits in the first direct contact with a stutterer? When should parents be interviewed separately or together? How should the therapist react in specific interview situations such as (a) when a stutterer has unusually severe difficulty in communicating, (b) when a stutterer states that he doesn't know why he was sent to see a therapist, (c) when a stutterer states that all he needs to solve his problem is more confidence, (d) when a parent expresses pronounced feelings of guilt about a child's stuttering, or (e) when a parent becomes hostile?

supplemental experiences

1. Re-do the speech examination for an adult stutterer and discuss the results with his therapist.

2. Invite a staff member or advanced graduate student in the psychology department or psycho-educational clinic to discuss personality tests.

3. Arrange to have a projective type test administered to a stutterer and interpreted to the class.

4. Set up some role playing situations in which students play the therapist role and the instructor plays roles representing various types of troublesome interviewees.

5. Make up original case history forms for children and for older stutterers.

references

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unit 12.

DIAGNOSIS: DIFFERENTIAL DIAGNOSIS

introduction

Disfluent or broken speech is not always stuttering. Sometimes it is normal behavior erroneously identified as stuttering. In other instances, what appears to be a problem of stuttering is actually some different disorder of fluency or a temporary siege of "stuttering" associated with some unusual condition or circumstance. Since the distinctions are critical for effective guidance or treatment, the differential diagnosis is an important phase of the treatment process.

lecture topics

The problem of differing definitions of stuttering (3, 4, 9, 11, 16). Normal vs. abnormal disfluency in children; criteria for judgments in differential diagnosis (1, 2, 6, 8, 12). Transient "stuttering" (13, 14, 15, 17). The disorder of cluttering (5, 7, 10). Stuttering vs. spastic dysphonia; stuttering vs. cerebral palsy; "aphasic" stuttering; "neurotic" stuttering. Measuring frequency and duration.

discussion topics

Are there two distinct disorders, one stuttering, the other stammering? How may cluttering become the problem of stuttering? How can stuttering be most easily identified early in young children? Does everyone stutter? What are the distinguishing features of stuttering in young children? How does the speech and other behavior of your classmates reflect the characteristics often identified with stuttering? Are there individuals among your acquaintances who "might be stutterers?" What makes you think so? Should you do anything about it? If so, what?

supplemental experiences

1. Observe the interview of the parent of a child referred for stuttering. Then observe the child and evaluate the accuracy of the parent's ideas about the child's speech.
2. Make a list of definitions of stuttering from the professional literature.
3. Question ten friends or acquaintances on their ideas about behavior that justifies being called stuttering.
4. List all the "symptoms" you can discover in the observation

of a stutterer. Use the list to examine non-stutterers of your acquaintance. Which of the symptoms are unique to stuttering?

5. Listen to some of the speech of two or three cerebral palsied individuals and note evidences of "stuttering." Describe any features that you feel differentiate these evidences from "typical" stuttering.

6. Do a similar assignment for some aphasic adults.

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unit 13.

DIAGNOSIS: DEVELOPMENTAL DIAGNOSIS

introduction

Stuttering changes as it persists. It tends to become more pronounced, to occur more frequently, and to vary in form and in its significance for the stutterer. As these changes take place, the problem that stuttering presents for treatment also changes. If stuttering is to be treated effectively, the therapist must be able to identify the various developmental stages and to appreciate the significance of each for therapy.

lecture topics

The concept of stuttering as a multi-stage disorder. The primary-secondary dichotomy (1, 2, 3); considered limitations (4, 9). The concept of a transitional stage (7, 8). Stuttering viewed as having four developmental stages; characteristic features of individual stages (5, 6, 10).

discussion topics

How are penalizing reactions to stuttering related to its development? What is the role of frustration in development diagnosis? How do tremors develop and what is their significance in diagnosis? What specific research projects can you suggest regarding developmental stages? Do word and situation avoidances differ in their significance for developmental diagnosis? How is the severity of overt stuttering related to the severity of the problem presented for therapy?

supplemental experiences

1. Compare the features that characterize stuttering in each of the four stages as presented by Bloodstein (5) and by Van Riper (6).
2. Write a report based on a discussion with a stutterer about the changes that occurred in his pattern of the stuttering over a period of several years.
3. Interview a stutterer about the changes that took place in the feelings about his problem over a period of years.

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unit 14.

APPRAISAL AND PROGNOSIS: DEFINING THE CLINICAL PROBLEM IN THE CHILD STUTTERER

introduction

The problem stuttering presents *clinically* in the majority of young children is something more than and indeed something other than a matter of broken fluency. Thus, treatment that focuses on the speech behavior seldom is successful. Instead, the therapist must be concerned with those factors in a child and/or his environment which are operating to precipitate and to aggravate the stuttering behavior. The obtained information for most young stutterers will include several possibilities. A review of these possibilities — the various conditions and environmental circumstances that can be related to the presented problem — is one of the purposes of this section. The other is to emphasize the importance of determining the relative significance of evident factors in individual cases.

lecture topics

An equation for stuttering in children (6: 358). Emotional disturbance and impaired interpersonal relationships (1, 2). Penalizing listener reactions (3: 47-58). Adequacy of developmental skills: speech, motor, language (4, 5). Communicative stresses in environment (6: 365). General physical health. Child's tolerance for frustration and for anxiety. The presence or history of stuttering in other members of the family. The role of academic difficulties. Prognosis; favorable and unfavorable signs (3: 122; 7: 6-9).

discussion topics

Are there identifiable kinds or types of stutterers? What may be the relationship between a lag in neuro-motor development and stuttering in children? What is hypersensitivity; what clinical significance may it have for stuttering in children? How may mental deficiency be a clinically significant factor for the stuttering in children? What is meant by immaturity? When a young child who stutters also has some other speech disorder such as an articulation defect, how can the clinical significance of each be determined?

supplemental experiences

1. Interview a therapist about his experiences with children e stuttering ceased after some single environment change.

2. Question a therapist about his rationale for determining the responsible factor for stuttering in children.

3. Interview two parents of your acquaintance with several children. Record their descriptions of the differences in the speech development of the children and ways they have tried to adapt to the differences.

