STUTTERING SELF-HELP FOR ADULTS

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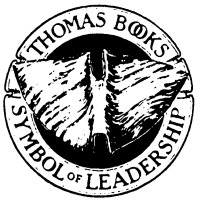

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This guidebook about stuttering is dedicated to the four generations of women who have inspired me to keep my shoulder to the wheel . . . and finish it.

Gertrude . . . mother

Patricia . . . wife

Laurie . . . daughter

Sabrina . . . granddaughter

And then there is Jane (sister-in-law)

PREFACE

Stuttering, also known as disfluency or stammering, is an intriguing subarea of speech pathology. This text is designed as a self-help resource for stutterers. No text can replace the therapeutic process based on rapport between clinician and client; my aim is for this book to be helpful as a supplement to clinician-guided therapy.

Charles Van Riper, an international expert in the area of stuttering, believes that the therapist's credibility must be established at the beginning of therapy. The therapist must impress the client with knowledge and clinical skills. Van Riper believes that such a clinician-client relationship is essential throughout the weeks or months of therapy; that, without it, little or no progress toward normal fluency patterns can emerge. Establishing these credentials helps instill the hope that the prognosis is favorable, and that progress toward fluency is possible. This hope motivates active, positive participation, leading to progress.

In line with Van Riper's prescription, I thought it appropriate to establish my credentials as the author of advice for stutterers. My first exposure to stuttering was in an introductory course in speech disorders taught by the late Wendell Johnson at the University of Iowa, one of the first universities in the United States to have a department of speech pathology. Under the leadership of Lee Edward Travis, the University of Iowa became the Mecca for aspiring speech pathologists, producing hundreds of doctorates. Among the outstanding graduates are Charles Van Riper, Wendell Johnson, Dean Williams, Oliver Bloodstein, and, more recently, Edward Conture and Frederick Darley.

I received professional training at Stanford University, where Virgil Anderson was building a viable program in speech pathology. Anderson was a California authority on stuttering as well as being an author of articulation and language development textbooks. His therapeutic approach was eclectic, incorporating elements from such diverse schools of thought as psychology, learning theory, and operant conditioning. He also emphasized the necessity of a specifically tailored therapy pro-

gram for each client, based on research of the literature, extensive clinical experience, and thorough knowledge of the client's individual needs.

My first professional publication was a translation of the ideas of Leopold Treitel, a German speech pathologist, about therapy for stutterers. Subsequently, I gained extensive practical experience by establishing a speech therapy program in the public schools in Santa Ana, teaching speech pathology at the University level, and being a speech pathologist in a rehabilitation center. My first book, *Speech Correction at Home* (Charles C Thomas, 1959), included a chapter on stuttering. In the ensuing years, I have dealt with hundreds of stutterers, both directly in therapy and indirectly as a supervisor of students with stuttering clients.

For over twenty years, I was a faculty member of the Department of Speech Pathology and Audiology at California State University, Sacramento (CSUS), where my professional assignments included teaching stuttering theory and supervising student therapists. Until 1985, my duties were those of a full-time, tenured full professor; now, semi-retired, I have kept professionally active by working as a speech therapist for the Robertson Adult Day Health Care Center in Sacramento, California. To add to my knowledge, I attend numerous state and national conferences, as well as workshops by leading experts on stuttering such as Hugo Gregory, George Shames, Joseph Sheehan, William Perkins, and Frederick Murray.

When I studied Lloyd Hulit's *Stuttering: In Perspective* (1985), I was reminded of a long-standing controversy among professionals in speech pathology. Is having had a speech defect in a specific subarea, i.e., stuttering, aphasia, laryngectomy, hearing loss, etc., a prerequisite for becoming a therapist in that area? In identifying himself, Hulit writes, "It is important for you to know that I am a stutterer... One of my qualifications is that I am a stutterer. I have lived with this speech disorder most of my life, certainly all of the life I can remember." Indeed, some of the most widely known university experts in stuttering have been severe stutterers; these include Charles Van Riper, Joseph Shechen, Wendell Johnson, and Frederick Murray.

Many stuttering therapists have implied that the "condition" is essential to becoming a successful therapist. Since I am not a stutterer and never have been, I was concerned with this assertion. My anxiety was relieved somewhat when Hulit continued, "My experience as a stutterer is the least of my qualifications. It is the understanding of stuttering I have achieved in the clinic and in my own studies that I want to share with you."

Many nonstutterers have become highly successful therapists for stutterers. Being a stutterer is not an essential qualification. An understanding of the nature of stuttering is vital both for the clinician and for the client.

I have no statistics concerning my success, such as the 95 percent rate claimed by Martin Schwartz or the 40 percent rate of George Shames, as he reported at a recent workshop in Modesto, California. My best guess is something like 75 percent, but percentage is elusive.

> We state confidently that, as a stutterer, you do not need to surrender helplessly to your speech difficulty because you can change the way you talk. You can learn to communicate with ease rather than with effort. There is no quick and easy way to tackle the problem, but, with the right approach, self-therapy can be effective. . . . Even with competent guidance, authorities would agree that stuttering therapy is largely a do-it-yourself project anyway. (Speech Foundation of America, No. 12, *Self-Therapy for the Stutterer,* 4th ed., p. 15–16.)

This book is a summation of my clinical experience and a review of the literature. I invite you to read, to ponder, and to apply the suggestions which are applicable to your case. You will need to select the sections which are personally useful. I am interested in your reactions to aid me in possible revisions.

