PREFACE

This issue is addressed to four matters. First, treatment objectives. Despite commonalities, objectives diverge widely. Second, procedures for accomplishing objectives. Even when the objective is the same, procedures differ. Third, long-term results. Results in the clinic or classroom are one thing; in real life over the long haul they are quite another. Fourth, difficulties achieving objectives. Authors address this matter relative to their own procedures, but philosophical problems peak out around the edges of some of these articles.

The biggest philosophical problem I can see is that of measurement. It goes beyond finding a valid and reliable measure of stuttering, which in itself is a major problem. It goes to the question of using therapies that yield seemingly unmeasurable results. How do you know what you're doing if you cannot measure your effects?

This problem, however, is a two-edged sword. If you can only select procedures whose effects can be measured adequately, then therapy is dictated by measurement rather than by needs of the patient. Which should be the overriding concern, both efficaciously and ethically? Personally, I am of the opinion that any therapy which produces observable results, either directly or indirectly, can be measured. The big challenge as I see it is to find ingenious ways of measuring successful subjective as well as objective effects. Otherwise, measurement becomes the tail that wags the therapy dog. This issue is addressed in Ingham's article and in Manning's Epilogue, which addresses some of the questions Ingham raises.

I had intended to set the tone of this issue by discussing my growing conviction that hardly anything about stuttering is what is appears to be. Then I read an article by Dr. David Williams, Editor of *The Journal of the National Council on Stuttering.* Now retired from Northern Illinois University, he has been devoted to stuttering throughout his professional life, he has lived with stuttering throughout his personal life. In the excerpts that follow, he makes my point more eloquently than I could have.

We still have a tendency to view a problem of speech therapy as we do a dose of medicine. We take a three-week, or three-month, "dose" of therapy and hope that it will have permanent effects.

We blithely overlook the fact that the "dose" of therapy is usually bucking many years of habit and attitude formation and reinforcement, many years of particular self-perceptions and life experiences. To expect the "dose" to permanently reduce or remove stuttering behavior (and all that goes with it) is like expecting to stop a charging bull elephant with a popgun. It may take a great many doses. Real, solid, long-term *voluntary* behavior and attitude change is slow, hard work—far harder than many people are willing to do. You don't always get a pat on the head for doing the right thing, and it isn't always fun;

All this is not to denigrate stuttering therapy of any type. As long as we don't know for sure just what stuttering is, or what the causes are, we can't be certain of the best way to treat it. So we have to use whatever methods come to hand, whatever seems to work; we have to be pragmatic. And we can't always worry too much about the degree of 'respectability' of the method, how well it has been accepted by the professional community. Stutterers have reported improvement, temporary or seemingly permanent, stemming from all sorts of events and procedures. Sometimes these events and procedures have nothing to do with planned treatment; a therapist was never involved. The stutterer himself may not have been aware that anything was going on that directly affected his stuttering, until after some period of time he did begin to notice that he was stuttering less, or that what stuttering he did continue to do bothered him much less than it used to.

Bloodstein[1] gives examples of some of these unplanned events that apparently eliminated stuttering:

> . . . experiences so overwhelming that they shake people to their psychological roots. For example, one stutterer, according to a reliable report, recovered from stuttering after surviving an airplane crash. In a similar case . . . a young man got over his stuttering when his hand was battered in a machine-shop accident that almost cost him his life. The incident was said to have made his old problems and anxieties seem like trifles.
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> . . . recovery from stuttering may come from vicissitudes which recreate the stutterer's system of personal values so radically that fears or pressures involving speech no longer have a high priority. There are certainly other examples besides narrow escapes from death. Intense mystical or religious experiences appear to have this potentiality. A young woman of the author's acquaintance stopped stuttering after she became a Christian Scientist. For a few stutterers the potential for such vicissitudes is to be found in psychotherapy. For many it may exist in personal development and maturation.

For stutterers, I think it is safe to say that no therapy will help everyone but that almost any therapy will help someone. In some cases recovery takes place with no therapy. The same therapy may help someone at some time in his life but not at other times. Therapy may have no immediate effect, but may have a delayed effect when the stutterer finally begins (months or years later) to act on what he learned during the active therapy period. Effects of therapy are frequently unstable: the problem of relapse remains a crucial issue in dealing with stuttering. As any number of therapists have noted, it's no big deal to get a stutterer fluent—the problem is to keep him that way.

One thing is apparent. Any decrease in stuttering means that *something* has happened. If a number of different therapies all produce a decrease in stuttering, it would seem that there is some common factor among these therapies, a common denominator, operating to reduce stuttering. The alternative assumption would be that there is no common denominator, that the different therapies produced different effects all of which reduced stuttering. This possibility seems less likely; it is certainly less parsimonious. So, assuming there is some common denominator, just what is it? That is an intriguing question. If we knew the answer, we would probably have the answer to the entire riddle of stuttering.

All things considered, I believe we are left with the inescapable realization that success in stuttering therapy results from an incredibly complex interaction among a great many variables, some known, many unknown.

Obviously no therapist can control and manipulate all of these variables, since we don't even know what all of them are. Quite probably only certain ones are significant in

the therapy process. Would that we knew which are necessary and sufficient! I've always had a sneaking suspicion that success in stuttering therapy may be due in part to clinical skill and in part to sheer luck . . . the therapist just happened to punch the right buttons, and the stutterer just happened to have the right buttons to punch.

It has become almost axiomatic among therapists that the permanent elimination of stuttering is difficult to achieve, particularly in adults, but almost any kind of therapy is likely to bring about at least temporary reduction or elimination of stuttering.

Accurately measuring the effectiveness of therapy is extraordinarily difficult. There are so many factors involved. As Bloodstein points out[1] (p. 385): "The assessment of results of therapy is a process fraught with opportunities for error and self-delusion." Wishful thinking so often plays a part. I have been academically and clinically involved with the stuttering problem since 1945, and I've heard and read countless papers and books and seen countless demonstrations on some "new" method of therapy with countless claims for effectiveness. It would seem that in the treatment of stuttering there has always been and may always be an unending supply of Messiahs.

At best, stuttering is a nuisance, at worst it can be a nightmarish, ego-shattering experience. It's never fun. And it's right there where everyone can see and hear it. You've spent tremendous amounts of time and energy trying to avoid and conceal it, and of course you really can't. Your efforts to do so have succeeded just enough (always temporarily) to keep you trying, though, and that's what causes the constant frustration. So, it helps a great deal if you can stop fighting your stuttering so desperately and fruitlessly. Instead, try to go along with it just a little more, ride it out, feel to hell with it. Be happy when you handle your blocks well or reasonably well, but don't feel guilty when you think you've screwed up. Be tolerant, patient with yourself, try to like yourself.

Your stuttering is an important and unwanted part of your life. It has caused you pain. It has messed up interpersonal relationships. But think very carefully about this: of all the pain coming from your stuttering, how much has been caused directly by other people—by their actual reactions to you— and how much has been caused by yourself, by the way you feel about yourself in relation to others? It took me many years to realize that I was the source of nearly all of my pain. As Pogo said, "We have met the enemy, and he is us."

William H. Perkins, Ph.D.
Guest Editor

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[1]Bloodstein, O., *A Handbook on Stuttering*. 3rd ed., 1981

The preceding excerpts were reprinted with the author's permission from: Williams, J.D. (Spring, 1991) Some thoughts on stuttering therapy. *The Journal of the National Council on Stuttering*.