4. Explore with two parents of your acquaintance the ways that interruptions or other characteristics in the speech of their children were noted and reacted to or "handled" and how the children have responded. Write a report relating these findings to the lectures and readings.

5. Interview parents of two young stutterers about any differences in the early development and special problems encountered for the stuttering child and their other children.

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unit 15.

APPRAISAL AND PROGNOSIS: DEFINING THE CLINICAL PROBLEM IN THE SECONDARY STUTTERER

introduction

When stuttering behavior has become established and the associated emotional reactions have become internalized, the problem presented for therapy tends to have multiple components. The individual factors vary markedly in their significance for treatment. Successful therapy for established stuttering depends on accurate identification of the various components and skillful assessment of the significance of each component for the treatment process.

lecture topics

The concept of patterns of clinical problems presented by secondary stutterers (1, 2). Evaluating motivation for treatment. Identifying stutterers who need treatment that emphasizes psychotherapy. Approach-avoidance conflicts at various levels (3). Identifying and evaluating the stuttering behavior component in the secondary stutterer. Determining the extent to which stuttering is a personal, a social, or an academic problem. Evaluating the role of guilt, anxiety, hostility. Evaluating the significance of earlier treatment. The clinical significance of the stutterer's self-concept. The primacy of problems; stuttering coexisting with other problems (4, 5). Prognosis; favorable or unfavorable signs (6).

discussion topics

What is the clinical significance of specific component features of secondary stuttering such as poor eye contact, marked abulia, prolonged "silent blocks," profound struggle behavior, observable tremors, and compulsive stuttering? What are the advantages and disadvantages of the team approach in diagnosis and appraisal for stutterers? What patterns of stuttering behavior offer the best prognosis? Can stuttering be a problem in the absence of an emotional factor? How would you proceed to determine whether stuttering is being used to conceal some other problem? Would superior intelligence be favorable or unfavorable for prognosis? What is the minimum information needed about a stuttering problem before formal therapy can be initiated?

supplemental experiences

1. Arrange, if permissible, to review the collected information from the files of an adult stutterer and record what you consider to have been the significant factors of the problem.

2. Present a report about the case of Robert (7) or of Bob (8).

3. Interview a therapist about his approach to appraisal and prognosis.

4. Prepare a report of the characteristics and significance of a problem or pattern of behavior of your own that has many equivalences to stuttering. Describe the development and present status and evaluate these findings in terms of a "treatment" program.

5. Select a behavior pattern of your own that has many equivalences to stuttering and discuss how this affects your concept of yourself.

6. Observe as much as possible of a complete diagnosis of a problem of stuttering. *List* the activities of the therapist during these sessions and describe how each activity contributed to the diagnostic report.

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CHAPTER IV

Treatment

4

unit 16.

A HISTORICAL OVERVIEW SHOWING HOW TREATMENT HAS REFLECTED THEORIES OF NATURE AND ETIOLOGY

introduction

Throughout our history the various practices and procedures used by therapists in treating stutterers have often reflected their views of the nature and cause of the disorder. There have been many differing methods used in treating stuttering, some simple, some silly, some very sophisticated and based upon scientific hypotheses. At the present time, many different procedures are being employed by many people who are professionally trained. Some of these are remnants from the past, and must be viewed as such. There are current conflicts even within our own profession concerning how the stutterer should be treated. By examining the history of the various *treatments* of stuttering in terms of the rationales on which they were based, we are thereby made aware of the necessity of examining our own practices.

lecture topics

In the following listing, the underlined phrases refer to the nature or etiology concept upon which the treatment that follows was based. *Organic disorder of tongue:* spices, cautery, surgery (1, 4). *Disorder of breathing:* Demosthenes leaden plates and the formerly frequent use of breathing exercises (1, 3, 29). *Disorder of phonation:* singing and chanting and the octave twist (1, 7, 23). *Disorder of articulation:* the elocutionist approach, blending, slurring (3, 25, 26, 28). *Disorder of rhythm:* arm swinging, phrasing (11, 22, 24, 25). *Neurological disorder of coordination:* shift of handedness, talking and writing (8, 29, 12). *Disorder of language:* auditorization (7), visualization (6, 7). *A learned response:* negative practice (5), operant conditioning (13), "fluent stuttering" (12). *A psychoneurosis:* counseling (10), hypnotherapy (15, 18), psychoanalysis (9, 17, 19). *A biochemical deviancy:* drug therapy (15). *The result of misdiagnosis and misperception:* semantic therapy (21).

discussion topics

Why do so many different treatments of stuttering seem to help some stutterers? What are the roles played by suggestion or distraction in each of the treatments mentioned? Why do so many stutterers seek hypnosis or magical forms of treatment? What com-

mon fear-reduction components seem to be present in many of the methods used? The urgent need for long term follow-up of casework with stutterers has long been recognized but few such studies exist. Why? What is meant by the "Cure" of stuttering?

supplemental experiences

1. After a thorough discussion of the *temporary* reduction or remission of stuttering under certain conditions, present an adult stutterer performing the following activities: choral reading; chanting in a monotone; profoundly relaxing; syllable tapping or arm swinging; using a foreign accent or exaggerated type of speaking; singing; belly-thrusting in unison with each speech attempt or other similar behavior. The weaknesses and dangers of such procedures.

2. Read Charles Pedrey's "Letter to the editor," *Journal of Speech and Hearing Disorders*, 15, 1950, 266-269 and formulate the basic theory as to the nature and cause of stuttering which would lead to the use of the various treatments described therein.

3. Interview some stranger and report his view of the nature, causes and treatment of stuttering.

4. Assuming that stuttering is an allergic reaction to communicative stress, akin perhaps to asthma, invent a rationale of treatment based upon this view.

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unit 17.

