

STUTTERING: A REVIEW FOR COUNSELLORS AND TEACHERS

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Abstract

Theories concerning the onset of stuttering are grouped into three categories and briefly reviewed. Current treatment strategies are described. Guidelines for the counsellor and teacher are provided to enable them to work co-operatively with the speech pathologist toward more effective management of the stuttering child in the school setting.

Résumé

Dans cet article, on groupe en trois catégories et on passe en revue les théories relatives aux premières étapes du bégaiement. On décrit les procédures thérapeutiques courantes. Enfin, on offre des lignes de conduite tant au professeur qu'au conseiller afin de leur permettre de collaborer de façon plus efficace avec le praticien en orthophonie, cette collaboration visant de meilleures démarches dans le milieu scolaire auprès de l'enfant qui bégaié.

The problem of stuttering is not solely a communication problem but a multi-faceted disorder that affects the stutterer in many ways. Educationally stutterers have tended to fall behind other students with similar academic potential. Daily and hourly humiliations have caused many stutterers to skip school or drop out prematurely. On the employment market those stutterers who braved and survived the employment interview are often isolated in dead-end jobs out of the public view where they are not required to communicate. It is in social development that the stutterer faces the greatest obstacle. Every verbal interaction carries the threat of embarrassment, humiliation and even pity. It is difficult for normal speakers to appreciate the profound impact that this disorder can have on a child's self-concept, his role and his style of life. Once the stuttering has developed, almost every aspect of the child's life is coloured by the frustrations in communication. In a highly verbal community, adequacy in verbal communication is an absolute pre-requisite for successful living. Van Riper (1971) has pointed out that "Stuttering is not merely a speech impediment; it is an impediment to social living." The sociologist, Lemert (1951) summarized the problem in this way: "The stutterer finds himself at a distinct loss in a culture where such a large proportion of adjustments are predominantly verbal and where competitive success in many areas depends upon the ability of the person to manipulate others through verbal controls.

The stutterer simply does not possess the effective speech through which the more important roles are implemented." In a society where social interaction is the key to social development stuttering becomes a major handicap. Because of these many difficulties the stutterer is faced with the difficult task of trying to build and keep a positive self-concept.

Approximately one percent of the population is normally identified as having a stuttering problem. Male stutterers outnumber females with a ratio of about five to one. Although an undetermined proportion of stuttering children may overcome the problem without professional help, most of these individuals could still benefit from help. Many stuttering children and adults clearly need professional help to overcome the handicapping effects of the disorder.

The purpose of this paper is two-fold; a) to discuss briefly some of the more recent developments in the understanding and treatment of stuttering and, b) to provide some guidelines for teachers and counsellors as to how they might assist the person who stutters.

Nature of Stuttering

The search for a cause and cure for stuttering has had a long, curious and frustrating history. What men believed to be the cause of stuttering generally determined the type of treatment for stuttering. In

desperate attempts to find relief stutterers have had their tongues burned, blistered and severed. Others have participated in bizarre rituals, changed to a monotone, or stuffed their mouths with strange spring and lever-like appliances. Still others have given up speech entirely to live in silent misery.

During the past 50 years, hundreds of investigations have been made on the nature of stuttering. Although much progress has been made in understanding the development of this disorder, the final answer is still slightly beyond the grasp of the researcher. The following is not intended as a detailed review of the many convolutions and controversies in research but rather a brief summary of the major positions.

The oldest theory is that there was something wrong physically with the stutterer, that he differed from non-stutterers along some organismic dimension. As far back as Aristotle stuttering has been attributed to gross structural abnormalities in the speech organs. More recent organic theories have looked for the source of difficulty not in the speech apparatus itself but in subtle aspects of the neuromuscular or metabolic organization of the body. Current theories also assume a predisposition position. These theorists see the disorder as being the joint product of a hereditary predisposition to breakdown and environmental precipitating factors.

The very large number of studies aimed at locating the physical difference have consistently failed to find significant differences. The small differences that have occasionally appeared, such as heightened blood calcium or abnormal EMG readings, have turned out to be reflections of the increased muscular activity associated with stuttering and not to be the cause of the stuttering. An extensive review by Perkins (1970) confirms that a physical cause or predisposition to stutter has not yet been found.

The second major approach has looked for the cause of stuttering in a deviant or neurotic personality. Since the advent of psychoanalysis several writers have viewed the stuttering act as a symptom of an underlying neurosis. Using a vast array of modern assessment techniques researchers have attempted to identify and measure personality variables that might account for stuttering. The only differences that emerge consistently are that adult stutterers are more withdrawn, less self-confident and somewhat more anxious than non-stutterers. The evidence suggests that these differences are clearly the result of stuttering and not the cause. Reviews by Sheehan (1970), Bloch and Goodstein (1971) and Bloodstein (1975) agree that this line of research has

not been productive in identifying a cause of stuttering.

