ANNALES
UNIVERSITATIS MARIAE CURIE-SKLODOWSKA
LUBLIN — POLONIA
VOL. XLVI/XLVII, 15 SECTIO AAA 1991/1992

Northwestern University, Evanston, Illinois (USA)

H. H. GREGORY

Stuttering: Where Are We? Where Are We Going?

For one thing, we have decided that we cannot simplify stuttering. For years, there was hope of finding the one cause of the problem or the best method for treating it. Now, with references to research knowledge and clinical experience, we recognize that stuttering is a complex problem, with many factors contributing to its development in children and its maintenance in children and adults.

When I confer with other therapists, I am pleased to find a positive attitude toward this complexity. They understand it and they accept it. We are no longer looking for simple answers! We recognize that successful therapy involves and effective problem solving approach that deals with many variables. In this article, I will tell you how, as a practising therapist and teacher of therapists, I deal with our present knowledge about stuttering. Prospects for the future will also be considered.

When I was a student, we saw how Charles Van Riper talked about stuttering in terms of predisposing, precipitating, and maintaining factors. Today, we know more about these factors than in previous years, but it still appears that this is one of the best ways to organize our consideration of the problem.

PREDISPOSITION TO STUTTERING AND PRIMARY PREVENTION

The concept of predisposition affords a way to deal with (1) evidence from family history studies that there is probably a genetic factor and (2) the findings of differences in stutterers and nonstutterers speech motor, linguistic, and brain hemispheric functioning. To elaborate briefly, geneticists assume that environmental variables interact with the inherited predisposition and speech pathologists have speculated that the syndrome of late talking, articulation difficulties, and stuttering in some children is a manifestation of this inherited condition. Rapid progress is being made in the study of chromosomal differences, and looking to the future, this is an area of study that offers promise.

In terms of primary prevention, dealing with the process that leads to the disorder, a profile of high risk would recognize stuttering in the family at its base. Risk would be increased by late developing language. We have made great progress in the realm of secondary intervention, intervention soon after the process of development has begun. Research on family history and the genetics of stuttering suggests that more attention be given to primary prevention. For example, if there is stuttering in the family or a delay of early language development, and especially if there are both, a family should be counselled about the relationship between environmental stress and speech fluency.

PRECIPITATING FACTORS — ENVIRONMENTAL STRESS

Based on clinical and research experience, no one disputes the importance of environmental influences in the development of stuttering. Parent-child interaction studies have provided support for the observations that styles of communicative and interpersonal interaction differ between the parents of children beginning to stutter and parents of nonstuttering children.

The social-psychological nature of stuttering has been studied for many years. Reduced propositionality of speech reduces stuttering. Increased time pressure increases stuttering. Observations by stutterers that they have little or no difficulty when speaking alone has been confirmed by many studies. My clinical experience agrees with that of others that the way in which a situation is subjectively perceived is very important in determining the degree of stuttering. No doubt this reaction to speaking is one of the important factors in the development of stuttering. In children just beginning to stutter, we focus on preventing speech from being perceived as different or difficult.

It is very difficult to design studies of environmental influences. One reason we have had so many investigations of motor factors recently is that it is somewhat easier to execute such studies. But, I believe the pendulum is swinging back now toward more of a balance of research relating to both physiological-developmental and social-psychological aspects of stuttering. The greatest challenge is to design studies that consider the interaction between child characteristics and environmental factors. Observations indicate that stuttering arises out of this interaction.

DIFFERENTIAL EVALUATION—DIFFERENTIAL THERAPY

A world-wide survey of clinicians indicated that most of them believe that the evaluation of a child just beginning to stutter or a child or adult stutterer should be broad including a thorough case history and observation or testing of the subject's speech and related behavior. In children, in addition to an analysis of fluency, we examine characteristics of the child's development (language, articulation and motor control) and environmental variables such as communicative stresses (the way people talk with the child) and interpersonal stress (the way people interact in the family). With school age children, characteristics of the speech behavior,

environmental factors, and the child's attitudes are probably the most important variables with which to deal, but language and articulation problems may also be involved. There are commonalities in therapy for children, but therapy is individualized for each child based on the results of the evaluation. There is more specificity about how evaluation is related to therapy in children than there is for teenage and adult stutterers. In teenagers and adults, we believe that the characteristics of stuttering and personality factors are the most important considerations. Some have stronger avoidance and inhibitory characteristics in their speech and differences in psychological characteristics influence the way in which they can respond to treatment.

