Stuttering Therapy: Disciples of the New Technologies

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In retrospect, I feel fortunate at having entered the field of speech-language pathology as a practising clinician about 13 years ago. My chosen specialty was stuttering, an intriguing disorder that had been examined and re-examined from all perspectives. Yet, even though the nature of the disorder and its treatment remained very much an enigma, I had the distinct impression while pursuing my doctoral studies that we were about to take a revolutionary and dramatic new direction in stuttering therapy.

In the mid-1970s, new and structured programs incorporating empirically derived procedures and state-of-the-art instrumentation were gradually evolving. For the first time in decades, clinicians and their patients were able to start therapy armed with a scientifically produced, logical and systematic series of procedures to follow in their pursuit of fluency. No longer would clinicians have to hunt for novel ideas and concepts to introduce each of their sessions. They now could spend their time more effectively becoming proficient in the administration of whatever current published program they chose to use.

Experts in stuttering would convene at conferences to report on dramatic improvements in speech fluency exhibited by their patients following short but intensive periods of therapy. New and refreshing terminologies began to emerge — *"fluency shaping"*, *"speech targets"*, *"recycling"* and *"zero percent stuttering"*, and, yes, even the word "data" was seen and heard over and over again. No longer were anecdotal accounts of therapy procedures and vague reports of treatment results considered even remotely acceptable. We professionals in stuttering had finally arrived and could stand proudly along side computer scientists and biomedical engineers.

As I nervously assumed my position as department head of speech-language pathology at the Clarke Institute of Psychiatry in 1974, I immediately began my quest for the most appropriate new program to meet the therapeutic needs of the numerous stutterers in our caseload.

After spending a few weeks with Ronald Webster in Virginia, I decided to introduce the Precision Fluency Shaping Program (PFSP) to both the Clarke Institute and the rest of the country. The PFSP is an intensive 3-week program designed to acquaint stutterers with a series of rules for establishing and transfering fluent speech (Webster, 1975). We began working with the program on an experimental basis, anticipating that we would offer the treatment on an irregular schedule if and when enough interest was generated. That was our first mistake in planning. Soon after we observed the speech performance of our patients in our inaugural program, we, along with the stutterers, were swept up in the wave of euphoria and jubilation that so often follows intensive speech therapy.

The work has not stopped since that first program in the summer of 1975. We have generated a tremendous amount of enthusiasm and demand for service from patients, professionals and the community at large. It has and continues to be a most gratifying experience to observe the incredible accomplishments of highly motivated individuals as they trudge their way tirelessly through hours and days of speech exercises and drills.

As the program evolved, data were systematically collected, and patient progress was carefully scrutinized during the weeks, months and years following therapy. The need for structured maintenance programs and support systems was made obvious as we watched with concern some of the difficulties our patients ran into in the post-treatment environment. We thus established a component model for the treatment program in which the intensive therapy portion represented the first phase. The three additional components included a structured follow-up program, a patient-run alumni association and a refresher seminar program (Kroll, 1986a; 1986b).

In addition to refining our comprehensive treatment program, our staff tried to determine which factors might serve as critical prognostic indicators of patient performance. Staff conferences were held following assessments where difficult decisions were made regarding choice of therapy. As we learned more about the complexity of stuttering and about the individual patient, we realized how important it was to make the therapy fit the patient, not the other way around.

As I achieved the dubious honour of being one of the local experts in stuttering, a strange sensation began to well up inside me. Even as I proceeded to present papers, workshops and seminars on the work we were doing at the Clarke Institute, I realized that I had generated more questions than answers about stuttering. I began responding to my colleagues' probing queries with such noncommittal phrases as "yes and no", "usually but not always","that's true but so is the opposite" and so forth. I had finally discovered what so many others had experienced and written about long before: Stuttering and its treatment are such complex issues that each case must be carefully evaluated, analysed and studied

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before, during and after treatment so as to provide the best possible course of remedial programming.

As I became more engrossed in trying to determine the most efficacious therapy approaches and formats for our patients, the clinical picture grew more and more fuzzy. To my added consternation, I began to observe a growing feeling among several of my colleagues that, indeed, the riddle of stuttering had finally been solved. Time and again, national and international conferences would be attended by experts on stuttering offering slick and polished presentations on the effectiveness of their treatment programs. Exhibitors would consistently display sparkling instruments, neatly packaged program components in trendy colours and dramatic audiovisual presentations of before-and-after speech samples to passersby. I recall sitting in on a panel of seven or eight experts at an international conference and getting the feeling that I was either at an all-candidates meeting before an election or watching a series of advertisements for new cars.

While the picture grew more clouded for me, it appeared to become crystal clear for many of my colleagues and their students. The recipe seemed simple: Choose your favourite program, become very proficient in its administration and treat the stutterers. I began to see the same trend with my own students as I supervised their clinical placements. Even though I consistently encouraged them to review all therapy options for their patients, most still insisted on mirroring the work that we were doing with the "ideal" patients in the intensive program. As I crossed paths with more of the leaders and their students, I soon sensed the rivalry and defensiveness that was flourishing among the proponents of the various treatment programs. It seemed that we "experts" in communication were no longer even communicating among ourselves. Our professionalism had given way to competition, marketing and selling new graduates and clinicians specific for the treatment of perhaps the most perplexing of communication disorders.

My experience with the media was equally troublesome. Journalists and television producers were not really interested in covering any of our traditional, long-term work with patients exhibiting special needs. They were, as were my students, interested only in reporting on our glitzy, dramatic and intensive program, often leading the community and other professionals to view this treatment as applicable to all stutterers. I have since learned to reserve the right to final authorization before any of these stories reach the newspapers or electronic media.

Our clinical programs and procedures can assist the stutterer more today than ever before. However, let us never lose our objectivity and professional perspective. Our programs are only as effective as the patients and clinicians participating in them. Now more than ever speech-language pathologists dealing with fluency disorders must be trained to make sophisticated clinical judgements about their patients as soon as the assessment process begins. It is the responsibility of the educators and academics to expose students to the myriad of theories and therapies for stuttering and to encourage continued scientific inquiry and evaluation. And those of us operating clinical programs must continue to offer as many therapy options for patients as required. Let us not compromise our professionalism by pushing our glitziest of programs on both our patients and our students.

The last decade has been very exciting for those working with stutterers. Structured, logical and intensive programs have helped hundreds of patients achieve significant improvements in fluency. Our clinical research has led to the development of stronger and more effective follow-up programs that are often instrumental in preventing relapse. About 60% of the individuals assessed in this clinic are judged to be suitable for inclusion in our intensive program. Our work continues with the other 40% through deintensified programming, counselling, stuttering modification, delayed auditory feedback and several other approaches.

I must vehemently disagree with Schwartz (1976) and others of similar schools of thought who write so boldly that the problem of stuttering has been solved. Until we really understand the beast, let's leave the disciple-making to the evangelists and car salespeople.

References

Kroll, R.M. (1986a). *Evolution of a Comprehensive Therapy Paradigm for Stuttering.* Invited Paper, Winnipeg: Canadian Association of Speech-Language Pathologists and Audiologists

Kroll, R.M. (1986b). *Manual of Fluency Maintenance: A Guide for Ongoing Practice.* Toronto: Clarke Institute of Psychiatry

Schwartz, M.F. (1976). *Stuttering Solved.* New York: J.B. Lippincott Co.

Webster, R.L. (1975). *The Precision Fluency Shaping Program: Speech Reconstruction for Stutterers.* Roanoke, Virginia: Communications Development Corp.