CURRENT APPROACHES TO STUTTERING THERAPY: PSYCHOTHERAPY.

introduction

The present unit concerns psychotherapy. While some psychotherapy seems inevitable in any form of treatment whether we call it by that name or not, there are some stutterers for whom this is the treatment of choice, the basic, the essential approach. There are some therapists who confine themselves solely to this approach and there are various ways in which they use it.

lecture topics

The goals of psychotherapy (2, 21). The various methods: psychoanalysis (1, 3), counseling (2, 5, 11), group therapy (17, 18, 22), play therapy (2, 10), psychodrama (9, 10), suggestion and hypnotherapy (15 20, 23), bibliotherapy (18, 22), exhortation and pledging (19, 24). Necessary training required for administering these different methods, the dangers and cautions and common difficulties encountered (2, 21).

discussion topics

What is the evidence for considering stuttering as a neurotic symptom of a disordered personality? How could the experience of communicative frustration and social penalty create a neurosis? How does the stutterer profit from his stuttering? How effective is psychotherapy alone with stutterers? What changes in personality seem to occur in different stutterers as the disorder develops? Should the speech therapist do psychotherapy as such? How much could the disorder itself interfere with the counseling process? How would group psychotherapy be structured with stutterers? What are the diagnostic indications for using this approach?

supplemental experiences

1. Paper and pencil interview a stutterer in which the therapist's responses are omitted.

2. Answer the questions on page 21 and 27 in Van Riper, C. and L. Gruber: *A Casebook in Stuttering*. New York: Harper, 1957.

3. Interview some stutterer concerning his experiences with psychotherapy.

4. Invent an interview with a mother who is covertly rejecting her stuttering son.

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Unit 18.

THE INTERACTION APPROACH TO STUTTERING THERAPY.

introduction

It has been stated previously, that most clinicians vary their approach to fit the needs of the client. Basic to all of these approaches is the fact that they interact with each other. As humans, the most basic component of this interaction is verbal — the language they use.

This approach emphasizes the need to evaluate continuously the changing interactions between speaker and listener because it helps to define operationally the current needs of the client. A careful evaluation of the language he uses assists the clinician to evaluate these interactions. As these interactions change, it provides a changing criterion for the clinician to assess improvement or regression. This section provides the rationale for this approach to therapy.

lecture topics

The use of the concepts in General Semantics to change evaluations and attitudes (3). The importance of the language we use in shaping the attitude and beliefs we hold about ourselves — and others (3, 5). The degree to which our basic assumptions determine the observations we make. The concept of "normal" versus "abnormal" and its effect on our behavior (1, 2, 5, 7). The difference between descriptive and evaluative statements and the difference it makes (3, 5). The degree to which our verbal behavior affects the interaction between speaker and listener (1, 2, 5, 7). The dynamics of the interaction involved in (a) the way the child speaks, (b) the listener's reactions to this, and (c) the child's reactions to the listener's reactions (1, 2).

The problems involved in helping parents become aware of their own perceptions and evaluations in observing the speech of their child (1, 7).

The problems of helping the person who stutters (a) to test reality, (b) to increase talking time, (c) to decrease "avoidance" of stuttering and to increase a positive approach toward talking, and (d) to define and to come to act in more ways considered to be "normal." The importance of listening in communication (1, 2, 5, 6).

discussion topics

In what ways and to what extent does the language we use do

our thinking for us? What are the differences in the implications for therapy of thinking of the word "stuttering" as an evaluative rather than a descriptive term? To what degree is it meaningful to think of of "stuttering" as some things one "does" to interfere with talking that he must change rather than as something one "has" that he must attempt to control? What is the meaningfulness in instructing a person to do more things to talk instead of fewer things to not stutter? To what extent are the concepts of General Semantics (the way one talks about a problem) also employed (or not employed) in the "psychotherapy" and "eclectic" approach to therapy?

supplemental experiences

1. Keep track of your own talking time for an entire day with a stop watch and card. Compare it with that of three stutterers.

2. Keep a log of all the disfluencies you have or hear for a day and try to determine the stresses which evoked them.

3. Deliberately use some easy repetitions with strangers and note their reactions.

4. Stutter very severely to a stranger and describe your own feelings and behavior.

5. Ask a stutterer to do the same assignment and compare.

6. Select among your acquaintances a person whom you speak to to say "hello" but not to converse with at length. For at least *one week* attempt to engage this person in short conversations on each encounter. See how long you can detain him, short of being obnoxious. Do this by complimenting him in various ways, commenting on his appearance, clothes, etc., asking him questions about his activities, and in general setting a tone of "how interested you are in him." Avoid talking about yourself. After at least five interactions — keep a log — describe the change in behavior of your subject toward you and also any change in your attitude toward him.

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unit 19.

CURRENT APPROACHES TO STUTTERING TREATMENT: LEARNING A NEW WAY OF STUTTERING.

introduction

The emphasis of the devotees of this approach is upon the direct modification of the stuttering behavior. Essentially, the stutterer is taught a new and presumably better way of stuttering, one with only minor abnormality and interruption. Indeed the stutterer is encouraged to stutter, but in a more fluent and acceptable fashion. The task of the clinician here is to find ways of weakening the old stuttering behavior and of substituting a new fluent variety in its place.

lecture topics

Stuttering as learned behavior (2, 3, 16). The varieties of stuttering behavior (1, 14). The underlying purposes served by stuttering behaviors: avoidance, postponement, anti-expectancy, release, and escape (6, 15). How behavior is modified: confrontation and identification of the behavior to be eliminated (7, 3) reducing its reinforcements (4) experimenting with new forms of stuttering (6, 8) substitution of a better variety of stuttering (9, 13) stabilizing the new response to the old cues (7, 6). Different forms of acceptable stuttering (10, 11).

discussion topics

What is the evidence for the concept that much of the stuttering behavior is learned? Why are there so many different varieties of stuttering? Defend the statement that all stuttering behavior except the momentary fixations or oscillations is habitual. How can we decrease the built-in reinforcement which stuttering seems to create? How do we "break habits"? Is the process of learning a new form of stuttering a substitution or a progressive approximation process? How do new behaviors become automatized? What is meant by "negative practice"?

supplemental experiences

1. Play a tape recording of a severe stutterer, note the variations in behaviors used in stuttering, and attempt to locate and identify some instances of stuttering which have little abnormality interruption in them.