The third approach suggests that stuttering develops when children, who are progressing normally, are subjected to unusual environmental pressures. Bloodstein (1975) points out that the "single environmental factor to which a probable causal relationship has most clearly been established is competitive pressure for achievement or conformity." The major body of supportive research is the mammoth 30-year study of Wendell Johnson and his associates (1959). The research points out that preschool children normally exhibit disfluencies, pauses, repetitions and even tension in speech production. The amount and severity appears to vary with such things as listener attention, stage of linguistic development and physical condition of the child. There does not appear to be any clear dividing line in terms of disfluency between the children who are considered to be normal and those children who are labelled as stutterers, at least in the initial stages.

Another factor which emerged from this research was a tendency for the parents of the stuttering children to be more perfectionistic and demanding than parents of non-stuttering children, particularly with reference to speech development. In the home atmosphere of unrealistic expectations and low tolerance for normally disfluent speech, the child becomes wary of making mistakes and begins to worry about the speech process. If his normal way of speaking produces criticism from those around him, parents and teachers, he soon begins to think of speech as something that requires special effort. The child may accidentally discover that he can avoid disfluencies by using temporary distractors such as eyeblinks or head-nodding. If such behaviors are successful in avoiding the disfluencies they quickly are learned. When the distracting effect wears off the child adds more eyeblinks or new gimmicks. He may soon acquire a considerable repertoire of struggle-type behaviors which are not only totally irrelevant to speech production but even inhibit normal speech. Meanwhile, on the other side of this child-adult dyad, the parent is alarmed by the child's increasing difficulties and doubles her efforts towards "correcting" the child's way of speaking. A vicious cycle is soon established. Once the child has experienced difficulty with certain sounds or situations he begins to anticipate future difficulties and generalize these fears to similar words and situations. He reacts to these anticipated difficulties with fear and tension, thus fulfilling his own prediction. It can be said that a person stutters because he believes in the difficulty of speech, anticipates failure and struggles to avoid it. His very efforts to avoid the difficulty are manifest in

stuttering behavior or may lead progressively towards stuttering. Once he has stuttered he is vindicated in his expectation of speech difficulty and so the cycle continues.

Although the third of the theories listed above has gained wide acceptance among speech pathologists it is not yet complete. A final satisfactory explanation for this baffling disorder may well assume a multi-causal form.

Treatment of Stuttering

As a general rule, the treatment should be started as soon as possible. The outcome of therapy is more likely to be successful in the case of a young child than in an adult who has stuttered for 20 years.

It was noted in the previous section that the onset of stuttering seems to be gradual and that there is not clear differentiation between the child who is thought to be stuttering and the normal child. A crucial factor then is whether someone in the child's environment is concerned about the problem. Once the concern has arisen, for whatever reason, it is likely to affect the further development of stuttering and should, therefore, be dealt with. If a child is referred for treatment in the very early stages of the disorder, the speech pathologist is most likely to initiate a program of indirect therapy. Working together, the speech pathologist, teacher and parent will try to analyze the child's environment to determine the points of stress and communicative pressures. They will then develop a program aimed at reducing this stress and providing the child with positive speaking experiences.

If the disorder has progressed to the point where the child is struggling, is aware of and reacts to his own stuttering it is usually necessary to work directly with the child as well as the parents and teacher. Therapy for stuttering has taken many forms in the past but for purposes of this discussion it can be divided into two major approaches: the traditional which focuses on the attitudes and anxieties of the stutterer; the behavior which focuses on the overt stuttering symptoms.

The traditional therapy, described in detail by Van Riper (1973), proceeds on the assumption that people stutter or struggle in an attempt to avoid disfluency. That is, they have learned to stutter in a futile attempt to avoid discomfort or being corrected. The major portion of this therapy is directed at reducing the fear of stuttering. The stutterer is encouraged to discuss the problem openly with family and friends, explore his feelings and attitudes about the disorder and thus

diminish his fear. At the same time he is taught how to control his struggle behavior by stuttering at a more relaxed, easy manner. As his attitude toward his stuttering changes, so does his fear of stuttering and he consequently stutters less. The less he stutters, the less he fears and the vicious cycle begins to unwind.