Personality dynamics as related to stuttering and stuttering therapy has received less attention in recent years. But, we working therapists know that the person's adjustment and ego strength, stutterer or parent, influences the response to therapy. There are two challenges here: (1) To recognize the way in which personality characteristics influence responses to therapy and (2) to help the person who stutters to respond constructively to new experiences, challenges and responsibilities. Behavior change has to be integrated into the life style of a person whose life style is in process. In England, the use of personal construct therapy has been particularly valuable in helping a person relate speech difficulty and speech change to self-concept. In the United States, the findings that stutterers personality make-up as assessed does not differ from nonstutterers as groups, has led to overlooking individual differences that exist. I believe that more multidisciplinary cooperation with clinical psychologists and psychiatrists, who share a reasonably comparable understanding of the nature of stuttering with us, will lead to dealing more effectively with psychosocial factors related to stuttering.

STUTTER MORE FLUENTLY AND SPEAK MORE FLUENTLY MODELS

The stutter more fluently approach, as used with older children and adults, emphasizes monitoring, analyzing, and gradually modifying stuttering. Supposedly, the resulting reduction of avoidance tendencies increases fluency. The speak more fluently approach stress the use of various procedures to increase fluency with minimal or no attention to the stuttering behavior. At an international conference of stutterers in Kyoto, Japan in 1986, stutterers from West Germany and Sweden proclaimed themselves as followers of Van Riper's stuttering modification method. They spoke in a way that revealed their easy stuttering. I believe that they should be able to speak more fluently. The Australian group of stutterers said, "We have the best fluency shaping in the world". However, they said that they felt very sensitive about their stuttering and feared regression. They thought that some attention to the analysis and modification of their stuttering would be beneficial.

At Northwestern, we have shown how the identification, monitoring, and gradual modification of stuttering and associated unadaptive speaking behaviors (rapid rate, erratic prosody, etc.) can be combined with fluency building skills such as easier initiation, blending, and variation in rate, loudness, effort, and inflection.

There is a paradox here that stutterers should recognize. "Acceptance and modification of stuttering" as a part of therapy contradicts "building fluency" and vice-versa. Although it is very difficult through research to prove that one model results in more effective treatment, more and more clinicians seem to be integrating the two.

If and when we work more directly on the speech of younger preschool and school age children, we model more easy relaxed speech for them and attend to the remaining stuttering behavior only to the extent necessary. Thus, there is more emphasis on the speak more fluently model.

TRANSFER AND MAINTENANCE (FOLLOW-UP)

When I am asked about new developments during the last 15 years, I state that one of the most important is the recognition by clinicians, and also I believe by stutterers themselves, that just as the acquisition of stuttering is a process occurring over a period of time, that change is a process and ordinarily not a short term one. Effectiveness of therapy has been enhanced by the development of procedures for transfer, employed from the beginning of therapy, and by providing follow-up programs. If a program does not provide follow-up, this demonstrates a lack of understanding of the cyclic nature of stuttering and the tendency for regression to occur following a core period of therapy. I now say to teenage and adult stutterers, "Let this be your last therapy. This means participating in follow-up activities for 9–18 months after a period of formal therapy". Returning to the clinic for review sessions must be viewed as a positive thing to do, not a sign of weakness, as I believe it was 20 years ago. Follow-up with children involves keeping in touch with the parents by telephone and home visits, or seeing the parents and the child at the clinic or school periodically.

Achieving fluency in a child or an adult is not particularly difficult. Transferring, maintaining and extending improved speech in real life is the critical aspect of therapy. One of the greatest research needs is for follow-up studies that demonstrate this process.