2. Fake a series of stutterings on the same word which have approximately the same duration but try to make each successive stuttering less abnormal than the one which precedes it.

3. Demonstrate the different types of stuttering described in the following article, first quoting the passage you are illustrating. Dougless, E. and Quarrington, B., "Differentiation of Interiorized and Exteriorized Secondary Stuttering," *Journal of Speech and Hearing Disorders*, 17, 1952, 377-382.

4. Stutter in three different ways to strangers and report their reactions and your own.

5. Write a careful description of the different behaviors shown by a stutterer while stuttering.

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unit 20.

CURRENT APPROACHES TO STUTTERING THERAPY: ECLECTIC THERAPY.

introduction

We have said earlier in our discussion of present methods of treating stuttering that the majority of clinicians use a variety of approaches to the problem. This does not mean at all that we merely try anything that seems to produce some temporary relief or fluency or flit from one technique to another. There is always the need to create a design of therapy specifically tailored to the individual client's needs. There must be an overall plan based upon careful diagnosis and continuing assessment. This plan must also always be subject to revision. Our stutterers' needs change even during the course of treatment. The clinician must be alert to the need for flexibility and the redesign of therapy when such a change seems needed. We include this special unit to make this point crystal clear.

lecture topics

Stuttering as a multidimensional problem (1, 3). The necessity for a global approach: for treating the stuttering speech behavior as but one part of the stutterer's overall difficulties (4). Varieties of problems presented by stutterers (6). Van Riper's stuttering equation as a model for eclectic therapy (2). Common features in the psychotherapeutic, semantic reorientation and learning a new form of stuttering approaches (5). Levels of conflict in therapy design (3). The more common types of problems presented by secondary stutterers (6). Unusual problems sometimes encountered (8, 9, 10, 11, 12, 13, 14).

discussion topics

What are the common causes of clinical failure in stuttering therapy? Why is it often so difficult to revise our therapy planning? In what ways can the same clinical experience be viewed as consistent with the several approaches? What revisions in Van Riper's stuttering equation should be made? What are the criteria of failure in applying a given approach? How can we account for the concept of therapy as an oscillatory process with ups and downs and plateaus?

supplemental experiences

1. Choose students to assume the roles of the six authors in

Eisenson's Symposium and have them give a panel discussion before the class.

2. Have a student defend the proposition that semantic therapy is an eclectic approach.

3. Have a therapist describe in detail his current therapy methods with a stutterer and have the class analyze his presentation in terms of the components of semantic, psychotherapeutic and modification therapies.

4. Analyze the strengths of the various factors in the stuttering equation (as described by Van Riper) of a stutterer presented before the class and interviewed there.

5. Summarize Wendell Johnson's "Introduction: The Six Men and the Stuttering," in: Eisenson, J. (ed.) *Stuttering: A Symposium.*

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unit 21.

TREATMENT OF THE CHILD REFERRED FOR STUTTERING.

introduction

There is a special challenge for the therapist when a child is referred for stuttering which has not yet become an established problem. If treatment can be successful at this time, a more or less permanent and handicapping problem may be prevented. The purpose of this section is to present information about the goals of treatment and the various methods of dealing with the problem in the earlier stages.

lecture topics

The goals and major targets of treatment (1, 2, 3, 4). Treatment approaches: indirect, semi-direct, direct; criteria for applications (5, 6). Specific treatment methods: education, giving of information and advice, bibliotherapy (5); counseling (9, 11, 12, 13, 14); speech improvement programs (7, 8); play therapy (9, 10, 11); projective therapies (9, 11, 15); desensitization therapy (3, 5); manipulation of home or school environment; summer camps and clinics; direct modification of stuttering behavior (5, 16); psychotherapy for parents (17, 18).

discussion topics

Why do some children outgrow stuttering? Should children who stutter be treated individually or in groups? To what extent should parents be involved in the treatment process for the child stutterer? How may the uncooperative parent be managed? Does drug therapy have a legitimate role in the treatment of the child stutterer? How may a child's intelligence influence the treatment approach? How does the treatment of stuttering children in Russia compare with that in this country (19)? How does the psychoanalytic psychotherapist treat stuttering in children (18)?

supplemental experiences

1. Interview a public school therapist concerning difficulties of treating stuttering in young children in that setting.
2. Make a collection of pamphlets and booklets offering information about stuttering in children.
3. Write a speech about stuttering in children for a teachers' meeting; for a pre-school mothers study group.

4. Design a section for a speech improvement program that would be particularly suitable for children who stutter.

5. Interview a practicing clinical therapist about his criteria for deciding to work directly with a stuttering child.

6. Invite a person experienced in play therapy, projective or release therapy, or psychoanalytic psychotherapy to discuss his method with your class.

7. Observe some direct treatment of a pre-secondary stutterer. Report your observation to class for discussion.

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unit 22.