The behavioral approaches (Ryan, 1974; Shames and Egolf, 1976; Boberg, 1976) have incorporated the principles of behavior modification into stuttering therapy. The focus is on overt, observable struggle behaviors. The programs are designed to reduce struggle behavior and produce normally fluent speech as quickly as possible. It is assumed that changes in attitude will follow after the person has acquired normal speech. One example of this approach is the program developed at the University of Alberta. This intensive summer program runs for seven hours a day for three weeks. At the beginning the stutterers acquire fluency through the use of prolonged speech and a token reward economy system. They then move through a series of small steps until they can speak fluently at a normal rate. At this point they move out of the clinic to transfer their newly established fluency into their normal environment. The patients are assisted in the program by electronic equipment which provides immediate and individualized feedback to each member of the group. A recent article (Boberg, 1976) reported the results for 21 stutterers who had completed the program. Pre- and post-program speech samples indicated that the percentage of stuttered syllables had decreased from a mean 21% to 1.3%.

Current research efforts are aimed at determining how well the clinical gains are maintained in the post-treatment environment and how such maintenance programs can be improved. The indications are that some stutterers are not able to maintain a satisfactory level of fluency in the post-treatment environment. Most follow-up programs are not well developed and there is a critical lack of objective data. Although this type of research presents many logistic difficulties there are hopeful indications that progress will soon be realized in this area as well.

It is still too early to attempt a definitive assessment of the results of stuttering therapy. It may be safe to conclude that gains have been made during the last 20 years, particularly since the application of behavioral methods to stuttering therapy. The use of intensive therapy periods, as opposed to the once-a-week style has also increased the effectiveness for some patients. It remains to be seen whether the critical problem of maintenance in the post-treatment environment can be solved.

Guidelines for Counsellors and Teachers

The teacher and counsellor can play a vital role in the prevention and treatment of stuttering. Working with the speech pathologist and parent they can assist in reducing the communicative stress on the child and provide more positive speaking experiences. The teacher and speech therapist need each other. The therapist can profit enormously from the teacher's daily contact with the child. The teacher is in the best position to notice the daily variations in the child's behavior. The therapist can provide specialized information about the treatment of stuttering.

Luper and Mulder (1964) have provided some excellent suggestions for co-operation between the speech therapist and teacher. We will summarize the major points and add some of our own.

1. If the counsellor/teacher has a stuttering child in her class she should make every effort to obtain the services of a speech therapist. If the school does not have a therapist, they can usually be contacted through the public health agencies, metropolitan hospitals or University centres. A number of hospitals and universities offer intensive summer programs for stutterers.

2. A counsellor/teacher can often reduce the harmful effects of peer-group teasing by talking to the children doing the teasing (the stuttering child should not be present). It should be explained that stuttering will change and disappear if given a chance but that continued teasing will only make it worse. The teacher may be able to enlist the aid of some children to ensure that other children do not tease the stuttering child.

3. The teacher's attitude and behavior toward the child are critical as children tend to model their attitudes on hers. She should try to maintain a calm, unhurried, patient attitude when interacting with the child. She should avoid completing a word for the child as it is most deflating for a stutterer to struggle on a word and then have someone else produce it effortlessly.

4. The counsellor/teacher should never teach a trick to the child to help him get through a particular word. Tricks such as finger-snapping appear to be helpful but the long-term results are very unfortunate. Fluency at any price must not be condoned.

5. The question of how much participation in oral activities is a difficult one and can best be answered on an individual basis. The general rule is to encourage as much oral participation as possible but this must be qualified. In cases of very severe stutterers it may be unwise for both child and class if he participates in such things as book reports. The

teacher should try to arrange questions to which he can answer yes or no or merely nod. This will avoid his feeling of being completely ignored. Under no circumstances should he be forced to participate.

When the stuttering is mild or moderate, he should be encouraged to talk as much as possible. Although he may be embarrassed sometimes this is probably less harmful than the effects of avoiding speech entirely. It is generally wise to discuss the matter of participation with the child, his therapist and the parents. The teacher may be able to reach an agreement with the child on how much and when he will participate. If it is necessary to excuse the child from some oral work he should be required to make this up in additional written work. The teacher should generally avoid situations which demand quick, specific responses and always avoid going down the row for oral recitation.

6. It may help the teacher to realize that stuttering will vary from day to day depending on a number of factors. A sudden burst of severity does not necessarily indicate that the teacher has "messed it up." A warm, friendly, patient teacher who sincerely tries to understand the child will serve as a source of strength for the stuttering child.

7. It should be recognized by the counsellor/teacher that the stutterer's repeated failures in trying to find a cure for his problem might result in some initial resistance to his seeking professional assistance. An understanding but still encouraging approach should be taken by the teacher.

8. The counsellor/teacher who is working with a student undergoing treatment should personally contact the speech therapist to try and gain some understanding of how the therapist is approaching the problem. This contact might result in obtaining some suggestions on how you could help in the classroom. The counsellor/teacher also might be able to offer some helpful information to the therapist.

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