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STUTTERING SELF-HELP FOR ADULTS

Part I
BACKGROUND INFORMATION

REVIEW OF THE LITERATURE

ANTHONY GALLI

No speech pathology has caused more speculation, controversy, or conflicting research results than stuttering. Experts argue its definition, theory of causation, dynamics, measurement, and clinical management.

Stuttering has no widely accepted definition. Most dictionaries define stuttering as *hesitating or stumbling in uttering words.* Speech pathology experts describe stuttering variously. In one context, Wendell Johnson (1956) said, "stuttering is an *anticipatory apprehensive, hypertonic, avoidance reaction*" (p. 32). In other words, "stuttering is what a speaker does when he:

(1) expects stuttering to occur,
(2) dreads it,
(3) becomes tense in anticipation of it, and
(4) then even tries to avoid doing it."

According to Van Riper (1963) "Stuttering is

(1) when the flow of speech is broken by
    (a) hesitations,
    (b) stoppages,
    (c) repetitions, and/or
    (d) prolongations of the speech sounds.
(2) fluency is interrupted by
    (a) contortions,
    (b) tremors or
    (c) abnormalities of phonation and respiration.
(3) interruption of frequency as to
    (a) attract attention,
    (b) interfere with communication and
    (c) produce maladjustment.

(4) speech behavior that has been
  (a) labeled by others and
  (b) accepted by its possessor

as stuttering" (p. 306).

An estimated 1 percent of the population stutters, more men than women. The literature reveals a gender ratio of anywhere from 2:1, extending to a high of 9:1. The ratio of male to female stutterers appears to increase from childhood to adolescence (Milisen, 1957).

In appraising the differential gender ratio in stuttering, Schuell (1946, 1947) emphasized the following:

(1) Although the male child
  (a) is in many ways physiologically . . . more vulnerable

and

  (b) matures more slowly than the female child,
(2) he is . . .
  (a) subject to heavier demands for achievement . . .
  (b) receives inconsistent management, and
  (c) encounters more conflict with parental authority

than does the female. Schuell hypothesized that the gender differences in stuttering could be accounted for largely in terms of the differential treatment accorded boys and girls. By virtue of their experiences with inconsistencies in management and a general pattern of heavier demands, boys develop a more basic insecurity than do girls. This insecurity and anxiety become infused in their speech through both direct and indirect means.

Other experts define stuttering as *disruption in the fluency of verbal expression,* characterized by involuntary, audible or silent repetitions or prolongations in the utterance of short speech elements, such as sounds, syllables, and words of one syllable.

These disruptions

(1) usually
  (a) occur frequently or
  (b) are marked in character and
  (c) are not readily controllable.

(2) sometimes are accompanied by activities involving
  (a) the speech apparatus,
  (b) related or unrelated body structures, or
  (c) stereotyped speech utterances. (These activities appear to be speech-related struggle.)
(3) frequently are indications or reports of the presence of an emotional state ranging from
  (a) a general "excitement" or "tension"
  (b) to more specific negative emotions, i.e.,
    (i) fear,
    (ii) embarrassment,
    (iii) irritation.

The immediate source of stuttering is some incoordination expressed in the peripheral speech mechanism. The ultimate cause is presently unknown and may be complex or compound (Wingate, 1964, p. 498).

A quantitatively precise definition of stuttering is difficult. Perhaps stuttering is best characterized as *a cluster of particular speech behaviors, feelings, beliefs, self-concepts, and social interactions.* Each component may vary from person to person. In each person, the components can influence each other to generate a complicated problem involving disruptions of speech and the associated reactions. The emotional and social problems must be handled as well as the disordered speech.

THE FOUR TRACKS OF STUTTERING

Van Riper (1982) believes that stuttering develops fairly consistently according to one of four major sequences or "tracks."

Track I

Track I stutterers repeat syllables. (Single syllable words are repeated whole.) Initially, these syllabic repetitions are:

(1) *frequent*
(2) *multiple*—averaging about three per word, rarely exceeding five per word.
(3) *effortless*—no signs of awareness by the stutterer.
(4) *clustered,* followed by considerable normal fluency, thereby consti-

tuting only a small but very noticeable fraction of the total speech output. Additionally, these repetitions are spoken

(5) at the *same tempo* as the normally spoken syllables
(6) most frequently on the *first word after a pause or on the most meaningful word* of the sentence.

As the disorder develops, however, the pattern changes. The tempo of the disfluent syllables often increases. The repeated syllables become irregular. Then, first the range of the repetition increases and then the average number of repetitions.

Occasionally, prolonged "voiced continuant sounds" indicates that the stutter has developed even further. As the disorder continues to grow, the prolonged sounds move forward from the final repeated syllable of a series to the initial syllable. Very soon, prolonged sounds tend to dominate.

Next, surges of tension appear with obvious signs of struggle. The stutterer seeks to interrupt his closures and fixations. Facial contortions, jaw jerks, and comovements of the limbs are seen in various combinations. Much of this behavior almost appears random and unstereotyped. The tension, first located in the lips or jaws, overflows to adjacent structures. The stutterer is now highly aware of his difficulty, greatly frustrated by it, and doing his utmost to interrupt it so that he can communicate.

Track II

One of the marked differences between Track I and Track II is that the fluency disruptions observed in Track II begin much earlier in speech development. Most, though not all, of Track II stutterers show retarded speech development and do not use phrases or sentences until they are three to six years of age. Distinctively, Track II stuttering begins right when connected speech does.

Early Track II behavior differs from that of Track I. In Track II, the initial syllabic repetitions are hurried and irregular, mostly one-syllable words. Later, Track II has more:

(1) silent gaps
(2) hesitations
(3) stumbling
(4) abortive beginnings
(5) revisions
(6) interjections