PLANNING THE TREATMENT FOR THE ADULT OR SECONDARY STUTTERER.

introduction

The design of therapy involves more than the selection of the appropriate overall approach. The sequence of experiences must also be considered. Some stutterers come to us with high motivation; others with very little. The time available for therapy is often of crucial importance. So too is the setting. We seldom have an ideal situation in which we do our work. The stutterer may have other needs of greater importance than the relief we may be able to give him. Compromise is often necessary and when this occurs, our planning must consider all these factors. We may have to revise our goals downward. We may have to do what we can with the limited time available to make gains or even merely to create a state of readiness for future therapy.

lecture topics

The therapeutic settings: home; school; clinic (1, 6, 7). The dynamics of group, individual and self-therapy (6). The goals and subgoals of therapy (3, 4, 5, 8, 9, 10). Programming the sequence of treatment experiences (6). Time factors in treatment — scheduling (1, 6). Realistic versus unrealistic planning (3, 9, 11, 12).

discussion topics

In planning the sequence of therapy are there differing goals for each phase or stage of treatment, and, if so, what are they? What are the limitations of Van Riper's concept of Midvas? What are some of the crucial experiences that often occur in therapy? How can we program an appropriate schedule of reinforcement for signs of improvement? What should determine the setting of maximum and minimum goals for a given assignment? What are the criteria of a good clinical assignment? How can the stutterer be brought into the planning of his own therapy or in its evaluation?

supplemental experiences

1. Construct assignments to achieve progress in the attainment of the following subgoals: (a) Reduction of the fear of phoning, (b) Learning to stutter slowly; (c) Revising the language used to code the stuttering experience.

2. Create a better acronym for the course of therapy than Midvas.

3. Assign different types of stuttering behavior to four members of the class and a fifth member to be the therapist of a group session devoted to the ventilation of feelings about stuttering. The instructor provides a commentary.

4. Demonstration of actual group therapy with stutterers.

5. Record an individual therapy session, play to the class, and analyze the dynamics.

6. Summarize the article by Cypreanson, L., "Group Therapy with Stutterers," *Journal of Speech and Hearing Disorders*, 13, 1948, 313-319, and criticize it.

7. Summarize the planning aspects material on group therapy in Murphy, A. and Fitzsimons, R. N., *Stuttering and Personality Dynamics*. New York: Ronald Press, 1960.

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unit 23.

REDUCING THE STUTTERER'S FEARS.

introduction

Perhaps the most vivid feature presented by the confirmed stutterer of any age is the amount of fear and anxiety that permeates most communication. No treatment can afford to ignore this basic aspect of the disorder. These fears range in intensity; they have become associated with many environmental and communicative stimuli; they extinguish with difficulty and recur often even after long periods in which they are absent. The stutterer must come to deal with these fears and so must the therapist.

lecture topics

The nature and variable intensities of the stutterer's fears (2, 4, 7, 8). How the stutterer's fears are born and reinforced (11, 12, 13, 16). The role of avoidance in maintaining fears (6, 14, 15). The role of communicative frustration as well as social penalty in creating fear (5, 10). Reality testing, desensitization and adaptation as methods of fear reduction (1, 3, 18, 19, 20, 21). Distraction as a fear reducer (6, 7, 31). Tranquilizers and drug therapy (4). Ventilation (24, 25). Supportive role of the therapist: reassurance, etc. (23, 25, 27). Association of reward with expectation of stuttering (1, 22, 25). Use of more fluent and less punishing forms of stuttering in fear reduction (6, 15, 17, 28, 29).

discussion topics

How do stutterers keep their fears hot by avoidance? What are the tricks of avoidance commonly found? What are the different listener reactions to stuttering? How does the use of eye contact during stuttering reduce fear? How does the stutterer speak about his fears? In what way is stuttering seen as being a threat to the integrity of the self? What differences are there between fear, anxiety, and panic, if any? How can the therapist help the stutterer reduce his situational or word fears?

supplemental experiences

1. Go with a stutterer into some feared situations and have him verbalize his feelings before, during, and after the experience.
2. Construct two assignments to lessen phonetic or word fears.

3. Write out your imagined account of the feelings of a stutterer going to apply for a job.

4. Make three phone calls, stuttering severely for a long time, and note listener responses.

5. Deliberately try to refrain from using any word that begins with an *L* sound by circumlocution and report your feelings.

6. Stop a stranger and fake a long, twenty toe-tap silent block on the second word; then stop another and fake an easy repetitive one or a smoothly prolonged one. Report the listener reactions.

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unit 24.

CHANGING THE OVERT FORM OF STUTTERING.

introduction

Although we have previously described the learning of a new way of stuttering as one of the current approaches to find ways of decreasing the stutterer's word and phonetic fears, we must somehow be able to teach him a new way of stuttering that will be less provocative of audience penalty or communicative frustration than that possessed by his old abnormal ways of stuttering. How can we teach him that it is possible to stutter with a minimum of abnormality or interruption? Since there seem to be literally thousands of ways of stuttering on a given word, surely there must be a few of those ways which are more tolerable than others.

lecture topics

The necessity for identifying the behavior to be changed, for confronting and analyzing and recognizing it (5, 12). The need to use descriptive rather than evaluative language in this study of the old way of stuttering (7, 9). How to present models of more fluent stutterings and to recognize and reward those instances in the stutterer's speech which come close to the model (1, 2, 10)? The techniques of cancellation and pull-outs and preparatory sets (1, 2, 3, 4, 5, 8, 10). Learning to modify the stuttering tremor (2, 4). Slow-motion stuttering (4, 6, 9). Problems frequently encountered in modifying stuttering behaviors (4, 11).

discussion topics

Is stuttering behavior a learned and highly organized response or is it a breakdown in organization? How can we reduce the constant reinforcement which communicative continuation brings to the occurence of the old stuttering behavior? Why do stutterers find it so hard to confront their speech behavior? What are the kinds of pseudo-stuttering which would help the stutterer identify his behavior? How important is time pressure in stuttering and what can we do to decrease it?

supplemental experiences

1. Stutter in unison with a severe stutterer, duplicating his behaviors exactly.

2. Illustrate a series of repeated attempts on a stuttered word, each of which reduces the abnormality progressively.

3. Telephone a stranger, duplicate one of the severe stuttering behaviors of a stutterer you know, then cancel it carefully and report your feelings.

4. Learn to tremor with your hands, legs, lips and jaw. Then put some lip or jaw tremors into some of your conversational speech, then smooth them out slowly before uttering the word.

5. Present a stutterer before the class and have the students demonstrate slow pull-outs and cancellations whenever he stutters.

6. Go with a stutterer into feared situations and observe him working to modify his stuttering behavior.

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unit 25.

COPING WITH COMMUNICATIVE STRESS.

introduction

Society makes it rather hard for the stutterer in many ways. It not only penalizes his abnormal utterance but it also fails to help the stutterer even talk as well as he otherwise might do. There are many forms of communicative stress: the necessity to speak instantly, to speak in the presence of competing speakers, to withstand interruptions, anticipatory finishing of his blocked communication. While all speakers must run this communicative gauntlet, the stutterer is especially vulnerable to such stresses. It is frequently necessary to provide the stutterer with therapeutic experiences in building buffers and barriers against them.

lecture topics

Communicative conditions which disrupt fluency in the normal speaker (3, 4, 14). Bluemel's concept of the need to keep speech highly organized (4, 13). Weiss' view of stuttering as a form of cluttering (2). Building barriers by deliberate adaptation (3, 5, 10, 11, 12). Training in recognition and analysis of communicative stress (9, 16). Desensitization programming of inserted fluency disruptors (3, 6, 7, 8, 16). Using the delayed response as a buffer to communicative demand (3).

discussion topics

How important is the listener as a part of the stutterer's problem? How should the clinician listen to the stutterer? What role is played by the speech rate of the conversational partner? How important is propositionality, the urgency of the meaning to be expressed, in creating communicative stress? Do all stutterers show, as Weiss claims, the disorganization of message formulation that is so characteristic of clutterers? How can we create communicative stress deliberately in the therapy session so that the stutterer can learn better ways of coping with it?

supplemental experiences

1. Keep track of your own breakdowns in fluency for a day and attempt to define the stresses which produced them.

2. Demonstrate a "heckle-session" in which a stutterer successfully learns to resist the stress.

3. Have two students talk on different topics before the class at the same time and note fluency breaks, and how they resist them.

4. Interview a stutterer concerning the communicative conditions which are most stressful.

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unit 26.

REINFORCING THE STUTTERER'S NORMAL SPEECH.

introduction

There are very few stutterers who have more stuttering than normal speech when the actual counts are made. In most of them the proportion is highly in favor of the normal fraction. They do talk normally much of the time. Yet this normal speech seems to have no utility in freeing the stutterer from the persistence of his fluency breaks. This appears to be due primarily to the lack of awareness (acoustically or kinesthetically) since most of the stutterer's free speech operates about as automatically as the normal speaker's. The purpose of this unit is to stress the need to give the stutterer's normal speech some stimulus value.

lecture topics

The stimulus value of normal versus stuttering speech (9, 11). The stutterer's over-concern with his moments of stuttering (1, 7, 16). How speech is monitored: servo-system theory (2, 3, 4). The relative predominance of tactile and proprioceptive feedback controls in the normal speaker as opposed to the predominance of auditory (side-tone) feedback in the stutterer (6). Historical methods used to enhance proprioception in stutterers: objects in the mouth, breath, chewing, mouth rituals, etc. (5, 15). Modern methods for stressing awareness of the normal speech: analysis of talking-time versus stuttering time (1, 13); use of mirrors, tape recordings, delayed feedback, the electro-larynx, and masking (8, 10, 12, 14).

discussion topics

How aware are we of our normal speech? Why does the auditory delayed feedback apparatus often cause breaks in fluency in normal speakers? Why must we amplify the delayed auditory feedback so greatly before it has this effect? Why does masking of the airborne sidetone cause a dramatic decrease in stuttering? Why does the use of the electro-larynx or esophageal speech reduce stuttering? Why is there such an incredibly small incidence of stuttering among the congenitally deaf? How can we reduce the stimulus value of stuttering and increase the stimulus value of normal speech? Does increased awareness of normal speech have any dangers?

supplemental experiences

1. Interview a stutterer concerning his speech awareness.
2. Try to beat the delayed feedback apparatus by gradually increasing the volume and report how you do it.
3. Demonstrate a stutterer speaking with an electro-larynx.
4. Speak for five minutes before a mirror watching and feeling the movements of your mouth.
5. Rehearse in pantomimic speech the first sentences of phone calls with some pseudo-stuttering on only the first words.
6. Demonstrate a stutterer reading aloud but omitting all stuttered words and interview him.
7. Demonstrate a stutterer speaking with and without masking noise.

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unit 27.

TERMINAL THERAPY AND PROCEDURES.

introduction

The ending of any treatment always presents certain problems and certainly these exist in stuttering therapy. The clinician must be able to cope with the spontaneous but usually transient remissions which occur early in some of our clients once they come to grips with their problems. He must know how to respond to the stutterer when the latter suddenly, and perhaps unwisely, decides to terminate the clinical relationship. He should know how to help the stutterer stabilize his newly found attitudes and fluency and to be his own therapist before treatment is ended. Provision for future consultations or referrals should be incorporated into the therapy design. Necessity for follow-ups.

lecture topics

The flight into fluency. Training the stutterer to be his own therapist (2, 5). The management of separation anxiety. Realistic planning for the future (3). The problem of relapse in stuttering: What forces precipitate it? How should it be viewed and managed? (2). Use of role-playing in realistic planning for the future (6). Criteria for dismissal (1, 8). The final interviews (9).

discussion topics

What are the common reasons for terminating therapy? What are the problems encountered in terminating psychotherapy with normal speakers? What are the indicators in the stutterer's behavior, apart from increased fluency, which signify readiness for termination? What are some of the unwise ways for terminating treatment? How do we prepare the stutterer for dismissal?

supplemental experiences

1. Interview a former stutterer concerning his experiences since he left therapy.
2. Write an imaginary interview between you as a therapist and a stutterer who is about to return home after treatment.
3. Prepare a paper showing how you would assess the stutterer's readiness for terminating therapy.
4. How can transitional groups be used in therapy to facilitate

ending of therapy. See Van Riper's discussion in Eisenson's Symposium on Stuttering, pages 316-317.

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unit 28.

INVESTIGATIONS OF STUTTERING THERAPY.

introduction

One of the sad deficiencies in our field is that it is relatively barren of detailed case studies of the therapeutic process with stutterers. The research in this area is also sparse. Nevertheless, we feel the matter important enough to devote a unit to what is available. We need much more information concerning the detailed diagnoses of actual cases; we need careful protocols of the ongoing therapeutic process; we hunger for comprehensive and professional case reports.

lecture topics

Preparation of published case reports (8, 15, 16). The use of protocols in therapy (5, 12). Problems often encountered in research on therapy or therapy outcomes (1, 3). Evaluating anecdotal accounts of therapy (6, 7, 9, 10). Methods for follow-up of clients (2, 4, 5, 12). What criteria of success should be used? (5, 17, 19).

discussion topics

How can experienced clinicians of stutterers share that experience most effectively? What journals would publish case reports of speech therapy with stutterers? What are some of the hazards of undertaking research in stuttering therapy? Which areas of the problem of stuttering therapy are most urgently in need of exploration?

supplemental experiences

1. Review one of the case files of a stutterer and prepare a case report suitable for publication.
2. Prepare a questionnaire to be sent to stutterers formerly in therapy to assess their present communicative status.
3. Play a tape recording of an actual therapy session and write up an account of what actually occurred.
4. Apply the Iowa Scale of Severity of Stuttering to a series of samples of stuttered speech taken at different stages in the therapy process.

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CHAPTER V

Understandings and Personal Characteristics Needed By The Therapist

5

TO THE STUDENT

unit 29.

THE CLINICIAN AS A PERSON.

introduction

It is possible for the therapist to become concerned too deeply with procedures and methodologies, to forget that the most important variable in therapy, outside of the stutterer himself, is the therapist. The influences of his personal attributes often are crucial in terms of therapy processes and results. These factors also deserve careful concern.

This chapter provides an opportunity to consider how personal factors in the therapist may affect his role relationships and therapeutic efficiency with stutterers. We recognize that it is not possible to describe ideal models of personal characteristics; each therapist needs to maximize his strengths, minimize his weaknesses. Every therapist, regardless of theoretical position or therapeutic approach, needs to consider seriously the import of his person in the therapy process.

lecture topics

Increasing self-awareness: knowing oneself as a requirement for knowing others; learning to recognize and to cope with one's own personal limitations; increasing awareness of personal biases and prejudices (1, 2, 3, 6, 7, 8, 10, 12, 14). *Personal factors in therapeutic relationships:* the meaning of "clinical sensitivity," "ability to empathize," "acceptingness" and "maturity;" sharing feelings and experiences; avoiding excessively manipulative or passive behavior (9). *Examples of critical incidents:* recognizing and dealing with clinical errors, premature decisions; living with one's decisions (8, 9, 10, 13). The increase in personal comfort as knowledge of the professional discipline increases (4, 5, 11).

discussion topics

(a) What personal satisfactions are there in being a therapist?

(b) What qualities needed for working with other speech problems apply to stuttering therapy?

(c) Discuss the import for therapy of differing therapists having different personal needs.

(d) Does working with stutterers require personal attributes which differ from those required in working with other kinds of speech impairments?

supplemental experiences

1. For a specified period of time, keep a professional diary of your own experiences as a clinician.

2. Arrange if possible to have a personality test administered to you and discussed.

3. Discuss with a clinician who has had personal therapy his impression of the contribution of his therapy to his functioning as a therapist with others.

4. Prepare a list of your assets and liabilities as a clinician working with stutterers, then set up a self-improvement program based on your list, and discuss it with another clinician who is doing the same.

5. Describe your conception of an ideal therapist.

6. Write three answers to the question: "Who am I?" and describe the possible implications in terms of working with stutterers.

7. Ask a therapist what have been his most satisfying and frustrating experiences in working with stutterers.

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unit 30.

THE ROLE OF THE THERAPIST WORKING WITH STUTTERERS.

introduction

Earlier sections on diagnosis and treatment described functions of the therapist. This unit is related to those sections but stresses the personal involvement in the clinical processes, with special emphasis on the therapist's perception of himself and by others and the implications for interactions in therapy.

While clinical satisfactions for the therapist occur, clinical experiences which are more likely to frustrate, upset or perplex occur, too. This unit provides opportunities to consider such experiences as they affect the therapist's role.

lecture topics

What the therapist does. Maximum and minimum goals in establishing working relationships. *Relating to the stutterer:* interest in and acceptance of his behavior; motivating him at initial and later stages of therapy; kinds of motivation; identifying and empathizing with the stutterer (4, 5, 8, 14, 15). *Personal attributes and role:* Effects of the therapist's own attitudes and feelings on the therapy process; managing one's own feelings; effect of the therapist's biases and prejudices in therapy (1, 7, 10, 13). *Managing stress situations:* reactions to the stutterer's resistances; dealing with hostility, guilt, anxiety, and transference reactions (11, 18). *Evaluating therapy's effects:* problems in recovery or improvement; signs of probable success or failure; responding to and analysis of failures in therapy. Dangers in therapy (9, 10, 16). The degree to which the stutterer is helped to help himself (2). Frustration and satisfactions of being a therapist. Other therapists as models. Relationships with allied professional personnel (3, 6, 12, 17).

discussion topics

(a) What other personal differences or handicaps may be considered as a parallel to stuttering?

(b) Why cannot friendship in an ordinary social sense and therapy usually be mixed?

(c) How does the function of the therapist differ from that of the teacher or physician?

(d) How does the therapist's behavior tend to differ in these work settings: schools, hospitals, university clinics, private practice.

supplemental experiences

1. Stutter in five situations involving face to face contact as in a store and in five telephone conversations all with strangers. Describe how these situations differ in terms of your personal experience.

2. Interview a stutterer to find out what previous therapists they have had and how they tried to help him.

3. Interview a therapist working with stutterers to find out what he likes about the work and what he doesn't.

4. Role-play a therapeutic interaction between stutterer and therapist; between the parent of a stutterer and therapist; between a stutterer's classroom teacher and a therapist.

5. Compile a list of various prejudices and discuss or report on how, as a therapist, each may effect the therapeutic relationship with stutterers.

6. Ask a group of students majoring in other disciplines to describe what they consider to be the role of the therapist who works with stutterers; compare their responses to those given by workers in an allied profession and by therapists who have worked with stutterers.

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unit 31.

THE INFLUENCE OF THE THERAPIST ON THE THERAPY PROCESS.

introduction

An aspect of therapy perhaps not sufficiently recognized by many therapists is the extent to which their own personalities shape those of the stutterers with whom they work. Through the process of identification, many stutterers take on characteristics of their therapists, just as many children take on characteristics of their parents. In the section which follows many of the ways in which the therapist does influence the therapy process are considered — not only in formal orientation, but in many ways related directly to his own personality.

lecture topics

How personality changes (1, 2, 3, 6); basic features of therapeutic change; the contribution of the therapist to this process (3, 4); effects of the therapist's language behavior; language which is and is not suitable for dealing with stuttering (8); who takes the lead in therapy; rapport; identification and transference; counter-transference; the importance of the therapist's own personality; need for the therapist to be objective about his own problems (7); the therapist as a model; others as models for therapeutic change; other stutterers as auxilliary therapists; therapy outcome as a joint product of the stutterer and the therapist; research on the personality of the therapist (3, 4, 5).

discussion topics

How do people change? How much change can be expected in a stutterer? What kinds of people make good stuttering therapists? The therapist asks, "Why won't that word come out?" What are the implications of this question? What determines the outcome of therapy? Does personality change depend more on change of behavior or change of attitude?

supplemental experiences

1. From your observation of three therapists and the stutterers working with them, note if you can two signs of identification in the behavior or mannerisms of each.

2. After reading Dean Williams', A Point of View on Stuttering,

Journal of Speech and Hearing Disorders, 1957, interview three therapists working with stutterers and rate them as to their use of animistic terms to describe stuttering.

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unit 32.

CHANGES IN THE THERAPY RELATIONSHIP AT DIFFERENT STAGES IN THERAPY

introduction

During the course of therapy a therapist needs to serve many different functions. As therapy progresses the role of the therapist shifts, so that the therapist needs from time to time to pause, to re-evaluate, and occasionally to restructure the therapeutic relationship. This section deals with the need for the therapist to be flexible, to serve various functions as therapy progresses. Flexibility is an important element in therapeutic skill and success. Early in therapy, for example, the therapist must provide much support for the stutterer's venture of facing situations and people he has avoided, attacking old fears. At a later stage in therapy the therapist's function may be quite different. He may need to help the stutterer accept and adjust to the consequences of his own improvement, or to teach socially constructive patterns of aggressiveness, or to help him explore all sorts of new possibilities opening up before him.

lecture topics

Need for therapist recognition of stages of growth of development of stuttering (4, 6, 8); age level differences typically met (3); the pre-school stutterer; the elementary school stutterer; the adolescent stutterer; the adult stutterer; the therapist's function in relation to these differences (5); differences in setting: individual therapy with children (1, 2); family therapy; parent counseling; small group therapy with children; play therapy (2, 5); supplemental techniques; group therapy with adolescents; individual therapy with adolescents, special problems; individual therapy with parents; group therapy with parents of stutterers; therapist's function in giving information; in providing support, reducing parental guilt (8); indications of need for additional psychotherapy at various stages of working with parents or children. Changes in goals and techniques related to these settings (1, 3, 6, 7, 8).

discussion topics

(a) How does the therapist function differently with children than with adults?

(b) What are some special problems in relation to the adolescent stutterer?

(c) What techniques derived from adult therapy are applicable to children? What are not?

supplemental experiences

1. Ask an adult stutterer to observe therapy with a child stutterer and report to you his reactions. How does the therapy differ from his own experiences?

2. Go out on three exploring situations in stores with an adolescent and with an adult stutterer, and note the differences in their behavior.

3. Visit or observe a parent counseling group or listen to a recording of the same. To what extent do they see themselves as being part of the problem? What can they do?

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TO THE STUDENT

We could not end this outline without a comforting and personal word to the student who has become involved in it. You must realize that the writers of this booklet, your instructors and supervisors, all of us, are students together. Not one of us has complete possession of all this information. Yet, like you, we are still struggling to improve the breadth and depth of our own knowledge, skills and sensitivity. We continue to study because not one of us feels that he knows enough. Nevertheless, all of us — and this includes you — are faced with the practical necessity for improving our ability to help stutterers simply because they continue to come to us for help — and too often we feel helpless. Since our present competencies as therapists always have real limitations for some of our clients we all are forced to continue to study and observe and experiment. We hope that you will be encouraged to consider with interest the variety of ideas and questions that this outline brings (in perhaps such an overwhelming quantity) but find somewhere herein the keys to successful therapy. We know that you will inevitably discover things we have not seen, partial truths which may point a path we have missed. Whether you wish it or not, you carry our hopes that some day a solution to this unhappy problem may be found.

We are not under the illusion that this book in itself presents a complete survey of everything one needs to be a competent clinician with stutterers. We are assuming that you have had or are getting a good general education and also a solid grounding in communication, speech science and psychology. We hope you are being provided the appropriate kinds of clinical experiences and opportunities to observe skilled therapists at work. We hope that you have come to know yourself to some degree.

Let us wish you good instructors and supervisors. We hope that they will be men and women who can have faith in your potential, patience for your mistakes, and who can show as well as tell. If you are already a practicing therapist, unhappy about your previous training and troubled by the stutterers whom you seemed unable to help, we hope that this book has given new insights and renewed the old challenge. We who write it are still training ourselves to be better therapists. Our cases, our readings, and our questions have had to be our teachers. We hope that, by sharing with you some of our own efforts to explore systematically the mystery of stuttering, you too may help some of your stutterers to speak without anxiety and with ease.

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